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

January through March 2025

Issued May 27, 2025

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ABOUT QUARTERLY REPORTS

Quarterly reports provide an overview of the Office of Inspector General's regular monitoring, auditing, and review of activities related to the Los Angeles County Sheriff's Department (Sheriff's Department) over a given three-month period. This quarterly report covers Department activities and incidents that occurred between January 1 and March 31, 2025, unless otherwise noted. Quarterly reports may also examine issues of interest. This report includes special sections on the following topics:

- Failure to Exercise Due Diligence in Obtaining a Search Warrant
- Sheriff's Department's Policies for Cooperating with Federal Immigration Authorities

During the first quarter of 2025, the Office of Inspector General issued the following reports relating to the Sheriff's Department:

- Twelfth Report Back on Implementing Body-Worn Cameras in Los Angeles County
- Report Back on People Over Profit – Fairness and Equity in Commissary Prices for the Los Angeles County Jails
- Fifth Report Back on Meeting the Sheriff's Department's Obligations Under Senate Bill 1421
- Report Back on Ensuring Accessibility to Menstrual Products in the Los Angeles County Jails, Patrol Lockups, and Court Holding Tanks

MONITORING SHERIFF'S DEPARTMENT'S OPERATIONS

Deputy-Involved Shootings

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

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

Temple Station: Non-Hit Shooting – Non-Fatal

On January 5, 2025, at approximately 12:48 p.m., deputies from Temple Station responded to a report of an assault with a deadly weapon, a firearm, that occurred on Garvey Avenue in the city of Rosemead. A deputy, who was accompanied by a 16-year-old Explorer ride-along, arrived at the scene and observed the suspect, a 53-year-old Hispanic man. As the deputy exited his vehicle, the suspect turned toward him and raised the firearm with his left hand. In response, the deputy fired one round, missing the suspect. The suspect subsequently dropped the firearm and assisting deputies took him into custody. A loaded firearm was recovered from the scene. The deputy who shot at the suspect failed to activate his body-worn camera prior to or during the incident. This deputy-involved shooting is not listed on the Los Angeles County Sheriff's Department website because only the deputy-involved shootings that result in injury or death are reported there.

Areas for Further Inquiry

Why did the deputy fail to activate his body-worn camera in violation of Sheriff's department policy? Should deputies with Explorer or other ride-alongs be the primary responding unit to this type of call and if so, how can they best be protected? What was the backdrop of the shooting? Were there any bystanders in the line of fire?

Century Station: Hit Shooting – Fatal

On January 21, 2025, at approximately 1:29 a.m., deputies from Century Station received a call for service regarding a domestic disturbance on 77th Place in the City of Los Angeles. The caller reported that her boyfriend was sending her threatening messages and knocking on her window.

When deputies arrived and contacted the victim, they saw the suspect, a 45-year-old Hispanic man, about two blocks north of the location. As they approached the suspect, he opened fire on the deputies, striking their patrol vehicle multiple times. The deputies returned fire, and the suspect fled north about half a block with the deputies in foot pursuit, when a second deputy-involved shooting took place.

Following the second exchange, the suspect continued fleeing another half block and then entered a white Toyota Sienna minivan, at which point a third deputy-involved shooting occurred. Deputies gave repeated commands to the suspect, to exit the vehicle but received no response. An armored vehicle was deployed, and additional commands were issued, but the suspect remained unresponsive.

Deputies then approached the minivan, opened the door, and removed the suspect. Deputies, along with Los Angeles Fire Department personnel staged nearby, provided medical aid, but the suspect was pronounced dead at the scene. A firearm was recovered. A total of 39 rounds were fired by deputy personnel. No deputies were injured.

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

Areas for Further Inquiry

Was the initial contact consistent with training and best practices? Was the foot pursuit conducted in compliance with Sheriff's Department policy and training? What specific imminent threat to the deputies or others was present during the second and third shootings that justified using deadly force? Did the suspect receive timely medical aid?

Lakewood Station: Hit – Fatal

On January 30, 2025, at approximately 12:15 a.m., a deputy was seated in his patrol vehicle parked in a row of unoccupied patrol vehicles outside of the Paramount substation when he heard a loud banging noise. As he drove forward to investigate the noise, the deputy saw a 34-year-old Hispanic man, holding a machete repeatedly striking an unoccupied parked patrol car. The deputy exited his vehicle and ordered the suspect to stop and drop the machete, but the suspect pointed the machete in his direction and began walking towards him. The deputy again ordered the suspect to drop the machete and get on the ground, but the suspect continued walking towards him. When the suspect got to within 15-20 feet of the deputy still holding the machete, the deputy fired 5 rounds, hitting the suspect multiple times.

Once assisting deputies arrived, they approached the suspect and rendered first aid. Los Angeles County Fire Department personnel responded to the location and the suspect was pronounced deceased at the scene. A machete, approximately, 24" in length, was recovered at the scene. The Sheriff's Department posted a Critical Incident Briefing on its website with body-worn camera video.

Areas for Further Inquiry

Did the deputy consider a tactical retreat thus creating time and distance from the suspect?

Temple Station: Hit Shooting – Fatal

On February 26, 2025, at approximately 6:00 p.m., Temple Station deputies responded to a call reporting an arson in progress on Scott Street in the city of Rosemead. The call included information that the suspect, a 56-year-old Asian woman, ignited an unknown item and threw it towards a neighbor. The patrol deputies and deputies on the Mental Evaluation Team (MET), who also responded, set up a containment and made multiple unsuccessful attempts to contact the suspect by cell phone and the public announcement system to convince the suspect to exit her residence and surrender. The Special Enforcement Bureau (SEB) was contacted but declined to respond to the scene given the circumstances of the call and the information communicated to SEB regarding the suspect.[1] A Crisis Negotiation Team was not called to the scene, but MET deputies are cross trained in crisis negotiations. While the deputies on scene were attempting to contact the suspect, Temple Station detectives prepared a search warrant and received judicial authorization to execute the warrant at the suspect's home.

On February 27, 2025, shortly before 12:30 a.m., the Sheriff's Department requested that the suspect open the door for the deputies to execute the warrant. The suspect remained barricaded inside the home and did not respond to that request. The warrant team's tactical plan assigned at least two deputies to use any necessary non-lethal force, and one deputy was assigned to use lethal force in the event such force became necessary to ensure the safety of the deputies or the public. The warrant team forced entry into the home.

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[1] In response to reviewing a draft of this report, the Sheriff's Department noted: *On February 26, 2025, the on-call SEB Duty Lieutenant received information that Temple Station was possibly dealing with an arson suspect. Being proactive, the SEB Duty Lieutenant contacted the Temple Station Watch Commander and dispatched an Arson/Explosives Detective to assist with the investigation. The detective determined the elements of arson were not present in that call for service. The SEB Duty Lieutenant continued to consult with the Temple Station Watch Commander regarding the circumstances. According to the Department Manual of Policy and Procedures 5-06/110.05, a barricaded suspect is defined as a person who is armed or reasonably believed to be armed with a weapon, explosive, or other destructive device, who occupies a fortified location and resists apprehension violently or by threat of violence. In this case, although the suspect refused to exit her residence, there was no information at the time indicating she was armed, had made threats of violence toward law enforcement, or had fortified the location in a manner that would elevate the situation to meet the criteria for SEB deployment. Based on the totality of circumstances and the information available SEB determined the incident did not meet the deployment criteria outlined in policy.*

Upon entering the room occupied by the suspect, the deputies saw that the suspect had a meat cleaver in one hand and a spray bottle in the other. One of the deputies ordered the suspect to drop the weapon but she did not drop the cleaver. The deputy assigned to use the less-lethal 40 mm foam baton rounds, fired several rounds at the suspect. The rounds had minimal effect, even though the rounds hit her on the right thigh and the center mass of her chest. After being hit by the 40 mm rounds, the suspect moved the cleaver to her right hand and raised it above her shoulder, with the cleaver aimed in the direction of the deputies. At the time, the suspect was less than 5 feet away from the deputies. The deputy assigned to use lethal force fired three rounds at the suspect from his department issued firearm, striking her in the upper torso. Deputies immediately rendered aid, followed by medical assistance from Los Angeles County Fire Department personnel, who were standing by to assist. The suspect was transported to the hospital, where medical staff pronounced her dead. A meat cleaver was recovered from the scene.

Personnel from the Office of Inspector General, IAB, and other LASD units were denied access to the shooting scene. The explanation later given by the Homicide Bureau was that due to the size and layout of the scene, investigators were concerned about the preservation of evidence. Representatives from the District Attorney's Office were permitted entry to the scene. Office of Inspector General staff and IAB personnel should be provided with the same access as District Attorney personnel[2]

The Sheriff's Department posted a Critical Incident Review of this incident on its website.

Areas for Further Inquiry:

Was all the information known by the Temple Station communicated to SEB? Should SEB have responded?

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[2] In response to reviewing a draft of this report, the Sheriff's Department noted: *Access to the residence at the shooting scene was restricted due to concerns about evidence preservation in the tight and complex layout. As a result, the Office of Inspector General, Internal Affairs Bureau, and other LASD units were denied entry. However, the Los Angeles County District Attorney's Office was allowed access due to its independent investigative role. JSID's presence was essential for conducting an impartial review of the evidence, as they later determine whether the deputy's use of force was legally justified. Accordingly, their access was necessary and immediate to ensure an independent prosecutorial review, which differs in scope and purpose from internal oversight or administrative investigations.* (This explanation is more disturbing than the exclusion as it demonstrates careful disregard for state law providing for Inspectors General to conduct independent investigations and requiring local law enforcement to cooperate in those investigations. See Government Code sections 25303 and 25303.7 and Penal Code section 13510.8(b)(8)).

Other Shooting

West Hollywood Station: Discharge of Duty Weapon by Suspect – Non-Fatal

On March 29, 2025, at approximately 5:57 p.m., deputies from West Hollywood Station received a domestic violence call. Two single-deputy units were dispatched to the scene and were talking with the victim when they observed the suspect, a 24-year-old Black man across the street. The deputies immediately returned to their patrol vehicles and proceeded to the suspect's location to effectuate an arrest.

