PUBLIC REQUEST TO ADDRESS
THE BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES, CALIFORNIA

Correspondence Received

MEMBERS OF THE BOARD

HILDA L. SOLIS
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JANICE HAHN
KATHRYN BARGER

			The following individuals submitted comments on agenda item:	
Agenda #	**Relate To**	**Position**	**Name**	**Comments**
42.		**Other**	Melissa Camacho	see attached pdf
		Item Total	**1**	
Grand Total			**1**	

As of: 10/7/2026 9:00:14 AM

ACLU
AMERICAN CIVIL LIBERTIES UNION FOUNDATION
Southern California

September 25, 2026

Via Email
Los Angeles County Board of Supervisors
Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Re: *Rosas* compliance presentation for October 6, 2026 Board Meeting

Honorable Members of the Board of Supervisors:

The *Rosas* panel filed their Seventeenth Report with the federal court on September 8, 2026. (Report attached). LASD made its *Rosas* compliance presentation to the Public Safety cluster on September 16, 2026 and is scheduled to present to the Board on October 6, 2026. We are submitting this letter in advance of the presentation to highlight issues we believe the Board should focus on when it questions the Sheriff's Department and the Monitors.

THE ACLU SHOULD BE INCLUDED IN PRESENTATIONS TO THE BOARD ON *ROSAS* COMPLIANCE

Before addressing the issues posed by the Monitors' Seventeenth Report we request that the Board include representatives of the ACLU of Southern California as presenters on *Rosas* compliance along with LASD and the Monitors. There are multiple reasons why the ACLU should be included in the *Rosas* presentation. The ACLU has been monitoring conditions in the jail for more than 30 years. Our reports about violence in the jails[1] were a key driver of the Board's decision to create the Citizens Commission on Jail Violence.[2] We are one of the

[1] *See, e.g.*, Sarah Liebowitz, Peter Eliasberg, et al., *Cruel and Usual Punishment: How a Savage Gang of Deputies Controls LA County Jails*, (ACLU So Cal Sept. 2011), available at https://www.aclusocal.org/app/uploads/2016/11/97165508-Cruel-and-Unusual-Punishment-How-a-Savage-Gang-of-Deputies-Controls-LA-County-Jails.pdf

[2] The Board created the Citizens Commission on Jail Violence less than a month after the ACLU released its jail violence report. See October 18, 2011 Board Motion of Supervisors

EXECUTIVE DIRECTOR Chandra S. Bhatnagar

PRESIDENT Carlos Amador **VICE PRESIDENT** Malek Moazzam-Doulat

appointed counsel for the Plaintiff class in the *Rosas* case. Yet despite having equal status in the *Rosas* case with the Sheriff's Department we are forced to provide our perspective only through letters to the Board and public comments, which generally last only one minute. Finally, our perspective is particularly important because, as illustrated below, LASD's compliance reports generally provide an incomplete and overly optimistic view about what is happening in the jails.

Nothing in the *Rosas* court-ordered settlement prohibits the ACLU from participating in the compliance presentations. Paragraph 1.4 of the Implementation Plan, which is incorporated in the *Rosas* settlement, requires the Department to "report regularly to the Board of Supervisors on use of force and the status of the Department's compliance with this Implementation Plan."[3] But the Plan does not bar the Board from including others in the compliance presentations, as it has already done by inviting the *Rosas* Monitoring Panel to participate.

ISSUES PRESENTED BY THE SEVENTEENTH REPORT AND LASD's PRESENTATION

First, it is notable that the Sheriff's Department Presentation contains no negative information, only rosy assessments about the Department's *Rosas* compliance.[4] Yet, the Panel's Seventeenth Report contains a substantial amount of negative information, as has been the case in all the previous reports by the Panel. The Public Safety Cluster, the Board of Supervisors, and the public are poorly-served by the Sheriff's compliance presentation if it is largely a Potemkin Village – a false façade presenting an exclusively positive and therefore inaccurate picture.

