Seventh Report on the Probation Department's Compliance with the Department of Justice Settlement Agreement on Juvenile Halls

July 17, 2025

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SUMMARY OF DETAILED PLAN COMPLIANCE

Issue	Compliance
OC Spray	
At least 90% of the OC spray decontaminations reviewed comply with Probation Department policy and state law. (Detailed Plan ¶14(a).)	Out of compliance. The Probation Department properly followed the decontamination policy and properly documented compliance in 15% of incidents reviewed at LPJH and 60% at BJNJH. Although there were some notations regarding decontamination in 87% of incidents reviewed in either the incident review or narrative of associated PIRs at LPJH and 100% at BJNJH, those notations did not document decontamination sufficiently for the Office of Inspector General to determine if staff used proper decontamination procedures.
Document whether staff complies with policies and state law regarding decontamination after the use of OC spray in at least 90% of all uses of OC spray on youths in juvenile hall facilities. (Detailed Plan ¶14(a).)	LPJH: Out of compliance. The Probation Department properly documented compliance in 15% of the incidents. BJNJH: Out of Compliance. The Probation Department properly documented compliance in 60% of the incidents.
Maintain an internal process to provide training in 90% of OC spray incidents where the Probation Department identifies a training need. (Detailed Plan ¶ 14(c).)	BJNJH: Out of compliance. The Probation Department identified training needs in only one OC spray incident but failed to verify that training was provided. LPJH: Unable to determine compliance. The Department failed to review *any* of the OC spray incidents and therefore did not identify training needs.

Issue	Compliance
Use of Force Review	
All use-of-force incidents not accepted by the Probation Department's Internal Affairs Bureau (IAB) must be timely reviewed by the Department's Force Intervention Response Team (FIRST). (Detailed Plan ¶15.)	BJNJH: Out of compliance. Staff timely submitted use-of-force incidents that were not accepted by IAB to FIRST for review in only 67% of incidents.[1] LPJH: Out of compliance. Staff timely submitted use-of-force incidents that were not accepted by IAB to FIRST for review in 0% of incidents.
At least 90% of the cameras in juvenile facilities must be operational, in use, and provide sufficient coverage to capture use-of-force incidents. (Detailed Plan ¶ 17.)	BJNJH: In compliance. Probation Department reported a total of 97 use-of-force incidents at BJNJH. In its review of a sample of 12 incidents, the Office of Inspector General found that 100% of the incidents reviewed provided sufficient coverage to capture the use of force, and were properly video recorded [2] LPJH: Out of compliance. Probation Department reported a total of 892 use-of-force incidents at LPJH. In its review of a sample of 81 use-of-force incidents, the Office of Inspector General found that only 80% of the cameras provided sufficient coverage to capture the use of force, and only 67 had video recordings.[3]

[1] BJNJH had 97 use-of-force incidents during the reporting period. However, only use-of-force incidents occurring in December (28) were submitted to FIRST. Of those 28 use-of-force incidents, only 67% (17 of 28) were submitted to FIRST in a timely manner.

[2] All 12 use-of-force incidents had video recordings, but 2 incidents were not video recorded because they occurred in a restroom and a living unit, respectively, which don't have cameras for privacy reasons.

[3] In the sample of 81 use-of-force incidents, video recordings were provided for 67 use-of-force incidents, 14 incidents either occurred in an area where there were no video cameras or missing video recordings. Included in the 67 video recordings provided to the Office of Inspector General, were 2 video recordings that failed to capture the use of force – one occurred in a living unit hallway without a video camera, the other occurred in a restroom which do not have video cameras.

Issue	Compliance
Properly use video recordings to determine policy violations in 90% of use of force incidents. (Detailed Plan ¶ 17.)	BJNJH: Out of compliance. The Probation Department properly reviewed 75% of the sampled incidents. LPJH: Unable to determine compliance. The Office of Inspector General reviewed a sample of 81 use-of-force incidents at LPJH and received video recordings for only 67 incidents. The Probation Department provided Video Review forms for only 6 use-of-force incidents with video recordings. It is unknown whether the Department staff viewed the video recordings for the remaining 59 use-of-force incidents. Of the 6 Video Review forms provided, the Department properly viewed 33% of the indicated viewed use-of-force video recordings.
Prison Rape Elimination Act (PREA)	
Privacy Curtains: The County will use Prison Rape Elimination Act (PREA) certified auditors from the Office of Inspector General to monitor compliance on ensuring that privacy curtains are properly installed and consistently maintained in the bathrooms of all Units. (Detailed Plan ¶ 22(a).)	In compliance at both BJNJH and LPJH. Facilities continue to have several shower doors and curtains that provide adequate privacy while still maintaining safety.
Opposite Gender Announcements: The County Prison Rape Elimination Act (PREA) certified auditors from the Office of Inspector General to monitor compliance on ensuring that staff of the opposite gender announce their presence when entering a housing Unit. (Detailed Plan ¶ 22(a).)	In compliance at both BJNJH and LPJH. During unannounced visits conducted between July 1, 2024, and December 31, 2024, the Office of Inspector General found consistent compliance with opposite-gender staff announcing their entry into the living units.
Room Confinements	
The County must create an internal process approved by the Monitor to	Partial compliance. The Probation Department has created but still not