While the suspect initially complied with the deputies' instructions, reports indicate that he resisted when one of the deputies attempted to handcuff him. During the altercation, it was alleged that the suspect gained control of the deputy's firearm, which was in its holster, resulting in a discharge. The round struck the suspect, who was subsequently transported to the hospital for treatment of non-life-threatening injuries. Both deputies involved had their body-worn cameras activated at the time of the incident.

Based on interviews of the deputies, the suspect, and video evidence, the Sheriff's Department has determined that this was ***not*** a deputy-involved shooting. The Los Angeles County District Attorney's filed several charges against the suspect including domestic violence, assault, resisting arrest, and taking a firearm from a peace officer. The incident is included in this report due to the media attention garnered at the time.

Areas for Further Inquiry:

How was the suspect able to remove the deputy's gun from his holster?

District Attorney Review of Deputy-Involved Shootings

The Sheriff's Department's Homicide Bureau investigates deputy-involved shootings in which a person is hit by a bullet, except for deputy-involved shootings that result in the death of an unarmed civilian, which California law requires the Attorney General to investigate.[3] For those shootings it investigates, the Homicide Bureau submits the

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

completed criminal investigation of each deputy-involved shooting that results in a person being struck by a bullet and which occurred in the County of Los Angeles to the Los Angeles County District Attorney's Office (District Attorney's Office or District Attorney) for review and possible filing of criminal charges.

Between January 1 and March 31, 2025, the District Attorney's Office issued one finding on deputy-involved shooting cases involving the Sheriff's Department's employees.[4]

- In the September 4, 2023, non-fatal shooting of Eduardo Villasenor, the District Attorney opined in a memorandum dated January 29, 2025, that Deputy Inzunza reasonably believed that deadly force was necessary to defend against an imminent threat of death or serious bodily injury to himself or others.

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

Under California law, the state Department of Justice (DOJ) investigates any peace officer-involved shooting resulting in the death of an unarmed civilian and may issue written reports or file criminal charges against a peace officer, if appropriate.[5] The DOJ through its Police Practices Section (PPS) is currently investigating one shooting involving deputies from the Sheriff's Department that occurred in July 2024. During the first quarter of 2025, the DOJ issued two written reports regarding shootings involving Sheriff's Department deputies.

In addition to determining whether criminal charges should be filed, PPS uses the review process to identify recommendations to modify policies and practices that may reduce the likelihood that officers use deadly force, as well as recommendations to address any other deficiency or concern related to the officers' conduct or the agency's response.

- In its report on the February 17, 2022 deputy-involved fatal shooting of Pedro Morales Lopez, the DOJ opined that the evidence showed that detectives actually and reasonably believed that deadly force was necessary against an imminent threat of death or serious bodily injury to the detectives and others by the actions of defendant Andre M. Mora and that the shooting death of

[4] The District Attorney's Office posts its decisions on deputy and officer-involved shootings on its website under Officer-Involved Shootings. The Office of Inspector General retrieves the information on District Attorney decisions from this webpage. The one shooting referenced in this section is the only decision posted by the District Attorney's Office since the Office of Inspector General's report for the fourth quarter of 2024.

[5] Gov't Code § 12525.3(b).

Mr. Lopez was inadvertent. As such, there was insufficient evidence to support a criminal prosecution.

- The written report includes the following PPS recommendation:
  - **Recommendation One: Body-Worn Cameras Equipment and Policy:**
    - The report recommends that the Sheriff's Department issue body-worn cameras (BWCs) to all deputies, including plain clothes deputies, noting that 40 out of 58 counties provide policies for the use of BWCS by plain clothes or non-uniformed deputies. The report also recommends that the Sheriff's Department develop policies on the circumstances in which deputies who are in plain clothes or otherwise not in uniform can and must activate BWCs.[6]

- In its report on the January 11, 2023 deputy-involved fatal shooting of Christopher Lee, the DOJ opined that the evidence showed that the shooting deputy objectively and reasonably believed that the threat of death or great bodily injury was imminent and that she fired her weapon in self-defense. As such, there was insufficient evidence to support a criminal prosecution
  - The written report includes the following PPS recommendations:
    - **Recommendation One: De-Escalation Policy and Training**
      - That the Sheriff's Department expand its de-escalation policy to promote officer safety so that it includes specific guidelines, definition, and examples of potential de-escalation techniques, including a variety of tactics and strategies covering an array of circumstances.
      - In addition, that the Sheriff's Department provide its deputies with improved training on de-escalation tactics, techniques, skill, strategies, and approaches for safely and effectively addressing situations without use of force whenever possible. Training should focus on tactical decision-making

[6] In response to reviewing a draft of this report, the Sheriff's Department noted: *The Department is currently engaged with labor unions (ALADS and PPOA) regarding the use and policies for BWCs for specialized units. This policy will include the Department's Detective Division, which includes plain clothes deputies.*

skills and addressing situations in ways that may minimize the need to use force and/or the amount of severity of force to be used when feasible.

- **Recommendation Two: Policy and Training regarding Identifying and Responding to Individuals with Mental Health Conditions**

    - That Sheriff's Department policies provide deputies with effective guidance and training regarding how to identify people with a mental health condition by considering several factors, including: (1) self-reporting, (2) information provided by witnesses, (3) the agency's and justice system's previous knowledge of the individual, or (4) an officer's direct observations.

    - That the Sheriff's Department provide deputies with effective training on how to interact with people who have mental health conditions, and procedures to follow during these encounters. Deputies should know when and how to contact MET and any other resources available. Strengthening and maintaining deputies' training in this area will instill these core skills in a deputy's practice, which will support safer interactions for all involved.

- **Recommendation Three: Training regarding Conduct following an Officer-Involved Shooting**

    - That the Sheriff's Department provide refresher training on deputy requirements and responsibilities after an officer-involved shooting.

    - That deputies are made to fully understand that they are not to discuss the matter with any member or person other than a supervisor in the very limited manner proscribed by Sheriff's Department policy, or other authorized personnel like the Homicide Bureau Investigator, or the DOJ's Division of Law Enforcement.

    - PPS recommends that LASD provide refresher training on the importance of preserving evidence, and place greater emphasis on preserving evidence in the future.

Homicide Bureau's Investigation of Deputy-Involved Shootings

For the present quarter, the Homicide Bureau reports that it has nine shooting cases involving Sheriff's Department personnel open and under investigation. The oldest case in which the Homicide Bureau maintained an active investigation at the end of the quarter relates to a May 3, 2024, shooting in the jurisdiction of Industry Station. For further information as to that shooting, please refer to the Office of Inspector General's report *Reform and Oversight Efforts: Los Angeles Sheriff's Department – April through June 2024*. The oldest case that the Homicide Bureau has open is a 2019 shooting in the city of Lynwood, which was submitted to the District Attorney's Office and for which the Sheriff's Department still awaits a filing decision.

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

Internal Criminal Investigations Bureau

The Sheriff's Department's Internal Criminal Investigations Bureau (ICIB) reports directly to the Division Chief and the Commander of the Professional Standards Division. ICIB investigates allegations of criminal misconduct committed by Sheriff's Department personnel in Los Angeles County.[7]

The Sheriff's Department reports that ICIB has 77 active cases. This quarter, ICIB reports sending 10 cases to the District Attorney's Office for filing consideration. The District Attorney's Office is still reviewing 29 cases previously sent from ICIB for filing. The oldest open case that ICIB submitted to the District Attorney's Office and still awaits a filing decision relates to conduct that occurred in 2018, which ICIB presented to the District Attorney in 2019.

Internal Affairs Bureau

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

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

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

During this quarter, the Sheriff's Department reported opening 133 new administrative investigations. Of these 133 cases, 42 were assigned to IAB, 55 were designated as unit-level investigations, and 36 were entered as criminal monitors (in which IAB monitors an ongoing criminal investigation conducted by the Sheriff's Department or another agency). In the same period, IAB reports that 108 cases were closed by IAB or at the unit level. There are 475 pending administrative investigations, of which 333 are assigned to IAB and the remaining 142 are unit-level investigations.

Civil Service Commission Dispositions

The Civil Service Commission hears employees' appeals of major discipline, including discharges, reductions in rank, or suspensions of more than five days. Between January 1 and March 31, 2025, the Civil Service Commission issued final decisions in two cases involving Sheriff's Department employees.[8] In both cases, the Civil Service Commission sustained the Department's discipline.

One case concerned a sworn peace officer of the rank of deputy or higher and one case concerned a law enforcement technician. Both cases sustained Sheriff's Department decisions, one to discharge a sworn employee, and the other sustained a suspension of 25-days.

Employee Position	Date of Department action	Case number	Department actions	Date Final Decision was adopted	Civil Service decision
Deputy Sheriff	1-23-23	23-32	Discharge	1-22-25	Sustained the Department's decision.
Law Enforcement Technician	7-11-22	22-122	25-day suspension	2-19-25	Sustained the Department's decision

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

According to data posted by the Sheriff's Department, it deployed its Unmanned Aircraft Systems (UAS) 29 times between January 1 and March 31, 2025, as summarized in the

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

chart below, which reflects data from the Sheriff's Department Transparency page as of 4-8-25.[9]