Second, the Presentation makes no mention of the discussion in the Seventeenth report about a horrific force incident in Twin Towers during which two deputies

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Yaroslavsky and Ridley Thomas creating The Citizens Commission on Jail Violence and highlighting ACLU report, available at https://ccjv.lacounty.gov/wp-content/uploads/2012/02/Board-Motion-Amendment-10-18-11_1.pdf

[3] The Implementation Plan is attached as Exhibit 1 to the Joint Motion for Preliminary Approval and Notice of Settlement, *Rosas* Dkt 110.

[4] In this letter, we are referring to the slides the Department presented at the cluster meeting on September 16. Presentation available at https://file.lacounty.gov/SDSInter/clusteragendas/1217351_2026.09.16agendaanddocs-publicsafety.pdf. We recognize the Department may alter its presentation in light of some of the pointed questions from the justice deputies. However, because we wanted the Board to have this letter well in advance of the October 6, 2026 meeting, we are referring to LASD's cluster meeting slides rather than waiting to see the exact presentation LASD makes to the Board.

threw a person in handcuffs with serious mental illness into the metal frame of a plexiglass window, breaking his neck and causing him to become quadriplegic. He later died in a rehabilitation facility. The Panel found the use of force out of compliance with the *Rosas* use of force provision for head strikes. Yet the Department found the use of force **in compliance** with the relevant *Rosas* use of force provisions.[5] Seventeenth Report at p. 24. [6]

More significantly, the Monitors identified a number of clear inconsistencies between the officers' report and what was clearly observable on the videos of the incident. Specifically, the principal deputy claimed the "inmate had 'charged' him" while the Monitors noted "the video evidence depicts the inmate standing up, walking towards his cell, and *not* charging the deputy." *Id.* (emphasis added).

The Panel's Report noted another significant inconsistency between one of the involved deputy's report and the video evidence:

> Moreover, the video does not depict the deputy "guiding" the inmate to the floor. It depicts a rapid takedown that resulted in catastrophic injuries.

Id.

Despite these blatant inconsistencies, the Sheriff's Department's Executive Force Review Committee did not even flag the possibility of any inaccurate or dishonest reporting in its review of the use of force, much less discipline any involved deputy for dishonesty. *Id.*

Given the seriousness of the incident[7] and the catastrophic injury the incarcerated person suffered from being thrown head-first into a window frame, the failure of the Executive Force Review Committee to act on the multiple instances of

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[5] LASD did find violations for failing to use proper de-escalation tactics and for mistakes made after the force was over – e.g., failure to properly assess the incarcerated person's injuries. But the Department found the force used to be reasonable. During the cluster presentation, Commander Tomalsoff restated the Department's position that the incident did not qualify as a head strike because the deputies did not use personal weapons, i.e., fists or knees to strike his head.

[6] Citing to the page number at the lower left corner in the Seventeenth Report, not the pdf page number.

[7] While the Panel correctly found the force incident out of compliance with the *Rosas* head strike provision, *Rosas* 2.6, the incident arguably should be evaluated under the Department's even more stringent standard for "deadly force," which apply to situations in which a deputy "deliberately or recklessly strik[es] an individual's head against a hard, fixed object (e.g., concrete floor, wall, jail bars, etc.)." But under any standard, the force was clearly improper.

inaccurate or dishonest reporting is incredibly troubling. If deputies break someone's neck and cause them to become quadriplegic, and the use of force review completely ignores blatant inconsistencies between the involved deputies' descriptions of the force and the clear video evidence, it severely undermines LASD's rosy assessment of its "Accountability Infrastructure." *See* Compliance Presentation page 6 ("Force investigation, review and oversight have all been strengthened.").[8]

This brutal use of force that caused a handcuffed person with mental illness to be paralyzed and later die, and LASD's failure to impose accountability for it, would be tragic on its own. But it is not a one-off. The Monitors have identified repeated incidents that they have found to be clear violations of *Rosas* use of force provisions and/or involve dishonest reporting that LASD has rubber stamped.