Issue	Compliance
maintain and improve documentation related to and monitoring of youth who are placed in Room Confinement, including the development of individualized plans, and the provision of programming, recreation, exercise, and religious services, and verify the data, to assess implementation and develop appropriate corrective measures, as needed. (Detailed Plan ¶ 20.)	implemented an approved internal process to track room confinements, provide prompt notification of room confinements that violate policies and state law, document remedial measures, and provide the Office of Inspector General data regarding room confinement.
The Detailed Plan will include mechanisms for providing prompt notice to the Juvenile Hall Superintendent of instances of Room Confinement that do not comply with the requirements of Welfare and Institutions Code section 208.3 and for developing and implementing subsequent remedial measures in response to such instances. (Detailed Plan ¶ 20.)	Not applicable this Reporting Period. All room confinements reviewed complied with Department policies and state law, and without non-compliance cases, the Department's remedial measures in response to confinements that do not comply with state law cannot be measured. The Department still lacks sufficient internal processes, including a computerized database as required by the Detailed Plan, to ensure that all non-compliant room confinements are identified and documented thoroughly.
In 90% of Room Confinements that do not comply with the requirements of Welfare and Institutions Code section 208.3, time appropriate subsequent remedial measures must be implemented. (Detailed Plan ¶ 20.)	Not applicable this Reporting Period. All room confinements reviewed complied with Department policies and state law, and without non-compliance cases, the Department's remedial measures in response to confinements that do not comply with state law cannot be measured. The Department still lacks sufficient internal processes, including a computerized database as required by the Detailed Plan, to ensure that all non-compliant room confinements are identified and documented thoroughly.
Activities	
The Detailed Plan requires that Department staff document and log any denial of required activities by providing the staff member's reason for denial, the	In compliance. The Office of Inspector General reviewed all 29 room confinements that occurred at LPJH and all 109 that occurred at BJNJH

Issue	Compliance
signature of the staff member, and the validation of the superintendent of the facility. (Detailed Plan ¶24(c)(i-iv).)	during the reporting period. In all facilities, staff documented findings that a youth posed a threat to the safety and security of the facility in writing in 100% of the incidents.
The Detailed Plan requires that the Probation Department provide required activities for at least 93% of youths at LPJH and BJNJH who have not been found to pose a threat to the safety or security of the facility. (Detailed Plan ¶ 24(c)(i-iv).)	Unable to determine compliance for either BJNJH or LPJH. The Probation Department did not provide complete documentation of program activities for the reporting period of July to December 2024 for compliance calculations.[4]
The Detailed Plan requires that required activities are not denied as a form of punishment, discipline, or retaliation. (Detailed Plan ¶ 24(c)(i-iv).)	In compliance for both BJNJH and LPJH. The Office of Inspector General's review did not find the denial of any required activities due to punishment, discipline, or retaliation by the Probation Department staff.
The Detailed Plan prohibits room confinement on the basis of a youth's refusal to participate in required activities. (Detailed Plan ¶ 24(c)(i-iv).)	In compliance for both BJNJH and LPJH. The Office of Inspector General's review did not find room confinement because of a youth's refusal to participate in required activities.

[4] The Probation Department only provided the Office of Inspector General exception logs for youths that did not attend program activities. It did not provide documentation of when program activities were not available for the youths. In addition, the Department failed to provide logs regarding religious services, visitation, and phone calls.

Issue	Compliance
Grievances	
The County will implement a revised grievance policy and 90% of grievances are resolved in accordance with the approved policy. (Detailed Plan ¶ 31(a).)	In partial compliance. The Office of Inspector General reviewed the Probation Department's Grievance Log and determined that the Department resolved 90% of grievances at BJNJH and LPJH in accordance with the Department's current policies. The Department indicated that the Grievance Management System had a technological problem and was taken offline June 2024 by Probation Department IT. All grievances will continue to be handled manually until the problem is corrected, which the Department expects will be in early 2025. Probation still has not procured the grievance kiosks for youths to electronically file their grievances, although as previously reported, it has reported that it had identified a vendor that can provide appropriate kiosks with the necessary durability. The Department does not have an expected completion date and, indicated that the new kiosks will not exclude the use of hardcopy grievances.

BACKGROUND

On January 21, 2021, the Los Angeles County Superior Court approved a stipulated judgment and settlement agreement (Settlement Agreement) between the County of Los Angeles and the California Department of Justice (DOJ).[5] Pursuant to its role as court-appointed monitor on various provisions of the Settlement Agreement relating to conditions at Los Angeles County Juvenile Halls, the Office of Inspector General submits this *Seventh Report on the Los Angeles County Probation Department's Compliance with the Settlement Agreement* covering the period from July 1, 2024 to December 31, 2024 (Reporting Period).

