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

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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.[1] This quarterly report covers Department activities and incidents that occurred between April 1 and June 30, 2026, unless otherwise noted. Quarterly reports may also examine issues of interest. This report includes special sections on the following topics:

- Body-Worn Camera Buffering Time
- Law Enforcement Responses to Protests: The Columbus Model
- Immigration Policy Update

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 three incidents in which people were shot or shot at by Sheriff's Department personnel. Two people died as a result and one person suffered injuries and was admitted to the hospital in stable condition.

Office of Inspector General staff were notified of the deputy-involved shootings but responded only to the May 20, 2026 shooting, as OIG rollouts resumed on May 4, 2026, under the revised office protocol that staff members assigned to the rollout team now respond to the scene of deputy-involved shootings during the workday.[2]

[1] This report refers to the Sheriff's Department, the Department, or LASD when referencing the Los Angeles County Sheriff's Department. The Office of Inspector General is also referred to as OIG in some places throughout the report.

[2] On May 4, 2026, Office of Inspector General staff began responding to the scene of in-custody deaths during the workday. Deputy inspectors general and inspectors are assigned to the deputy-involved-shooting and in-custody-death rollout teams.

The Sheriff's Department maintains a page on its website listing deputy-involved shootings that result in injury or death, with links to incident summaries and video.[3]

The information in the following shooting summaries is based on the information provided by the Sheriff's Department at the Critical Incident Reviews (CIR) and the information on the Department's website, including the written summaries and Critical Incident Briefings.[4] The information presented at CIR, in the written summaries, and in the Critical Incident Briefing is preliminary in nature. Statements of deputies and witnesses are not provided until the Sheriff's Department completes its investigation.

East Los Angeles Station: Hit Shooting – Fatal

On Wednesday, April 1, 2026, deputies from the East Los Angeles Station responded to a residence regarding a call reporting a suicidal man with a handgun inside his home with family members present. Shortly before the call, there was another call reporting a man shooting a gun into the air in the neighborhood surrounding the residence that was later confirmed to be the same individual.

Upon arrival, two family members safely exited the home and spoke to deputies. One family member confirmed the individual inside was seen with a firearm and had a history of mental illness. While outside of the home, deputies could see the individual in the threshold of the doorway with a handgun.

Deputies requested the Mental Health Team (MET) and Crisis Negotiation Team (CNT) respond as they tried to negotiate with the individual and de-escalate the situation, including attempting to knock on the door and call out to the individual. The individual, however, exited the home, opened fire, and a deputy-involved shooting occurred. Two deputies shot four rounds each and, one deputy shot three rounds, wounding the man. Deputies began medical aid and the individual was pronounced dead at the scene. The Sheriff's Department later determined that the weapon at issue was firing blank rounds

[3] Penal Code section 832.7(b)(1)(A)(i) requires that in response to a Public Records Act request, records relating to the report, investigation, or finding of an "incident involving the discharge of a firearm at a person by a peace officer of custodial officer" be made available. Delaying the availability of some information is permissible if certain criteria are met. On April 10, 2026, OIG inquired as to whether non-hit shootings meeting the criteria in this subsection are posted on the website or whether LASD has any plans to include non-hit shootings on its deputy-involved shootings transparency page. The Department replied that it is in the process of determining the answer.

[4] Manual of Policy and Procedure (MPP) section 3-09/330.00 Critical Incident Review Panel identifies what is a critical incident and describes the process for reviewing such incidents.

rather than live ammunition. Pursuant to Assembly Bill 1506, the shooting is being investigated by the California Department of Justice.[5]

The Sheriff's Department posted a written summary and a Critical Incident Briefing of this incident on the Transparency page for Deputy-Involved Shootings.

Areas for Further Inquiry

1. Could the deputies have waited in a position of safety for MET and/or CNT to arrive prior to engaging the individual?

San Dimas Station: Hit Shooting – Non-Fatal

On May 20, 2026, Department of Mental Health (DMH) personnel and San Dimas Station deputies responded to a call for service involving a person exhibiting suicidal ideation. Upon arrival, the team approached and observed a Hispanic man and were reportedly told the man's family that he was armed with a knife. A deputy on scene reported seeing what appeared to be the handle of a knife but was not able to visually confirm that the man possessed a weapon.; DMH personnel felt unsafe and decided to disengage. Prior to leaving, DMH personnel provided the family with an action plan of how to help the man who, at the time, did not appear to a threat to others and was not actively harming himself. When DMH terminated their involvement, the deputies also elected to withdraw, relying on DMH's assessment and the safety plan provided to the family to mitigate the risk of self-harm by the suspect.

Later that day, deputies responded to the same location, including several who were part of the first call for service with DMH. The deputies set up a containment around the home by placing some deputies away from the residence and placing a deputy near to the front of the residence. The deputy placed in front of the residence was not part of the first call for service. As deputies were formulating a tactical plan to render the situation safe, the suspect walked out of the side gate of the home armed with a knife in one hand. The deputy in front of the home ordered the suspect to stop and get on the ground. The suspect ignored the commands and charged directly at the deputy with a knife in his hand. The deputy shot twice, striking the suspect once in the stomach.

[5] 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 suspect was transported to a hospital where he was listed in stable condition. The suspect's knife, which had an approximate three-inch metal blade, was recovered at the scene.

The Sheriff's Department posted a written summary and a Critical Incident Briefing of this incident on the Transparency page for Deputy-Involved Shootings.

Areas for Further Inquiry

1. During the first call for service, did deputies also engage with the suspect?
2. What is the protocol and expected role of deputies when responding to a call for service with DMH when the call requests assistance regarding a mental health crisis?
3. Should the tactical plan on the second call have included placing the deputy who had responded to the first call, closest to the home (rather than a deputy who had not been on scene previously)?
4. Did the deputies consider that the backdrop of the shooting was a residential neighborhood and assess whether any civilians were in the line of fire?

Lancaster Station: Hit Shooting – Fatal

On June 20, 2026, Lancaster Station deputies were dispatched to Sierra Highway after receiving a call for service reporting that a man was brandishing two knives at people in the area.

Within minutes, the first deputy arrived on scene and approached a person matching the description of the suspect. The deputy contacted the suspect, who immediately brandished a serrated kitchen knife, ran toward the deputy, and stabbed the deputy in the upper right corner of his chest. The deputy fired five rounds at the suspect, who fell to the ground.

A second deputy arrived at the scene and exited his vehicle as the deputy-involved shooting was occurring. The second deputy then advanced to the location where the where the suspect lay on the ground, issued commands for the suspect to stop moving, and fired one additional round.

Additional deputies and a field supervisor arrived on scene and rendered emergency aid to the first deputy, who was transported to Antelope Valley Hospital where he was treated for a stab wound to the chest. Remaining deputies rendered emergency aid to the suspect, who was transported to Antelope Valley Hospital where he was pronounced dead.

Pursuant to Assembly Bill 1506, the shooting is being investigated by the California Department of Justice due to the suspect potentially being unarmed at the time of the second shooting.

The Sheriff's Department posted a written summary and a Critical Incident Briefing of this incident on the Transparency page for Deputy-Involved Shootings.

Areas for Further Inquiry

1. Whether the Department employee who took the call for service was trained to handle emergency calls?
2. Was the call for service properly labeled a "priority" call or should it have been labeled "emergent?"
3. When the first deputy arrived on scene, did he discuss a tactical approach with other deputies in route?
4. Why didn't the first deputy activate his body-worn camera while driving to the scene?
5. Whether it was tactically safe for the first deputy to approach a suspect who was allegedly armed with two knives?

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 (CA-DOJ) to investigate.[6] For shootings it investigates, the Homicide Bureau submits the completed criminal investigation of each deputy-involved shooting in Los Angeles County that results in a person being struck by a bullet 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 April 1 and June 30, 2026, the District Attorney's Office posted memoranda on its website for three findings on deputy-involved shooting case involving the Sheriff's

[6] 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*.

Department's employees.[7] The District Attorney's Office declined to file charges in these cases, as they determined that the use of force was not unlawful. The memoranda may be found on the District Attorney's website page for Officer-Involved Shootings. The following are the deputy-involved shootings posted on the website:

- The December 4, 2023, fatal shooting of Niani Finlayson by Deputy Ty Shelton.
- The August 4, 2024, fatal shooting of Julio Palomares by Deputies Ramon Becerra and Carina Garcia-Moreno.
- The August 20, 2024 non-hit shooting of Dennis Bracamonte by Detective Eric Saavedra.

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

Under California law, CA-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.[8] Two CA-DOJ investigations were opened during the second quarter of this year regarding shootings by deputies from the Sheriff's Department. All previous investigations regarding Department shootings are closed. During the second quarter of 2026, CA-DOJ issued no written reports regarding shootings involving Sheriff's Department deputies.

Homicide Bureau's Investigation of Deputy-Involved Shootings

For the present quarter, the Homicide Bureau reports that it has seven shooting cases involving Sheriff's Department personnel that remain 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 June 9, 2025, shooting in the jurisdiction of Century 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 2025*. The oldest case that the Homicide Bureau currently has open is a 2019 shooting in the city of Lynwood, which was submitted to the District Attorney's Office and for which the Department continues await a filing decision. This quarter, the

[7] 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.

[8] Government Code § 12525.3(b).

Department reported it has not sent any 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 Department personnel in Los Angeles County.[9]

The Sheriff's Department reports that ICIB has 72 active cases. This quarter, ICIB reports submitting 14 cases to the District Attorney's Office for filing consideration. The District Attorney's Office is still reviewing 36 cases previously submitted by ICIB for filing consideration. The oldest case open ICIB case was submitted to the District Attorney's Office in 2019 and involves conduct that occurred in 2018.

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, IAB conducts an independent investigation to determine whether Department personnel violated any policies during the incident regardless of the District Attorney's decision not to prosecute. If the District Attorney files charges, IAB proceeds with a review for policy violations following the prosecution. If IAB identifies policy violations that the Department sustains, the Department may impose discipline up to and including termination.[10]

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 128 new administrative investigations. Of these 128 cases, 49 were assigned to IAB, 56 were designated as unit-level investigations, and 23 were entered as criminal monitors (in which IAB monitors an ongoing criminal investigation conducted by the Department or another

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[9] 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.

[10] If a deputy were convicted of criminal charges and decertified by the Commission on Peace Officer Standards and Training, the deputy would be unable to be employed as a peace officer.

agency). In the same period, IAB reports that 109 cases were closed by IAB or at the unit level. There are 453 administrative investigations pending, of which 318 are assigned to IAB and the remaining 135 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 April 1 and June 30, 2026, the Civil Service Commission issued final decisions in six cases involving Sheriff's Department employees. In these six cases, the Civil Service Commission sustained the Department's discipline in two cases and reduced the discipline in the remaining four cases. The Civil Service Commission reports its actions, including final decisions, in minutes of its meetings posted on the County's website for commission publications.

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) 42 times between April 1 and June 30, 2026.

The Office of Inspector General continues to recommend that the Sheriff's Department provide more specific information regarding the use of UAS for a "high risk tactical operation." Circumstances justifying use of a UAS for a search might include exigent circumstances, a reasonable suspicion that a crime is occurring, probable cause to conduct a search, or the execution of a search warrant. The law recognizes these reasons for conducting a search as legal under the Fourth Amendment of the United States Constitution, which does not have an exception for a warrantless search based on a "high risk tactical operation."[11]

Historically, members of the public have supported drone usage in law enforcement but have requested usage be limited to activity that provides the greatest benefit to life and safety, and that safeguards be in place to avoid usage encroaching into areas which are likely to result in excessive invasion of privacy. Imprecise categories and limited information can result in law enforcement action that undermines public trust.

[11] There are other exceptions to a search warrant and decisions on the legality of a search absent a warrant are decided by courts on a case-by-case basis. See *The Search Warrant Requirement in Criminal Investigations & Legal Exceptions*.

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 Office of Inspector General to include in its quarterly reports to the Board the status of the Department's updated taser policy, deputy compliance with updated policies and training, and documentation on the Department's taser use.

The Sheriff's Department reported that from the Phase 1 purchase of 3,197 Taser 10s, approximately 3,027 are currently deployed.[12] The Department reports that this number continues to grow and fluctuate, as LASD personnel return the Taser 10s due to long-term absences or transfers/promotions to positions that Taser 10s are not utilized. Additional Taser10s have not been purchased due to reported funding constraints. Of the 3,197 units, the Department reports that an ideal deployment level would be 3,150, allowing a reserve inventory to support training needs and reissuing equipment for replacement. The Department reports that it is currently 96% complete in equipping and training personnel with Taser 10s.

Tracking Taser Use

In May 2024, the Sheriff's Department launched a web dashboard reporting Taser usage by date range with options to narrow the result parameters by patrol or custody, patrol station or facility, incident type, or city.[13] The available data includes the result of the use of force (i.e., whether the use resulted in serious injury or death). The Department provided the following information for Taser usage:

- During the second quarter of 2026, the Department reports there were 67 Taser uses: 3 in Custody and 53 in Patrol Operations.

[12] This section on Tasers includes the information reported by the Sheriff's Department for the quarter covered in this report and does not include information reported previously. Tasers approved for use by the Department are Taser 10, Taser X26, and Taser 7. The intention is to phase out Taser X26 and Taser 7.

[13] The Sheriff's Department Body-Worn Camera Unit tracks only Taser 10 usage, the Department's dashboard tracks all Taser usage.

- The Department reports that in incidents involving a weapon, there were nine incidents in which a taser was used. Three of these nine incidents involved a firearm, three involved a knife and three involved another weapon.
- As of the end of the second quarter of this year, 100 Phase 1 Taser 10s have been allotted for the Department's Custody Division.
- Each Taser 10 is equipped with technology that signals the body-worn camera (BWC) to activate when a deputy turns off the Taser 10's *Safe Mode* as the deputy readies the Taser to fire. The Department reported seven such activations, referred to as signal activations, during this quarter.[14] Of the seven signal activations, six were used in patrol and one was in custody. Due to the recent implementation of body-worn cameras in custody facilities, staff may still be getting used to activating the cameras.[15]

Semi-Annual Report on the Family Assistance Program

The Los Angeles County Board of Supervisors established the Family Assistance Program (Family Assistance), first in 2019 as a one-year pilot that it later made permanent, with the aim of improving compassionate communication and providing trauma-informed support to families of those who died following a fatal use of force by a Sheriff's Department employee or while in the custody of the Department. The Office of Inspector General reports semi-annually on Family Assistance in its quarterly reports on the Department.