- In the Fifteenth Report, the Monitors discussed an incident where, in the aftermath of an inmate-on-inmate assault multiple deputies intervened. One inmate continued to resist and "four of the nine deputies involved punched the inmate 10 times, **six times in the head.** The Panel found the head strikes out of compliance, but "[a]ll levels of supervisory review found the force used to be objectively reasonable." Panel's Fifteenth Report, Dkt. 347, p. 3.

- In the same report, the Monitors described two additional very troubling incidents that they found to violate *Rosas* use of force of provisions, but which LASD found **in policy.** In addition, the Monitors expressed deep concern about the clear inconsistencies between the officers' use of force reports and the videos of the incidents. Yet LASD held no one accountable for the obvious misstatements in the use of force reports.

- The first incident can be viewed on the internet by using this link. https://www.youtube.com/watch?v=h1RntgTinMk
  The Monitors described the incident as follows:

[8] The ACLU urges the members of the Board to review the videos of the force incident, any interviews of the victim, and the deputies' reports and statements to Internal Affairs for yourselves.

> In the first case, two deputies removed a high-security, handcuffed inmate from his cell in order to escort him down a narrow jail hallway. Both deputies went hands-on, with one deputy gripping the back of the inmate's neck. **The inmate's head forcefully struck the window ledge of the wall** opposite his cell. In the deputy's use of force report, he claimed his hand ended up behind the inmate's neck by accident, that the inmate quickly turned and that it was the inmate's own momentum that drove his head into the wall/window ledge. This claim was belied by the video evidence, which reflected the deputy braced his body for leverage with his hand gripping the back of the inmate's neck, and drove the inmate's head into the window ledge. Serious head lacerations resulted from this impact, as depicted in this photo. While some discipline was imposed for the incident, "**no Rosas violations were found as to the force itself.**"

Panel's Fifteenth Report, Dkt. 347, p. 6 (emphasis added).

- The second incident involved use of significant force, including three punches to the face, of an incarcerated person with profound mental illness who was in a suicide gown. The Department credited deputies' reports that they responded to aggressive behavior from the incarcerated person even though no video evidence supported those assertions. The video contained very brief "gaps," but the Monitors concluded that the video showed the victim "sitting calmly as staff approached." Moreover, the Monitors found the deputies' reports not credible "because their reports included verbiage that was 'almost identical' and contained the same rare, unique errors, such as the phrase 'handcuffed immediately handcuffed" in both reports. Panel's Fifteenth Report, Dkt. 347, pp. 6-7.

Moreover, this significant failure of the Department to identify clear use of force violations and false reporting and hold LASD personnel accountable for them, long predates the most recent reporting periods. The Panel has repeatedly called out LASD for failing to take proper steps to rein in dishonest reporting. Here are just a few examples from the Panel's previous reports:

> As noted above, the Panel remains concerned that inaccurate reporting by Department staff regarding uses of force is not being consistently identified and addressed. Indeed, in the majority of cases where the Panel has found the use of force to be out of policy there is at least one report, either by the offending staff member or a witnessing staff member, that does not accurately describe the use of force or the inmate's conduct that prompted the use of force.

Panel's Ninth Report, Dkt. 203, p. 17.

> The Panel has previously noted its concern that reviewed use of force packages include staff reports that are inaccurate and self-serving, but which are not treated as "dishonesty" or "integrity" issues by the Department. In this Report, the Panel has found the Department Out of Compliance with Sections 5.2 (Commanders' reviews); 5.3 (unexplained discrepancies); and 15.3 (reports of force by other members), based on reports that do not accurately describe the use of force or the inmate's conduct that prompted the uses of force.

Panel's Tenth Report, Dkt. 205, p. 18.

