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INTERIM INSPECTOR GENERAL

April 20, 2026

TO: Michael P. Dempsey  
Monitor for California Department of Justice

FROM: Eric Bates   
Interim Inspector General

**SUBJECT: Monthly Report for February 2026 on Internal Affairs Bureau Investigations, Closed-Circuit Television Review, and Searches at Barry J. Nidorf and Los Padrinos Juvenile Halls**

This monthly report reviewing the Los Angeles County Probation Department's (Probation Department) compliance with the Internal Affairs Bureau (IAB) investigations, closed-circuit television review, and search mandates outlined in the Order Amending Stipulated Judgment (Amended Order) for the Barry J. Nidorf Juvenile Hall (BJNJH) and Los Padrinos Juvenile Hall (LPJH) covers the month of February 2026.

## Review of IAB Cases

The Amended Order in paragraph 18 requires the Office of Inspector General to report the number of new IAB referrals, open cases, and results of investigations conducted by the Probation Department. The Probation Department provided documentation to the Office of Inspector General indicating the following:

## Summary of Amended Order Compliance

February 2026

| Referrals <sup>1</sup> | Opened Cases <sup>2</sup> | Results of Completed Investigations  |
|------------------------|---------------------------|--|
| 21                     | 10                        | <ul style="list-style-type: none"><li>▪ 3 investigations were <i>Sustained</i> (1 criminal and 2 administrative)</li><li>▪ 0 investigation were <i>Not sustained</i></li><li>▪ 0 investigations were <i>Unfounded</i></li><li>▪ 7 <i>Bureau Determination</i><sup>3</sup></li></ul> <p>(89 total number of current open cases - 69 administrative, 20 criminal).</p> |

The Office of Inspector General did not review the underlying facts of the investigations to form an opinion as to whether the results were appropriate, or if the investigations were conducted properly.

### Closed-Circuit Television

The Amended Order (paragraph 20) requires that the Office of Inspector General randomly select two days per month to determine the Probation Department's compliance with the Department's Closed-Circuit Television (CCTV) review protocol. The Office of Inspector General is to review documentation and video recordings of use-of-force incidents and assess whether (1) the incident violates Department policies, the Amended Order or state law, (2) the incident has been properly identified and elevated to the appropriate Department staff and (3) the video recording was tampered with. Substantial compliance requires verification by the Office of Inspector General that

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<sup>1</sup> New cases referred to IAB for consideration for investigation.

<sup>2</sup> Cases opened for investigation by IAB during the month of February 2026.

<sup>3</sup> Cases rejected for investigation by IAB because they do not fit the criteria for a formal investigation and sent to the facility Bureau Chief at the facility to provide training or other non-disciplinary action to Probation Department staff.

the Department is compliant with its CCTV review protocol.<sup>4</sup> The Office of Inspector General reviewed CCTV video recordings to assess proper documentation of use-of-force incidents as well as the identification by Department staff of possible violations of law, judgment, or policy, and the proper elevation of such incidents for review. The Office of Inspector General also reviewed CCTV logs and monitored Department compliance with its CCTV protocols.

## Methodology

The Office of Inspector General constructed a sample of two days of CCTV video recordings relating to use-of-force incidents at BJNJH and LPJH for the month of February 2026. Office of Inspector General staff reviewed Physical Incident Reports (PIR), Safe Crisis Management Incident Reviews (SCM), as well as available CCTV video recordings. The Amended Order requires monthly verification by the Office of Inspector General that the Probation Department properly identifies and elevates use-of-force incidents that are not in compliance with its policies, the original stipulated judgment, or state law.