Family Assistance Service Data

The Los Angeles County Board of Supervisors established the Family Assistance Program (Family Assistance), first in 2019 as a one-year pilot that it later made permanent, with the aim of improving compassionate communication and providing trauma-informed support to families of those who died following a fatal use of force by a

[14] Per Sheriff's Department policy, a deputy should activate their BWC in advance of enforcement or investigative contact. In those incidents where the TASER 10 was deployed but no signal activation occurred, it was because the deputy's BWC was already recording. Per a response from the Department, the signal activation feature on the TASER 10 serves as a fail-safe to account for situations that unfold rapidly, where a deputy may need to react immediately for officer safety before manually activating the BWC. It also functions as a secondary safeguard in cases where the BWC was not activated as required.

[15] In patrol operations deputies are trained to activate the camera when interacting with civilians. Because custody staff interact with incarcerated persons throughout the day, the training for activating the cameras is not quite as straightforward.

Sheriff's Department employee or while in the custody of the Sheriff's Department. The Office of Inspector General reports semi-annually on Family Assistance in its quarterly reports on the Sheriff's Department. The Family Assistance Program is administered by the Office of Violence Prevention (OVP) within the Department of Public Health (DPH). OVP has a webpage with an overview of Family Assistance with links to the Family Assistance brochure in English and in Spanish and to the Family Assistance Application Form.

Family Assistance continues to support families affected by in-custody deaths and fatal use-of-force incidents involving the Sheriff's Department. Family Assistance has implemented the Board approved increase in the burial reimbursement cap from $7,500 to $12,828, established an Emergency Assistance Fund to help affected families meet immediate basic needs, and continues to develop their new client management system.

During the first two quarters of 2026, covering the reporting period from January 1 through June 30, 2026, a total of 29 families experienced the death of a loved one while the person was in the custody of the Sheriff's Department or during an encounter with a Department member. Out of these 29 deaths, 24 individuals lost their lives while in a custody facility, and 5 individuals died as a result of deputy-involved shootings. The Office of Violence Prevention (OVP) engaged with 28 of the 29 families referred to Family Assistance and each family received at least one of the following services: program information and access, crisis intervention, grief counseling, financial assistance, case management, advocacy, and referrals to additional resources. Family Assistance was unable to contact one family because no next of kin could be identified. OVP distributed burial expenses to 22 families, with expenses ranging from $1,021 to $12,818, totaling $166,778 for the period.

Immigration Policy Update

On June 16, 2026, the Sheriff's Department revised its Newsletter 18-06, "Immigration Policies, Protocols, and Procedures," to be in line with its existing Manual of Policies and Procedure section 5-09/271.00, "Immigration Inquiries and Notifications," and Senate Bill 54. The Department issues "Newsletters" to provide staff with updates, case law analysis, and/or reminders about Department policy. The Department updated its Newsletter on immigration protocols to include the sentence:

> *Victims, witnesses, and temporarily-detained suspects shall not be asked their place of birth for the purpose of determining their immigration status, unless necessary under the particular circumstances to investigate a criminal offense.*

The Sheriff's Department already had this explicitly stated in its policy, MPP 5-09/271.00. This recent revision to the Newsletter was to rectify an oversight where this sentence was not mirrored in the newsletter.

The Office of Inspector General staff inquired as to how the Department ensures compliance with the policy. Department staff stated that when such questions are posed, personnel must include the information in their investigative reports; thus, supervisors who sign off on reports review the report to ensure staff only pose this question when necessary to investigate a criminal offense. In addition, staff are required to utilize body-worn cameras when speaking to witnesses, meaning that if these questions are posed there will be video evidence unless the person being interviewed objected to being recorded due to the sensitive nature of the investigation, such as when a victim of human trafficking declines to be recorded. The Newsletter was amended to educate staff on the Department's existing policy and to remind staff that immigration-related questions are only permissible in very limited situations.

Body-Worn Camera Buffering Time

In 2019, the Board of Supervisors hired the International Association of Chiefs of Police (IACP) to conduct an independent assessment of the Sheriff's Department's proposed body-worn camera program.[16] While the assessment addressed implementation strategy, staffing, digital evidence management, governance, and best practices, it did not discuss a recommended pre-event buffer time. Since the inception of the use of body-worn cameras, the Department has used a 60-second pre-event buffer although it has not identified any policy rationale for choosing this buffer time as opposed to a longer time period.

The purpose of a body-worn camera (BWC) is to provide a more complete and accurate record of law enforcement encounters. While policy requires deputies to activate the cameras in most interactions with civilians, there are times when deputies do not activate the camera prior to situations that rapidly unfold. As a result, a 60-second buffer period may not always capture the full context preceding a use of force, detention, arrest, or other significant encounter. Expanding the pre-event recording period may

[16] According to the IACP report, "on August 7, 2018, the Board of Supervisors directed the Chief Executive Officer in consultation with the Sheriff, County Counsel, Office of Inspector General, and the Sheriff's Civilian Oversight Commission to engage a consultant to review and assess previous County reports on body-worn cameras and evaluate the Sheriff's proposed policies, procedures, deployment plan, staffing and corresponding operational impact on the Sheriff's Department and the community."

provide investigators, supervisors, and community members with a more comprehensive understanding of the circumstances surrounding an incident.

A longer pre-event buffer may improve the evidentiary value of BWC video by capturing additional preceding events leading up to critical incidents, including deputy approaches, subject behavior, verbal exchanges, and de-escalation efforts that occur before a BWC is activated.

Several major law enforcement agencies have adopted 120-second pre-event recording buffers, including the Los Angeles Police Department, Chicago Police Department, Metropolitan Police Department in Washington, D.C., and San Diego Police Department. Additionally, legislative bodies in several jurisdictions have considered or measures requiring 120-second pre-event recording periods, reflecting the expression of a need to preserve additional context before camera BWC activation.[17]

The Office of Inspector General understands that current BWC technology is capable of supporting a 120-second pre-event buffer and that LASD's body-worn camera contract provides for unlimited cloud storage. Because buffered video is retained only when a deputy activates the recording, increasing the pre-event buffer from 60 seconds to 120 seconds is unlikely to result in additional storage costs. While it is doubtful that doubling the pre-activation buffer time will increase storage costs, the Sheriff's Department should evaluate any operational, technological, financial, and labor-related considerations associated with implementing such a change.

A longer pre-event buffer may also advance several important accountability objectives. Additional pre-activation video can assist in evaluating deputy decision-making, assessing de-escalation efforts, and providing context during administrative investigations and critical incident reviews. At the same time, more complete recordings may help corroborate deputies' actions and protect personnel from unfounded allegations by capturing events that occurred before camera activation.

Recommendation: Evaluate Lengthening the Body-Worn Camera Pre-Event Buffer to 120 Seconds

Accordingly, the Office of Inspector General recommends that the Sheriff's Department assess the feasibility, costs, labor considerations, and operational benefits of increasing the BWC pre-event buffer from 60 seconds to 120 seconds and determine whether such

[17] In a letter in response to the validation draft of this report, the Sheriff's Department suggests that a 30-second buffer it identified as the prevailing practice is "the prevailing best practice." A prevailing practice is not necessarily the best practice. LAPD, the most similar agency to the Sheriff's Department in size and adoption of 21st Century policing principles, is the best comparison and, as noted in the report, has the 120-second buffer.

a change would enhance the Department's accountability, transparency, and investigative objectives.

Outstanding Requests to the Sheriff's Department

The Sheriff's Department has responded to all OIG requests made during this reporting period. Additionally, materials responsive to OIG's SDT served in October 2024, referenced as outstanding in previous reports, have now been provided. Counsel for the County stated that the materials are confidential, but OIG has the opportunity to review the materials.

CUSTODY DIVISION

Jail Overcrowding

As previously reported by the Office of Inspector General, overcrowding in certain Los Angeles County jail facilities continues to jeopardize the ability of the Sheriff's Department to provide habitable, humane, and safe conditions of confinement as required by the Eighth and Fourteenth Amendments to the U.S. Constitution.[18]

The Los Angeles County jails have a Board of State and Community Corrections (BSCC) total rated capacity of 12,404.[19] According to the Sheriff's Department Population Management Bureau Daily Inmate Statistics, as of June 30, 2026, the total population of people in custody in the Los Angeles County jail facilities was 11,902. As of March 31, 2026, the total population of people in custody in the Los Angeles County jail facilities was 12,462.

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),

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[18] 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).

[19] The total rated capacity is arrived at by adding the rated capacity for each of the County jail facilities: MCJ 3512, TTCF 2432, CRDF 1708, PDC-East 926, PDC-North 830, PDC-South 782, and NCCF 2214. Some portions of the jail facilities are not included in the BSCC capacity ratings. When referring to the jail facilities, this report includes only the BSCC rated facilities. The rated capacity has not been recently updated and does not take into account the 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.

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

Facility	BSCC Capacity	Facility Count			
		9/30/25	12/31/2025	3/31/2026	6/30/2026
MCJ	3512	3751	3609	3812	3668
TTCF	2432	2403	2309	2270	2177
CRDF	1708	1496	1414	1430	1293
PDC-East	926	17	11	15	13
PDC-North	830	1348	1321	1253	1286
PDC-South	782	640	611	640	613
NCCF	2214	3142	2961	3042	2852

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 the status on the availability and accessibility of menstrual products in its quarterly reports to the Board, until further notice.[20]

The Office of Inspector General monitored the availability of menstrual products as directed by the motion but has no updates to report for this quarter.

[20] See Penal 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, CDM 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 Order, CDM 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."); Penal 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.").

Commissary Prices

Background

On July 9, 2024, the Board of Supervisors passed a motion directing the Sheriff's Department to report back on measures taken to ensure commissary prices in the Los Angeles County Jails are not excessive and remain comparable with prices for groceries and other retail outlets. The motion directed the Office of Inspector General to review the Department's report back and provide an assessment, which was issued on February 6, 2025, entitled *Report Back on People Over Profit: Fairness and Equity in Commissary Prices for the Los Angeles County Jails*. The motion also directed the Office of Inspector General to provide quarterly updates on the Department's progress on the removal of the profit mark-ups and reduction of prices on commissary items.

The Office of Inspector General has no updates regarding the Sheriff's Department's progress on the removal of the profit mark-ups and reduction of prices on commissary items.

Title 15 Meetings with Keefe Commissary Network

The following topics were discussed at this quarter's meeting between custodial facilities and Keefe.

Vending Machine Installation and Purchase Process

As of mid-June 2026, there are a total of 194 vending machines in the Sheriff's Department's custodial facilities. This includes new machines already installed and operational, as well as machines that are staged and awaiting installation. Installation of additional machines at PDC-North and MCJ remains ongoing. Installation at MCJ has been delayed due to ensuring proper security features on the new machines.

The Office of Inspector General observed, and the Sheriff's Department has confirmed that people in custody now use wristbands, rather than cards, to make vending machine purchases. A person in custody can purchase only one item at a time and must scan their wristband and enter their PIN for each transaction.

The Office of Inspector General raised complaints from people in custody that this new process is slower than the former card process. This is a concern because of the Department's reported staffing shortages; the Department requirement that staff be available to escort and supervise the process results in limitations on the allotted time to access the vending machines. However, the contract with Keefe requires a two-factor

verification system to reduce theft or fraud, requiring people in custody to scan their wristband, and then enter their unique pin to purchase an item, meaning that the process cannot be expedited.

Kosher/Halal Menu Availability

In reference to the availability of updated Kosher/Halal menus originally discussed in the Office of Inspector General's report *Reform and Oversight Efforts: Los Angeles County Sheriff's Department – July through September 2025*, the contract change order for the new final menu with updated Kosher markers awaits executive signatures for release, but the Sheriff's Department indicated that it should be finalized soon. The Department continues to direct Keefe to distribute information to people in custody regarding Kosher and Halal products until the menus with the proper designations are finalized. Keefe handouts with the proper designations are available to people in custody to ensure that their commissary orders are in keeping with their dietary restrictions.

Commissary Surveys and New Commissary Items

The contract change order includes new commissary menu items. The following new items will be available for a trial run at NCCF, PDC-North, PDC-South and PDC-East:

Item Description	Qty Limit	Price
Whole Shabang Ripple Potato Chips 1.5 Oz	5	$1.51
Hot Chili and Lime Kettle Chip 1.5 Oz	5	$1.51
Dolly Madison Snack Cakes Golden Crème 2.7 Oz	5	$1.95
Dolly Madison Donuts Powdered Sugar 3 Oz	5	$1.88
Dolly Madison Donuts Glazed 3.7 Oz	5	$2.01
Moon Lodge Buffalo Mini Pretzels 4 Oz	5	$2.94
Moon Lodge Jalapeno Mini Pretzels 4 Oz	5	$2.94

The Sheriff's Department indicates that new items may be offered at other facilities depending on the popularity of the items. The intent is to include items that are appealing, meaning that there is sufficient demand to keep the items available. The prices for these newly offered trial items are generally lower than similar snack items previously available.

Inmate Welfare Commission

The Inmate Welfare Commission (IWC) presents its financials during Commission meetings. The financial information presented demonstrates the ability to meet IWC's financial obligations. OIG continues to recommend that any increase in available funds

be spent on programs and items that directly benefit the people in custody rather than on regular expenditures such as staffing and facility upkeep.

For Fiscal Year 2026-27, the following expenditures were approved by IWC:

Soledad Enrichment Action, Inc.

IWC approved $400,000 for a mobile tattoo removal program. The mobile van will be staffed by a medical professional and a driver. Security precautions will be in place with deputies present throughout the removal procedure. A screening application will include medical history and tattoo characteristics. People with visible tattoos linked to gangs or human trafficking will be given priority, as will those enrolled in programs (e.g., Fire camp, Education Based Incarceration, Forensic In-Patient Step Down). Program results will be reported to the IWC. Consent from participants will be required for photographs and interviews about participants' motivations and experiences in order for the Department to share program results with IWC and the public.

Getting Out by Going In

IWC approved a funding request for $200,000. Courses offered by Getting Out by Going In include parenting, domestic violence, substance abuse, and anger management.

Bold Recovery Program

IWC approved a funding request for $160,000 to contract with Bold Recovery, a community-based organization that assists in reintegrating people in custody back into society. Bold Recovery has a 21-week program for people in custody at county jails and state prisons. The program assists with transitions to other programs, such as sober living, and outpatient substance abuse treatment facilities. All participants receive a certificate of completion.

Facility Upgrades

IWC approved an MCJ funding request for $44,236 to upgrade exercise equipment to provide more exercise options to people in restrictive housing and allow access to the equipment at least twice a week to reduce psychological strains of isolation. The equipment has an expected lifespan of 20 years.

IWC approved a funding request for $15,088 to upgrade the engraver in the wood shop. The IWC also approved a PDC-North funding request for $13,410 to purchase 40 new televisions. Lastly, the IWC approved a funding request for $35,610.91 to purchase a new utility vehicle for use by the Fire Camp Inmate Training Program.