> The Panel has previously noted concerns with Use of Force packages including staff reports that are inaccurate and self-serving, but which are not treated as "dishonesty" or integrity issues – see Seventh Report (p. 18), Eighth Report (p. 15) and Ninth Report (p.15 Fn 26). In a few of the force packages reviewed for this Reporting Period, the Panel saw staff reports that were either inconsistent with the video evidence or were not forthcoming about their own actions. For example, a Deputy had placed his knee on an inmate's neck for 46 seconds. In his report, he noted he had "inadvertently" positioned his knee over the inmate's upper back and neck area. This characterization was not identified as dishonest or problematic in the supervisor reviews of the matter.

Panel's Eleventh Report, Dkt. 238, p. 33.

> The Panel is concerned that the Department does not appropriately identify policy violations, does not consistently and thoroughly refer inaccurate reports for administrative investigation, and has inconsistencies in staff reports compared to CCTV footage.

Panel's Fifteenth Report, Dkt 347, p. 16.

Effective review of use of force incidents whereby LASD personnel are held accountable for use of force violations and dishonest reporting are core components of an effective accountability system. As correctional expert Eldon Vails explains:

> [T]he core components necessary to a well functioning correction system where force is used appropriately are 1) good policies, which are clear, well-organized, and specific on use of force – when it may be used and what kind of force is appropriate in given circumstances; 2) appropriate academy and in-service training on those policies; 3) good supervision by senior officers of use of force by line personnel **4) a system of review of force incidents that is thorough and unbiased, and 5) a system of fair but firm discipline for improper use of force and inaccurate or dishonest reporting on uses of force.**

Expert Declaration of Eldon Vails ¶ 4, *Rosas* Dkt. No. 130-6 (emphasis added). The OIG agrees, concluding in a recent report: "To achieve compliance with the *Rosas* Settlement Agreement, investigations must be unbiased and rigorous, and discipline must be imposed."[9]

Yet for years LASD has failed to put in place an effective system of identifying force violations and dishonest reporting and imposing appropriate discipline, despite the Monitors repeatedly identifying LASD's failures.

We will never know for certain if the brutal use of force against a person in handcuffs with mental illness that caused him to become quadriplegic would have been avoided if LASD had instituted an effective system of accountability in response to years of warnings from the *Rosas* Monitors. But we do know that correctional experts have opined for years that only if LASD has in place a system

[9] Reform and Oversight Efforts: Los Angeles County Sheriff's Department October through December 2025, at p. 12

to hold staff accountable for the kinds of incidents highlighted above, will staff abide by proper use of force policies and standards. In 2023, Steve Sinclair, former Director of the Washington State Department of Corrections wrote after reviewing multiple use of force packages and reports from the *Rosas* Monitors:

> Effective staff training is essential, **but ultimately it is constant and effective supervisions and management and holding staff accountable that will cause those policy expectations to become practice.** Based on the material I have reviewed, it is my opinion that LASD has failed to hold employees accountable to published use of force standards.

Expert Declaration of Steve Sinclair ¶ 15, *Rosas* Dkt. 255-1 (emphasis added).

It is high time for LASD to stop approving improper force and dishonest reporting by officers. It is also high time for LASD to defend these failures by simply trying to write them off as "disagreements with the Monitors." If LASD's failure to have an effective system of accountability continues, there is a significant likelihood that other people in the jails will be severely injured -- even paralyzed or killed -- because officers know that there will likely be no repercussions for engaging in out of policy force and then lying about it.

For the remainder of this letter, we highlight issues the Panel raised in the Seventeenth Report that contradict the rosy picture presented in the Department's slides.[10]

Compliance Snapshot, slide 3:

Nineteen provisions were moved to non-reporting status, but not at the Panel's request. Defendants first approached the panel and class counsel, asking to move the provisions to non-reporting status. We agreed, with the caveat that they would put resources saved from reporting into working on compliance with provisions at the heart of the consent decree.

[10] We are referring to the slides the Department presented at the cluster meeting on September 16. We recognize the Department may alter its presentation in light of some of the pointed questions from the justice deputies. However, because we wanted the Board to have this letter well in advance of its October 6 meeting, we are referring to LASD's cluster meeting slides rather than waiting to see the exact presentation LASD makes to the Board.