## February 2026 – Los Padrinos Juvenile Hall

### Case Summary 1

Two youths started fighting in a living unit.<sup>5</sup> A Deputy Probation Officer (DPO 1) intervened and gave an Oleoresin Capsicum (OC) spray warning before deploying OC spray on Youth 1 and Youth 5. Youth 6 was contaminated by OC overspray. Youth 1 and Youth 2 stopped fighting. Across the living unit, Youth 2, Youth 3, and Youth 4 started fighting. DPO 2 intervened and utilized an Extended Arm Assist technique to separate Youth 2, Youth 3 and Youth 4. DPO 3 gave an OC spray warning and Youth 2, Youth 3 and Youth 4 complied and stopped fighting. DPO 3 and DPO 4 arrived and assisted in escorting all youths to their living units. Youth 1, Youth 5, and Youth 6 were decontaminated in a timely manner.

Multiple youths were not medically assessed within the required time frame. Youth 1 was medically assessed 36 minutes after containment of the incident, Youth 5 was medically assessed 1 hour and 3 minutes after containment of the incident, Youth 3 was

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<sup>4</sup> The Amended Order does not provide a numerical value for determining compliance.

<sup>5</sup> SCM LPJH 2026-0397.

medically assessed 1 hour 48 minutes after containment of the incident, Youth 4 was medically assessed 1 hour and 26 minutes after containment of the incident, Youth 5 was medically assessed 1 hour and 4 minutes after containment of the incident, and Youth 6 was medically assessed 39 minutes after containment of the incident. Child Safety assessments were not completed within one hour for Youth 4, Youth 5, and Youth 6. CCTV video for this incident was available.

| Violation of Policy or Law   | Failure to Identify and Elevate  | Evidence of Video Tampering           |
|--|--|---------------------------------------|
| <p style="text-align: center;">YES</p> <ul style="list-style-type: none"><li>▪ Youths were not medically assessed in a timely manner.<sup>6</sup></li><li>▪ PIR was not properly documented.<sup>7</sup></li><li>▪ Child Safety assessments were not completed in a timely manner.<sup>8</sup></li></ul> | <p style="text-align: center;">YES</p> <ul style="list-style-type: none"><li>▪ The SCM reviewer did not identify the lack of documentation for Youth 6.</li><li>▪ The SCM reviewer did not properly identify the Child Safety Assessment policy violation.</li></ul> | <p style="text-align: center;">NO</p> |

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<sup>6</sup> DSB Section 1008 (C) provides: “Any youth involved in a physical intervention incident in DSB facilities shall be referred to medical staff for assessment no later than thirty (30) minutes following containment of the occurrence.” The Probation Department indicated that the delay in medical assessment was due to the occurrence of multiple incidents.

<sup>7</sup> Youth 6 was not listed as an involved minor in the PIR and Section M of the PIR did not document the overspray of Youth 6.

<sup>8</sup> DSB Section 1008 (B) provides: “Upon being notified that a physical intervention incident as occurred, the duty supervisor shall immediately conduct a Child Safety Assessment (CSA) involved in the incident . . . The CSA shall be completed within *one hour* of being notified.” (Emphasis added) The Probation Department indicated that the delay was due to notification and staffing circumstances. Youths 4, 5, and 6 were not timely assessed.

## Case Summary 2

Six youths started fighting on the recreation field.<sup>9</sup> A DPO (DPO 1) intervened and gave an OC spray warning before deploying OC spray on Youth 1. A supervising Detention Services Officer (Sr. DSO) assisted and separated Youth 1 and Youth 2. Youth 3 and Youth 4 started fighting and DPO 1 gave an OC spray warning before deploying OC spray on Youth 3 and called for staff assistance. Youth 5 and Youth 6 started fighting and DPO 1 gave an OC spray warning and deployed OC spray on Youth 4. Assisting staff responded and escorted the youths from the field. Youth 1 and Youth 3 were decontaminated within the required timeframe but Youth 2 was decontaminated 1 hour and 17 minutes after containment of the incident. Youth 1 and Youth 3 were medically assessed within the required timeframe but Youth 2 was medically assessed 1 hour and 55 minutes after containment of the incident. CCTV video for this incident was available.

| Violation of Policy or Law  | Failure to Identify and Elevate   | Evidence of Video Tampering           |
|---|---|---------------------------------------|
| <p style="text-align: center;">YES</p> <ul style="list-style-type: none"><li>▪ Youth was not decontaminated in a timely manner.</li><li>▪ Youth was not medically assessed in a timely manner.<sup>10</sup></li><li>▪ Child Safety assessments were not conducted in a timely manner.</li></ul> | <p style="text-align: center;">NO</p> <ul style="list-style-type: none"><li>▪ The SCM reviewer properly identified the policy violations.</li></ul> | <p style="text-align: center;">NO</p> |

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<sup>9</sup> SCM LPJH2026-0561.