DATE	OPERATION TYPE	LOCATION	SUMMARY
1/14/2025	High Risk Tactical Operation	Los Angeles	SEB personnel assisted South Los Angeles Station. The UAS used to locate an armed and barricaded suspect.
1/16/2025	Scene Documentation for Fire-Related Incident	Eaton Fire Burn Area	SEB personnel used UAS to document the scene for investigation purposes.
1/17/2025	Scene Documentation for Fire-Related Incident	Eaton Fire Burn Area	SEB personnel used UAS to document the scent for investigation purposes.
1/24/2025	High Risk Tactical Operation	Lancaster	SEB personnel used UAS to assist Lancaster Station to locate a suspect.
1/27/2025	Search and Rescue	Wrightwood	SEB personnel assisted Homicide Bureau with a critical missing person. The UAS was used but unable to locate the person.
1/28/2025	Search and Rescue	Wrightwood	SEB personnel assisted Homicide Bureau with a critical missing person. Missing person located by airship.
2/5/25	Search and Rescue	Malibu Lost Hills Station	Malibu Lost Hills Station personnel used UAS to search for missing person. Missing person located.
2/5/2025	High Risk Theft Prevention	Altadena Station burn area	SEB personnel used UAS for theft prevention mission.
2/6/2025	Search and Rescue	Malibu	Malibu Lost Hills Station personnel used UAS to search for missing person. Missing person located.
2/6/2025	High Risk Theft Prevention	Altadena Station burn area	SEB personnel used UAS for theft prevention mission.
2/7/2025	High Risk Theft Prevention	Malibu Lost Hills Station burn area	Malibu Lost Hills Station personnel used UAS for theft prevention mission.
2/7/2025	High Risk Theft Prevention	Altadena Station burn area	SEB personnel used UAS for theft prevention mission.
2/8/2025	High Risk Theft Prevention	Malibu Lost Hills Station burn area	Malibu Lost Hills Station personnel used UAS for theft prevention mission.
2/8/2025	High Risk Theft Prevention	Altadena Station burn area	SEB personnel used UAS for theft prevention mission.
2/9/2025	High Risk Theft Prevention	Altadena Station burn area	SEB personnel used UAS for theft prevention mission.
2/10/2025	High Risk Theft Prevention	Malibu Lost Hills Station burn area	Malibu Lost Hills Station personnel used UAS for theft prevention mission.
2/11/2025	Search and Rescue	Malibu	Malibu Lost Hills Station personnel used UAS to search for missing hiker. Hiker located.
2/11/2025	High Risk Theft Prevention	Malibu Lost Hills Station burn area	Malibu Lost Hills Station personnel used UAS for theft prevention mission.
2/12/2025	High Risk Theft Prevention	Altadena Station burn area	SEB personnel used UAS for theft prevention mission.

[9] MPP5-09/570.10 - Unmanned Aircraft System Procedures requires that the Special Enforcement Bureau (SEB) unit commander notify the executive director of the COC of an authorized or unauthorized UAS use within 48 hours of deployment. In the Office of Inspector General's report for the fourth quarter of 2024, we noted that the COC executive director had not received any notifications since December 2023. In response to our report, the Sheriff's Department determined that it had not been sending the notifications to the COC. Notifications have since resumed and now also include a notification to the Chief Deputy for the Office of Inspector General. The Office of Inspector General requested additional information for instances in which a UAS was used to locate a suspect. To date, that information has not been provided.

DATE	OPERATION TYPE	LOCATION	SUMMARY
2/14/2025	High Risk Theft Prevention	Altadena Station burn area	SEB personnel used UAS for theft prevention mission.
2/14/2025	High Risk Theft Prevention	Malibu Lost Hills Station burn area	Malibu Lost Hills Station personnel used UAS for disaster assessment of mud slide area.
2/20/2025	High Risk Theft Prevention	Calabasas	Malibu Lost Hills Station used UAS to search of the area for multiple suspects. Suspects not located.
2/26/2025	Search and Rescue	Glendora	SEB personnel used UAS in a search and rescue operation for a missing person. Person not located.
2/28/2025	Search and Rescue	Malibu	Malibu Lost Hills Station personnel used UAS on a Search and Rescue operation. Person not located.
3/3/2025	Barricaded Suspect	Norwalk	SEB personnel used UAS to locate an armed and barricaded suspect inside the location. Suspect located.
3/7/2025	Barricaded Suspect	Gardena	SEB personnel used UAS to locate an armed and barricaded suspect inside the location. Suspect located.
3/10/2025	Barricaded Suspect	Los Angeles	SEB personnel used UAS to locate an armed and barricaded suspect inside the location. Suspect located.
3/11/2025	Barricaded Suspect	Los Angeles	SEB personnel used UAS to locate an armed and barricaded suspect inside the location. The suspect was not located.
3/17/2025	High Risk Theft Prevention	Malibu	Malibu Lost Hills Station personnel used UAS for theft prevention mission for possible suspects from an unoccupied vehicle. No suspects located.

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

Status of Taser Policy Implementation and Training

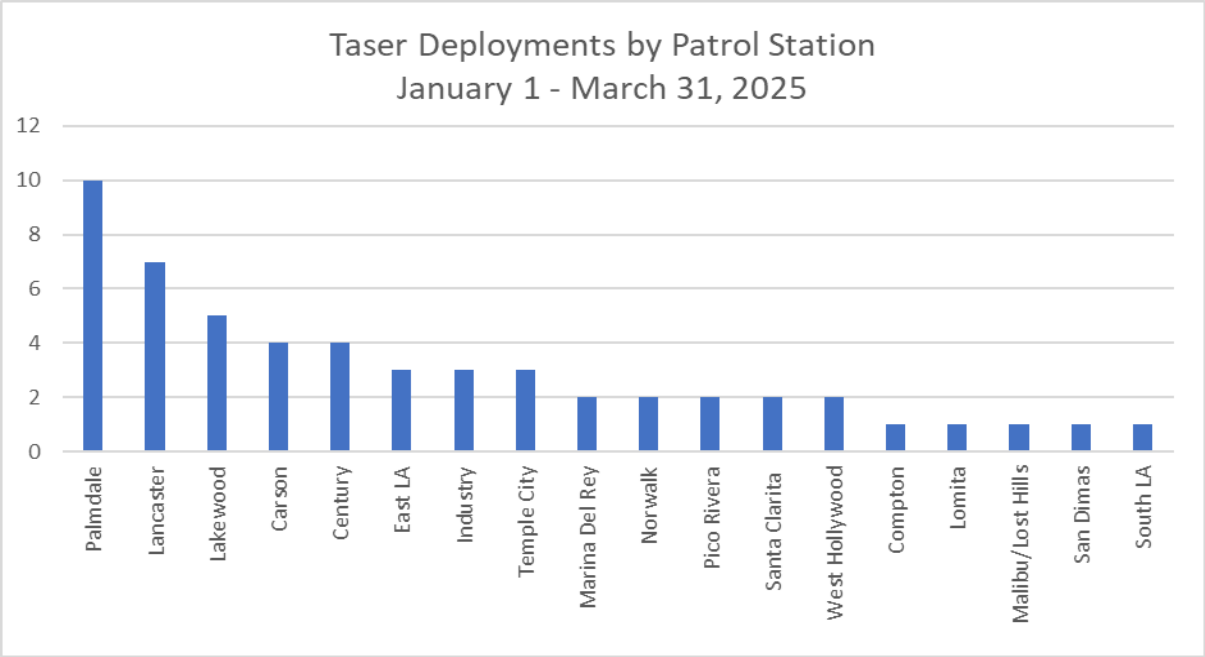
On October 3, 2023, the Board of Supervisors (Board) passed a motion instructing the Sheriff's Department to revise its Taser policies and incorporate best practices from other law enforcement agencies to ensure its policies complied with State and Federal law. The motion directs the Inspector General to include in its quarterly reports to the Board the status of the Sheriff's Department updated Taser policy, deputy compliance with updated policies and training, and documentation on the Department's Taser use.[10]

[10] On December 16, 2024, the Office of Inspector General published a detailed analysis of the policy titled Report on the Sheriff's Department's Taser Policy, Training, and Usage. As set forth in that report, the Sheriff's Department purchased 3,197 Taser 10s and conducted its first Taser 10 training class on July 17, 2024. As of the end of December 2024, approximately 1,400 deputies and sergeants in the Patrol Division had attended the 8-hour training course for the Taser 10 and been equipped with Taser 10s; approximately 1,200 of the 1,400 employees trained attended the course during the fourth quarter of 2024.

Tracking Taser Use

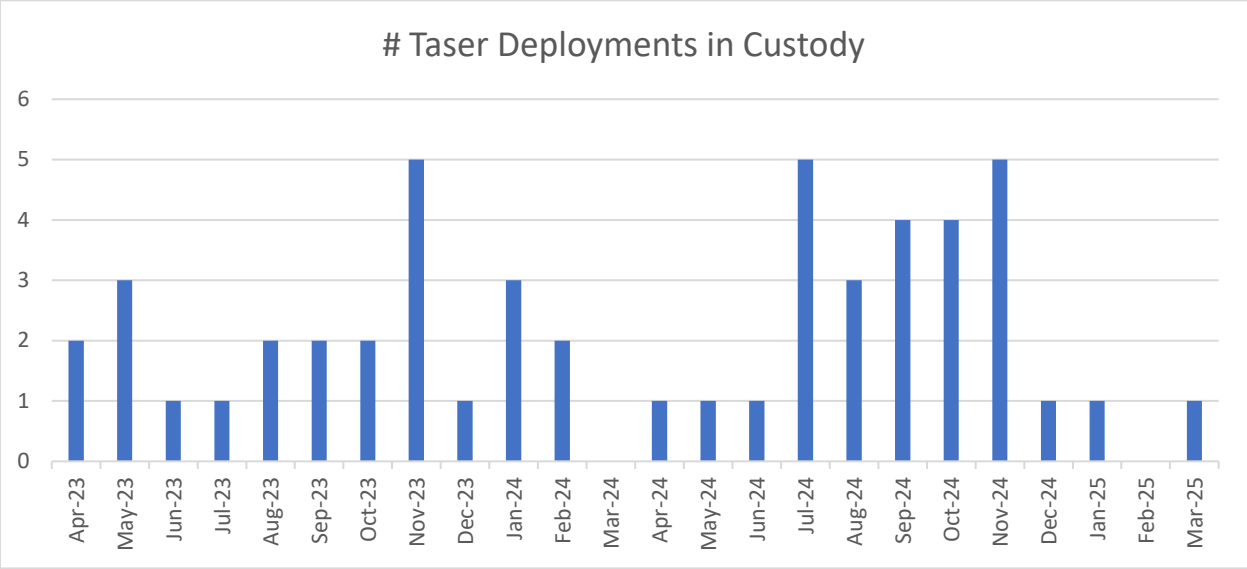
In May 2024, the Sheriff's Department launched a web dashboard reporting Taser usage occurring on or after April 1, 2024, by patrol station or facility, date, and subject description. Beginning in July 2024, the Department began including in that data the "Result of the Use of Force" (i.e., whether the use resulted in serious injury or death) for all incidents that occurred on or after July 1, 2024.

