AGN. NO.

MOTION BY SUPERVISOR JANICE HAHN March 3, 2026

Strengthening Accountability to Significantly Decrease Jail Deaths in the Los Angeles County Jails

In May 2025, the Los Angeles County (County) Board of Supervisors (Board) unanimously supported a motion called "Prioritizing Dignity and Life in the Los Angeles County Jails"[1] in response to a surge in in-custody deaths, demanding a comprehensive report on the causes of the rising fatalities. Though recommendations were made, through a series of reports back and public presentations by the Los Angeles County Sheriff's Department (LASD), Department of Health Services' (DHS) Correctional Health Services (CHS), the Chief Executive Office's Risk Management (CEO-RM), and the Auditor-Controller (A-C), it is apparent that immediate action must be taken and accountability measures be included to significantly reduce the number of in-custody deaths in the County jails. These deaths might have case-by-case factors, however, there are larger systemic issues that need to be resolved so that we see decreases, not increases of deaths.

As of February 11, 2026, nine people died while in the custody of our County jails[2].

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[1] https://file.lacounty.gov/SDSInter/bos/supdocs/202910.pdf?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=

[2] Seven people died in January. Two people died in February.

MOTION

MITCHELL	_____
HORVATH	_____
HAHN	_____
BARGER	_____
SOLIS	_____

If we don't address this now, we will see another record year of deaths in the County jails – a record we do not want to repeat.

People dying in the County jails isn't just a loss to the families, friends, and loved ones, but there is a fiscal loss in not fixing this problem. In the last five years, the County has spent millions in settlements and judgements linked to people dying in custody. These are tax dollars that could go to prevention and intervention programs, housing, social services, and other vital County services that support over 10 million people, especially during this fiscal crisis due to local settlement obligations, state funding reductions, and federal funding cuts.

There are not just areas of improvement in protocols, policies, and practices, but a demand for a systematic, holistic shift in culture with strong accountability measures if the County is going to see these numbers decrease. Simply stating that the population is "older and sicker" without changing our health approach; underinvesting in investigations and security of staff to limit the number of illicit drugs and narcotics entering the facilities; lax discipline, training, and accountability of all staff involved in the care and custody of people who are incarcerated; and other unresolved factors will not address how people die in our jails, rather we will see the upward trend – one we have seen, one we are too familiar with, and one we should demand to fix.

While the County continues its path to "care first, jails last" and while we have people who are incarcerated in our jails, we must do all that is necessary to keep those in our care safer and healthier.

I, THEREFORE, MOVE that the Board of Supervisors request that the Los Angeles County Sheriff's Department (LASD) and direct the Departments of Health Services' Correctional Health Services (CHS), Public Health's Substance Abuse, Prevention and

Control (DPH SAPC), and Medical Examiner (ME) to implement the directives listed below within 120 days, and report back to the Board, in writing in 30 days after completion, unless noted otherwise.

I, FURTHER, MOVE that the Board of Supervisors request the Los Angeles County Sheriff's Department (LASD) to:

1. Update existing policies to include that all individuals, including employees, entering custody facilities, are consistently and thoroughly screened for narcotics and other prohibited items, including clear bags, lunch bags, and other property.
2. Evaluate the custody facilities' ingress and egress points to limit the number, without impact to safety and security or visitation and unlocked areas of the facilities, as a strategy to limit the number of illicit substances and narcotics coming into the facilities, including the installation of adequate number of cameras for footage to be reviewed.
3. Abide by Title 15 Safety Checks by ensuring staff are taking the appropriate time to thoroughly assess for "signs of life" before moving to the next cell. This should include consistent supervisor's walks, checks of Electronic Uniform Daily Activity Logs (E-UDALs), and accurate and timely documentation of checks. This should also include reviewing whether the E-UDALs need to be updated to be used as an accountability tool to ensure safety checks are done appropriately.
4. Update Title 15 Safety Checks to be at random intervals or order, but within requirement, as checks currently are predictable, given they are conducted at set schedules.
5. In collaboration with the Chief Executive Office and the Department of Human Resources, evaluate the use of other staff classifications such as Custody Assistants to assist in performing safety checks to reduce the risk of checks being missed,

delayed, or rushed; as well as reducing mandatory overtimes that may lead to job fatigue and burnout.