Use of Restraints on Pregnant People in Custody

The Office of Inspector previously reported on the Sheriff's Department's use of restraints on people in custody who are in labor, delivery, or recovery.[21] California law prohibits restraining "[a] pregnant inmate in labor, during delivery, or in recovery after delivery…unless deemed necessary for the safety and security of the inmate, the staff, or the public."[22] Department policy creates a higher standard, prohibiting restraint of "[a]n inmate in labor, during delivery, or in recovery after delivery… unless the inmate poses an immediate threat of great bodily injury or death to herself, her fetus, or others."[23]

When monitoring the conditions of confinement for pregnant people in custody, the Office of Inspector General has identified instances in which staff used restraints on people in custody who were in labor, delivery, and post-labor recovery and discussed the use of restraints in these instances with Sheriff's Department executives, identifying policy violations to the Department because the circumstances did not reveal an "immediate threat of great bodily injury or death to herself, her fetus, or others."

For the first two quarters of 2026, the Office of Inspector General received multiple complaints from people in custody who claimed that they were handcuffed while at Los Angeles General Medical Center (LAGMC) recovering from labor. The Sheriff's Department investigated the allegations concerning the use of restraints on people in custody in recovery from childbirth and were unable to definitively conclude whether restraints were used. Thus, one of the grievances was closed with the disposition of "employee conduct appears reasonable" and one of the grievances was closed with the disposition of "unable to determine."

In the investigation, the Sheriff's Department referenced a "Pregnant Incarcerated Patient" bulletin, depicted below, that is distributed to Department staff working on the Labor and Delivery floor at LAGMC. The checklist states that "Pregnant Inmates (in labor, deliver, or recovery) shall not be restrained, unless *necessary for safety and security*." The language contained within this informational bulletin does not apply the

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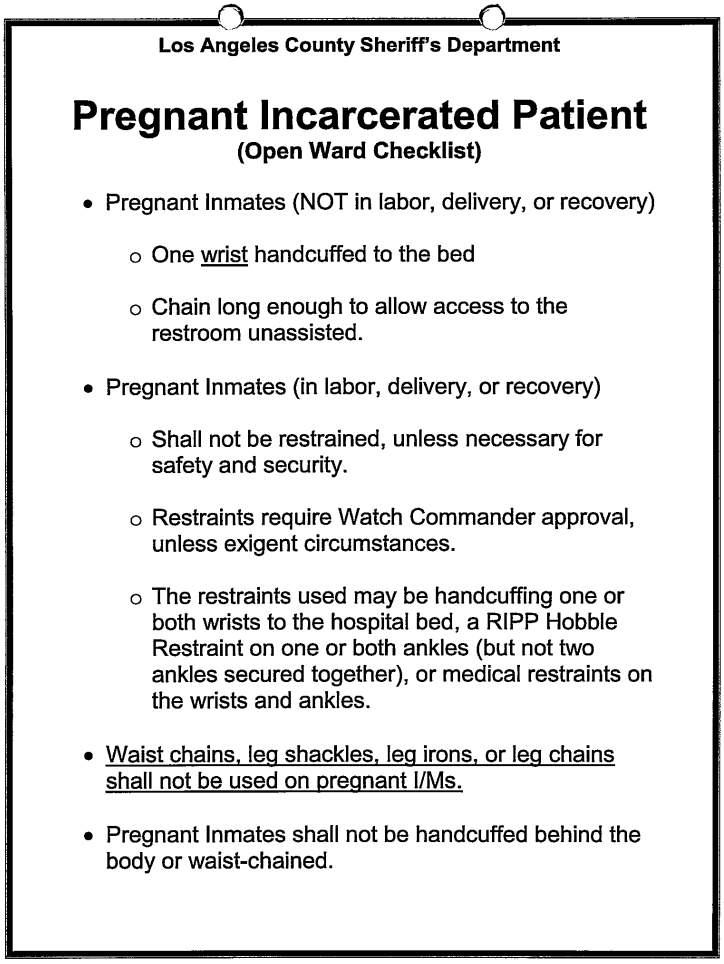
[21] *See* Office of Inspector General Reform and Oversight Efforts Report – October through December 2023, at 31.

[22] California Penal Code § 3407(b).

[23] *See* Los Angeles County Sheriff's Department, Manual of Policy and Procedures, § 7-02/010.00, *Pregnant Inmates*.

same standard required by Department policy, which reads that people in custody in labor, delivery, or recovery must pose an "immediate threat of great bodily injury or death to herself, her fetus, or others"[24] to necessitate the use of restraints.



Los Angeles County Sheriff's Department

Pregnant Incarcerated Patient
(Open Ward Checklist)

- Pregnant Inmates (NOT in labor, delivery, or recovery)
  - One wrist handcuffed to the bed
  - Chain long enough to allow access to the restroom unassisted.
- Pregnant Inmates (in labor, delivery, or recovery)
  - Shall not be restrained, unless necessary for safety and security.
  - Restraints require Watch Commander approval, unless exigent circumstances.
  - The restraints used may be handcuffing one or both wrists to the hospital bed, a RIPP Hobble Restraint on one or both ankles (but not two ankles secured together), or medical restraints on the wrists and ankles.
- Waist chains, leg shackles, leg irons, or leg chains shall not be used on pregnant I/Ms.
- Pregnant Inmates shall not be handcuffed behind the body or waist-chained.

The Sheriff's Department advised that rather than update the LAGMC bulletin checklist, it will change the language in the policy to conform with the lower standard in the California Penal Code to allow the use of restraints on people in custody in labor, delivery, or recovery if "deemed necessary for the safety and security of the inmate, the staff, or the public."[25]

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[24] *See* Los Angeles County Sheriff's Department, Manual of Policy and Procedures, § 7-02/010.00, *Pregnant Inmates*.

[25] California Penal Code § 3407(b).

As of the issuance of this report, the Department has not made changes to the policy. The Office of Inspector General recommends that the Department keep its current policy in place, cease distribution of informational bulletins that do not align with Department policy, and hold staff accountable where they fail to follow Department policy. Any intent to lower the standard in the future does not absolve current policy violations.

In-Custody Deaths

Between April 1 and June 30, 2026, 11 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 10 of these deaths: 5 natural, 2 accidental, and 3 suicides. [26] Currently, there is no public record for one death that occurred at CRDF. Four people died at MCJ, one person died at CRDF, one person died at NCCF, one person died at TTCF, and four people died at hospitals after being transported from the jails. The Department posts the information regarding in-custody deaths on a dedicated page on Inmate In-Custody Deaths on its website.[27]

Office of Inspector General staff attended the Custody Services Division Administrative Death Reviews and the Correctional Health Services (CHS) Mortality Reviews for each of the 11 in-custody deaths. The following summaries, arranged in chronological order, provide brief descriptions of each in-custody death:

Date of Death: April 2, 2026
Custodial Status: Pre-Trial
On April 2, 2026, custody staff distributing lunch at TTCF found an unresponsive person in a single-person cell with a ligature around his neck. Custody staff, CHS staff, and

[26] 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 CHS use evidence gathered during the investigation to make a preliminary determination as to whether an overdose is accidental or purposeful. Where the suspected cause of death is reported by the Sheriff's Department and CHS, the Office of Inspector General will include this in parenthesis.

[27] 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.

paramedics rendered emergency aid and administered Narcan. The person died at the scene. Preliminary manner of death: Suicide. The DME website reflects the manner of death as suicide, the cause of death as hanging, and other significant conditions as internal hemorrhage from right neck artery, not otherwise specified.

Areas of Inquiry: Title 15 safety checks, housing classification, physical environment safety for suicide prevention, restraints used during medical emergency responses, staffing and availability of mental health clinicians, and application of the suicide risk assessment checklist to identify risk factors.

Date of Death: April 4, 2026
Custodial Status: Sentenced
On April 4, 2026, people in custody at MCJ alerted custody staff of a "man down." Custody staff responded and observed the person's cellmates attempting to resuscitate him by administering cardiopulmonary resuscitation (CPR) on the person. Custody staff, CHS staff, and paramedics rendered emergency aid and administered Narcan.[28] The person died at the scene. Preliminary manner of death: Unknown. The DME website reflects the manner of death as an accident and the cause of death as acute fentanyl toxicity.

Areas of Inquiry: closed circuit television (CCTV) operability, administration of Narcan, availability of substance abuse treatment medication and rehabilitation, and adherence to body-scan search policies and protocols.

Date of Death: April 10, 2026
Custodial Status: Partially Sentenced
On April 10, 2026, a person in custody housed at TTCF's Correctional Treatment Center (TTCF-CTC) alerted CHS staff that he was experiencing difficulty breathing. Custody staff and CHS staff rendered aid, and the paramedics transported the person to White Memorial Hospital. The person died the same day. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, the cause of death as hypertensive and atherosclerotic cardiovascular disease and other significant conditions as hepatitis C-related cirrhosis and chronic renal insufficiency.

Areas of Inquiry: BWC activation and LASD policies for release of inmates on certain charges.

[28] The brand name of naloxone, a medication used to rapidly reverse opioid overdoses.

Date of Death: April 21, 2026
Custodial Status: Sentenced
On April 21, 2026, CHS staff alerted custody staff that a person in custody at TTCF-CTC was experiencing difficulty breathing. CHS staff rendered aid, and the paramedics transported the person to LAGMC. The person died the same day. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, the causes of death as cryptococcus neoformans meningoencephalitis, acquired immunodeficiency syndrome, human immunodeficiency virus infection and other significant conditions as viral pneumonia (human rhinovirus/enterovirus).

Areas of Inquiry: CHS's determination as to the necessary level of care.

Date of Death: April 28, 2026
Custodial Status: Pre-Trial

On April 28, 2026, civilian cleaning-crew workers at MCJ found an unresponsive person in a single-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid and administered Narcan. The person died at the scene. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, the cause of death as coronary artery disease.

Areas of Inquiry: AED training for custody personnel and housing classification.

Date of Death: May 1, 2026
Custodial Status: Pre-Trial
On December 6, 2025, custody staff conducting Title 15 safety checks at MCJ found an unresponsive person in his cell. Custody staff and CHS staff rendered aid, and the paramedics transported the person to LAGMC. The person died on May 1, 2026. Preliminary manner of death: Unknown. The DME website reflects the manner of death as an accident and the cause of death as sequelae of blunt traumatic injuries.

Areas of Inquiry: delay in emergency response and housing classification.

Date of Death: May 14, 2026
Custodial Status: Pre-Trial
On May 14, 2026, custody staff conducting Title 15 safety checks at MCJ found an unresponsive person in a two-person cell with a ligature around his neck. Custody staff, CHS staff, and paramedics rendered emergency aid and administered Narcan. The person died at the scene. Preliminary manner of death: Suicide. The DME website reflects the manner of death as suicide and the cause of death as hanging.

Areas of Inquiry: Title 15 safety checks, BWC activation, administration of AED and Narcan, cell tenting (visibility into cell), and housing classification.

Date of Death: May 17, 2026
Custodial Status: Pre-Trial
On May 5, 2026, people in custody at MCJ alerted custody staff of a “man down.” An inmate worker transported the person to the nearby nursing station for assessment, and he was subsequently transferred to the TTCF Urgent Care Clinic, LAGMC, and Cedars-Sinai Medical Center. The person died on May 17, 2026. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural and the cause of death as complications of pulmonary hypertension.

Areas of Inquiry: Title 15 safety checks, BWC activation and use of inmate workers for transportation to the Urgent Care Clinic.

Date of Death: May 31, 2026
Custodial Status: Pre-Trial
On May 31, 2026, people in custody at NCCF alerted custody staff of a “man down.” Custody staff, CHS staff, and paramedics rendered emergency aid and administered Narcan. The person died at the scene. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, the cause of death as atherosclerotic cardiovascular disease, and other significant conditions as diabetes mellitus type and hyperlipidemia.

Areas of Inquiry: timeliness of mental-health follow ups and administration of an Ambu Bag during the emergency response.

Date of Death: June 14, 2026
Custodial Status: Pre-Trial
On June 14, 2026, custody staff conducting Title 15 safety checks at MCJ found an unresponsive person in a single-person cell with a ligature around his neck. Custody staff, CHS staff, and paramedics rendered emergency aid but did not administer Narcan. The person died at the scene. Preliminary manner of death: Suicide. The DME website reflects the manner of death as suicide and the causes of death as asphyxia and hanging.

Areas of Inquiry: administration of Narcan, confirmation of patient identification for medication distribution, and housing classification.

Date of Death: June 24, 2026
Custodial Status: Pre-Trial
On June 24, 2026, custody staff conducting Title 15 safety checks at CRDF found an unresponsive person in her cell. Custody staff, CHS staff, and paramedics rendered emergency aid and administered Narcan. The person died at the scene. Preliminary

manner of death: Unknown. The DME website does not currently have a public record for this death.[29]

Areas of Inquiry: Title 15 safety checks, adherence to pill-call procedures, administration of AED, and adherence to policies and protocols for module searches.

Efforts to Reduce In-Custody Deaths

On March 3, 2026, the Board of supervisors passed a motion, *Strengthening Accountability to Significantly Decrease Jail Deaths in the Los Angeles County Jails*. The motion directs the Office of Inspector General to include in quarterly reporting information on the Medication Assisted Treatment program, summaries and status of corrective action plans instituted after an in-custody death, improvements to the Corrective Action Plan tracker, compassionate release efforts, and an analysis of the Mortality Review process. The Office of Inspector General began monitoring and tracking the requested items as of this quarter, including continuing to attend each administrative death review and mortality review, meeting with CHS and Custody Division executive staff, and reviewing Corrective Action Plan data provided by Custody Division Custody Compliance and Sustainability Bureau (CCSB).

Summaries of In-Custody Death Corrective Action Plans

An in-custody death may result in the Sheriff's Department opening multiple corrective action plans (CAPs). During this reporting period, the Department's CCSB provided the Office of Inspector General with preliminary data regarding CAPs opened between January 1, 2021, and June 30, 2026. When a CAP is opened, plans on how to best assess the risk of a reoccurrence and how to prevent reoccurrences are discussed and included in the plan. The plan may for instance call for a change in policy or practice, retraining, or developing training if a new policy is adopted. CAPs may remain open until the Department is satisfied that all aspects of the CAPs were completed. In many instances, the Department took action as set forth in the CAP, but that CAP is not officially closed because some actions remain or even that there is a necessary correction in the administrative CAP documentation. The Office of Inspector General and the Department think it is most accurate to report the status of the CAPs rather than simply whether a CAP is open or closed. While some of this data was reported to OIG, the data needs to be further refined to make it accurate and up to date.