The following chart reflects the number of Taser Deployments by station between January 1 through March 31, 2025.



Taser Use in Custody

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



Failure to Exercise Due Diligence in Obtaining a Search Warrant

Unreasonable Search and Seizure at a Home Where the Suspect No Longer Resided

In May 2022, Norwalk Station Operation Safe Streets (OSS) detectives prepared a search warrant for a home where a suspect named in their warrant no longer resided.[11] At the time of the suspect's arrest, there was evidence that the suspect was living in his vehicle, including that the suspect told the arresting deputies that he was homeless and lived in the car in which he was arrested. Later review supported the conclusion that had the detectives exercised due diligence, including reading the incident report, they likely would have discovered that the suspect did not reside at the address for which the search warrant was sought and issued, and the home had new occupants.[12]

Despite learning that the detectives did not exercise due diligence in confirming the suspect's address and that the checklist for the search warrant was missing the

[11] According to the Sheriff's Department's *About Us* page for OSS, the unit is "responsible for providing suppression, intelligence and expert investigation against criminal street gangs." The OSS Detail description includes that it "investigates high grade felonies of targeted gangs" and "[p]articipates in street gang suppression efforts within assigned OSS team areas."

[12] The terms incident report and arrest report refer to the report detailing the stop and arrest of the suspect and are used interchangeably.

requisite review by a sergeant and a lieutenant, the Sheriff's Department failed to initiate any internal investigation into the actions of the detectives who obtained the search warrant to determine whether any policy violations occurred. Such actions are necessary when formulating corrective actions to avoid the same or similar mistakes in the future.

The Office of Inspector General reviewed the Claims Board Recommendation for a settlement in the amount of $200,000 for a federal civil rights lawsuit brought by the residents of the home against the County and the Sheriff's Department alleging an unreasonable search and seizure at their home. The Claims Board Recommendation includes a case summary and a summary corrective action plan. In addition to reviewing the Claims Board documents, we requested and reviewed the search warrant for the plaintiffs' home and the reports relating to the arrest of a suspect who was the subject of the search warrant.

Summary of Suspect's Arrest and Preparation of Search Warrant

On May 18, 2022, at approximately 7:30 p.m., Norwalk Station deputies arrested a suspect for possessing body armor following a vehicle stop. Evidence recovered from the suspect's car led deputies to suspect him of trafficking methamphetamine. The incident report stated that the suspect "appeared as if he was living out of the vehicle, due to having a lot of personal living items inside." Body-worn camera video recorded the suspect telling deputies he was homeless and currently living in his car. However, the arrest report listed a residential address in the city of Norwalk as the suspect's residence.

Detectives from the Operation Safe Streets Bureau drafted a search warrant for the Norwalk residence. To verify the suspect's address as noted in the arrest report, they relied on outdated information from the Department of Motor Vehicles (last updated in 2021) and an address the suspect previously provided to the Department of Probation. The Sheriff's Department reported that at the time, both the incident report and the body-worn video from the arrest, which included the suspect's statements about being homeless and living out of the car, were not yet available for review. No explanation as to why the detectives didn't wait for the information from the arrest to be available was given.

According to a search warrant checklist prepared by the Department's Records and Identification Bureau, the detectives did not take additional steps to confirm the suspect's residence. They failed to check postal or utility records, recent parking tickets, or conduct surveillance of the home before drafting the warrant, all of which are common steps employed by law enforcement officers prior to requesting judicial

authorization for a search warrant. There is also no indication that the detectives made any attempt to speak with the arresting deputies to determine if they had additional information as to the suspect's address, a reasonable step given that the detectives did not review the incident report. The checklist has a place for a signature for Sergeant Review of the warrant prior to Judicial signing for accuracy and nexus, and a place for Lieutenant review prior to service. There is no signature by a sergeant, or a lieutenant as appears to be required.[13]

Execution of Search Warrant

As a result of the failures to conduct a diligent investigation into the suspect's address, the detectives did not discover that the suspect no longer lived at the location specified in the search warrant, as he stated to the arresting deputies at the time of arrest, and that a family with a young child had moved in. Deputies had no evidence linking the family living in the residence to the suspect, or to any illegal activity.

Deputies executed the search warrant at approximately 2:00 a.m. on May 19, 2022, less than eight hours after the suspect's arrest. Body-worn camera video shows the search team breaking down the door and escorting the couple from their home. The couple told deputies they had lived at the residence for about six months and did not know the suspect. The pregnant mother informed deputies that her young child, described in the summary corrective action plan as a baby, was still inside; the detective did bring the child from the house to the mother. After speaking with the couple, deputies chose not to search the home and left the scene.

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[13] In response to reviewing a draft of this report, the Sheriff's Department provided a criminal history for the suspect that shows the date generated as 9/26/23, which is more than a year after the execution of the warrant. The Department also noted that the subject provided this address at the time of booking. From a review of the documents, it cannot be determined that the suspect gave this address. It is true that this address is noted on the booking form, but it is not known whether the suspect provided this information, or the arresting officers used the last known address on the suspect's criminal history or some other source, such as a driver's license. The Department further noted, based on the criminal history printout from September of 2023, that *(1) Probation had last verified the address on 4/25/2022 (less than one month prior to the incident); (2) CCHRS still showed the same address on 7/6/2022 (less than two months after the date of the incident); (3) DMV records were not updated with a new address until 9/11/2023; and (4) Detectives are required to use three nexuses to an address, and four were used for the warrant in this case.* One of the four nexuses used was that the suspect gave that address without noting that the suspect also stated he was living in his car.

Sheriff's Department Review of the Search Warrant Preparation and Execution

Following the lawsuit by the residents of the home, the Sheriff's Department reviewed the process of obtaining and executing the search warrant. In the recommended corrective actions, the memo notes that:

> This incident was thoroughly reviewed by representatives from Operation Safe Streets Bureau. The review concluded the Detectives were working within the guidelines of what is expected from personnel assigned to Operations Safe Streets Bureau and the Los Angeles County Sheriff's Department.

While the recommended corrective action stated that the detectives worked within Department guidelines and expectations, the plan goes on to note:

> In the days following the incident, all teams at Operation Safe Streets Bureau were briefed on the importance of finding a solid nexus to a location for a search warrant using at least three current sources.

These two statements are at odds with each other. If the detectives operated within Sheriff's Department guidelines, there would be no reason to brief personnel on the importance of using at least three current sources for a suspect's nexus to a location, a process that the detectives may not have undertaken, as the checklist does not indicate whether the records checked showed a nexus between the suspect and the search warrant location.[14] Ensuring that there is a nexus is likely the reason for the requirement on the checklist that a sergeant sign off not only as to the accuracy of the warrant but also the suspect's nexus to the location and that a lieutenant review and sign off on the warrant prior to service. The checklist for this search warrant lacks both the required signatures. There is no mention in the summary corrective action plan that the checklist lacked the required review. The failure of the detectives to obtain the requisite approval alone, even absent their other failures, should have resulted in an administrative review. An administrative review was warranted, as was a summary corrective action plan that acknowledged the failures of the detectives.

The summary corrective action plan also fails to address any reason for rushing to search the location such that there was not time to wait for the completion of the

[14] As noted in a previous footnote, the Sheriff's Department reports the detectives used four nexuses to link the suspect with the address.

incident report for the detectives to review. Absent an imminent threat to law enforcement officers or public safety, a review of the incident report should be a minimum requirement for detectives to affirm under oath the information in an application for a search warrant. The Office of Inspector General recommends that the Sheriff's Department emphasize that the affiants for a search warrant application sufficiently evaluate all available information rather than rely on an arbitrary number of nexus points as sufficient.

Sheriff's Department's Policies for Cooperating with Federal Immigration Authorities

Background

On January 20, 2025, President Donald Trump issued the proclamation titled *Guaranteeing the States Protection Against Invasion* with its stated goal of "suspending the physical entry of aliens involved in an invasion into the United States across the southern border until I [the President] determine that the invasion has concluded."[15] On January 23, 2025, the Acting Secretary of the Department of Homeland Security followed that directive with an order *Finding of Mass Influx of Aliens* in which the Acting Secretary declared that under Title 28 of the Code of Federal Regulations, he can "request assistance from a State or local government in the administration of the immigration laws of the United States" to enforce the President's orders.[16]

Even before the issuing of the proclamation and order, the Board passed a motion, *Increasing Support for Los Angeles County Immigrants*, in November 2024, after President Trump's election. The motion includes an affirmation that all County departments will comply with the California Values Act, which "ensures that no local resources are used to assist federal immigration enforcement." In the months since these directives went into effect, local and state officials and immigration advocates continue to express concerns over the possibility that the federal government will enlist local law enforcement to assist with enforcement of federal immigration laws.

The Office of Inspector General reached out to the Sheriff's Department to inquire as to the status of its policies on immigration-related issues and whether any policy revisions

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[15] United States President, *Proclamation Guaranteeing the States Protection Against Invasion, 2025, Proclamation 10888 of January 20, 2025*, *Federal Registrar* 90 FR 8333.

[16] United States Acting Secretary of Homeland Security, Finding of Mass Influx of Aliens, January 29, 2025, Federal Registrar 90 FR 8399. The *Finding* was set to expire on March 29, 2025. The Secretary of Homeland Security extended the *Finding* on March 21, 2025, and it is set to expire 180 days from that date.

are anticipated in response to the federal government directives or possible requests for assistance with immigration enforcement. The Department's representatives stated they are engaging in regular discussions with County Counsel to make sure they are following the appropriate local, state, and federal laws and regulations. As of this report, the Department informed us that it has not changed any of its existing policies or practices relating to immigration enforcement. Recently, the Department re-briefed its personnel on several of the Department's immigration policies to remind personnel how they should conduct themselves in these matters.

Immigration and Custom Enforcement Agents in Custody Facilities

In 2017, under President Trump's first term, the Los Angeles County Board of Supervisors requested the Office of Inspector General to review, analyze, and make recommendations regarding Sheriff's Department policies as they relate to immigration issues. From 2017 to 2020, the Office of Inspector General issued several reports on the matter.[17] By 2020, the Department had made significant changes to its level of cooperation with ICE. In 2018, Immigration and Custom Enforcement (ICE) agents were physically present and had access to custodial facilities; by 2020, the Department had not only removed ICE from its facilities but also stopped notifying ICE about when inmates were about to be released.