<sup>10</sup> The Probation Department indicated the delay was attributable to the number of youths involved and the need to secure the scene prior to escorting youths to medical.

## February 2026 – Barry J. Nidorf Juvenile Hall

### Case Summary 1

A youth started operating a teacher’s laptop computer in a classroom and was instructed by the teacher to step away from the laptop.<sup>11</sup> A DPO (DPO 1) also instructed the youth to step away from the laptop. The youth became verbally aggressive, prompting DPO 1 to use an Upper Torso physical intervention technique to grab the youth and place him on the floor, where he was handcuffed. DPO 2 and DPO 3 assisted and escorted the youth to his room. The youth was medically assessed within the required timeframe following the incident. CCTV video for this incident was available.

| <b>Violation of Policy or Law</b>  | <b>Failure to Identify and Elevate</b>  | <b>Evidence of Video Tampering</b>    |
|--|---|---------------------------------------|
| <p style="text-align: center;">YES</p> <ul style="list-style-type: none"><li>▪ The Physical Intervention Packet was incomplete.</li><li>▪ Supervising staff failed to immediately speak with the youth and DPO following the incident. <sup>12</sup></li></ul> | <p style="text-align: center;">NO</p> <ul style="list-style-type: none"><li>▪ The SCM reviewer properly identified the policy violations.</li></ul> | <p style="text-align: center;">NO</p> |

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<sup>11</sup> SCM BJNH – 2026-0291.

<sup>12</sup> DSB 1008 provides: “All use of force incidents must include a post-incident debriefing with any staff or youth who was involved or witnessed the use of force to mitigate the effects of trauma and training. These debriefings must be conducted by a supervisor or higher within four (4) hours after completing the CSA. Documentation of the post-incident debriefing must be completed on a SUP PIR using PCMS and submitted to the Force Review Coordinator for review.”

## Case Summary 2

Two youths started to fight in a living unit.<sup>13</sup> A DPO intervened and gave an OC warning. The youths continued to fight and the DPO deployed OC spray on Youth 1. A DSO assisted and gave an OC spray warning and deployed OC spray on Youth 2. Youth 3 picked up a trash can and threw it towards Youth 2. The DSO deployed OC spray on Youth 3. Other staff arrived and assisted with escorting the youths to their rooms. Youth 1 and Youth 3 were decontaminated in a timely manner, but Youth 2 was decontaminated 25 minutes after the incident. Youth 3 was medically assessed in a timely manner, but Youth 1 was medically assessed 1 hour and 31 minutes after containment of the incident, and Youth 2 was medically assessed 57 minutes after containment of the incident. CCTV video for this incident was available.

| Violation of Policy or Law   | Failure to Identify and Elevate   | Evidence of Video Tampering           |
|--|---|---------------------------------------|
| <p style="text-align: center;">YES</p> <ul style="list-style-type: none"> <li>▪ Youths were not medically assessed in a timely manner.</li> <li>▪ Youth was not decontaminated in a timely manner.</li> <li>▪ Physical Intervention Report was not accurately completed.<sup>14</sup></li> </ul> | <p style="text-align: center;">YES</p> <ul style="list-style-type: none"> <li>▪ The SCM reviewer failed to identify the incomplete Physical Intervention Report.</li> </ul> | <p style="text-align: center;">NO</p> |

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<sup>13</sup> SCM BJNH-2026-0302.

<sup>14</sup> Section D of the DPO's PIR does not list the DSO as being involved. Section D of the SCM incident review does not list the DSO as being present. The narrative sections of both the PIR and the SCM review summary note the involvement of the DSO.