This report includes data and compliance determinations for key benchmarks based on information provided by the Probation Department. However, as noted throughout this report, the Department's continued lack of effective systems to document and track uses of force, room confinements, grievances, and other incidents in the juvenile halls and camps raises concerns about the accuracy of the documentation provided to the Office of Inspector General.[6] Despite the Department's lack of effective tracking systems, the Office of Inspector General conducted a manual review of logs, case files, and other documentation to assess the Department's overall compliance with the Los Angeles County Detailed Plan (Detailed Plan) for monitoring compliance with the Settlement Agreement.

DECONTAMINATION AFTER USE OF OLEORESIN CAPSICUM SPRAY

Despite stated efforts to eliminate the use of Oleoresin Capsicum (OC) spray in juvenile halls as required by the Los Angeles County Board of Supervisors (Board), the Probation Department still provides its staff at LPJH and the SYTF facility at BJNJH with OC spray.[7] The Detailed Plan mandates that the Probation Department follow its

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[5] See *People v. County of Los Angeles* (Super. Ct. Los Angeles County, 2021, No. 21STCV01309.)

[6] The Probation Department provided logs for use-of-force incidents at BJNJH and LPJH. The logs provided indicated two different amount totals for use-of-force incident for both facilities: BJNJH - 97, 91, and LPJH - 712, 861. A review of the PCMS system by the Office of Inspector General indicated a total of 97 use-of-force incidents at BJNJH and 861 at LPJH. The Office of Inspector General cannot provide an explanation for the discrepancy in the total.

[7] The Probation Department eliminated the use of OC spray in Central Juvenile Hall units that incarcerate youth with developmental disabilities, girls, and gender-expansive youth, pursuant to a Board motion on December 22, 2022. However, on July 28, 2023, Probation Department Chief Viera Rosa sent an email directing the Department to issue OC spray on a temporary basis to permanently assigned staff. The Department has not rescinded that

policies and state law and properly document compliance in 90% of all incidents in which Department staff used OC spray on youths.[8]

Methodology

The Office of Inspector General requested documentation relating to all OC spray incidents, including investigations and reviews, that occurred between July 1, 2024, and December 31, 2024. In response, the Probation Department provided PIPs for 290 incidents, of which 25 occurred at BJNJH and 265 at LPJH.

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email directive or provided any date for the OC ban to be implemented. In a letter to the Board dated September 12, 2024, the Probation Department stated, "The Department continues to collaborate with the California Department of Justice Court appointed monitor to develop an updated OC spray phase out strategic plan. Probation is committed to downscaling and ultimately eliminating the use of OC, and the plan will be completed by the end of the second quarter of 2024."

[8] DSB § 1006 "Post OC Spray Application Protocols" provides:

> Under no circumstances shall Officers delay decontamination of a youth exposed to OC spray for the purpose of punishment or due to a lack of attention. Youth shall be decontaminated immediately, but no later than ten (10) minutes after containment of the incident. If decontamination within ten minutes is not feasible, justification must be provided in the PIR [Physical Intervention Report]. The failure to affect the timely decontamination of the youth immediately upon concluding the chemical intervention and containment of the incident will result in disciplinary action. All youth exposed to OC spray shall be directly supervised until the youth are fully decontaminated or are no longer suffering the effects of the OC spray. Youth exposed to OC spray shall not be left unattended. Officers must ensure that all post-OC spray application protocols are followed immediately after each use of chemical intervention.

California Code of Regulations, Title 15, § 1357(b), governing the use of chemical agents such as OC spray in juvenile facilities, imposes the following requirements:

> (b) Facilities that authorize chemical agents as a force option shall include policies and procedures that:
>
> …(3) outline the facility's approved methods and timelines for decontamination from chemical agents. This shall include that youth who have been exposed to chemical agents shall not be left unattended until that youth is fully decontaminated or is no longer suffering the effects of the chemical agent.
>
> …(5) provide for the documentation of each incident of use of chemical agents, including the reasons for which it was used, efforts to de-escalate prior to use, youth and staff involved, the date, time and location of use, decontamination procedures applied and identification of any injuries sustained as a result of such use.

The Office of Inspector General selected and reviewed a sample of 20 OC spray incidents that occurred at BJNJH and a sample of 71 incidents from LPJH.[9] The Office of Inspector General determined compliance primarily based on information provided in the Probation Department's Physical Intervention Report (PIR) for each incident, including the information required in Section M, "OC Spray Deployment," which must be completed each time Department staff deploy OC spray on a youth. Because Department policy requires staff to complete Section M to document compliance with its decontamination policy, the Office of Inspector General only considered cases in which Section M was properly completed.