In the years since, the Department has continued to receive ICE detainers.[18] The Sheriff's Department's Custody Division Manual, section 4-06/005.05, *Immigration and Customs Detainer Notification*, explicitly forbids ICE agents from having access to any custodial facilities or station jails to conduct civil immigration enforcement. The policy includes that "[t]he Department shall not transfer inmates into the custody of the United States Immigration and Customs Enforcement (ICE) based solely on a civil immigration detainer." ICE must have a judicial order or criminal warrant before the Department will release an inmate into ICE custody. If an inmate posts a bail or bond, and has an ICE detainer, the detainer will not be used as a reason to refuse the bond or bail or delay the

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[17] See *Immigration: Public Safety and Public Trust* (October 2017); First Report Back on the Sheriff's Department's *Adherence to Policies Regarding Cooperation with Immigration Authorities* (June 2018); *Second Report Back – Sheriff's Adherence to Policies Regarding Cooperation with Immigration Authorities (*November 2018); *Inspector General's Monitoring of Los Angeles County Sheriff's Department's Cooperation with Immigration Authorities* (February 2019); and *Report Back on Truth Act Forum – LASD Inmate Locater System and Public Access to Inmate Release Information* (December 2019).

[18] A detainer is a request from ICE asking federal, state or local law enforcement agencies to do one of two things: to alert ICE before the agency releases an individual, or a request that the agency hold the individual for up to 48 hours beyond the time they would be released to give the Department of Homeland Security time to assume custody of the individual.

release of the inmate. If the Department receives an ICE detainer for an inmate, the inmate will be given a copy of that detainer and verbally notified about the Department's policy concerning transfer to ICE custody.

The Department generally receives two types of ICE detainers, *I-247 A* and *I-247 G*. *I-247 G* are detainers requesting for advance notification of release of a person, and *I-247 A* are titled *Immigration Detainer – Notice of Action*, which requires the Department to hold the individual so ICE can take the person directly from Sheriff's Department custody into ICE custody. As to the *I-247 G* detainers, the Department does not process those but keeps the requests for statistical purposes. For *I-247 A* detainers, these are served on the subject person and recorded and tracked for statistical purposes only. The Department emphasized that regardless of which detainer it receives, it makes no notification to ICE. On its website, the Department publishes the number of ICE requests it receives, and the number of inmates it transfers to ICE. For the year-to-date, as of April 11, 2025, the Department had received 163 ICE detainers. The Department reports it has transferred no inmates to ICE pursuant to a civil detainer.[19]

Immigration Inquiries

The Department's Manual of Policies and Procedure, section 5-09/271.00, *Immigration Inquiries and Notifications*, states Department personnel are prohibited from inquiring about anyone's immigration status, this includes persons who are being investigated for criminal activity, unless that information is absolutely necessary for the investigation.[20] The Department also prohibits asking witnesses and victims about their place of birth, unless it is again necessary to investigate the crime.[21] During the booking and fingerprinting process, the Department is required to ask arrestees about their place of

[19] SB 54, or as it is commonly known, the *California Values Act* limits the cooperation between local law enforcement agencies and ICE. Under its provision, local law enforcement can only transfer inmates to ICE custody if the inmates have committed one of the delineated crimes. Qualifying crimes include if the inmate has committed a serious and/or violent felony under state law, is on the Sex and/or Arson Registry, or if has a judicial criminal warrant for violating federal criminal immigration law.

[20] This language mirrors the language found in SB 54.

[21] *Field Operations Support Services Newsletter, 18-06 Immigration Policies, Protocols, and Procedures*, Los Angeles Sheriff's Department.

birth and country of citizenship as the Live Scan digital fingerprinting system requires the information and is governed by rules that are outside the Department's control.[22]

The Los Angeles County Regional Identification System (LACRIS) oversees the Live Scan and manages the identification of individuals booked in Los Angeles County. LACRIS requires information as to the booked suspect's place of birth and citizenship. LACRIS needs this information because the California Department of Justice requires that all Live Scans include such details. The California Department of Justice forwards this information to the Federal Bureau of Investigation.

Additionally, United States' treaties with foreign countries require the Sheriff's Department to obtain information regarding an arrestees' place of birth and citizenship. Under the terms of the treaties, the United States is required to notify foreign countries when a foreign national from a country has been detained or arrested in the United States. For these reasons, the Sheriff's Department requires that an arrestee provide place of birth and citizenship information during the Live Scan fingerprinting process.

Outstanding Requests to the Sheriff's Department

The Office of Inspector General made the following requests for information to the Sheriff's Department for which responses are still outstanding:

- A February 7, 2025 request for additional information on the deployment of Unmanned Aircraft System (UAS) to search for suspects, including any crime reports, investigatory reports, and warrants relating to the UAS deployment.
- An April 10, 2025 request for the number of deputies investigated by the Sheriff's Department for possible violations of MPP section 3-01/050.82 and the number of deputies investigated by the Sheriff's Department for possible violations of MPP section 3-01/050.83.

[22] Recently, the Los Angeles Times published an article stating the Los Angeles Police Department (LAPD) "has also stopped its previous practice of recording a suspect's place of birth during fingerprinting and uploading that info to an FBI database, which immigration authorities can access." The Office of Inspector General sought to corroborate this information, as it appeared to contradict the Sheriff's Department's position that it was required to ask a suspect about their place of birth during the booking process. We reached out to LAPD's Office of Inspector General, who directed us to LAPD's recent February 2025 report to the Los Angeles Board of Police Commissioners. In the report, under the section titled "2025 Los Angeles Police Department Federal Immigration Enforcement Frequently Asked Question," it states, "[a]n officer, however, may ask for and record an individual's place of birth if the person is arrested for a criminal offense. This is required to process the arrestee for a criminal offense, comply with consular notification requirements, investigate a crime, or otherwise comply with the law." This practice is identical to the above-described practices of the Sheriff's Department, and contradictory to the quote an unnamed source provided to the Los Angeles Times.

- An April 18, 2025 request for additional materials responsive to a subpoena duces tecum that included request for all documents and information relating to any Sheriff's Department surveillance of any County oversight officials; this follow up request was made after it came to the OIG's attention that surveillance of a County oversight official was conducted but information relating to that surveillance, including notes and an audio digital tape of an interview, were not provided. The subpoena duces tecum was served on October 1, 2024.

CUSTODY DIVISION

Jail Overcrowding

As previously reported by the Office of Inspector General, overcrowding in the Los Angeles County jails continues to jeopardize the ability of the Sheriff's Department to provide humane conditions of confinement as required by the Eighth and Fourteenth Amendments to the U.S. Constitution.[23]

The Los Angeles County jails have a Board of State and Community Corrections (BSCC) total rated capacity of 12,404.[24] According to the Sheriff's Department Population Management Bureau Daily Inmate Statistics, as of March 31, 2025, the total population of people in custody in the Los Angeles County jails was 12,255. As of December 31, 2024, the total population of people in custody in the Los Angeles County jails was 11,846.

The table below shows the daily count of people in custody, according to the Population Management Bureau Daily Inmate Statistics, at Men's Central Jail (MCJ), Twin Towers Correctional Facility (TTCF), Century Regional Detention Facility (CRDF), Pitchess Detention Center – East (PDC-East), Pitchess Detention Center – North (PDC-North), Pitchess Detention Center – South (PDC-South), and North County Correctional Facility

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

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

(NCCF) on the last day of the previous four quarters. On these dates, three facilities (MCJ, PDC-North, and NCCF) that together account for more than half the Department's jail capacity operated over the BSCC rated capacity.

Facility	BSCC Capacity	Facility Count			
		6/30/24	9/30/24	12/31/2024	3/31/2025
MCJ	3512	3572	3698	3850	3793
TTCF	2432	2378	2378	2350	2314
CRDF	1708	1255	1371	1341	1418
PDC-East	926	12	20	10	11
PDC-North	830	1286	1276	1221	1286
PDC-South	782	663	633	462	423
NCCF	2214	2775	2718	2612	3010

Availability of Menstrual Products in the Los Angeles County Jails

On June 25, 2024, the Board of Supervisors (Board) passed a motion requesting the Sheriff's Department and directing the Office of Inspector General, Sybil Brand Commission, and the Sheriff Civilian Oversight Commission to review and report back on policies related to the availability and accessibility of menstrual products in the Los Angeles County jails, in light of recent legislation, and directing the Office of Inspector General to include status on the availability and accessibility of menstrual products in its quarterly reports to the Board, until further notice. [25]

The Board also requested that the Sheriff's Department collaborate with Correctional Health Services (CHS) to develop a policy that would ensure accessibility and availability of menstrual products for incarcerated individuals with mental health needs. In its initial report back to the Board, staff from the Office of Inspector General determined that the Sheriff's Department and CHS had taken measures to ensure that

[25] See Pen. Code, § 4023.5(a). ("A person confined in a local detention facility shall be allowed to continue to use materials necessary for personal hygiene with regard to their menstrual cycle and reproductive system, including, but not limited to, sanitary pads and tampons, at no cost to the incarcerated person."); Cal. Code Regs., tit 15, § 1265. ("Each menstruating person shall be provided with sanitary napkins, panty liners, and tampons as requested with no maximum allowance."); Los Angeles County Sheriff's Department, Custody Division Manual, § 6-15/010.00 Inmate Clothing, Bedding, and Personal Hygiene. ("All menstruating inmates shall have ready access to sanitary napkins, panty liners, and tampons."); Los Angeles County Sheriff's Department, Custody Division Unit Orders, § 5-16-040 Distribution of Personal Care Items. ("Each menstruating inmate housed at CRDF shall be provided with sanitary napkins, panty liners, and tampons. All feminine hygiene products shall be readily available in a common space within each module or pod setting."); Pen. Code, § 3409(a). ("A person incarcerated…who menstruates or experiences uterine or vaginal bleeding shall, without needing to request, have ready access to, and be allowed to use, materials necessary for personal hygiene with regard to their menstrual cycle and reproductive system, including, but not limited to, sanitary pads and tampons, at no cost to the person.").

menstrual products were accessible and available for individuals in high observation housing[26] units, including those under suicide precautions.