## Search Logs

The Amended Order Detailed Plan in paragraph 25 requires the Office of Inspector General to review a randomly selected, representative sample of searches conducted by the Probation Department to determine the Department's compliance with its search policies and state law, and that searches were accurately documented. The Amended Order mandates that the Department follow its policies and state law in 90% of all searches. The Department's policy requires a *minimum* of *two* random searches of youths' rooms on the living unit during the morning and evening work shifts. (Required Searches).<sup>15</sup> Based on this policy there should be four total searches per living unit per day. In addition, the Department conducts body scans of youths in its interdiction efforts.<sup>16</sup>

## Methodology

The Office of Inspector General requested documentation relating to all searches conducted for all living units in both work shifts for the month of February 2026. In response, the Probation Department provided search logs for 964 work shifts at BJNJH and 1024 at LPJH for February 2026.<sup>17</sup>

The Office of Inspector General randomly selected and reviewed four days of living unit searches conducted by Probation Department staff during morning and evening shifts

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<sup>15</sup> Detention Services Bureau (DSB) Manual 700, Section 715 and Secure Youth Treatment Facility Manual 700, Section 715 provides: Staff shall search youth's rooms daily. At the minimum, two (2) random room searches shall be conducted per each AM and PM shift. Searches should be scheduled in a manner that does not create a pattern for the youth to predict such searches. During the search, if any weapons or contraband are found, staff shall complete a Special Incident Report (SIR) and follow the procedures per the Crime Scene Evidence Preservation/Evidence Handling policy.

<sup>16</sup> Directive 1519 provides: Staff members conducting the body-scan and those within sight of the visual display shall be of the same sex as the youth being scanned or adhere to the youth's stated gender search preference as indicated on the Unit Classification form. (Penal Code § 4030; 15 CCR 1360). The body scanner viewing monitors shall not be in direct view of other youth.

<sup>17</sup> The daily searches reviewed were conducted in all 18 units at BJNJH and all 18 units at LPJH. In addition to daily unit searches by unit staff, there are also occasional searches by Special Enforcement Operations (SEO) officers or unit staff, typically based on suspicion(s) and/or observed activities reported by unit staff. At BJNJH, SEO or unit staff conducted 7 such searches in February 2026, and 15 at LPJH.

for all units at BJNJH and LPJH.<sup>18</sup> The Office of Inspector General determined compliance primarily based on information provided in the Department’s search logs.

## Findings

### Unit Searches

The Office of Inspector General found that with a 92% compliance rate BJNJH met the requirements for conducting the Required Searches, meaning the Probation Department is in compliance with the Amended Order. LPJH failed to meet the requirements for conducting the Required Searches, with an 88% compliance rate.

### Barry J. Nidorf Juvenile Hall

Of the sampled four days of unit searches at BJNJH in February 2026, the Probation Department conducted searches per unit as follows:

| 73 Sampled Living Unit Searches   |
|---|
| <i>4 searches per unit</i> – 67 times; 92% of the sampled living units. |
| <i>3 searches per unit</i> - 0 times; 0% of the sampled living units.   |
| <i>2 search per unit</i> - 2 times; 3% of the sampled living units.     |
| <i>1 search per unit</i> - 0 times; 0% of the sampled living units.     |
| <i>0 searched per unit</i> - 4 times; 5% of the sampled living units.   |

The Office of Inspector General’s review found that at BJNJH, the Probation Department conducted two searches per shift (four searches per day), as required by its

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<sup>18</sup> The four days reviewed were February 10, 2026, February 19, 2026, February 23, 2026, and February 25, 2026. In constructing the samples described in this report, the Office of Inspector General followed current government audit standards to obtain a statistically valid sample and used a research randomizer to select incidents. (Off. of the Comptroller of the United States, U.S. Accountability Office (2018), <https://www.gao.gov/yellowbook>).

policy in 92% of the sampled living units and is therefore in compliance with the Amended Order.