6. Consistently monitor cameras and increase supervisor walks of the facilities to increase the number of informal and formal safety and security checks and that continual monitoring occurs.
7. Closed Circuit Television (CCTV) installed in the jail facilities should be checked frequently and monitored to ensure they are in working order, functional, and operable. CCTV cameras should be operable at all times.
    a. Policies should include, especially in in-custody death cases and investigations, should there be cameras that were inoperable and/or footage deleted, a thorough investigation conducted.
8. In collaboration with the Department of Health Services:
    a. Implement an inventory control and inspection mechanism to ensure emergency response equipment, such as Automated External Defibrillators (AEDs), are available, inspected, in working order, and replaced if necessary; and
9. In the interest of transparency and accountability, add the name of the jail facility of where an individual was housed prior to their death on the LASD's In-Custody Death dashboard.

I, FURTHER, MOVE that the Board of Supervisors direct the Department of Health Services' Correctional Health Services (CHS) to:

1. Provide the Office of Inspector General (OIG), seven days after the passage of this motion, with a monthly report on the Medicated Assisted Treatment (MAT) program waitlist per facility and the number of unique individuals participating in the MAT

program for the OIG to include in their quarterly reports to the Board, until further notice.

2. Conduct an evaluation on the existing MAT delivery process and identify other alternatives and options, such as, but not limited to daily pill versus monthly injection, to increase the number of MAT participants and treatment for different type of patients and levels of dependencies.
3. In collaboration with DPH SAPC, identify best practices and recommendations on how to reduce substance use related deaths inside the jails.
4. Develop a plan, in collaboration with the LA Sheriff's Department, to:
    a. Expedite and track compassionate releases submitted to the Superior Court of Los Angeles (Court); and
    b. Ensure Naloxone is more accessible to individuals, regardless of their housing situation, especially those housed in specialized units or units without open program space.
5. In collaboration with the Medical Examiner (ME), improve the death review process by:
    a. Establishing Key Performance Indicators, such as corrective action and/or death review completion timeliness requirements, and monthly monitor and escalate the death review statuses to Executive Management to ensure death reviews and their respective corrective action are completed and implemented in a timely manner; and
    b. Reduce the amount of time for death review cases to be completed and closed, including ensuring that corrective actions are completed and implemented.
6. Review CHS staff duties to include daily walkthroughs so incarcerated patients can

submit their non-emergency health request forms in a timely manner.

7. In collaboration with the CEO-Risk Management and Auditor-Controller and Medical Examiner, develop a process to periodically review completed corrective actions and share with management and leadership to identify emerging trends and an assessment tool to determine whether corrective actions were effective in preventing deaths.
8. In collaboration with the CEO, request funding for:
    a. The electronic health service request form along with the development of an evaluation process to ensure the investment is resulting in an increase in accessibility and efficiency for medical staff and addresses delays in the delivery of medical treatment;
    b. An electronic movement/appointment system that can assist in properly tracking upcoming appointments for patients and flagging conflicts in scheduling; and
    c. Unmet needs for Medication Assisted Treatment in the jails.
9. To address suicides in the County jails:
    a. Engage with the Superior Court of Los Angeles and in collaboration with the Sheriff's Department, streamline court notifications so custody staff are noticed sooner when an incarcerated individual had court and received negative news or updates that might impact their mental status despite lack of or recent suicidal ideation/suicide attempt history;
    b. Conduct an evaluation to review any gaps in the delivery of services, timeliness of services and dispatch of the Jail Mental Evaluation Team.
10. In collaboration with LASD, ME, Auditor-Controller, CEO-Risk Management, in

consultation with County Counsel, to identify the top repeated factors related to the causes of death, such as, but not limited to staff error, equipment malfunction, lack of training, delayed communication, poor Title 15 safety checks, that resulted in an in-custody death for the last five years, along with recommendations to improve and resolve.

I, FURTHER, MOVE that the Board of Supervisors direct the Medical Examiner (ME) to:

1. In consultation with County Counsel, identify opportunities to strengthen existing policy on the use of "security holds" on autopsies of individuals, including the need for delegated authority to enforce the policy, especially in situations of dispute; and criteria that need to be met for security holds to be lifted or waived.
2. In collaboration with the Countywide Criminal Justice Coordinating Council, create an engagement and education plan with other jurisdictions and law enforcement agencies that are serviced by the County's ME on their security hold policy and protocol.

I, FURTHER, MOVE that the Board of Supervisors direct the Auditor-Controller to conduct:

1. An initial audit of the Los Angeles Sheriff's Department's and the Department of Health Services' Correctional Health Services' (CHS) corrective action processes and efficacy tools 60 days upon development.
2. Annual audits of the LASD's and CHS's corrective action plans, processes, and efficacy of their tools.

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