[29] The public record for this death is not posted as the decedent's next of kin has not been notified.

Rather than report misleading information, OIG and the Department agreed to collaborate on a process to provide the most accurate and timely data and to delay reporting until next quarter.

The Department also expressed concerns regarding maintaining legal privileges applicable to Departmental corrective actions. The extent to which the information is protected will be discussed with the Department and advice of counsel will be sought if necessary. If the conclusion is that there is a need to provide the Board of Supervisors with information protected by a legal privilege, OIG will do that in a separate confidential report. Of course, OIG's mission is to promote transparency, and every effort will be made to provide the public with meaningful information while preserving the Department's legal rights.

Correctional Health Services Compassionate Release Efforts

The Board's motion directed CHS to "identify ways…to expedite compassionate releases" with consideration to California Penal Code section1172.2. Penal Code section 1172.2 provides that the California Department of Corrections and Rehabilitation (CDCR) may recommend that a person in custody's sentence be recalled where they present with a "serious and advanced illness with an end-of life trajectory" or are "permanently medically incapacitated with a medical condition or functional impairment that renders them permanently unable to complete basic activities of daily living." Subsection (c) of 1172.2 section additionally provides that "the court shall hold a hearing to consider whether the incarcerated person's sentence should be recalled" within 10 days of receiving a recommendation from CDCR.

However, the legal standard governing compassionate release in local detention facilities is narrower than the standard established by Penal Code section 1172.2. California Government Code sections 26605.5 and 26605.6 grants the Sheriff authority to compassionately release people in county custody when the person is so severely physically incapacitated that they no longer pose a threat to the safety of others or where the person has a life expectancy of less than six months and they no longer pose a threat to the safety of others. To exercise his authority to compassionately release a person in custody who is physically incapacitated, Government Code section 26605.5 requires the Sheriff to confer with a "physician who is neither a county employee nor under a preexisting contract with the county." To exercise his authority to compassionately release a person in custody who has a life expectancy of six months or less, Government Code section 26605.6 requires the Sheriff to confer with a "physician who has oversight for providing medical care at a county jail, or that physician's designee." The Sheriff's Department Custody Division Manual (CDM) outlines the procedures by which the Sheriff may compassionately release people in

custody pursuant to the Government Code.[30] The Department reported that between January 1 through June 30, 2026, the Department's Access to Care Bureau (ACB) attempted to initiate the compassionate release process for one person in custody, but the person died in custody before the Department could finalize and submit the release letter for approval.

Recognizing the limitations of the legal authority authorizing compassionate release, namely that the person in custody must suffer from severe physical incapacitation or have a life expectancy of six months or less to be eligible for compassionate release, the Chief Medical Officer of CHS has developed an alternative protocol to petition the courts to release people in custody based on their medical condition. The Chief Medical Officer reported that CHS providers regularly send requests for release letters on behalf of people in custody with significant medical conditions to the court, the defense attorney, and the prosecutor attorney assigned to the person's criminal case. From January 1 to June 30, 2026, CHS submitted 27 requests for release letters. Of the 27 submitted letters, 12 were granted, 7 of the requests were no longer necessary due to the release of the person for reasons unrelated to their medical condition or because the person died, and 8 are pending.

Correctional Health Services Mortality Review

The Office of Inspector General reported on changes to the CHS and Custody Division Administrative Death Review Process in the *Reform and Oversight Efforts: Los Angeles Sheriff's Department – July through September 2025* report. Prior to the third quarter of 2025, CHS and the Sheriff's Department jointly engaged in the Death Review process. In August of 2025, CHS began conducting a separate Mortality Review lead by the Chief Medical Officer with participation limited to medical and mental health leadership, the CHS quality assurance team, Office of Inspector General staff, and the two Department custody division Chiefs.

CHS executives reported that conducting a Mortality Review separate from but in addition to the Department's Administrative Death Review aligns with national best practices. The National Commission on Correctional Health Care (NCCHC), a non-profit organization that seeks to "improve the quality of health care in jails, prisons, and juvenile facilities," established a standard procedure in the event of an in-custody

[30] *See* CDM 5-03/145.00 *Compassionate Release Procedures*.

death.[31] In addition to working with custody staff to assess the "correctional and emergency response actions surrounding an [in-custody] death" in an administrative review, NCCHC compliance indicators establish that correctional health authorities should conduct a clinical mortality review, defined as an "assessment of the clinical care provided and the circumstances leading up to an [in-custody] death," within 30-days of an in-custody death.[32] CHS executives also reported that they developed the separate Mortality Review process to mitigate concerns raised in a lawsuit filed by the California Attorney General against the County of Los Angeles, the Department, and CHS, in which the Attorney General noted that "CHS fail[ed] to conduct its own death review or morbidity-and-mortality review process."[33]

Office of Inspector General's Monitoring of Administrative Death Review and Mortality Review

Office of Inspector General staff have attended every CHS Mortality Review meeting since inception and continually evaluated the CHS Mortality Review process. The initial development of the Mortality Review process involved CHS nursing, mental health, and medical leadership who conducted an independent review of each in-custody death. CAPs that CHS developed at Mortality Reviews were reviewed every two weeks until completed, and CHS tracked CAPs longitudinally as long-term improvement projects. CAPs developed at Mortality Review were provided to the CCSB death team at each 30-day Administrative Death Review and documented in the CCSB death book. The Chief Medical Officer attends each custody Administrative Death Review to address issues that involve both CHS and custody.

The CHS Mortality Reviews have continued to conform to this format. The Office of Inspector General recognizes and agrees that an independent Mortality Review is necessary to thoroughly evaluate the level of medical care provided to each person who has died within LASD Custody. However, upon the inception of CHS Mortality Review, CHS no longer provides custody with any relevant medical information concerning the decedent, nor does the Chief Medical Officer, who is present at every Administrative Death Review, disclose relevant information. The bifurcation of the Administrative Death Review has presented issues and inhibited both custody personnel and CHS

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[31] National Commission on Correctional Health Care, Strategic Planning Summary Document (2024). Available at: 2024 NCCHC Mission Vision Goals.

[32] National Commission on Correctional Health Care, Standards for Health Services in Jails, Procedure in the Event of an Inmate Death (J-A-09) (2018).

[33] *The People of the State of California v. County of Los Angeles*, Case No. 25STCV26152.

personnel's ability to conduct a thorough analysis concerning potential systemic contributory factors to each in-custody death.

For example, in instances where custody staff expressed concern about whether a person in custody was housed appropriately, the Chief Medical Officer was reticent to disclose that the person in custody had a disorder in which they would benefit from an alternative housing location. Similarly, at CHS Mortality review, medical leadership, who were no longer attendees at the Administrative Death Review, were unable to review CCTV or BWC to properly and thoroughly evaluate an emergency response.

Prior to CHS establishing the CHS Mortality Review, CHS personnel would provide custody staff with a truncated synopsis of the medical conditions a person presented with and medical care CHS provided to each person who died in Department custody. At the administrative death review, custody staff and CHS staff would evaluate the person's conditions of confinement, including CCTV evaluating the Title 15 safety checks that custody staff conducted prior to each in-custody death and emergency response that custody staff and CHS staff employed upon discovering an unresponsive person in custody.

The Office of Inspector General discussed the aforementioned issues with both CHS leadership and custody executives, and both entities acknowledged that the dichotomized process has inhibited collaboration in addressing systemic issues ranging from CHS to custody. CHS executives have agreed to provide preliminary health information, when possible, to custody staff at each Preliminary Administrative Death Review, and to provide CAPs when established.

Disclosure of Mortality Review Records

The California Public Records Act (PRA) grants public individuals the authority to request and access public records unless exempted from disclosure by law.[34] Senate Bill (SB) 519 expands PRA establishments and requires that records concerning an in-custody death incident, including reports, videos, and photographs maintained by a detention facility, must be made available for public inspection pursuant to the California Public Records Act. Moreover, Penal Code section 832.10, provides that "any record relating to an investigation conducted by the local detention facility involving a death incident maintained by a local detention facility shall not be confidential and shall be made available for public inspection pursuant to the California Public Records Act."

[34] Cal. Gov. Code § 7920.000 et seq.

Penal Code section 832.10 codifies SB 519 and requires that investigative records concerning any in-custody death, absent redactions to retain privacy, be disclosable under the PRA. Regarding local in-custody deaths, Penal Code section 832.10(b) provides, "any record relating to an investigation conducted by the local detention facility involving a death incident maintained by a local detention facility shall not be confidential and shall be made available for public inspection pursuant to the California Public Records Act." The statute further provides that:

> The record shall include all investigative reports; photographic, audio, and video evidence; transcripts or recordings of interviews; autopsy reports; all materials compiled and presented for review to the district attorney or to any person or body charged with determining whether to file criminal charges against a person, whether the person's action was consistent with law and agency policy for purposes of discipline or administrative action, or what discipline to impose or corrective action to take; documents setting forth findings or recommended findings; and copies of disciplinary records relating to the death incident, including any letters of intent to impose discipline, any documents reflecting modifications of discipline due to the Skelly or grievance process, and letters indicating final imposition of discipline or other documentation reflecting implementation of corrective action.

While Penal Code section 832.10 establishes broad disclosure of in-custody death records, California Evidence Code section 1157 prohibits "evaluation and improvement of the quality of care rendered in the hospital, or for that peer review body, or medical . . . review . . . [being] subject to discovery." The purpose of the statute is for peer review committees to provide transparent and candid evaluations concerning a person's medical care absent fear of civil or disciplinary actions.

Thus, while Administrative Death Review records may be readily disclosable pursuant to Penal Code section 832.10, Evidence Code section 1157 may effectively exempt CHS's Mortality Review meeting records from disclosure.

Discussion

As previously stated, the CHS's Mortality Review is robust in discussion of a decedent's medical care while incarcerated, potentially fulfilling NCCHC standards requiring a clinical mortality review to wholistically evaluate patient care proceeding death. However, the Office of Inspector General recognizes that the strict separation between the CHS Mortality Review and the Administrative Death Review may impact CHS's and Custody Division's ability to thoroughly

evaluate and address systemic factors that may have contributed to an in-custody death.

Although CHS and the Sheriff's Department are separate county entities, both are responsible for ensuring the security and safety of people in custody. Separating Death and Mortality Review, may impact the ability of CHS and the Sheriff's Department to collaboratively discuss and identify issues contributing to an individual's death The Director of CHS agreed to provide preliminary relevant health information, when available, verbally in administrative death reviews, and provide CHS CAPs to CCSB once created. While the more forthcoming disclosure of information may assist custody staff in identifying and immediately rectifying concerns, the Office of Inspector General recommends that CHS consider providing relevant health concerns, in writing, prior to each Administrative Death Review in order to best identify and resolve systemic issues in an effort to prevent future in-custody deaths.

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 OIG," and [s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the facility, beyond visual inspections." The Board also directed the Office of Inspector General to report quarterly on the 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 11 people who died in the care and custody of the Sheriff's Department between April 1 and June 30, 2026, the medical examiner's final reports, including toxicology assessments, confirm one person died due to accidental overdose. As of this report, the DME has confirmed that one individual died due to accidental overdose during the first two quarters of calendar year 2026.

Tracking and Improving Narcotics Intervention Efforts

As previously reported, 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 seizures by drug detection

mechanism, nor is it able to compile extractable data collected in the Los Angeles Regional Crime Information System (LARCIS) to evaluate the efficacy of drug detection intervention. Instead, the Department takes the position that constructing an all-encompassing jail management data system would best support the Department's efforts to track narcotics recovery and evaluate the efficacy of drug detection interventions. The Office of Inspector General continues to recommend that the Department examine ways to comply with the Board's directive by standardizing search procedures division-wide, improving reporting requirements for staff, and compiling data on detection interventions and seizures using existing technologies.

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

Body Scanners and Searching People in Custody

The Office of Inspector General continues to examine how the Sheriff's Department utilizes body scanners to search people in custody and conducts random cursory searches of sworn and civilian staff entering custodial facilities.

The Sheriff's Department reports that the previously used Smith Detection body scanners, which were approximately ten years old, were removed and seventeen LINEV Systems Clearpass body scanners were purchased and installed to use to search people in custody. The unit price per scanner was $133,715.91 and the total cost for the seventeen body scanners was $3,390,620.83, which is inclusive of installation, software, and initial training. Department policy dictates Custody Assistants (CAs) are the primary staff responsible for operating the machines and evaluating the scanned images.[35] The Department, however, reports there are currently more sworn staff trained to use the body scanners than CAs. As of July 20, 2026, 399 sworn personnel (including sergeants, bonus deputies, and generalist deputies) and 113 Custody Assistants (CAs) have been trained on how to use the LINEV body scanners.[36]

[35] CDM 5-08/020.00 *Custody Safety Screening Program*.

[36] The Sheriff's Department does not have a set retraining schedule; facilities hold refresher courses as needed.

The Office of Inspector General recommends training more CAs to use the scanners given the Department's high overtime costs for sworn staff.

The breakdown of total custody personnel trained and number of scanners per facility is as follows:

Facility	Trained Custody Personnel	Total Operational Scanners
IRC	116	6
MCJ	38	1
CRDF	25	2
NCCF	22	4
PDC North	55	2
PDC South	23	2
TTCF	0[37]	0

The LINEV scanners have three settings - low, medium, and high - to balance contraband detection with radiation exposure. Currently, the machines retain the setting used during the previous scan, however, the Sheriff's Department is working with LINEV to develop software to reset the default to low after each use. The low setting is designed to safely allow up to 1,000 scans per person yearly. Scans are tracked using each person's assigned wristband with the person's booking number. The database records the amount of radiation and number of scans and generates a warning when a person approaches or meets their annual limit. When the body scanners are down, Department personnel conduct tactical searches such as pat-downs or visual body cavity searches when authorized.

If a body scan reveals the presence of a foreign object in a body cavity, the person is asked about the item. If the individual denies concealing contraband, consent to conduct a strip search or visual body cavity search is sought. If the individual refuses, they are placed under continuous observation in isolation on contraband watch to monitor whether contraband eventually expels from the body.[38] During this quarter, the Office of Inspector General received approximately nine notices of individuals in custody being placed on contraband watch post body scan screening.

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[37] TTCF does not currently have body scanners due to operational and structural constraints like staffing shortages and limited physical floor space. According to the Sheriff's Department, there is no plan to purchase additional machines in the immediate future, but the goal is to eventually do so.

[38] CDM 5-07/000.05 *Contraband Watch Procedures*.

The Sheriff's Department is re-briefing staff on person and group searches, with an emphasis on strengthening the level of privacy for individuals. The is part of the Corrective Action Plan (CAP) developed as part of the settlement of two federal civil rights lawsuits, *Sammy Newman, et al. v. County of Los Angeles, et al.* and *Edward Malloy v. County of Los Angeles*, on June 9, 2026. The lawsuits alleged that Department deputies conducted an unconstitutional group search at MCJ. The CAP also included implementation of the new body scanners and increasing scanner resolution.