Findings

The Office of Inspector General found that BJNJH and LPJH, failed to meet the requirements of the Detailed Plan. At BJNJH, 60% (12 of 20) of the sampled incidents properly documented the decontamination process. At LPJH, 15% (11 of 71) of the sampled incidents reviewed properly documented the decontamination process after use of OC spray as required by policy and state law. In 100% (20 of 20) of the sampled incidents at BJNJH, and 87% (62 of 71) at LPJH, Probation Department staff made notations indicating the decontamination of youth after the use of OC spray, either in the incident review or the narrative sections of the associated PIRs.[10] However, because of the failure to include the required decontamination information in Section M or in the narrative sections, the Office of Inspector General cannot adequately determine if youths were properly decontaminated, and therefore, the Department failed to comply with the requirements of the Detailed Plan. This is the second reporting period in which there was significantly more mention of decontamination procedures in the Department staff's reports than what was properly documented in section M. Given the failure to achieve the mandated compliance rate, the Office of Inspector General recommends that the Department re-train staff on the importance of documentation requirements and hold them accountable for failing to properly document decontamination, to ensure both that youth receive required care following application of OC spray and that documentation accurately reflects the Department's decontamination efforts.

Adoption of Review Checklist. During the previous Reporting Period the Probation Department began using the "Physical Intervention Packet Review Checklist" (Review

[9] 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.)

[10] The Office of Inspector General reviewed other sections of the sampled PIRs to determine if information regarding decontamination was memorialized elsewhere in the reports.

Checklist). This checklist reviews and details many of the components of Section M in a checkbox format. The addition of this checklist aids in determining the accuracy and efficiency of the decontamination process, preventing the need to look through numerous documents to get a clear understanding of an OC incident and the decontamination process

The Review Checklist contains a section entitled “Suggested Corrective Action,” that does not have a checkbox, in which the reviewer can address concerns about Probation Department staff actions and make recommendations for the staff member to review certain policies and protocols or receive additional training. However, in this Reporting Period, no reviewer suggested any training in any of the Review Checklists. A specific box for training would be helpful in identifying and addressing training as mandated by the Detailed Plan.

Also included on the Review Checklist form is a “Debriefing by Supervisor” checkbox. Although this box indicates that a Probation Department supervisor conducted a de-briefing with the involved Department staff, the Office of Inspector General continues to recommend an amendment to the section to allow the inclusion of identification of Department staff involved and any identified deficiencies or possible policy violations. Debriefing after each incident is a valuable tool for the review of an incident for deficiencies and improvements.

In this Reporting Period, the Office of Inspector General observed that the Review Checklist was used in only two incident reports. The Office of Inspector General recommends the Probation Department use the Review Checklist in every incident report.

Use of Portable Showers for Decontamination: As previously reported, the Probation Department revised its policy on OC spray decontamination with additional language regarding the use of portable showers for decontamination as follows:

> *Temporary Portable Showers*
>
> The purpose of this policy is to establish procedures for the temporary use of portable cold showers during the decontamination process following the deployment of Oleoresin Capsicum (OC) spray.
>
> *Procedures*
>
> Decontamination for OC Spray is exposure to fresh air and the application of cold water. After the youth is removed to a safe area, only cold water shall be gently sprayed or splashed into the facial area of the contaminated youth. Officers contaminated with OC Spray shall follow the same decontamination procedures

outlined for youth. Hot or warm water shall never be used for decontamination purposes as it aggravates the effect of the spray.

To ensure the safe and effective use of portable shower kits, staff should adhere to the following:

- Portable shower kits shall be charged and ready in advance. Each unit includes a wall charger, which can be used to charge the unit by inserting the plug into the water cover. It may take several hours to fully charge, and the battery life can be monitored with the voltmeter. If the voltmeter reads 10.8v or lower, the unit should be charged immediately. The power button is used to turn on the unit, but the unit will not turn off automatically when the water tank is empty. Therefore, it is important to turn the unit off when not in use.
- Water shall be filled using the cold tap water from the utility closet. The unit shall be refilled only before immediate use, not in advance. Any leftover water in the unit must be disposed of after use. The unit must be kept upright to prevent any leaks. After each use, the unit should be tipped to the side to drain any remaining water below the tray.[11]

The Probation Department reports that the showers have been implemented but once again, could not provide information on the number of times staff have used the showers or where staff keeps the showers, because the Department still does not track that information. The Office of Inspector General continues to recommend that the Department make the most of the additional resources for decontamination by fully training all DSB staff on the use of the portable showers and tracking both training and use of the showers such that the showers are charged as necessary and to ensure staff use the showers properly and according to policy.

TRAINING AND SUPPORT AFTER USE OF OLEORESIN CAPSICUM SPRAY

The Detailed Plan requires the Probation Department to identify any need for training and support related for Department staff to decontamination following the use of OC spray and to provide such support in 90% of cases where it identifies a need. The Department has not complied with these requirements.

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[11] DSB Manual § 1006, *Post OC Spray application Protocols*.

The Office of Inspector General examined the PIPs in the sample of 91 OC spray incidents at both facilities combined to determine if the Probation Department identified training needs and provided that training. As in the previous report, this review found that not only did the Department not consistently identify training needs or provide training, but that the Department did not consistently review OC spray incidents as required by the Settlement Agreement.