In March and April 2025, Office of Inspector General staff re-examined the availability and accessibility of menstrual products in high observation housing units, including the Forensic Inpatient (FIP) Stepdown program housing units, at Century Regional Detention Facility (CRDF).[27] This inquiry included a review of Sheriff's Department policies, and conversations with CRDF leadership, custody and CHS personnel, and people in custody.

Restrictions on property. In high observation housing units, where people require a higher level of mental health care and may have property restrictions due to mental health conditions, custody personnel report providing menstrual products as requested and needed. As previously reported, while there is no general restriction on menstrual products for people in custody who have mental health conditions, in certain circumstances limitations on products may be necessary for certain individuals, such as those under suicide precautions, to ensure their own safety.

Property restrictions apply to all individuals newly placed in high observation housing or those under suicide precautions.[28] Department policy requires a mental health professional conduct a clinical assessment within 24 hours of initial placement, and as needed thereafter, to determine whether property restrictions are still required.[29] When restrictions are imposed, an "Allowable Inmate Property" sign listing allowable property is generated and placed on the incarcerated individual's cell door.[30] A mental health clinician will update or reaffirm any restrictions following each subsequent evaluation and notify custody personnel, who are responsible for replacing any new or updated signs and for providing individuals with their allowable property.

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[26] See Los Angeles County Sheriff's Department, Custody Division Manual, § 5-01/050.10, *Housing for Mentally Ill Inmates.* ("Level of Care P3 - Significant impairment. Generally requires high observation housing (HOH) in jail with mental health supervision.")

[27] Staff from the Office of Inspector General visited modules 1200 (comprised of two high observation housing units and two FIP Stepdown program housing units), 1300 (comprised of four FIP Stepdown program housing units), and 2200, 2300, and 2400 (comprised of four high observation housing units, respectively).

[28] *See* Custody Division Manual, § 5-01/050.15, *Property Restrictions for Mentally Ill Inmates.* ("Upon initial placement in High Observation Housing (HOH), except when transferred directly from Forensic Inpatient (FIP), inmates shall be provided only suicide-resistant blankets, gowns, and approved mattresses, unless otherwise specified, as determined and documented by a Jail Mental Health Services (JMHS) clinician.").

[29] Custody Division Manual, § 5-01/050.15, *Property Restrictions for Mentally Ill Inmates.* ("Within 24 hours of initial placement in HOH, a clinician will make recommendations regarding allowable property based upon an individual clinical assessment (Refer to JMHS policy 70.7 Suicide Prevention).").

[30] Custody Division Manual, § 5-01/050.15, *Property Restrictions for Mentally Ill Inmates.*

The Sheriff's Department's policy on allowable property includes sanitary napkins, tampons, and panty liners.[31] Custody personnel report it is highly uncommon for individuals in high observation housing to have restrictions on menstrual products. Even those under suicide precautions are generally allowed to have menstrual products unless the items present a specific risk of self-harm. Restrictions are determined on a case-by-case basis. For example, tampons may be restricted for an individual who has previously attempted to ingest them. Similarly, pads may be restricted for someone who has used them to obstruct custody or CHS personnel's view into their cell.

Accessing menstrual products. In high observation housing units, custody personnel manage the distribution of menstrual products by either handling this task themselves or assigning it to incarcerated workers also known as "trustees." In the FIP Stepdown program housing units, this responsibility is assigned to Mental Health Assistants.[32]

All high observation housing units, except for the FIP Stepdown program housing units, have clear plastic bags filled with menstrual products tied to stair railings in common areas on the upper and lower tiers. As previously reported, individuals in these units do not have access to the common areas for most of the day and are generally cuffed when they leave their cell – for example, when they are escorted to shower or when they are escorted to the day room, where they remain handcuffed. As a result, they generally must request menstrual products. Those in the FIP Stepdown program housing units have access to the common areas for longer periods of time and are uncuffed. In these housing units, menstrual products are readily available and accessible in cardboard boxes set out in common areas.

Types and amounts of menstrual products supplied. The supply of tampons and sanitary pads provided in common areas was ample and consistent across high observation housing units and the FIP Stepdown program housing units. While the supply of panty liners varied by housing unit, every unit had at least some inventory. Custody personnel and trustees report that requests for panty liners are infrequent, but they ensure availability by putting out a supply and maintaining an inventory in supply closets.

People in high observation housing units continue to report varying experiences regarding the availability and accessibility of menstrual products. Those who have encountered issues have identified problems such as being instructed to wait and

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[31] See Los Angeles County Sheriff's Department, Custody Division Manual, § 5-06/010.10, *Allowable Inmate Property - Female Inmates.*

[32] The FIP Stepdown program in the Los Angeles County Jails employs "volunteer, specially-trained, Mental Health Assistants who are incarcerated and live in the modules and care for and mentor patients and assist them in acclimating to the less restrictive environment in the modules." See Board motion, *Supporting the Expansion of FIP Stepdown and HOH Dorm Units in the Los Angeles County Jails* (June 27, 2023).

experiencing delays in receiving products. Custody personnel in turn point to operational constraints, and report providing an ample supply of products when distributed to the person to alleviate potential future delays.

Suicide prevention gowns. While the Department does not have a blanket prohibition on providing menstrual products to individuals under suicide precautions, those who are required to wear suicide prevention gowns are unable to affix pads to the existing gowns.[33]

With input from CHS, CRDF leadership decided to purchase suicide prevention jumpsuits with a middle lining that would allow menstruating people under suicide precautions to affix pads to the jumpsuit. Following procurement, the facility will pilot the distribution of the jumpsuits to evaluate their use prior to full implementation and before developing or updating existing policy. Piloting the distribution of the suicide prevention jumpsuits will involve briefing custody personnel and assessing any operational challenges that may arise.

Recommendations. As reported in the Office of Inspector General's initial report back to the Board, the Sheriff's Department and CHS have not yet developed a policy or updated existing policy to address the accessibility and availability of menstrual products for people with mental health needs. The Office of Inspector General continues to recommend that until such a policy change is implemented, the Sheriff's Department and CHS should document the protocols currently in place for providing menstrual products to this population, and additionally, the protocols for providing suicide prevention jumpsuits to those who need them.[34] When a policy is developed or updated, the Department should make it clear that menstrual products are not automatically restricted for those who are placed in high observation housing units or under suicide precautions. The protocols and policy should ensure the dignity of menstruating individuals in custody while also maintaining facility security and the safety of the people in custody.

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[33] See Los Angeles County Sheriff's Department, Custody Division Manual, § 5-01/050.00 *Handling of Suicidal Inmates.*

[34] Currently, CHS informs custody personnel of those who require a suicide prevention gown, and custody personnel are responsible for helping the individual change into the gown.

Commissary Prices

On July 9, 2024, the Board passed a motion directing the Sheriff's Department to report back on measures taken to ensure commissary prices for people in the Los Angeles County Jails, especially for food, drinks, and hygiene items, are not excessive but remain comparable with prices for groceries and other retail outlets.

In January 2024 the County prepared a Request for Proposals for Inmate and Commissary and Vending Services (RFP No. 525-SH). The timetable in the RFP provided that proposals were due on May 10, 2024. The RFP was on presented at the Public Safety Cluster Agenda Review on May 14, 2025.The only proposal submitted was from the current vendor, Keefe Commissary Network, LLC.

In-Custody Deaths

Between January 1 and March 31, 2025, 15 people died in the care and custody of the Sheriff's Department. The Department of Medical Examiner's (DME) website currently reflects the manner of death for 11 deaths: five natural, five accident, and one suicide. For the remaining four deaths, the DME findings remain deferred.[35] Four people died at MCJ, one person died at CRDF, one died at the transportation compound, and nine people died at hospitals after being transported from the jails. The Sheriff's Department posts the information regarding in-custody deaths on a dedicated page on Inmate In-Custody Deaths on its website.[36]

Office of Inspector General staff attended the Custody Services Division Administrative Death Reviews for each of the 15 in-custody deaths. The following summaries, arranged in chronological order, provide brief descriptions of each in-custody death:

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

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

Date of Death: January 10, 2025
Custodial Status: Sentenced.[37]
People in custody alerted Court Services Transportation Bureau (CSTB) staff to multiple "man downs" on a transportation bus in the CSTB secured bus compound. Custody staff, CHS staff, and paramedics rendered emergency aid to three individuals. Custody staff and CHS staff administered six doses of Narcan to one person. This person died at the scene. Areas of concern include not searching people in custody prior to being transported to the IRC for Courtline, placement and maintenance of the Automated External Defibrillators (AEDs), custody staff not escorting medical staff to the scene as is common practice, and lack of access to Addiction Medicine Services (AMS) for people with heightened security levels. Preliminary manner of death: Unknown. The DME website currently reflects the manner of death as an accident, and the cause of death as heroin toxicity.

Date of Death: January 14, 2025
Custodial Status: Sentenced
Custody staff at MCJ were alerted to a "man down" and found a person unresponsive in a multi-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered six doses of Narcan. The person died at the scene. Areas of concern include the availability of Narcan in the housing unit, and staff failing to adhere to wristband count procedures. Preliminary manner of death: Unknown. The DME website currently reflects the manner of death as an accident, and the cause of death as combined effects of methamphetamine and fentanyl.

Date of Death: January 15, 2025
Custodial Status: Sentenced
Custody staff at MCJ found a person in a single-person cell unresponsive during a Title 15 safety check. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered five doses of Narcan. The person died at the scene. The preliminary cause of death according to the hospital is urine positive for methamphetamine, an enlarged heart, and left ventricular hypertrophy. The DME website currently reflects the manner of death as an accident, and the cause of death as fentanyl and methamphetamine toxicity.