Sheriff's Department Search Statistics

As previously reported, the comprehensiveness of the searches varies across facilities as does the minimum requirement per week. The table on the following page details the staff search practices at all custodial facilities from April 1 to June 30, 2026. The data regarding the number of staff searches and searches with K-9 illustrated in the table was supplied by Custody Support Services Bureau (CSSB). CSSB extracted data on searches from the CWCL on July 2, 2026. K-9 data was obtained from the Custody Investigative Services (CIS) K9 Detail Facility Checkpoint Report on July 9, 2026. The Office of Inspector General was unable to verify the data provided by CSSB without additional information:

	Number of Staff Searches	Number of Staff Searches with K-9	Monthly Minimum Search Requirement[39]	Search Inside Security	Search Evasion Concerns	Where Searches Logged
Facility	**Q2**	**Q2**				
MCJ	109	27	Unable to Determine[40]	No	Yes	Watch Commander Log; Searches of Custody Personnel Report

[39] 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 Office of Inspector General 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 found in compliance.

[40] 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.

TCF	200	11	Yes[41]	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report
IRC	46	6	Unable to Determine[42]	No	Yes	Watch Commander Log; Searches of Custody Personnel Report
CRDF	75	6	Yes[43]	No	Yes	Watch Commander Log; Searches of Custody Personnel Report
NCCF	180	14	Yes[44]	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report
PDC-North	52	5	Unable to Determine[45]	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report
DC-South	75	9	Yes[46]	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report

[41] 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").

[42] 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.

[43] 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 CSSB 3/11/2024 ("The searches shall be conducted a minimum of once per week, per shift." [unit order obtained via email message]).

[44] 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.").

[45] 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.

[46] 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.").

Medication Assisted Treatment

Correctional Health Services' Medication-Assisted Treatment (MAT) program administers opioid use disorder treatment to people in custody. The MAT program has recently received media coverage and criticism.

A June 2026 Los Angeles Times article reported that, despite an $8 million settlement earmarked for drug treatment in custody, CHS staff, jail reform advocates, and people in custody reported that incarcerated patients still waited weeks, and sometimes several months, to receive MAT services.[47] The same article includes a statement from CHS reporting that although budget restrictions may delay treatment, there is no waitlist for MAT services and has not been one for months.

The Director of CHS responded to the article in a letter to the editor, reporting that there is no waitlist for MAT services, and the County is investing $30 million annually into jail-based addiction treatment.[48] The Director of CHS also reported that the Sheriff's Department's lack of contraband detection in the jails presented more of a risk to in custody overdoses than CHS's lack of drug addiction treatment. The CHS Chief Medical Officer reiterated this at the July 2, 2026, Sybil Brand Commission for Institutional Inspections (SBC) meeting.[49] In a meeting with Officer of Inspector General staff, the Chief Medical Officer clarified that if a person in custody submits a request for MAT services over the weekend, the person may experience delays in receiving treatment. The Chief Medical Officer reported that emergency medical services are always available to people in custody experiencing withdrawal symptoms and in need of immediate assistance.

The Department of Public Health (DPH) issued a press release, citing data from the DME showing an overall decline in overdose deaths across the County (for people both in and out of custody), which DPH attributed to investments in prevention, treatment, and recovery efforts. [50]

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[47] Gavin J. Quinton, "Overdoses in L.A. jails are fueled by long waits for drug addiction treatment, staffers say," *The Los Angeles Times*, June 19, 2026.

[48] Tim Belavich, "Letters to the Editor: Contraband drugs, not wait lists, are killing people in our jails," The Los Angeles Times, June 25, 2026.

[49] Meeting minutes pending approval at the next SBC meeting.

[50] County of Los Angeles Public Health, New Release, "Drug-Related Overdose Deaths in A County Continue to Fall," June 25, 2026.

On March 3, 2026, the Board of Supervisors passed a revised motion aimed at decreasing jail deaths in custody, particularly drug-related deaths, through overdose prevention efforts.

The motion requires that the Office of Inspector General include information on the MAT program in its quarterly reports. CHS is required to provide the Office of Inspector General with data, including the number of incarcerated individuals on the waitlist, the number of unique participants receiving treatment at each custodial facility, and the types of medications being administered, such as oral medications or long-acting injectable formulations.

Medication Assisted Treatment Administration

CHS implemented the MAT program in 2021. The MAT team consists of four clinical pharmacists, fifteen nurses, and one supervising nurse with a current budget for the program at $29.03 million. The Chief Medical Officer reported that CHS requested additional funding for medication and staffing, was only provided funding authorized for medication, but that it is awaiting approval of supplemental funding from CEO to address the shortfall.

In their June 30, 2026, report back to the Board, DHS provided an overview of MAT services available to people in custody who are experiencing withdrawal symptoms or self-identify as having opioid use disorder. DHS reported that people in custody may request MAT services upon their initial booking at the IRC, and CHS indicated there is no waitlist for MAT services requested at the IRC.[51]
Upon request, a referral is made to Addiction Medicine Services (AMS) and CHS administers treatment within hours of the person in custody's evaluation.

MAT is available as an oral dose of Suboxone administered once per day, or an injectable medication administered once a month referred to as a long-acting injectable (LAI). The Chief Medical Officer reported that if CHS has a record of the requestor previously receiving LAI treatment, the individual will likely receive one dose of the daily oral medication and then immediately begin LAI treatment. If CHS does not have a record of the requestor receiving LAI treatment, they will receive the daily oral medication for seven days and then begin LAI treatment. CHS reported that if LAI is unavailable due to late shipments or otherwise, individuals will receive daily oral doses as needed. Under the current budget, CHS can administer approximately 50-60 injections per day, depending on the housing areas of the request.

[51] The June 30, 2026 report back to the Board states that, "[a]s of May 2026, CHS did not have a waitlist, but this required spending of funds not allocated for MAT services."

If an individual does not request and receive MAT services after their initial booking into IRC, they may later submit a Health Services Request (HSR) form and receive a referral for MAT Referrals and requests are made to AMS, which then screens the individual and, if approved, treatment begins within three to five business days.

Clinical Pharmacists who conduct screenings for MAT services also use criteria to prioritize who receives MAT. CHS reported that people in custody who return from the hospital after experiencing an overdose are supposed to be seen within 24 hours, and those who have experienced withdrawal at the hospital and have already begun MAT treatment are to continue treatment when they return to custody. If an individual has an extradition date to be released to an Office of Diversion and Re-Entry (ODR) or other drug treatment program, they receive an LAI to prevent withdrawal during their transition to community-based treatment. Otherwise, CHS processes requests for MAT treatment in the order in which they receive the requests.

CHS indicates that most individuals remain on MAT unless they refuse treatment or are released from custody. If an individual refuses an LAI, they are removed from MAT services but can reenter the program. If a person refuses LAI treatment twice, they are suspended from receiving MAT services for six months.

Medication Assisted Treatment Data

CHS has provided the Office of Inspector General with the following data:

Count of patients waiting for LAI per their request[52]:

Facility	Male	Female	Total
MCJ	15	0	15
PDC	9	0	9
TTCF- Tower I	3	0	3
TTCF- Tower II	3	0	3
Total	30	0	30

[52] This data is a snapshot of the waitlist on July 13, 2026. Future reporting will include a snapshot for at least one day per month.

Individuals receiving *oral* MAT per facility on the 5th of each month:

Facility	April 5th	May 5th	June 5th	July 5th
MCJ	27	10	171	128
CRDF	39	17	57	52
IRC	122	113	109	197
PDC	18	7	113	70
TTCF-CTC	1	3	4	4
TTCF-Tower I	7	2	43	37
TTCF-Tower II	3	4	43	35
Total	217	156	540	523

Individuals receiving *LAI* MAT per facility on the 5th of each month:

Facility	April 5th	May 5th	June 5th	July 5th
MCJ	631	558	597	486
CRDF	204	164	154	131
IRC	294	313	286	388
PDC	466	451	458	419
TTCF-CTC	17	18	16	15
TTCF-Tower I	126	103	124	120
TTCF-Tower II	101	98	96	81
Total	1839	1705	1731	1640

Number of individuals receiving MAT (oral or LAI) per facility each month by gender:

Month	LAI Female	LAI Male	Oral Female	Oral Male
April 2026	202	1,664	112	940
May 2026	136	1,365	97	872
June 2026	93	1,027	126	1,168

Total number of injections provided by gender April 2026-June 2026.

Gender	LAI Doses
Female	452
Male	4254
Total	4706

Accessibility of Naloxone in Custodial Facilities

The motion also directed the Office of Inspector General to collaborate with the Sheriff Civilian Oversight Commission (COC) and the Sybil Brand Commission for Institutional Inspections (SBC) to monitor the accessibility and availability of Naloxone (or Narcan) throughout Sheriff's Department's custodial facilities. The motion emphasizes the importance of ensuring Narcan is readily available in locations where people in custody and staff have immediate access during overdose emergencies.

Deputies and people in custody may administer Narcan. CDM 5-03/060.00 *Response to Inmate Medical Emergencies*, states that "in cases where the inmate is found to be unresponsive, custody personnel shall administer Naloxone (Narcan Nasal Spray)." Sheriff's Department policy requires each facility's training unit or the Custody Training and Standards Bureau to provide Narcan administration training.[53] Several deputies also reported initially receiving training on how to administer Narcan at the academy and as part of their required First Aid/CPR training.

After Narcan is administered, custody staff must verbally notify medical staff of the time of administration and report any change in the person's condition. Custody staff must also complete the Narcan Use Report, Injury/Illness Report, and if necessary, an Incident Report.[54] During this quarter, the Office of Inspector General received notifications for approximately 46 Narcan deployments.

In June 2026, two Sheriff Civilian Oversight Commission (COC) commissioners, a COC staff member and a COC intern joined Office of Inspector General staff for an inspection of MCJ and TTCF. Office of Inspector General staff inspected other facilities. Custodial

[53] CDM 5-03/060.15 *Nasal Spray Administration for Suspected Overdoses*.

[54] Custody Operations Informational Bulletins, 2-22 Informational Bulletins, Custody Division Narcan Tracking System, Bulletin #2022-01. 5-03/060.15 Nasal Spray Administration for Suspected Overdoses.

staff were interviewed during the inspections. Overall, Narcan seemed to be available, but not readily accessible to people in custody.

Generally, custodial facilities have Narcan on the wall attached to laminated posters displaying information about the medication with designated squares to which two Narcan devices should be attached for use, as depicted in the photograph below. However, not every observed poster, was stocked with two Narcan devices. When asked, custody personnel indicated that the Training Unit restocks Narcan as needed, or the Watch Commander is advised to request Narcan from the Training Unit.

Each Sheriff's Deputy booth within the dorms and other areas of the facilities reported having an emergency response kit containing two to three Narcan devices. This comports with CDM 3-14/090.00 *First Aid and Emergency Response Kits*, which requires each emergency response kit to contain two units of Narcan.

Example of a laminated poster displaying information about the medication with spots to hold up to two Narcan devices. This example has no Narcan and needs to be restocked.

CDM 3-06/055.00 *Mandated Equipment* recommends that custody personnel carry two units of Narcan, however, it is not mandatory. Some, but not all deputies we spoke with during the inspections had Narcan on their person.

The Sheriff's Department staff also stated that CAs are encouraged, but not required, to carry Narcan on their person. Under CHS policy, staff "who have viewed the Narcan nasal spray instructional video" are permitted to administer Narcan to people in custody

who are suspected of experiencing an opioid overdose.[55] However, CHS policy does not require staff, including pill-call nurses, to carry Narcan. In practice, some pill-call nurses reported proactively keeping Narcan on their pill carts to ensure more immediate access if needed.

Men's Central Jail

Housing on the 2000 and 3000 floors of MCJ were inspected by OIG staff. There are four cell rows in each dorm, with a laminated poster on the wall at the start of each row (like the poster depicted in Photo 1 above). Not all inspected rows had two devices available. One deputy conducting Title 15 safety checks indicated he was not carrying Narcan on his person.

Aside from Training Bureau restocking Narcan, the Watch Commander at MCJ noted that there is a deputy dedicated to restocking Narcan throughout the facility. However, the deputy was currently on leave and there was no deputy to serve as backup. The Office of Inspector General recommends there should be a deputy designated to restock Narcan at the beginning of each shift at every custodial facility.
CAs can also be trained to restock Narcan, so that if a deputy is unavailable for restocking a CA can ensure all posters are stocked.

Regarding the laminated posters with up to two Narcan devices at the start of each row, the Office of Inspector General recommends that devices also be placed at the end of each row to shorten the distance to travel should a person in custody at the far end of the row be found in need of Narcan. Also concerning, the devices on the wall are not accessible to people in the cells of the row, meaning if someone needs Narcan, people in the cells have to yell out to deputies in the booth to retrieve the Narcan, delaying administration. This type of inaccessible placement was a problem in multiple areas of all the inspected custodial facilities.

When asked why the Narcan devices were not put in a place accessible to those in custody, custody staff expressed concerns about misuse. Multiple deputies reported concerns that people in custody would take the Narcan devices off the wall, for example, when coming back from showers, for improper purposes such as using the needle to make tattoo devices.

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[55] Correctional Health Services, Policy and Procedure Manual, § 70.01 *Opioid Overdose and the Use of Narcan Nasal Spray*.

The Office of Inspector General recommends that the Sheriff's Department track any misuse and explore the use of a more readily accessible, needle-free Naloxone, such as nasal spray.

The 4000 floor of MCJ also had laminated posters with up to two Narcan devices at the start of each row, but most of the inspected rows were out of stock.

There was one laminated poster at the MCJ Chapel for up to two Narcan devices, however, there were no devices at the time of the inspection. There was no Narcan in the MCJ school, but deputies in the Access to Care Bureau (ACB) classrooms reported carrying Narcan on their person.

The deputy booth supervising the attorney room had multiple Narcan devices, and the MCJ visitor waiting room has a vending machine stocked with free Narcan.

The medical clinic ("Mini Clinic") on the 3000 floor was inspected.

The 5000 floor has both dorm and single-person cell housing. There were laminated posters with spaces for up to two Narcan devices in the halls, but not all were stocked. There were stocked laminated posters observed in the dorms as well as Narcan available at the deputy booth.

The dayroom in the 8100 unit had no Narcan. Some of the dorms in the unit were dark inside, however, most of the dorms had laminated posters with two Narcan devices under the televisions or by the phones. The phones are next to the windows of the dorms, so they are easily viewable by deputies should they need to be replenished. Units 8200 and 8118-8122 are comprised mostly of single-person cells and had laminated posters with two Narcan devices at designated spots on the walls.