While SCM reviewed 100% of BJNJH OC spray incidents (20 of 20), it made recommendations for corrective action in 35% of the OC incidents, only one of which included recommendations for any specific type of OC spray training. The remaining recommendations for corrective action involved staff failing to properly document facts in the PIPs. The Office of Inspector General attempted to confirm that the required training was provided to the Deputy Probation Officer (DPO) involved in the sole incident that the Department recommended OC spray training. However, the Probation Department only provided a copy of a memo sent from a Supervising Detention Services Officer to the DPO, containing the language of the policy related to the incident that the Department determined the DPO had not followed. The Probation Department reported that the DPO was provided "verbal training" two days after the incident and not formal training that requires written documentation. It should be noted that the memo was provided to the DPO 166 days after the incident, one day after the Office of Inspector General inquired whether training was provided to the DPO. Because the Department identified training needs in one OC spray incident reviewed and did not provide written verification that training was provided, the Department is not in compliance with the Detailed Plan requirement that the Department is providing support in 90% of cases where it identifies a need. Moreover, given that 35% of the incidents at BJNJH had recommendations for corrective action, and the Department's continuing problem of incomplete and untimely reporting, formal training on accurate and complete report writing should have been recommended in each of the 35% of incidents discussed above, and not just the single incident recognized by the Department.

At LPJH, SCM failed to review *any* of the OC spray incidents and therefore did not make recommendations for corrective action. In addition, only two of the PIPs contained Review Checklists. Additionally, in each of the prior monitoring reports, the Office of Inspector General found the Probation Department out of compliance with policies and state law on decontamination after the use of OC spray, thus identifying training needs regarding OC spray decontamination to address that noncompliance.[12] The Department

[12] The Office of Inspector General's second monitoring report notes that Central Juvenile Hall (CJH) reviewed only 10% of the sampled reports and BJNJH reviewed only 19% of the sampled reports. We did not report on the

received each of these reports both as a validation draft and as a final report, thus notifying the Department of the Office of Inspector General's findings and the need for training to ensure compliance with OC spray decontamination laws and policies. Because the Department failed to review *any* of the OC spray incidents, the Office of Inspector General cannot determine whether the Department is providing support in 90% of cases where it identifies a need. Given the lack of proper documentation and review, it is likely that necessary training is not being provided.

The Probation Department also still has not implemented its Early Intervention System (EIS) for identifying staff in need of training. The Department reports that it continues to work on the EIS system and is developing algorithms that will encompass PIRs which will ultimately assist with identifying Department staff in need of training. The Department reports a high turnover in the unit assigned to develop the EIS but is working with the Department's Information Services Bureau to create the EIS system. The Department still has no expected date for the launch of the EIS, without which it has no system to track whether recommended training gets delivered.

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identification of training, as the low percentage of review made it impossible for the Department to meet the 90% requirement. In the third monitoring report, the Office of Inspector General's review of randomly sampled incidents of OC spray use found that only 43% of the incidents at CJH followed policies and state law and properly documented decontamination and only 72% of the randomly sampled OC spray incidents at BJNJH followed policies and state law and properly documented decontamination, thus flagging the need for training to achieve compliance. The fourth monitoring report found that only 38% of the sampled incidents at CJH and 33% of the incidents at BJNJH followed policies and state law and properly document decontamination , again identifying a need for training. The fifth monitoring report continued to identify the need for training. Of the randomly sampled documentation for OC spray incidents, the Office of Inspector General found that only 14% at CJH and 57% at BJNJH followed decontamination policies and state law and properly documented the decontamination process. The Office of Inspector General review also found that not only were training needs not identified or provided, but that the Department did not consistently review OC spray incidents for training or support issues, with SCM reviewing only 74% of the sample of PIPs far below the 90% rate required by the Detailed Plan. In only 27% of the cases reviewed did SCM make a recommendation for corrective action, none of which included recommendations for any specific type of OC spray training. The Sixth monitoring report continued to identify the need for training. Of the randomly sampled documentation for OC spray incidents, the Office of Inspector General found that only 30% at BJNJH, and 36% at LPJH followed decontamination policies and state law and properly documented the decontamination process. The Office of Inspector General review also found that not only were training needs not identified or provided, but that the Probation Department did not consistently review OC spray incidents for training or support issues, with SCM reviewing none of the sample of PIPs at LPJH far below the 90% rate required by the Detailed Plan. At BJNJH 100% of the sample of PIPs had SCM reviews. At BJNJH in only 35% of the cases reviewed did SCM make a recommendation for corrective action, none of which included recommendations for any specific type of OC spray training.

Also as noted in the Office of Inspector General's last report, the Probation Department's continued failure to review all OC-related cases and implement an Early Intervention System makes it highly unlikely that it will meet the Detailed Plan's further requirements that training, and support be provided in 90% of cases where the need is identified.