The provisions are not "released from monitoring." "The Panel reserves and retains the right to reinstate any of those provisions to reporting status, without Court involvement, if the Department makes changes that are contrary to those provisions or if the Panel becomes aware that the Department is no longer in compliance with any of the nineteen (19) provisions." Seventeenth Report at p. 2.

Measured Outcomes, slide 4:

Much of the decline on the slide, which shows declines in uses of force and category 2 uses of force compared to 2016 and declines in head strikes since 2020, can be attributed to the decline in overall population. The average daily inmate population (ADIP) in 2016 was 16,613.[11] The ADIP in 2025 was 13,054.[12]

One can see the impact of lower numbers of people in custody on the head strike numbers as well. The Measured Outcomes slide indicates 60 head strikes in 2020, the year of the COVID-19 population reduction. That year, ADIP went down to 14,212, a 17% decrease from the year before.[13] From April through August 2020, the ADIP held below 13,000, reaching a low of 11,867.[14] The following year, the ADIP went up to 14,576,[15] and the following slide ("The Progression") notes that head strikes also increased to 82 in 2021.

Reducing overcrowding has a positive impact on overall uses of force and head strike incidents. The County should consider population reduction when discussing paths to compliance with the *Rosas* provisions.

We cannot verify, and the Panel has not reported, on the 2025 numbers presented here because the Seventeenth report only covers 1Q25 and 2Q25. Seventeenth Report at p. 5. Moreover, graphs in the Seventeenth Report show that all is not well, especially at MCJ.

Head strikes at MCJ have gone up for three reporting periods in a row. "MCJ has had consistent increases in head strikes over the last three reporting periods – from five (5) to seven (7) to nine (9)." Seventeenth Report at p. 5. To address issues with head strikes at MCJ, "The Panel requests the Department evaluate these head strike incidents at MCJ to determine if there are commonalities across incidents and corrective measures to implement to decrease the use of head

[11] Custody Division Year End Review 2017, p. 8 (showing ADIP numbers from 2011 to 2017).
[12] Custody Division Population Year End Review 2025, p. 3.
[13] Custody Division Population Year End Review 2020, p. 3.
[14] *Id.* at p. 7.
[15] Custody Division Population Year End Review 2021, p. 3.

strikes." *Id.* The Department's report does not contain any indication that they plan to conduct the recommended evaluation.

Most of the decline in head strikes over the last three reporting periods can be attributed to the IRC, Seventeenth Report at p. 5, which is a fundamentally different facility now that it no longer suffers from massive overcrowding and delay.

The Progression, slide 5:

We cannot verify the total of 29 head strikes in 2025. The 17th report counts 26 head strikes through 3Q25, including 11 in 3Q25 alone, an 83% increase in head strikes from 2Q25 to 3Q25. Seventeenth Report at p. 5. Were there only 3 head strikes in 4Q25? That number is likely too low to be credible, given the previous low of 6 head strikes in a quarter. Note too that the Department did not count the incident described above, where deputies threw a man head-first into the wall, as a head strike because they did not punch or kick him in the head.

In several places in the report, the Panel notes that the Department has been exceedingly slow in getting use of force packages to the panel. Indeed, in a footnote to the sentence where the Panel notes that the Department achieved compliance with 2.6 for the first time, the Panel notes that it reviewed fewer head strike cases in this reporting period than in the previous two: "For this reporting period, the panel reviewed 13 cases involving head strikes, which is lower than the 19 cases in the Sixteenth Reporting Period and 15 cases in the Fifteenth Reporting Period." Seventeenth Report at p. 6 n.3. There appears to be a backlog in head strike cases that may be masking problems with non-compliance.

We do not dispute that tighter policy and better training have contributed to the lower number of head strikes. To sustain compliance, however, the Department must commit to accountability for policy violations and dishonest reporting.

Accountability Infrastructure, slide 6:

Missing from the Department's report is any acknowledgment of the egregious violations detailed by the Panel or any of the admonitions contained in the report.