Court Line

The IRC Old Side area where Court Line is located was also inspected. Court Line presents higher risks of drug use and overdoses as individuals may be able to access drugs while going to court to bring back into the facility.

The deputy station at the entry way has large signs that read *NARCAN AVAILABLE AT THIS WORKSTATION*. The Office of Inspector General recommends these highly visible signs be placed throughout custodial facilities at deputy booths that have Narcan. Since most booths have Narcan available, such signs will assist people in custody should there be a need for Narcan.

Each deputy at this booth indicated they were carrying Narcan on their person.
A second deputy station towards the back of the housing unit also had multiple Narcan

devices and emergency response kits. This was particularly beneficial as there are cells located in view of the deputy booth that do not have access to Narcan devices from inside.

This area also has Naloxone boxes. Whereas the laminated posters have up to two Narcan devices, the boxes store four to ten devices. The boxes also sound an alarm when they are opened and stop when closed. When asked the reason for the alarm, deputies indicated it was so they could respond to any medical emergencies.

Twin Towers Correctional Facility

As compared to MCJ, Narcan at TTCF was less accessible, but available. The Sheriff's Department indicated that people do not have access to Narcan due to their classification and reiterated that people in custody take Narcan devices to use for improper purposes, such as making tattoo machines.

The Forensic In-Patient (FIP) Stepdown dorms do not have Narcan accessible within the dorms. This is due to their classification. The Mental Health Assistants (MHAs) who live in the dorms and work with the patients in custody also do not carry Narcan on their person. The way the dorm is situated, deputies in the large middle booth area can see patients directly and deputies indicated that the door to come inside the booth area is often open for patients to enter freely. Most deputies working in FIP Stepdown were carrying Narcan on their persons and the booths were equipped with emergency response kits with Narcan devices. High Observation Housing units at TTCF similarly had no Narcan accessible inside the dorms due to the housing classification.

The IRC Custody Line and IRC Booking area booths had emergency response kits with Narcan devices, and some, but not all deputies working at the booths had Narcan on their persons. Rows 202-220 in the IRC Custody Line unit did not have any laminated posters with Narcan as observed at MCJ.

The Mental Health Area of IRC, where people in custody wait for mental health assessments and screening, had multiple laminated posters with up to two Narcan devices each, signage throughout the room that Narcan is available, and all the deputies working at the booth had Narcan on their person, as well as emergency response kits equipped with Narcan. The IRC Release area was stocked with free Narcan devices, as well as fentanyl testing strips.

The ADA (Americans with Disabilities Act) unit that houses individuals with disabilities did not have any Narcan devices accessible within the dorm. Deputies indicated the same issue with misuse of the devices, but deputies had Narcan on their persons and in emergency response kits at the booth.

Century Regional Detention Facility

Office of Inspector General staff inspected the General Population (GP), Medium Observation Housing (MOH), High Observation Housing (HOH), restrictive, and disciplinary housing areas of CRDF.

In GP and MOH units, Narcan was consistently available and accessible to people in custody. The laminated posters with up to two Narcan devices each were affixed to pillars in common areas and on the wall behind deputy stations. Most posters had two devices attached to them. Additionally, most emergency response kits also contained at least two Narcan devices. People in housing units with common areas can readily access Narcan as needed while in common areas. Deputies and CAs consistently reported carrying one or two Narcan devices on their persons.

In HOH, restrictive, and discipline housing units, Narcan was broadly available but not readily accessible to people in custody because of their classification status. Each module consists of four pods, and incarcerated individuals in these units generally do not have access to the common areas for most of the day. Even when they are permitted into the common areas, Narcan is not available within the pods. Instead, Narcan is available on the hallway wall outside the pods and near the entrance to the housing module.

Incarcerated individuals identified at intake as being at risk for withdrawal or requiring medical observation are temporarily housed and monitored in a medical/detox module.[56] The module consists of four pods, but unlike other four-pod modules, where Narcan is not available within the pods, each medical/detox pod was equipped with Narcan devices. In the reception center, Office of Inspector General staff observed that the areas designated for Narcan devices were empty. Reception staff replenished the devices while Office of Inspector General staff monitored the area.

Recommendations

To improve accessibility of Narcan, the Office of Inspector General recommends the following:

1. Require that every deputy, custody assistant, and mental health assistant carry Narcan on their person, or at a minimum, require any deputy conducting Title 15 safety checks carry Narcan on their person.

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[56] CRDF Unit Order 5-21-00 Transitional Detox Program-CSS approved 12/14/2022.

2. Designate a deputy or CA to restock Narcan at each custodial facility during each shift.
3. Place Narcan at the start and end of each dorm row, and in a manner where people inside the cells can access the devices. All multiple-person dorms and two-person cells should have accessible Narcan.
4. Research the potential to use and make more readily accessible, Naloxone that does not use a needle, such as nasal spray, to limit the improper use of Narcan devices.
5. Record data on how often Narcan devices are found dismantled for the needles during routine searches to track prevalence of the problem.
6. Require nurses who conduct pill call and have viewed the Narcan nasal spray instructional video to carry Narcan. Although Narcan is readily available throughout custodial facilities, keeping it on the nurse's person or pill-call cart could provide more immediate access.
7. Place highly visible signs throughout custodial facilities at deputy booths that have Narcan. Since most booths have Narcan available, such signs will assist people in custody should there be a need for Narcan.
8. Ensure all schools and classrooms have accessible Narcan.

Prison Rape Elimination Act Compliance

The Prison Rape Elimination Act (PREA) is a federal law that establishes national standards to prevent, detect, and respond to sexual abuse and sexual harassment in correctional environments.[57] Institutionalizing the PREA standards establishes consistent practices for screening, staff training, reporting, and responses to incidents within Sheriff's Department jails and lockups.

Access to Emotional Support Services for In-Custody Victims of Sexual Abuse

PREA Standard §115.53, Inmate Access to Outside Confidential Support Services, requires that custody facilities provide "access to outside victim advocates for emotional support services related to sexual abuse by giving inmates … telephone numbers, including toll free hotline numbers where available, of local, State, or national victim advocacy or rape crisis organizations."[58]

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[57] 28 CFR Part 115.

[58] 28 C.F.R. § 115.53.

As the Office of Inspector General previously reported, the previous provider of emotional support services ceased providing services to victims of sexual abuse in Sheriff's Department custody at MCJ, TTCF, IRC, and CRDF due to lack of funding as of December 31, 2022. On June 28, 2024, the Inmate Welfare Commission approved $120,000 to fund 12 months of part-time emotional support services and monthly workshops for transgender people in custody at MCJ.[59] The services commenced in November 2024 and ended October 2025.

On April 23, 2026, the Sheriff's Department partnered with Valley Oasis to provide 24-hour telephonic emotional support services to people in custody at MCJ, TTCF, and IRC.[60] These services are provided at no cost to the Department.

Additionally, on May 4, 2026, the Sheriff's Department partnered with the Young Women's Christian Association (YWCA) to provide telephonic 24-hour emotional support services to people in custody at CRDF.[61] The YWCA will also provide trauma informed classes to people in custody at CRDF.[62] These services are provided at no cost to the Department.

Strength United continues to offer no-cost 24-hour telephonic emotional support services to people in-custody at NCCF, PDC-North, PDC-South, and PDC-East. Upon renewing the Memoranda of Understanding (MOU) with the Sheriff's Department on March 20, 2026, Strength United agreed to provide services to individuals housed at Sheriff's Department patrol station lockups, which surpasses the requirements of the PREA standards.[63] The Department reports that it is still working with its telephone provider to make services available at the patrol station lockups.

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[59] People in custody could dial a posted shortcut number from any jail telephone to speak with trained advocates on an unrecorded and unmonitored line Monday through Friday from 9:00 AM to 1:00 PM.

[60] Although services were available to people in custody as of April 23, 2026, the Memoranda of Understanding (MOU) was signed by Sheriff Robert G. Luna on June 11, 2026, and is effective for one year.

[61] In December 2025, there was a one-month trial run where Young Women's Christian Association (YWCA) was providing 24-hour emotional support services over the telephone to people in custody at CRDF, MCJ, TTCF, and IRC. The MOU for services at CRDF was signed by Sheriff Luna on July 21, 2026.

[62] The Sheriff's Department's Gender Responsive Services Unit is currently working with the YWCA to approved curriculum and create a schedule for the classes.

[63] PREA includes four distinct sets of standards tailored to different facility types: prisons and jails, lockups, community confinement facilities, and juvenile facilities. PREA Standard 115.53 is reserved from the lockup standards.

People in custody who have experienced sexual abuse and/or sexual harassment now have 24-hour access to confidential telephonic emotional support by dialing a posted shortcut number from any jail telephone to speak with trained advocates on an unrecorded and unmonitored line. In addition, when a forensic medical examination is required following an allegation of sexual abuse, an advocate from Strength United or the YWCA may accompany the victim to the local hospital in compliance with PREA Standard §115.21.[64] Also, victims transported to LAGMC for a forensic medical examination are offered an advocate upon arrival.

Reducing Harms for Incarcerated Transgender, Gender-Diverse and Intersex People

On April 7, 2026, the Los Angeles County Board of Supervisors passed a motion titled "Reducing Harm for Transgender, Gender-Diverse, and Intersex (TGI) People Who Are Incarcerated in the Los Angeles County Jails." The motion directs the Office of Inspector General to engage with incarcerated TGI people and review their access to services related to gender-affirming care, resources, housing, safety, programming, staff interactions, and other key areas. The Office of Inspector General is required to provide the Board with quarterly updates on these assessments and on the Department's implementation of related policies.

Throughout this reporting period, Office of Inspector General staff interviewed TGI people at MCJ, CRDF and TTCF and collaborated with the Department's Office of PREA Compliance (OPC), the Los Angeles County Lesbian, Gay, Bisexual, Transgender, and Queer + Commission (LGBTQ+ Commission), the American Civil Liberties Union (ACLU) and other stakeholders to review proposed policy revisions, discuss implementation, and evaluate progress on the Board's directive. The Department has made notable progress in improving its policies and engagement with the TGI population.

On June 30, 2026, the Sheriff's Department updated its CDM 5-06/010.05 *Allowable Inmate Property* to ensure TGI individuals receive items reflective of their gender identity and disseminated the policy electronically to all custody personnel. Although the commissary vendor's current catalog still separates items into "male" and "female" selections, TGI individuals are permitted to order items from the K-6G housing menu, which includes items from both the "male" and "female" menus.[65] While some

[64] 28 C.F.R. § 115.21.

[65] K6G is a segregated housing unit for individuals who identify as LGBTQI+ and limits interaction with the general population. Placement in K6G housing requires an interview to determine suitability.

transmasculine people at CRDF reported that the selection of male-related products remain insufficient, the Department's long-term plan is to eliminate gender-based labeling and transition to a restricted versus non-restricted item structure, in which limitations are based solely on safety considerations rather than gender identity. Full implementation is expected upon renewal of the vendors' contract, which will allow the Department to adopt gender-neutral language and expand access to all non-restricted items.

The Department has additionally revised its policy on razor access for TGI people after receiving grievances about difficulties obtaining razors.[66] Previously, unclear guidelines led to inconsistent access, especially in mental-health-related housing.[67] The updated policy clarifies that people with MOH classifications have access to razors and requires staff to provide razors for only supervised use when safety or mental health restrictions apply. These revisions aim to ensure safer, more consistent, and more dignified access for all people in custody. On a recent visit to MCJ, the Office of Inspector General did not receive complaints regarding razor access from TGI individuals, indicating that the policy change is likely resolving concerns about razor access. On June 30, 2026, CSSB disseminated the revised CDM policy to all Department personnel via a Custody Services Division Announcement.

As of June 30, 2026, the Department updated its CDM policies to standardize the provision of five bras and five panties and/or three boxers/briefs and three undershirts that are appropriately sized and aligned with each person's identity. [68] The previous policy only addressed the provision of undergarments to transfeminine people in custody and did not acknowledge the need for transmasculine people to access gender affirming undergarments. Although still in early implementation, TGI individuals at MCJ reported no concerns, and Office of Inspector General staff observed a surplus of gender-affirming clothing and undergarments available to people in custody upon request. In contrast, several transmasculine individuals at CRDF and transfeminine individuals at TTCF reported not receiving gender appropriate undergarments or receiving undergarments that were ill-fitting, underscoring the need for standardized procedures and consistent implementation across all facilities.

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[66] CDM 5-06/010.15 *Proper Handling of Razors*. (Policy has not been revised on LASD PARS website.)

[67] In some K6G housing units, people with MOH classifications are housed with GP people in custody.

[68] See CDM 5-06/010.05 *Allowable Inmate Property - Male Inmates* and CDM 5-06/010.10 *Allowable Inmate Property - Female Inmates*.

The Sheriff's Department's launch of the Gender Expansive Academic and Rehabilitation (GEAR.) classroom on March 2, 2026, reflects meaningful progress in providing therapeutic and rehabilitative programming for TGI individuals at MCJ. The Center for Health Justice (CHJ) is the primary provider, and the programming opportunities include life-skills, trauma-informed classes, and support groups while also providing opportunities for people in custody to earn work and milestone credits toward release. People in custody reported that they enjoy and look forward to the classes, noting that the program provides a positive and welcoming environment. The available opportunities also include recreational programming such as dance and art, as well as practical resources including library books, brochures with TGI resources, clean clothing, and hygiene kits with razors. Representatives from the LGBTQ+ Commission, the Office of Constitutional Policing and the Office of Inspector General observed GEAR programming. The classroom was full of participants engaging in an art class, and attendees praised the program and the Department's efforts to develop programming for the K6G population.

In September 2025, the OPC collaborated with the Office of Inspector General, Data Systems Bureau (DSB), Population Management Bureau (PMB), and community stakeholders to identify TGI people in custody with a unique identifier. The unique identifier functions as a discreet marker to notify staff of required search procedures, shower-privacy needs, appropriate pronoun usage, and other PREA-related protections. To ensure voluntary participation, an informed-consent process was established to explain the purpose of the identifier and allow TGI people in custody to opt out if they do not wish to be identified as TGI. On June 2, 2026, CSSB issued an Informational Bulletin directing personnel on the use of the unique identifier and began identifying people who consented to the unique identifier two weeks later.