While the Probation Department does provide general OC spray training that all employees must complete to work in the juvenile hall facilities, that training is not based on Departmental reviews of OC spray incidents and the identification of needed training and support. Between July 1, 2024, and December 31, 2024, the Department provided generalized training in the proper use of OC spray and decontamination procedures to 271 employees, of which 49 completed a four-hour course and 222 completed a two-hour refresher course.

Continuing Recommendations: The Office of Inspector General also reiterates recommendations made in prior reports to facilitate documentation, review of OC spray deployments and training, including:

- Placing the report of the Probation Department staff member who deployed the OC spray first among the reports in the packet to facilitate the location of this important document for easier locations review by Department supervising staff.
- Eliminating use of the "OC Deployment Report" form, which asks for most, but not all, of the information required in Section M of the PIR, "OC Spray Deployment," or amending the form to request all the information requested in Section M — most importantly, the decontamination procedures used.
- Mandating Review Checklists and SCM reviews in every case.
- Maintaining data on the maintenance and usage of Portable showers.
- Implementing the EIS.
- Mandating training or review of policy in every OC case in which protocols were not adhered to or properly documented.

TIMELY SUBMISSION TO THE FORCE INTERVENTION RESPONSE SUPPORT TEAM

For the seventh consecutive reporting period, the Probation Department did not timely present use-of-force incidents to its Force Intervention Response Support Team (FIRST). The Department recently reconfigured FIRST and the Department's process of reviewing use-of-force incidents as discussed below. The Office of Inspector General's

review is based on the FIRST policies existing for this reporting period. FIRST was not operational from August 2024 until December 2024 due to its disbandment in July 2024, meaning it was not operational for much of this Reporting Period. The requirement of FIRST review is part of the Settlement Agreement, and thus FIRST is now operational again.

Background: The Probation Department's Use-of-Force Review Process

When any use of physical force by Probation Department staff occurs at a facility, Department policies require each staff member on duty assigned to the unit or camp to document their observations and knowledge of what occurred in a report. These reports are bundled into a Physical Intervention Packet (PIP), which must be submitted to the unit supervisor or Officer of the Day for review. After the supervisor reviews each document and interviews all the youths involved, the supervisor signs off on the PIP and submits the packet to the facility's Safe Crisis Management (SCM) team for review of the written documentation and video evidence, and to check for any possible Department policy violations. If the SCM review identifies policy violations, the facility director refers a duplicate PIP to the Department's Internal Affairs Bureau (IAB) for investigation.

After the review by the SCM, the facility's director must conduct a final review. If the director identifies no policy violations or discrepancies, the director signs and closes the PIP, and then submits it to FIRST.

As defined in paragraph 8 of the Settlement Agreement, FIRST refers to a team of seven Probation Department staff responsible for providing secondary review of use of force incidents in the juvenile halls, "who are independent of the Juvenile Hall command structure and who report directly to the Chief of Probation or a Probation executive designee, who is at the level of Deputy Director or above." Paragraph 15 of the Settlement Agreement requires that" all uses of force not accepted by Internal Affairs for review are timely reviewed by FIRST for compliance with State law and Probation policy." Department policy requires that the facility director submit the PIP to FIRST within seven days of the incident.

When FIRST receives the PIP, it must identify possible policy violations, preventable risks, and proactive measures that will assist in ensuring the Probation Department staff follow use-of-force policies and state law. In cases in which the facility director refers a duplicate PIP to IAB, FIRST must concurrently review the incident to identify emerging trends, policy gaps, programming needs, or necessary training in order for the facility's staff to engage in a discussion of potential remedial actions. FIRST then returns the PIP to the facility with its review and determinations documented in a Physical Intervention Review Summary Form.

If a facility director refers a use of force to IAB, the Central Intake Team (CIT) reviews the PIP form to determine whether a formal investigation is necessary. If IAB declines to open an investigation, it must notify the facility within ten days.

Compliance with Detailed Plan Requirements for Force Review

Under the Detailed Plan, the Office of Inspector General reviews use-of-force incidents declined by IAB for investigation to determine whether they were presented in a timely manner to FIRST for review. In addition, the Office of Inspector General reviewed all use-of-force incidents to determine if all cases were timely sent to FIRST for review. As part of the review process, the Office of Inspector General reviewed the FIRST accountability logs for use-of-force incidents during the Reporting Period as well as for use-of-force incidents that IAB declined during the same period.

The Office of Inspector General reviewed all 28 incidents that IAB declined to investigate.[13] Although all the reviewed incident reports accurately documented the use of force, none of the use-of-force incidents declined by IAB were sent to FIRST for review within seven days as required by Probation Department policy. The Probation Department is out of compliance with the Detailed Plan's requirement that declined cases are to be reviewed by FIRST in a timely manner. The longest delay in reviewing a use-of-force incident was 724 days from the date the incident occurred.

BJNJH had 97 use-of-force incidents from July 1, 2024, through December 31, 2024. FIRST only reviewed a total of 28 PIRs for BJNJH, which were all from the month of December because FIRST was disbanded from July 2024, until November 2024. Of those 28 PIPs, only 61% (17 of 28) were received by FIRST within 7 days.