The Panel emphasizes the need for timely reviews. "In order to achieve compliance with the *Rosas* Action Plan, the Department must focus on accountability, which begins with the Department conducting thorough and timely force reviews and, if warranted, administrative investigations. The Department is

not completing its force reviews in a timely manner and has not documented for the Panel that sufficient actions are being taken to address these delays. Force reviews often take several months to over one year to complete." Seventeenth Report at p. 6.

The Panel notes that CFIT has not sped the review, as Defendants promised the panel (and the Board) that it would. Seventeenth Report at p. 7. While CFIT review has sped the *first level* of review (and that first level appears to be what is tracked on slide 6), the Panel has not seen a change in total review time. The Panel instead notes that "[f]ive (5) of the cases reviewed during this reporting period took the following days from the dates of the incidents to Commander (final stage) review: 424 days, 255 days, 340 days, 322 days, and 567 days." Seventeenth Report at pp. 6-7.

The delay in getting packages to the panel inhibits effective review and monitoring: "Delays in the Panel receiving force packages are a significant and ongoing problem that is adversely impacting the Panel's ability to assess recent cases and inform the Court of what is currently occurring at the jails." Seventeenth Report at p. 7.

Pages 11-12 of the Seventeenth Report detail significant issues with lack of accountability with policy violations. The Panel calculates that discipline takes an average of 471 days and up to 966 days. Seventeenth Report at p. 12. The Panel expressed concern about the "efficacy of imposing discipline over two and a half years after the policy violation." *Id.* Corrective actions fail to deter misconduct when discipline is not imposed in a timely manner.

The Panel describes one case in which a deputy violated a use of force policy, received a 15-day suspension but never served it because he committed – and was discharged for – a separate incident. "Discipline was imposed 401 days after the Department became aware of the second policy violation and 583 days after the Department became aware of the initial violation." Seventeenth Report at p. 12.

As discussed above, neither of the deputies who threw a handcuffed man into a wall – for no reason at all – paralyzing him and ultimately leading to his death, received any discipline for the force used. As far as we are aware, those deputies are currently employed by the Department and on the County's payroll. If so, they are a danger to the incarcerated population and a liability to the County.

<u>Inmate Grievances, slide 7:</u>

The Panel found the Department out of compliance with provision 8.1, Anti-Retaliation. Only 2 of 308 retaliation grievances filed across 3 reporting periods have been investigated, leaving an unaddressed backlog that prevents any meaningful assessment of outcomes. Seventeenth Report at p. 43. The grievance system, particularly when it comes to investigating reports of misconduct or retaliation, is broken.

The decline in overall grievance numbers is mostly attributable to ACLU SoCal's decision to stop filing third-party grievances for issues not related to our active lawsuits. We went from filing thousands of grievances a year to just over 300 in 2025. The Panel also noted that grievance boxes in the housing units did not contain forms in their April 2025 visit. Seventeenth Report at p. 38. The Office of the Inspector General (OIG) reported on serious problems with access to grievances in their most recent quarterly report. "Overall, the [OIG] identified inconsistent and, in some cases, a complete lack of access to required forms."[16] They found empty grievance or inadequately filled grievance bins and raised concerns that "staff may withhold access to forms" in areas where people cannot access the bins themselves.[17]

At the August 2026 Sybil Brand Commission meeting, Commander Montoya also explained that the Department puts a cap on the number of grievances incarcerated people can file: only four grievances a month.[18] This policy artificially suppresses the total number of grievances that would be filed if people had unlimited access and unlimited ability to register complaints or seek help.

Thank you in advance for taking the time to read the Seventeenth Report and ask critical questions at the Board meeting. We hope this letter provides a necessary counterpoint to the Department's self-serving presentation.

Sincerely yours,

[16] Reform and Oversight Efforts: Los Angeles County Sheriff's Department, April through June 2026, at p. 57.
[17] *Id.*
[18] Sybil Brand Commission Meeting Minutes, August 6, 2026, at p. 7

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Enc.

Cc: Justice Deputies