In June 2026, the Sheriff's Department posted signs in the classification windows at the IRC advising newly incarcerated people of the availability of LGBTQI+ housing at MCJ.[69] Additionally, the Department will distribute flyers in sack lunches and has held

[69] "There is LGBTI+ housing available at Men's Central Jail. The housing is known as "K6G" housing and is a segregated housing location that prevents you from interacting with the general population. If you wish to be housed in the K6G housing dorms, you are required to complete an interview with me to determine your suitability for K6G housing. You can also choose to be housed with general population. You may change your mind after making either decision. Should you change your mind after making the decision. Should you change your mind, you can contact the nearest staff member and express your concern about your current housing or submit an Inmate Request Form requesting a new classification interview. Also, if you identify as Transgender or Intersex, you can request a Gender Identity Review Board interview to assess your housing suitability better. Please know that all opportunities afforded to the general population, such as credit earning ability and programming, are offered in K6G housing."

town hall meetings to inform LGBTQ+ people in custody of available housing options. Individuals who choose to be housed in the general population can change their decision at any time and request movement to K6G housing by speaking with Department staff or submitting an Inmate Request Form for a new classification interview. Those who identify as TGI may request a Gender Identity Review Board (GIRB) assessment to determine whether the individual may be transferred to their gender-affirming housing.

The GIRB policy establishes mandatory guidance concerning safety, medical needs, and housing of TGI people in custody[70] The GIRB committee is comprised of a multi-disciplinary team that evaluates objective criteria, including the requestor's medical and mental health needs, personal safety views, PREA screening results, and safety concerns to determine whether to transfer the requestor to their gender-affirming facility.

The Sheriff's Department recently generated a unit order governing the GIRB process. The Department recognized that re-housing determinations for TGI people in custody have been historically delayed due to GIRB scheduling and post-GIRB transfers, resulting in TGI people in custody being housed in non-gender affirming housing for extended periods of time.[71] The Department's updated unit order requires that GIRB meetings be held within five days of receipt of request[72] and that, in instances where the GIRB panel approves a person's request for gender affirming housing, the Department shall make "every effort…to transfer the [person in custody] within 24 hours."[73]

Though the unit order has developed institutional safeguards to prevent TGI people in custody from remaining in non-gender affirming housing, the Office of Inspector General has received complaints from TGI people reporting sexual harassment and increased safety risk due to improper housing assignments in non-gender-affirming housing. Ongoing delays, gaps in implementation, and operational inaction undermine policy safeguards and expose TGI individuals to preventable harm. The Office of Inspector General recommends that the Sheriff's Department develop a case-tracking system to

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[70] *See* CDM 5-02/050.00 *Classification, Screening, and Housing of Gay, Gender Non-Conforming, Intersex, and Transgender Inmates*.

[71] *See* *Office of Inspector General Reform and Oversight Efforts report*, July through September 2025, at page 29.

[72] Exceptions include when an assessment from Correctional Health Services is required, if required representatives cannot meet the five-business-day requirement, or further investigation time is required (based on articulable facts as to why further inquiry is required).

[73] *See* Los Angeles County Sheriff's Department, Custody Services Division Specialized Programs, Prison Rape Elimination Act (PREA) Gender Identity Review Board (GIRB) Unit Order, effective June 21, 2026. (Not posted online.)

monitor the time between when a GIRB is requested and when the meeting and movement take place.

Interviews conducted by the Office of Inspector General at MCJ, TTCF, and CRDF revealed that many TGI people in custody were unaware of the availability of GIRB assessments. Additionally, TGI people in custody who have requested a GIRB hearing have reported that they only became aware of the opportunity to request transfer to gender affirming housing after speaking with Office of Inspector General staff. The Office of Inspector General recommends that the Sheriff's Department continue to inform TGI people in custody of the opportunity to request a GIRB evaluation following a gender identity interview at initial intake and during Department town halls, and post signage informing TGI people in custody of GIRB hearings in K6G living spaces.

Although Sheriff's Department policy[74] outlining appropriate staff interactions with TGI individuals has long been in place, the Office of Inspector General has received complaints from TGI people at CRDF alleging that staff deliberately misgender and engage in disrespectful treatment. In contrast, TTCF and MCJ staff used correct pronouns when discussing individuals in their care and TGI people in custody stated that, even where staff misgendered them, it was not purposeful and quickly corrected. Although the unique identifier is intended to notify staff of PREA-related protections, it also serves as a staff-accountability measure to inform staff of a person in custody's gender identity to ensure respectful and dignified treatment. The Office of Inspector General will continue to monitor TGI people in custody's grievances concerning staff treatment to assess whether conditions improve.

As requested by the Board of Supervisors motion, the Sheriff's Department provided the Office of Inspector General with a comprehensive anonymized list of relevant complaints filed by people in custody. Using targeted keyword searches, the Department identified grievances submitted by LGBTQ+/TGI individuals between April 7, 2025, and April 7, 2026, which pertained to access to essential items and programming, staff conduct, self-identification, K6G/GIRB informational materials, and reports of interpersonal harm. Reports of interpersonal harm are investigated promptly to ensure safety and dignity at all times.

Of the 1,743 grievances submitted during this period, 186 were filed by TGI people in custody and fell within the reporting categories required by the motion. Many of the complaints concerned identification/classification and access to programming. Most grievances have been addressed, but some of the recent grievances are still under

[74] See Manual of Policies and Procedures, § 5-09/560.00 Interactions with Transgender and Gender Non-Conforming Persons.

Sheriff's Department review. The Office of Inspector General continues to assess the Department's responses to these complaints and to identify any potential gaps in reporting.

The Sheriff's Department has made meaningful progress in strengthening policies, expanding gender-affirming resources, and improving day-to-day conditions for TGI people in custody. Key accomplishments include updated commissary and clothing policies, institutionalizing clear guidelines to ensure consistent razor access, and the successful launch of the GEAR classroom, which has been overwhelmingly well-received by participants. However, delays in GIRB housing determinations remain challenges. Thus, the Office of Inspector General recommends that the Department continue to inform TGI people in custody of the opportunity to request a GIRB evaluation following a gender identity interview at initial intake and during Department town halls, and post signage informing TGI people in custody of GIRB hearings in K6G living spaces.

The Sheriff's Department's collaboration with stakeholders, responsiveness to concerns, and increased staff engagement demonstrate a strong commitment to advancing safety, dignity, and equitable treatment for TGI people in custody. Continued focus on consistent implementation will help ensure these gains are fully realized across all facilities.

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 second quarter of 2026, Office of Inspector General personnel completed 134 site visits, totaling 352 monitoring hours, at IRC, TTCF, CRDF, MCJ, PDC-North, PDC-South, PDC-East, NCCF, East Los Angeles Station, Lakewood Station, Lomita Station, Marina del Rey Station, Norwalk Station, and South Los Angeles Station.

As part of the Office of Inspector General's jail monitoring, Office of Inspector General staff attended 168 Custody Services Division (CSD) executive and administrative meetings and met with division executives for 223 monitoring hours related to uses of force, in-custody deaths, PREA compliance, restrictive housing, and general conditions of confinement.

Shower Access

During this reporting period, multiple people at MCJ who are housed in cells without a shower reported that custody staff are not permitting shower access, in violation of California State Law and Departmental policy. Although this summary focuses on MCJ,

the Office of Inspector General received similar complaints from people in custody at TTCF.

Title 15 of the California Code of Regulations requires that, absent exigent circumstances, incarcerated persons shall be permitted to shower/bathe at least every other day (or more often if possible) upon assignment to a housing unit. If showering is prohibited, it must be approved by the facility manager or designee, and the reason(s) for prohibition shall be documented.[75]

The Sheriff's Department policy reinforces Title 15 regulations and requires that all people in custody be allowed to shower at least every other day.[76] Any restriction requires unit commander approval documented in the e-UDAL. Department policy requires that accessible shower[77] usage be documented in the e-UDAL for people in custody with mobility impairments.[78] An MCJ unit order requires that all showers and shower refusals be documented in e-UDAL for people in custody housed in MCJ unit 1750, which is the most restrictive housing unit in MCJ.

The Office of Inspector General conducted a review of MCJ's CCTV footage and e-UDAL documentation for the period of April 1 through June 30, 2026, to assess whether the Sheriff's Department was compliant with Title 15 and departmental policies in general population (2500), restrictive (1750), and medical observation (7100) housing modules. Although policy requires the Sheriff's Department to permit showers every other day, a common practice within the jails is for custody staff to allow showers only three times per week. During this reporting period, the Office of Inspector General could not verify whether showers were permitted as recorded in e-UDAL for April due to the unavailability of CCTV footage.[79] In May and June, showers were permitted on Mondays, Wednesdays, and Fridays and CCTV footage confirmed showers occurred. However, the Office of Inspector General identified the lack of documentation in e-UDAL explaining why showers were prohibited on days showers should have been permitted in modules 1750 and 7100. Additionally, although showers

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[75] Cal. Code Regs., tit 15, §1266.

[76] Incarcerated workers and individuals making court appearances shall be permitted to shower daily. MCJ unit order requires that all shower offers, refusals, and shower access for court returnees be documented in the eUDAL. See MCJ Unit Order 5-17-031 *1700 1750 Procedures*.

[77] Accessible showers are designed to accommodate people in custody with mobility impairments.

[78] See CDM 5-13/040.00 *Showering*.

[79] CCTV footage was unavailable due to a system update.

were permitted three times a week, there were several weeks this quarter when showers were documented as only being permitted once per week.

This analysis indicated that showers are being permitted, but not at the frequency outlined in Title 15 and Departmental policies. The Sheriff's Department should align its practices with policy by permitting showers at least every other day, and review and reconcile their policies to ensure consistent documentation in e-UDAL to more clearly reflect when showers are permitted, prohibited, or refused.

Getting Out by Going In

Getting Out by Going In (GOGI) is an in-custody rehabilitation and life-skills program dedicated to supporting successful reentry and reducing recidivism through the use of the 12 GOGI Life Tools. According to GOGI and LASD, the tools are practical, mindset-shifting strategies developed to help people break free from destructive patterns, manage stress, and make positive choices and include Boss of My Brain, Belly Breathing, Five Second Lightswitch, Positive Thoughts, Positive Words, Positive Actions, Claim Responsibility, Let Go, For-Give, What If, Reality Check, and Ultimate Freedom. In February 2008, the Sheriff's Department first offered GOGI as a "full-immersion pilot program" known as the "GOGI Campus," at CRDF.[80] However, limited support led to the official program's discontinuation after only a brief period.[81] GOGI was officially relaunched at CRDF in December 2024 and is currently available throughout CRDF and in designated housing areas at MCJ, TTCF, NCCF, and PDC-North.

Although the Sheriff's Department has broadly supported GOGI since its relaunch, the program operated without dedicated funding until this quarter. Despite this, GOGI has achieved success through the efforts of students, line staff, and Department leadership. At CRDF, solo study is available in GP, MOH, HOH, restrictive, and disciplinary housing. In the FIP Stepdown program, Mental Health Assistants (MHAs) facilitate

[80] Special Counsel Merrick J. Bobb and Staff and Police Assessment Resource Center (PARC). *The Los Angeles County Sheriff's Department: 26th Semiannual Report* (Retrieved June 30, 2026).

[81] For several years, the program was offered informally in select housing areas at MCJ and later through the Community Transitions Unit's (CTUs) re-entry services.

regular peer support groups for students classified as HOH and occasionally engage in group study among each other.[82]

According to Sheriff's Department leadership, a few GOGI graduates at CRDF have successfully transitioned from HOH to MOH, and a small number later transitioned to GP. Although a formal study has not been conducted, the Department also indicated that the program may have contributed to an overall reduction in use of force and behavioral problems at the facility. Additionally, GOGI graduates have consistently described the program as transformative, reporting meaningful changes in how they make decisions, take accountability for their behavior, and approach their healing and growth.[83] Some have begun sharing the tools with family members and friends, and every graduate interviewed by the Office of Inspector General reported a renewed sense of hope and confidence in their ability to move forward with insight, accountability, and purpose.

As reported in the section on IWC approved expenditures, the program secured $200,000 from the Inmate Welfare Fund (IWF) to hire additional program staff and help graduates become certified GOGI coaches.[84] The Office of Inspector General is encouraged by this investment and recommends that the Sheriff's Department promptly use the funds to increase staffing and expand the program's valuable work.

Access to Forms

The primary method for incarcerated people in the Los Angeles County jails to make requests or to file complaints during their confinement is by submitting a written form.[85] Sheriff's Department policy requires that an adequate supply of Inmate Request Forms,

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[82] The Forensic In-Patient (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). The Sheriff's Department reported that having Mental Health Assistants facilitate peer support groups has helped the facility make progress toward providing adequate structured and unstructured out-of-cell time for individuals in High Observation Housing (HOH), as required by Provision 80 of the settlement agreement reached in *United States of America v. County of Los Angeles, et al.*, United States District Court, Case No. 2:15-CV-05903.

[83] The program tracks students' participation and progress and provides them with report cards and certificates.

[84] CDM 3-05/020.00 *Inmate Welfare Fund*. The IWF is a state-mandated fund financed by commissary purchases, hobby craft sales and vending sales. The IWF is to be expended by the Sheriff's Department via the Inmate Welfare Commission "primarily for the benefit, education, and welfare of inmates."

[85] See CDM 8-01/005.00 *Filing of Requests, Grievances, and Appeals*; CDM 5-04/010.00 *Psychiatric and Psychological Services*.

Grievance forms, and HSR forms (collectively, forms) be reasonably accessible to incarcerated people in all housing areas. [86]

Between April and June 2026, Office of Inspector General staff periodically verified the availability and accessibility of forms during site visits. Overall, the Office of Inspector General identified inconsistent and, in some cases, a complete lack of access to required forms. Many incarcerated people across jail facilities reported the same concern.

The Office of Inspector General found that many housing locations at CRDF, MCJ, NCCF, and TTCF did not have forms readily available in dedicated bins. Several incarcerated people reported having to verbally request forms from custody staff, which often resulted in delays or in some cases not receiving any forms at all. The practice of verbally requesting forms raises concerns that staff may withhold access, and in some instances may delay access to medical care or limit access to basic necessities. During some site visits, Office of Inspector General staff had to search for forms in different housing locations to assist people in custody who requested them.

Additionally, many designated form bins were either empty or did not have an adequate number of forms for the number of people housed in the location. To ensure compliance with Sheriff's Department policy and procedures, the Office of Inspector General recommends that forms be available and easily accessible in the designated bins during each shift and that line supervisors check the designated bins at least once per shift to ensure availability and access.

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 Department or CHS personnel by people in custody.[87] The Department's most recent force report is for use-of force-incidents in custody through the fourth quarter of 2025. This report and reports for prior quarters may be found on the Department website's transparency section under the page for use of force.

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[86] CDM 8-01/020.00 *Responsibilities*. "It shall be the responsibility of line personnel on each shift to ensure an adequate supply of Inmate Request Forms, Inmate Grievance Forms, and medical envelopes are available and reasonably accessible to inmates in the housing location. Line supervisors shall check each housing location a minimum of once per shift to ensure the forms and medical envelopes are reasonably available."