LPJH had 892 use-of-force incidents from July 1, 2024, through December 30, 2024. Of these, *zero* were sent to FIRST for review. The Probation Department staff indicated to Office of Inspector General staff that the review team created after the disbanding of FIRST, did not have access to the electronic email system that contains the use-of-force PIRs sent from the facilities. The Department did not explain why the staff failed to rectify this problem in order to properly review the use-of-force incidents. This is especially concerning given the very high number of use-of-force incidents at LPJH during this Reporting Period.

[13] During this reporting period, there were a total of 954 use-of-force incidents for BJNJH and LPJH combined, of which 186 were sent to IAB. The fact that 20% of these incidents were referred to IAB is in and of itself concerning.

The Probation Department's Reconfiguration of FIRST

As reported in the last semi-annual report, on July 9, 2024, the Probation Department's executive leadership disbanded FIRST. Department staff explained this decision as a response to significant delays in the review of use-of-force incidents that continued to add to the existing backlog of cases not reviewed. The Department intends to reconfigure FIRST and require it to review use-of-force incidents that it considers the most serious use-of-force incidents.[14] The Department estimates that FIRST will review approximately 20% of all use-of-force incidents occurring at LPJH, while the majority of the use-of-force cases will be reviewed by the newly created Independent Force Review Team (IFRT) which currently consists of three Department review staff with the expectation of increasing to five. In addition, the new FIRST policy will require the incident to be forwarded to FIRST within 21 days of the date of incident as opposed to the current 7-day requirement.

Under the new FIRST policy, all use-of-force incidents that occur at BJNJH will be reviewed by the IRTF and not sent to FIRST because there are currently significantly fewer use-of-force incidents occurring at BJNJH. In addition, Department executive leadership informed the Office of Inspector General staff that the Department plans to develop a weekly forum where use-of-force incidents will be tracked and reviewed, but did not provide any information on the staffing, scope, and other details of that forum. The Department discussed the proposed changes to FIRST with the DOJ monitor who approved the Department's restructuring of FIRST.[15] The Office of Inspector General will continue to monitor FIRST and IFRT to ensure proper use-of-force review by the Department as required by the Settlement Agreement.

REVIEW OF THE PROBATION DEPARTMENT'S COMPLIANCE WITH VIDEO CAMERA MANDATES IN JUVENILE HALLS

The Detailed Plan mandates the Probation Department to follow its use of force policies and ensure that video cameras capture 90% of the use of force incidents in its juvenile halls, LPJH and BJNJH. The Office of Inspector General reviews compliance in three specific areas: (1) whether cameras provide sufficient coverage, (2) whether cameras are operational and in use, (3) and whether recordings are properly used in analyzing

[14] The changes to FIRST are being discussed with the DOJ monitor and DOJ to ensure their approval.

[15] While the DOJ monitor approved the restructuring of FIRST and the change from the 7-day to a 21-day reporting requirement, the Office of Inspector General recommends that the County seek court approval for the changes, which appear to be material.

compliance with the Department's use of force policies and state law. This report analyzes a sampling of use of force incidents from BJNJH, and LPJH for the Reporting Period.

Methodology

The Office of Inspector General requested a list of all use-of-force incidents that occurred at both juvenile hall facilities during the Reporting Period. The Probation Department reported that for this period there were 892 use-of-force incidents at LPJH, and 97 at BJNJH. The Office of Inspector General constructed a stratified representative sample which resulted in our review of 81 use-of-force incidents at LPJH and 12 at BJNJH.

Sufficiency of Camera Coverage

The Detailed Plan requires that Probation Department's video cameras provide sufficient coverage of use-of-force incidents to assist in determining whether involved personnel have complied with use-of-force policies 90% of the time. The Office of Inspector General interprets sufficient coverage to mean camera coverage of an area of the facility that captures any use-of-force incident sufficiently to allow the Department staff to review its recording of the incident to determine if staff followed its policies and procedures. To determine compliance, the Office of Inspector General reviewed video recordings for the selected sample, in combination with SCM investigations and other documents, to determine whether the cameras captured the incident on video sufficiently to allow the Department to use video in its investigation and analysis.

During this Reporting Period, at BJNJH, 100% (12 of 12) of sampled use-of-force incidents had sufficient video coverage for review putting BJNJH in compliance with the Settlement Agreement Detailed Plan. In prior reports, the Office of Inspector General noted that BJNJH lacked sufficient cameras to meet the requirement in the Detailed Plan that 90% of the cameras are operational, in use, and provide sufficient coverage to capture use-of-force incidents, and that the Probation Department's plan to install additional cameras was delayed to September 2024. The Department has now completed the installation and has a total of 654 video cameras operable and providing reviewable video recordings (up from about 200 before the installation).

For LPJH, the Probation Department only provided video recordings for 67 of the random sample of 81 incidents. The Office of Inspector General found 80% (65 of 81) of sampled use-of-force incidents had sufficient video coverage for review, without obstructed views, causing LPJH to be out of compliance with the Detailed Plan.

