

REVISED MOTION BY SUPERVISOR JANICE HAHN

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~~, February 24, 2026, 10 people died while in the

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

MOTION

MITCHELL	_____
HORVATH	_____
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BARGER	_____
SOLIS	_____

custody of our County jails². 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 on settlements and judgments 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'

² Seven people died in January. ~~Two~~ Three people died in February.

Correctional Health Services (CHS), Public Health's Substance Abuse, Prevention and Control (DPH SAPC), Office of Inspector General (OIG), Auditor-Controller, 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. Report back should also include potential need for funds and staffing to implement.

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

1. Report back on recent efforts and how the current security equipment, such as scanners, can be utilized to consistently and thoroughly scan sworn and civilian staff
~~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. In consultation with County Counsel, report back on recent vulnerability assessments of each facility, recommendations made, and strategies
~~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~~ and ensuring scanners are available at all facilities.
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 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. Report back on the details of Title 15 safety check policies related to quality and timeliness; the accountability processes and system upgrades that allow for it, including the BREAVA, a computerized logging system and percentage of compliance; consistent application of security checks conducted at random intervals and/or staggered; and the work the Department is doing in partnership with the USDOJ monitor to ensure quality safety checks are performed. This should also include any recent updates to the Title 15 safety check policies and accountability processes that were created or updated that will specifically reduce the number of in-custody deaths.
5. ~~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.~~
6. Report back on how other classifications are used to support safety checks and escorts to medical appointments, including Custody Assistants, and other options explored previously or being explored and mandatory overtime, including an evaluation on whether the current ratio needs to be updated to support the Department's efforts to reduce the number of in-custody deaths. 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.
7. 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.

8. Report back on the current use of CCTV and body worn cameras and how it's used currently to reduce in-custody deaths, in addition to the feasibility of doing consistent camera monitoring, including cost estimates and budget implications.
9. 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.
10. ~~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~~
11. 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.
12. Ensure Naloxone is more accessible to individuals, regardless of their housing situation, especially those housed in specialized units or units without open program space.
13. Ensure grievance forms, including Health Request forms are available and accessible to people who are incarcerated at all times.
14. Develop a periodic self-monitoring process as required by CFM Section 1.0.2 and as mentioned in the CEO-Risk Management report. Section 1.0.2 indicates that

department management has primary responsibility for designing, implementing, and maintaining a system of preventative and detective internal controls on an ongoing basis to ensure any weaknesses or non-compliance are promptly identified and corrected.

- a. In collaboration with CHS, establish key performance indicators, monitor and escalate death review statuses, and develop a process to periodically review completed corrective action plans.
- b. 90 days upon implementation, Auditor-Controller to conduct an independent review and identify further recommendations.

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. Report back on an analysis on ~~Conduct an evaluation on~~ the existing MAT delivery process, cost analysis of staffing involved in oral medications compared to the long-acting injectables (LAI), and ~~along with the identification~~ identify of 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. Additionally, an evaluation on current processes and identify areas of improvement in the identification of patients who need MAT and delivery of MAT services.

3. In collaboration with DPH SAPC, identify best practices and recommendations on how to reduce substance use related deaths inside the jails.
4. Report back on the Automated External Defibrillator (AED) inventory control and inspection mechanisms and make changes as needed to ensure emergency response equipment is available, inspected, in working order, and replaced if necessary.
5. Provide the Office of Inspector General monthly reports of compassionate release efforts for the OIG to include in their quarterly reports to the Board. Additionally, identify ways with relevant stakeholders how to expedite compassionate releases, including legislation similar to Assembly Bill 960 (Penal Code 1172.2). 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~~
6. ~~Ensure Naloxone is more accessible to individuals, regardless of their housing situation, especially those housed in specialized units or units without open program space.~~
7. In collaboration with LASD and OIG, report back on the recent changes to the death review process, including the addition of the mortality review process, and improvements to the Corrective Action Plan tracker. 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.~~
- 8. Explain and review the current process for submission of non-emergency health request forms and what would be needed to include daily walkthroughs as part of CHS staff duties, addressing delays in care, and setting medical appointments. Review ~~CHS staff duties to include daily walkthroughs so incarcerated patients can submit their non-emergency health request forms in a timely manner.~~
- 9. ~~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.~~
- 10. 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.
- 11. To address suicides in the County jails provide a timeline of when the Joint Quality Improvement Committee will be evaluating the current court notification process to review any gaps in the delivery of services, timeliness of services, and dispatch of the

Jail Mental Evaluation Team.

- 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.~~

12. In collaboration with LASD, ME, OIG, Sheriff Civilian Oversight Commission, Sybil Brand Commission, Auditor-Controller, and CEO-Risk Management, report back on a potential scope of work for CHS to seek funding to obtain an outside consultant to evaluate recent deaths, identify trends, and provide recommendations and best practices to reduce in-custody deaths. ~~In collaboration with LASD, ME, Auditor-Controller, CEO-Risk Management, in consultation with County Counsel, to identify the top repeated factors related to the cases 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 ~~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.

1. ~~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~~ review 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~~ reviews of the LASD's and CHS's corrective action plans, processes, and efficacy of their tools.

I, FURTHER MOVE, that the Board of Supervisors direct the Office of Inspector General to:

1. Include in their quarterly report backs to the Board:
 - a. Information about the Medication Assisted Treatment program on the following, but not limited to: the number of people on the MAT waitlist, the number of unique individuals who are participating in MAT per facility, and the type of MAT assistance that individuals are receiving.
 - b. Implementation status and brief summaries on death in custody corrective action plans.
2. In collaboration with the Sheriff Civilian Oversight Commission and the Sybil Brand Commission monitor the accessibility and availability of Naloxone in the jail facilities.

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