[87] Institutional violence is defined as assaultive conduct by a person in custody upon another person in 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.[88] The Department categorizes these comments into three categories:

- External Commendation: an external communication of appreciation for and/or approval of service provided by the Sheriff's Department members;
- Service Complaint: an external communication of dissatisfaction with the Sheriff's Department service, procedure, or practice, not involving employee misconduct; and
- Personnel Complaint: an external allegation of misconduct, either a violation of law or Sheriff's Department policy, against any member of the Sheriff's Department.[89]

The Sheriff's Department has a complaints dashboard that can be sorted by date range, with options to narrow the results by practice area (such as Patrol or Custody), rank, or station or unit.

Sheriff's Department's Response

The Sheriff's Department was provided with a draft of this report and sent a letter in response, which is incorporated on the following pages.

[88] *See Manual of Policy and Procedures*, MPP 3-04/010.00 *Department Service Reviews*.

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

OFFICE OF THE SHERIFF

COUNTY OF LOS ANGELES

HALL OF JUSTICE

ROBERT G. LUNA, SHERIFF

August 27, 2026

Mr. Eric D. Bates, Interim Inspector General
Office of Inspector General
County of Los Angeles
500 West Temple Street, Suite 383
Los Angeles, California 90013

Sent via Electronic Transmission

Dear Interim Inspector General Bates:

RESPONSE TO THE OFFICE OF INSPECTOR GENERAL'S REPORT, REFORM AND OVERSIGHT EFFORTS: LOS ANGELES COUNTY SHERIFF'S DEPARTMENT, APRIL THROUGH JUNE 2026

On August 14, 2026, the Office of Inspector General (OIG) provided the Los Angeles County Sheriff's Department (Department) with a validation draft of its report titled, *Reform and Oversight Efforts: Los Angeles County Sheriff's Department, April through June 2026,* and requested a response by August 24, 2026, ("Draft Report"). We thank the OIG for the opportunity to comment on the Draft Report.

The Draft Report was distributed to the Department units responsible for the subject areas addressed in the report. Following a review, the Department determined that, due to the amount of comments received, it is appropriate to respond in letter form to address certain statements that may benefit from clarification or additional context, provide corrections where necessary, and identify areas where the Department's position or understanding differs from that described in the Draft Report.

The following sections address the specific areas identified during our review.

Body-Worn Camera Buffering Time Section

The OIG recommended to the Department that it assess the feasibility, costs, labor considerations and operational benefits of increasing body-worn camera (BWC) pre-event buffer time from the current 60 seconds to 120 seconds.

The Department has evaluated that recommendation and concluded that it does not agree with the recommendation for the reasons noted below.

The Department's current 60-second, pre-event buffer was implemented with clear intention, grounded in extensive research, and has consistently proven appropriate and effective in practice. Prior to deployment in 2020, the BWC Unit surveyed agencies locally and nationwide and found that a 30-second buffer was overwhelmingly the prevailing best practice. The Department deliberately exceeded that standard by adopting a 60-second buffer to enhance transparency, capture late activations, and provide additional context before rapidly unfolding incidents. A follow-up survey in 2023 reaffirmed that 30 seconds remains the prevalent practice, with 77 percent of Los Angeles County agencies, 74 percent of Orange County agencies, and 70 percent of surveyed agencies nationwide using a 30-second buffer.

Expanding the buffer to 120 seconds is anticipated to create significant operational, technological, and labor impacts. A longer buffer sweeps substantially more non-evidentiary footage into each activation, increasing review and redaction workload at a time when staffing levels for records and discovery are already critically low. In contrast, the 60-second buffer already exceeds established practices and provides meaningful pre-incident context for investigations and administrative review.

We note that the OIG's report reflects an interest among some jurisdictions in requiring extended pre-event recording periods for BWCs, with discussions in some legislative bodies about adopting a 120-second buffer to preserve additional context before activation. The BWC Unit, however, was unable to identify any jurisdiction that has actually enacted such a 120-second mandate. In the few instances where legislatures have set explicit minimums, the requirements are 30 or 60 seconds. While Maryland did seriously debate a two-minute standard, the proposal was twice rejected in favor of a 60-second requirement.

While the Department respectfully disagrees with the OIG on this recommendation, the Department remains committed to transparency and accountability, and believes the 60-second buffer remains the best practice in

providing reliable pre-incident context for investigations, administrative reviews, and critical incident analysis.

Jail Overcrowding Section

The OIG report addresses the overcrowding in the Los Angeles County jails and its impact on safe and humane conditions of confinement. Although it was noted that the jail population has decreased, it still remains close to the system's rated capacity.

The Department continues to utilize various methods to manage the inmate population, including but not limited to, maintaining the misdemeanor bail at $50,000 (increased from $25,000); applying accelerated releases for all inmates by 30 days pursuant to California Penal Code 4024.1; keeping the percentage release at 10 percent of their court ordered sentences for non-violent charges; and releasing inmates with non-violent charges and short sentences of less than 240 days.

On October 1, 2023, Pre-Arraignment Release Protocols (PARP) was implemented and assisted in diverting additional incarcerated individuals who would have otherwise entered the Los Angeles County jail system. The Department continues to work with the California Department of Corrections and Rehabilitation (CDCR) to coordinate the transfer of incarcerated individuals sentenced to state prison.

During the first quarter of 2026, 489 incarcerated individuals were awaiting transfer to CDCR (SP – SP4). This represented approximately four percent of the total incarcerated population. The number of incarcerated individuals sentenced to state prison has stabilized, as the Department has sustained the number of newly sentenced state prisoners, and there is no backlog. As of March 31, 2026, there were 98 SP4 incarcerated individuals (all paperwork processed) pending transfer to CDCR.

The Department continues to work with state hospitals coordinating and quickly transferring inmates sentenced to go to state hospitals. During the first quarter of 2026, the average population of incarcerated individuals waiting to be transferred to state hospitals was 81, which amounts to a four percent year-over-year increase and represents approximately one percent of the total incarcerated population.

The Department continues to collaborate with the Office of Diversion and Reentry (ODR) on diverting qualified incarcerated individuals to ODR releases, who otherwise would have gone to state hospitals.

Commissary Prices Section

The Draft Report characterizes commissary pricing as involving Department "profit mark-ups." The Department does not purchase commissary items, add a profit mark-up, and resell them.

Under the Board-approved Keefe contract, Keefe conducts local market surveys and commissary prices are capped at comparable retail market prices. At the Board's direction, Keefe's revenue share to the Inmate Welfare Fund (IWF) was reduced from 50 percent to 39 percent to allow lower inmate prices.

In-Custody Deaths Section

The OIG reported attending the Custody Services Division Administrative Death Reviews and the Correctional Health Services (CHS) Mortality Reviews for each of the eleven (11) in-custody deaths that occurred between April 1, 2026, and June 30, 2026.

The "Areas of Inquiry" noted for each of the eleven (11) in-custody deaths summarized in the report were specifically derived from confidential and privileged in-custody death review meetings. The Department's position is that the "Areas of Inquiry" information should not have been included in the report.

Correctional Health Services Mortality Review Section

Office of Inspector General's Monitoring of Administrative Death Review and Mortality Review

The Draft Report states, "Similarly, at CHS Mortality review, medical leadership, who were no longer attendees at the Administrative Death Review, were unable to review CCTV or BWC to properly and thoroughly evaluate an emergency response."

The Custody Compliance and Sustainability Bureau Death Review Team collaborates with CHS staff to provide them any relevant video (CCTV/BWC) where it would assist them in evaluating their emergency responses.

In-Custody Overdose Deaths in Los Angeles County Jails Section

In the Department's efforts to improve narcotics intervention efforts, Custody Investigative Services (CIS) continues to take a proactive approach to the reduction of contraband within custody facilities through intelligence-driven

investigations, targeted enforcement operations, enhanced screening, K-9 searches, and strategic partnerships. These efforts are focused on identifying and disrupting contraband before it can enter or circulate within custody environments, while addressing emerging threats and factors that contribute to contraband-related incidents.

These combined efforts have contributed to a notable reduction in contraband-related activity in 2026, including decreases in jail-made weapon incidents, narcotics recoveries, and in-custody overdose deaths compared to the same period in prior years. The CIS K-9 Unit and Operation Safe Jails have been particularly effective in identifying and removing narcotics, jail-made weapons, cellular devices, and other prohibited items.

The Organized Crime Task Force (OCTF) remains focused on dismantling outside criminal groups involved in smuggling contraband into detention centers. Their search warrants have led to the recovery of fentanyl, heroin, methamphetamine, K-2 (Spice), firearms, and ammunition. Thanks to the CIS K-9 Unit's target searches in custody facilities, station jails, and courthouses, the overall number of suspected narcotics recovered has experienced a drop. Collectively, these initiatives demonstrate CIS' continued commitment to prevention, enforcement, and intelligence-based strategies that enhance the safety and security of custody facilities for staff and incarcerated individuals.

Sheriff's Department Search Statistics

Staff searches generally and staff searches with K-9 are continually briefed to the facilities, with documentation of these searches required in the Watch Commander's Log. A custody facility's security starts at its perimeter. Staff searches serve as a critical barrier to prevent contraband, narcotics, weapons, and other threats from entering. Staff searches are documented throughout Custody Services Division in the Custody Watch Commander Log, which allows the data to be tracked and verified across facilities.

Body Scanners and Searching People in Custody Section

The OIG recommends training additional custody assistants to operate body scanners to reduce reliance on sworn deputies, especially with their high overtime costs.

The Department already has an agreement with the relevant bargaining units that custody assistants will be utilized as the primary operators of the body scanner

system; however, the Department has struggled to hire personnel for that classification.

Although Twin Towers Correctional Facility (TTCF) does not have body scanners or trained personnel, TTCF inmates are body scanned by the Inmate Reception Center during the booking process, court returnee process, and when there is reason to believe they have contraband (narcotics/weapons) hiding on their person.

Facilities are continually training additional operators and their staff on the use of body scanners. Proper notifications were provided to each facility indicating that these sessions would be conducted in a "Train-the-Trainer" format. This process allows each facility to subsequently train its own personnel, particularly those who regularly operate the body scanners.

Accessibility of Naloxone in Custodial Facilities Section

The Draft Report indicated there were areas within Men's Central Jail (MCJ) that did not have Narcan readily available. According to the report, during one of the OIG's facility visits, they were told it was due to the deputy responsible for replacing it was on leave.

The MCJ has assigned a deputy whose responsibility is to monitor and restock Narcan supplies, and that deputy has not recently been on leave. While there was a period in which Narcan might have been unavailable, that issue has since been addressed and fully rectified. Narcan is currently available and is routinely stocked as required.

Additionally, a spot check confirmed that the deputy assigned to this responsibility is appropriately performing their duty and is maintaining Narcan supplies as required. The previously identified availability issue has been resolved, and appropriate procedures are in place to ensure continued availability.

As to Narcan availability, OIG recommends that Narcan be even more readily available and placed at the start and ends of each dorm row. While this reflects a legitimate concern regarding the increased availability of Narcan within a custodial setting, particularly as it relates to inmate overdoses and deaths. However, Narcan is intended as a life-saving intervention, unmonitored access can create unintended risks, including the potential for misuse of the needle contained in the Narcan dispenser.

This concern is not completely theoretical. Improvised syringes containing the Narcan packaging needle have been recovered following incidents of inmate overdose, demonstrating the potential for Narcan-related equipment to be deviate from its intended purpose and potentially contribute to drug-related activity within the facility.

The fact that Narcan can reverse an opioid overdose does not eliminate the security and operational concerns associated with making the medication and its delivery components readily accessible to inmates. A custodial setting requires that lifesaving measures be balanced against the potential for misuse, diversion, and unintended consequences.

Regarding Narcan signage, the OIG recommends the placement of highly visible signs throughout custodial facilities at deputy booths that have Narcan. Custody Services Division agrees with the recommendation to display signage at MCJ indicating that Narcan is available at designated workstations. Wording such as, "Narcan Available at This Workstation," or similar language would clearly identify the locations where Narcan can be accessed and help ensure all individuals are aware of its availability during an emergency.

Century Regional Detention Facility

At Century Regional Detention Facility, Module 1400 is the medical/detox module for incarcerated individuals identified as being at risk for withdrawal or requiring medical observation at intake. Unlike other four-pod modules within the facility where Narcan is not available within the pods, each medical/detox pod is equipped with Narcan devices.

In the reception center, the OIG reported their observations that the areas designated for Narcan devices were empty. Reception staff replenished the devices while the OIG staff monitored the area.

Office of Inspector General Site Visits Section

Shower Access

During the reporting period, the OIG was made aware that numerous inmates reported not being permitted shower access.

The MCJ recognizes that past practices on certain floors resulted in situations where showers were not consistently made available on designated days and

acknowledged that documentation in the electronic Uniform Daily Activity Log (e-UDAL) was not completed consistently or accurately.

To address these concerns, MCJ implemented a new shower program beginning on the 2000 floor and has since expanded the program to the 3000 floor. The program ensures that inmates are offered access to showers at least every other day.

As part of the implementation of this program, staff have been instructed to consistently document both completed showers and inmate refusals in the appropriate e-UDAL logs. These measures are intended to improve accountability, ensure consistent access to showers, and provide accurate documentation of shower offers and refusals.

Access to Forms

The Draft Report indicated that between April and June 2026, OIG staff periodically verified the availability and accessibility of forms during site visits, and overall identified inconsistent and, in some cases, a complete lack of access to required forms.

As a corrective measure, Custody Support Services Bureau's Correctional Innovation Technology Unit notified custody sergeants and lieutenants of an update to the Grievance Collection Log section of the e-UDAL. Upon retrieving completed grievance forms from the boxes, the e-UDAL will prompt supervisors to confirm whether any forms are available. When supervisors respond "YES" in e-UDAL, they will be permitted to electronically sign to the log. A "NO" response will prompt a "REASONING" field (i.e., why are there no forms available?) which is required to be completed. This recent update went live on July 8, 2026.

Conclusion

The Department takes the OIG reports seriously as they are a public presentation of the status of the Department's efforts in several areas. We recognize that these are complex reports for your office to compile and that many communications occur in the months prior to their publication. At the same time, the Department presents the above comments in an effort to ensure a complete presentation of the issues and to avoid misunderstandings with your office and the public.

Should you have any questions or concerns, please contact Commander Ernest Bille, Office of Constitutional Policing, at (323) 307-8358.

Sincerely,

ROBERT G. LUNA, SHERIFF

April Tardy

APRIL L. TARDY
UNDERSHERIFF