### Los Padrinos Juvenile Hall

As noted above, the Probation Department policies require each living unit to be searched twice per morning and evening shifts, for a total of four (4) searches per day. Of the sampled searches at LPJH in February 2026, the Department conducted searches per living unit as follows:

| 74 Sampled Living Unit Searches   |
|---|
| <i>4 searches per unit</i> – 65 times; 88% of the sampled living units. |
| <i>3 searches per unit</i> – 2 times; 3% of the sampled living units.   |
| <i>2 searches per unit</i> – 7 times; 9% of the sampled living units.   |
| <i>1 search per unit</i> - 0 times; 0% of the sampled living units.     |
| <i>0 searches per unit</i> - 0 times; 0% of the sampled living units.   |

The Office of Inspector General’s review found that at LPJH, the Probation Department conducted two searches per shift (four searches per day), as required by its policy in 88% of the sampled living units and is therefore not in compliance with the Amended Order.

### Body-Scan Searches

The Office of Inspector General requested documentation relating to all body-scan searches conducted in February 2026. Based on documentation provided, the Probation Department conducted 210 body scans at BJNJH and 730 at LPJH. The Office of Inspector General selected and reviewed a representative sample of searches for February 2026: 35 for BJNJH and 151 for LPJH.

The Probation Department is required to document each body scan in its electronic Probation Case Management System (PCMS). In addition, each body-scan search is

required to be conducted by a Department staff of the same sex/gender as the youth being searched.<sup>19</sup>

For BJNJH, based on the Office of Inspector General's review of PCMS records and body-scan documentation, the Probation Department entered body-scan information into PCMS in 23 of the 35 (66%) body scans conducted. In addition, the Department conducted appropriate same sex/gender body scans in 34 of 35 (97%) of the body scans conducted on the youths. BJNJH is in compliance with the Amended Order regarding conducting same sex/gender body scans, but not in compliance with properly entering body-scan information into PCMS.<sup>20</sup>

For LPJH, based on the Office of Inspector General's review of PCMS records and body-scan documentation, the Probation Department entered body-scan information into PCMS in 146 of the 151 (97%) sampled searches conducted. The Department conducted required same sex/gender body scans in 150 of 151 (99%) of the body scans conducted on the youths. LPJH is in compliance with the Amended Order regarding conducting same sex/gender body scans of youths and properly entering body-scan information into PCMS.<sup>21</sup>

## Conclusion

The Office of Inspector General continues to recommend that the Probation Department: (1) continue to properly review CCTV video recordings for misconduct

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<sup>19</sup> Directive 1519 provides: Each youth's scan records shall be included in their file and PCMS to prevent exceeding annual scan limits upon transfer within juvenile facilities. Staff members conducting the body scan and those within sight of the visual display shall be of the same sex as the youth being scanned or adhere to the youth's stated gender search preference as indicated on the Unit Classification form. (Penal Code § 4030; 15 CCR 1360). The body scanner viewing monitors shall not be in direct view of other youth.

<sup>20</sup> The Office of Inspector General also noted that only 66% of the body scans were conducted by Probation Department staff with certification for conducting body scans.

<sup>21</sup> Directive 1519 requires all staff members to complete comprehensive training prior to the operation of the body scanners. This comprehensive training includes a (2) hour course which addresses system operations, fundamental safety protocols and radiation safety, as well as hands-on training in scanning and camera operation. After certification, staff are also required to complete an annual refresher training. The Office of Inspector General noted that only 45% of the body scans were conducted by Probation Department staff with certification for conducting body scans.

Michael P. Dempsey, Monitor

April 20, 2026

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involving uses of force and investigating and determining whether staff engaged in misconduct, (2) continue to conduct living unit searches as required by policy, (3) continue to enter body-scan information into the PCMS system, (4) continue to ensure that body-scan searches are always conducted by a staff member of the same gender as the youth searched or the stated gender search preference of the youth, (5) ensure that medical assessments are conducted in a timely manner.

c: Guillermo Viera Rosa, Chief Probation Officer  
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Edward Yen, Executive Officer  
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