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

Date of Death: January 19, 2025
Custodial Status: Pre-trial
Custody staff at TTCF found a person in a single-person cell unresponsive during a Title 15 safety check. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered three doses of Narcan. The person was transported to Los Angeles General Medical Center (LAGMC) for a higher level of care. Despite efforts by hospital staff, the person died. Areas of concern include the use of the handheld radios during medical emergencies, the handcuffing of incarcerated individuals experiencing a medical emergency, and limited direct line of sight resulting from the custody staff workstation layout. Preliminary manner of death: Unknown. The DME website currently reflects the manner of death as natural, and the cause of death as dilated cardiomyopathy.

Date of Death: January 21, 2025
Custodial Status: Pre-trial
On January 20, 2025, a person in custody who was exhibiting signs of distress was transported from the Inmate Reception Center (IRC) to LAGMC for a higher level of care. On January 21, 2025, the person died at the hospital while receiving medical treatment. Areas of concern include the quality and timeliness of Title 15 safety checks. Preliminary manner of death: Unknown. The DME website currently reflects the manner of death as an accident, and the cause of death is methamphetamine toxicity.

Date of Death: January 27, 2025
Custodial Status: Pre-trial
CHS staff at CRDF found a person in a two-person cell unresponsive during a mental health check. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff administered three doses of Narcan. The person died at the scene. Areas of concern include the quality of Title 15 safety checks and an inoperable cell light. Preliminary manner of death: Unknown. The DME website currently reflects the manner of death as an accident, and the cause of death is effects of methamphetamine.

Date of Death: February 2, 2025
Custodial Status: Sentenced
On February 2, 2025, a person in custody was found unresponsive in a single-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid. The person died at the scene. Areas of concern include the quality of Title 15 safety checks, a delay in rendering emergency aid, and inadequate mental health follow-up. Preliminary manner of death: Unknown. The DME website currently reflects the manner of death as suicide, and the cause of death as sharp force injuries of neck.

Date of Death: February 13, 2025
Custodial Status: Sentenced
On January 11, 2025, a person in custody who was exhibiting signs of distress was transported from the Correctional Treatment Center (CTC) to White Memorial Medical Center for a higher level of care. Despite efforts by hospital staff, the person died. The preliminary cause of death according to the hospital is cardiopulmonary arrest due to congestive heart failure and pneumonia. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: February 19, 2025
Custodial Status: Pre-trial
On February 3, 2025, a person in custody was transferred from the CTC to LAGMC for a higher level of care. On February 19, 2025, the person died at the hospital while receiving medical treatment. Areas of concern include follow-up medical care, adherence to procedures for hospital returnees, and appropriateness of medical care. The preliminary cause of death according to the hospital is respiratory failure, due to pneumonia and septic shock. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: March 9, 2025
Custodial Status: Pre-trial
On March 3, 2025, a person in custody who was exhibiting signs of distress was transported from MCJ to LAGMC for a higher level of care. On March 9, 2025, the person died at the hospital while receiving medical treatment. Areas of concern include the quality of Title 15 safety checks, missed court proceedings due to transportation issues, and CHS staff did not communicate Narcan deployment to custody staff. The preliminary cause of death according to the hospital is cardiac arrest due to kidney failure due to diabetes mellitus. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: March 18, 2025
Custodial Status: Pre-trial
On March 12, 2025, a person in custody was transferred from the CTC to LAGMC for a higher level of care. On March 18, 2025, the person died while receiving medical treatment. The preliminary cause of death according to the hospital is cardiopulmonary arrest due to myxedema coma. The DME website currently reflects the manner of death as natural, and the cause of death as hypertensive atherosclerotic cardiovascular disease.

Date of Death: March 21, 2025
Custodial Status: Sentenced
On February 14, 2025, a person in custody was transported from the CTC to LAGMC for a medical appointment. On March 21, 2025, the person died at the hospital while receiving medical treatment. Preliminary manner of death: Natural. The DME website currently reflects the manner of death as natural, and the cause of death as metastatic biliary adenocarcinoma.

Date of Death: March 30, 2025
Custodial Status: Pre-trial
On March 30, 2025, custody staff at MCJ found a person unresponsive in a single-person cell during a Title 15 safety check. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered four doses of Narcan. The person died at the scene. Preliminary manner of death: Unknown. The DME website currently reflects the manner of death as natural, and the cause of death as pneumonia.

Date of Death: March 30, 2025
Custodial Status: Sentenced
On March 14, 2025, a person in custody was transported from MCJ to LAGMC due to complications from a possible overdose. On March 30, 2025, the person died at the hospital while receiving medical treatment. Areas of concern include the arresting agency's handling of healthcare issues, missed mental health follow-up appointments, not conducting a dorm search following a possible overdose, and failure to document critical incident in electronic Uniform Daily Activity Log. The preliminary cause of death according to the hospital is renal failure due to septic shock. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: March 30, 2025
Custodial Status: Pre-trial
On March 16, 2025, a person in custody was transported from MCJ to LAGMC for a higher level of care. On March 30, 2025, the person died at the hospital while receiving medical treatment. Areas of concern include a missed medical appointment due to wheelchair transportation issues. The DME website currently reflects the manner of death as natural, and the cause of death as lung cancer.

Other Death

On March 11, 2025, Santa Clarita Valley Station deputies responded to a business disturbance call and placed the suspect under arrest. Upon arrival at the hospital for medical clearance, the suspect suffered a medical emergency. Despite efforts by

hospital staff, the person died. Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

In-Custody Overdose Deaths in Los Angeles County Jails

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

Of the 15 people who died in the care and custody of the Sheriff's Department between January 1 and March 31, 2025, the medical examiner's final reports, including toxicology assessments, confirm that five people died due to an accidental overdose. Toxicology results remain pending for four of the 15 deaths and may indicate additional overdose deaths once completed.

Tracking Narcotics Intervention Efforts

Since the Office of Inspector General's last quarterly report, all jail facilities reported searching random people in custody prior to transporting them to court line at the Inmate Reception Center (IRC).[38] The Sheriff's Department decided not to implement a division-wide search plan. Instead, the Sheriff's Department left the decision to search people prior to transport to court line to the discretion of each jail facility. Thus, this practice varies across jail facilities.[39] As described in previous reports, the Sheriff's Department does not presently track narcotics detection in a format that allows data to be analyzed and reports that it does not have the capacity to build a mechanism to track narcotics seizure by drug detection mechanism, nor is it able to compile extractable data collected in the Los Angeles Regional Crime Information System (LARCIS) to

[38] Court line is the holding area where people going to court are held prior to being transported and where they are held upon their return before going back to their assigned housing location.
[39] Men's Central Jail is the only facility that has created a search plan. The plan outlines a monthly schedule of designated housing locations where randomly selected people are supposed to be searched prior to being transported to court line.

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

Improving Searches of Staff and Civilians

The Board's second directive required that the Sheriff's Department "[s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the [jails]." The Sheriff's Department previously reported that its current policy grants the Sheriff's Department broad authority to search staff and civilians entering the jails, so that no changes to existing policy are required to implement more comprehensive searches. The Sheriff's Department previously reported that it implemented more frequent unannounced and randomized staff searches beginning in May 2024.

Despite the policy granting broad authority to search staff and civilians and the Board's motion supporting searches "beyond visual inspections," the Sheriff's Department does not employ body searches via body-scanner or pat-down. All searches of staff and civilians entering the jail are visual: deputies look inside see-through backpacks and cases.

The comprehensiveness of the searches varies across facilities as does the minimum requirement per week. The table below details the staff-search practices at all jail facilities from January 1 to March 31, 2025. The data regarding the number of staff searches and searches with K9 illustrated in the table was supplied by Custody Support Services Bureau (CSSB). CSSB extracted the data on staff and contractor searches from the Custody Watch Commander's Log on April 3, 2025. The Office of Inspector General was unable to verify the data provided by CSSB without additional information.

Facility	Number of Staff Searches Q1	Number of Staff Searches with K9 Q1	Monthly Minimum Search Requirement[40]	Search Inside Security	Search Evasion Concerns	Where Searches Logged
MCJ	116	22	Unable to Determine[41]	No	Yes	Watch Commander Log
TTCF	77	6	No[42]	Yes	Yes	Watch Commander Log
IRC	27	2	Unable to Determine[43]	No	Yes	Watch Commander Log
CRDF	21	2	No[44]	No	Yes	Watch Commander Log
NCCF	116	7	No[45]	Yes	Yes	Watch Commander Log
PDC-North	35	2	Unable to Determine[46]	Yes	Yes	Watch Commander Log
PDC-South	38	4	Yes[47]	Yes	Yes	Watch Commander Log

[40] Each jail facility's unit order regarding staff searches was used to determine whether it met its minimum search requirement by month. Where the unit order is silent regarding the minimum search requirement, the OIG was unable to determine if the requirement was met. Also, the jail facility must meet the minimum search requirement during each of the three months in the quarter in order to be in compliance.

[41] Los Angeles County Sheriff's Department, Custody Division Unit Orders, § 3-08-021 *Security of Personal Property* does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

[42] TTCF did not meet its minimum search requirement in January. Los Angeles County Sheriff's Department, Custody Division Unit Order, § 3-08-010 *Security of Personal Property*. ("Watch commander shall ensure a minimum of two random searches are conducted each week of persons entering the secured area during their assigned shift").

[43] Los Angeles County Sheriff's Department, Custody Division Unit Order, § 5-23/006.00 *Security and Searches of Person Property* does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

[44] CRDF did not meet its minimum search requirement in January and March 2025. Los Angeles County Sheriff's Department, Custody Division Unit Order, § 3-01-090 Searches of sworn Personnel, Custody Assistants, Professional Staff and their personal property-Approved by CSS 3/11/2024 ("The searches shall be conducted a minimum of once per week, per shift. [unit order obtained via email message]).

[45] NCCF did not meet its minimum search requirement for January 2025. Los Angeles County Sheriff's Department, Custody Division Unit Order, § 07-145/10 *Personal Property Searches*. ("A minimum of four (4) random searches per shift per week of any personnel and/or official visitors shall be conducted at the discretion of the watch sergeant.").

[46] Los Angeles County Sheriff's Department, Custody Division Unit Order, § 3-06-010 *Security of Personal Property* does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

[47] Los Angeles County Sheriff's Department, Custody Division Unit Order, § 3-02-080 *Searches of Sworn Personnel, Custody Assistants, Professional Staff and Their Property on the Facility*. ("The searches shall be conducted at a minimum of once per week, per shift.")

Office of Inspector General Site Visits

The Office of Inspector General regularly conducts site visits and inspections at Sheriff's Department custodial facilities. In the first quarter of 2025, Office of Inspector General personnel completed 122 site visits, totaling 361 monitoring hours, at IRC, TTCF, CRDF, MCJ, Pitchess Detention Center North, PDC South, and NCCF.

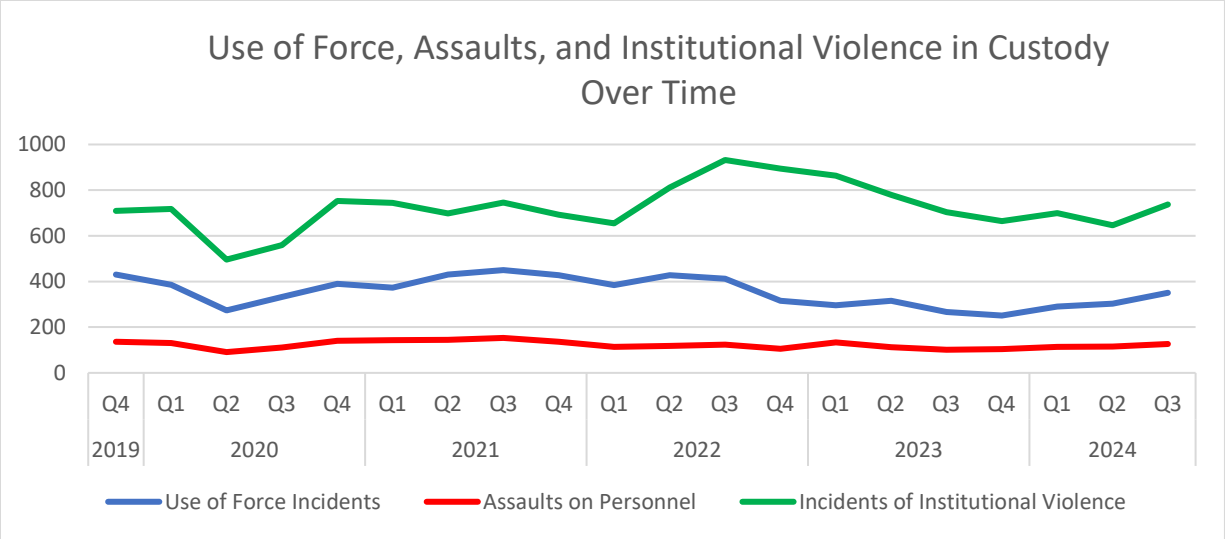
As part of the Office of Inspector General's jail monitoring, Office of Inspector General staff attended 143 Custody Services Division (CSD) executive and administrative meetings and met with division executives for 155 monitoring hours related to uses of force, in-custody deaths, COVID-19 policies and protocols, Prison Rape Elimination Act (PREA) compliance, and general conditions of confinement.

Use-of-Force Incidents in Custody

The Office of Inspector General monitors the Sheriff's Department's use-of-force incidents, institutional violence, and assaults on Sheriff's Department or CHS personnel by people in custody.[48] The Sheriff's Department reports the following numbers for the uses of force and assaultive conduct for people in its custody.[49]

		Use of Force Incidents	Assaults on Personnel	Incidents of Institutional Violence
2019	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
	2nd Quarter	303	115	646
	3rd Quarter	350	127	737

[48] Institutional violence is defined as assaultive conduct by a person in custody upon another person in custody.
[49] This chart includes only those quarters for which the data has been verified for accuracy by the Sheriff's Department. When data is adjusted by the Department, this chart is updated for previous quarters with the new information.



HANDLING OF GRIEVANCES AND COMMENTS

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

The Office of Inspector General received two hundred and fifteen new complaints in the first quarter of 2025 from members of the public, people in custody, family members and friends of people in custody, community organizations and County agencies. Each complaint was reviewed by Office of Inspector General staff.

One hundred and ninety-six of these grievances were related to conditions of confinement within the Department's custody facilities, as shown in the chart below:

Grievances/Incident Classification	Totals
Medical	91
Personnel Issues	16
Living Condition	12
Food	11
Mail	8
Classification	7
Transportation	7
Property	5
Dental	5

Bedding	5
Showers	5
Education	4
Commissary	3
Mental Health	1
Telephones	1
Visiting	1
Other	14
Total	**196**

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

Complaint/Incident Classification	Totals
Personnel	
Discourtesy	5
Improper Tactics	4
Neglect of Duty	2
Off Duty Conduct	2
Force	1
Service	
Policy Procedures	2
Traffic Citation	1
Response Time	1
Other	**1**
Total	19

Handling of Grievances Filed by People in Custody

The Sheriff's Department has not fully implemented the use of computer tablets in its jail facilities to capture information related to requests, and eventually grievances, filed by people in custody. There are currently 77 iPads installed in jail facilities: 40 at TTCF; 12 at MCJ; and 25 at CRDF. During the first quarter there were no new installations or iPad replacements. There were 134,431 automated responses provided to people in custody using the iPad application to request information.

The Sheriff's Department continues to experience malfunctioning iPads and has identified power source problems as the major cause. Facility Services Bureau (FSB) was able to install a dedicated power source to limited areas within MCJ and TTCF. The Department found that the Wi-Fi connection was weak and inconsistent. The Department reports that after further discussions with FSB, it was decided that direct

power and data sources would yield better results if installed simultaneously. FSB started the project at TTCF in early September and is still pending completion. Custody Support Services Bureau – Correctional Innovative Technology Unity (CITU) acquired two new MacBooks to assist with reconfiguring and programming the iPads. Apple administrator problems have resurfaced preventing the completion of necessary software and program updates. The Department states that once the FSB project is completed at TTCF, the reconfiguring and programming of the iPads will be readdressed.

As previously reported, the Sheriff's Department implemented a policy in December 2017 restricting the filing of duplicate and excessive grievances by people in custody.[50] The Sheriff's Department reports that between January 1 and March 31, 2025, no one in custody had been placed on restrictive filing and it therefore did not reject any grievances under this policy.

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

Sheriff's Department's Service Comment Reports

Under its policies, the Sheriff's Department accepts and reviews comments from members of the public about departmental service or employee performance.[51] The Sheriff's Department categorizes these comments into three categories:

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

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

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

- Personnel Complaint: an external allegation of misconduct, either a violation of law or Sheriff's Department policy, against any member of the Sheriff's Department.[52]

The following chart lists the number and types of comments reported for each station or unit.[53]

INVESTIGATING BUREAU/STATION/FACILITY	COMMENDATIONS	PERSONNEL COMPLAINTS	SERVICE COMPLAINTS
ADM : GEN POPL ADM HQ	0	1	0
AER : AERO BUREAU	0	0	1
ALD : ALTADENA STN	2	1	1
AVA : AVALON STN	0	1	0
CAF : COMM & FLEET MGMT BUR	1	0	0
CEN : CENTURY STN	3	8	4
CER : CERRITOS STN	3	2	2
CIS : CUSTODY INVESTIGATIVE SERVICES	0	1	0
CMB : CIVIL MANAGEMENT BUREAU	4	2	1
CNT : COURT SERVICES CENTRAL	1	3	1
COM : COMPTON STN	0	6	2
CRD : CENTURY REG DETEN FAC	1	0	0
CRV : CRESCENTA VALLEY STN	1	2	0
CSB : COUNTY SERVICES BUREAU	1	2	0
CSN : CARSON STN	1	6	2
CST : COURT SERVICES TRANSPORTATION	0	2	0
ELA : EAST LA STN	4	2	0
EOB : EMERGENCY OPER BUREAU	4	0	0
EST : COURT SERVICES EAST	0	3	0
FS : FISCAL ADMIN	0	1	0
HOM : HOMICIDE BUREAU	1	0	1
IND : INDUSTRY STN	5	3	1
IRC : INMATE RECEPTION CENTER	2	2	0

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

[53] The chart reflects data from the Sheriff's Department Performance Recording and Monitoring System current as of April 7, 2025.

INVESTIGATING BUREAU/STATION/FACILITY	COMMENDATIONS	PERSONNEL COMPLAINTS	SERVICE COMPLAINTS
LCS : LANCASTER STN	11	11[54]	2
LKD : LAKEWOOD STN	3	7	1
LMT : LOMITA STN	6	0	1
MAR : MARINA DEL REY STN	4	5	2
MCB : MAJOR CRIMES BUREAU	1	0	0
MLH : MALIBU/LOST HILLS STN	11	6	0
NAR : NARCOTICS BUREAU	2	0	0
NCF : NORTH CO. CORRECTL FAC	1	1	0
NWK : NORWALK REGIONAL STN	4	4	0
OCP : OFFICE OF CONSTITUTIONAL POLICING HQ	0	1	0
OSS : OPERATION SAFE STREETS BUREAU	2	2	0
PKB : PARKS BUREAU	2	0	0
PLM : PALMDALE STN	10	24	5
PRV : PICO RIVERA STN	2	3	2
RMB : RISK MANAGEMENT BUREAU	0	1	0
SCV : SANTA CLARITA VALLEY STN	11	12	3
SDM : SAN DIMAS STN	1	6	1
SIB : SHERIFF INFORMATION BUREAU	0	1	0
SLA : SOUTH LOS ANGELES STATION	0	5	0
SO : PITCHESS SOUTH FACILITY	0	1	0
SSB : SCIENTIFIC SERV BUREAU	1	0	0
TEM : TEMPLE CITY STN	8	4	4
TSB : TRANSIT SERVICES BUREAU	1	2	1
TT : TWIN TOWERS	1	2	0
WAL : WALNUT/SAN DIMAS STN	6	5	3
WHD : WEST HOLLYWOOD STN	2	14	2
WST : COURT SERVICES WEST	0	2	0
Total :	**124**	**169**	**43**

[54] PRMS shows 13 personnel complaints for Lancaster Station. Two of these complaints were generated by an internal Sheriff's Department audit, meaning that there were 11 personnel complaints as noted.