Cameras Operational and In Use

The Detailed Plan requires that 90% of the Probation Department's video cameras are operational and in use, which the Office of Inspector General interprets to mean that each camera operates as designed, providing a clear video stream that can be viewed on the designated monitors and is recorded for later playback.

At BJNJH, the Office of Inspector General inspected video cameras during the Reporting Period and found all 654 cameras operable. During a recent follow up re-inspection the cameras were viewable and functioning. Based on the most recent findings, BJNJH is in compliance with the Detailed Plan requirement that 90% of installed cameras be operational and in use for use-of-force review.

At LPJH, the Office of Inspector General conducted inspections during the Reporting Period and determined that 288 cameras were operable with viewable video recordings. The Probation Department reported plans to install 193 additional cameras throughout the facility, which commenced in March 2025.

Use of Camera Video in Determining Compliance with Use of Force Policies

The Detailed Plan requires that the Probation Department properly use video recordings to determine policy violations in 90% of use-of-force incidents. The Office of Inspector General deems video recordings properly used when Department staff review the video, compare it to the written reports, and staff statements and correctly apply the law and relevant Department policies to the use-of-force review.[16] The Department's review is indicated by use of its Video Review Form which is executed by a supervising staff member after review of the video recording.

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At BJNJH, 92% (11 of 12) of the sampled incidents had Video Review Forms, indicating that the video recording was viewed by Probation Department staff to determine policy violations and were properly reviewed. As a result, BJNJH is in compliance with the requirement for using video recordings in determining compliance with use-of-force policies at BJNJH. The following case provides an example of the Department's failure

[16] The relevant standards for uses of force are set forth in the Probation Department's Detention Services Bureau Manual sections 1000-1007, and Probation Directives 1194 and 1427, which outline the Department's response to uses of force, as well as current Department training and relevant statutory and case law. These authorities generally require that the use of non-deadly force by Department staff be both reasonable and necessary to facilitate the restoration of order. See also, California Penal Code section 835a; *Graham vs. Connor* (1989) 490 U.S. 386.

to properly review video recordings to analyze uses of force to identify violations of policy or law at BJNJH.[17]

CASE 1

Two youths were fighting and a DPO (DPO 1) came from behind Youth 1 and grabbed Youth 1 using a chokehold technique around the neck of Youth 1 and pulled the youth to the floor. A second DPO assisted DPO 1 with securing Youth 1.

Probation Department use-of-force policies prohibit the use of chokeholds on youths.[18] DPO 1 failed to utilize other intervention methods that are within policy.[19] A review of the video recording clearly demonstrates that the DPO could have used the Department's Disengagement ("step-between") tactic where the staff steps between the youth to prevent a fight, the Extended Arm Assist where the staff secures the arm of the youth, or the Upper Torso Assist tactic where the staff holds the youth around the chest area to separate youths who are fighting. In addition, DPO 1 was untruthful in his Physical Intervention Report in not stating that he grabbed Youth 1 from behind and around the neck. Instead, DPO 1 stated that he was unable to perform an upper torso assist and "was able to wrap my arm around his chest area." The video recording clearly demonstrates that DPO 1 never attempted an Upper Torso Assist and instead came directly to Youth 1 and used a chokehold to take Youth 1 to the floor. The incident was reviewed by the Probation's Department's SCM unit and was closed. The Office of Inspector General requested that this use of force be referred to IAB for consideration for investigation, and the Department referred the case as requested.

Los Padrinos

At LPJH, only 9% (6 of 67) of the sampled incidents had Video Review Forms indicating that the video recording was viewed by Probation Department staff to determine policy violations. This rate is far below the Detailed Plan's requirement of 90%, making the

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[17] Use-of-force incidents in case examples: SCM Nos. BJNJH-2024-1492, BJNJH-2024-0799.

[18] DSB Manual § 1006(G) provides: Inappropriate or excessive use of force is prohibited . . . The following examples are PROHIBITED USES OF FORCE AND CONDUCT: "Carotid," "arm-bar," ***chokehold,*** or any other deliberate chokehold restraint utilized to or having the impact of restricting the airway or blood flow. (Emphasis added).

[19] DSB § 1004 provides: Disengagement: – Officer ***steps between*** youth engaged in a physical altercation, separating the combatants with a gentle, open-handed guiding movement that does not involve confinement of an appendage; Extended Arm Assist: Officer secures the arm and/or shoulder (or shirt/sweatshirt) of the youth for the purpose of inducing a youth that is acting out to cease their involvement in negative behavior and/or to assist them in moving to a safer area. (Emphasis added).

Probation Department out of compliance.[20] The following two cases provide examples of the Department's failure to properly review video recordings to analyze uses of force to identify violations of policy or law at LPJH.[21]

CASE 1

> *A youth was entering a living unit, and a DSO reported that the youth refused to let go of a threshold and spat toward a Special Enforcement Officer (SEO). The SEO is seen on the video recording grabbing the youth as the youth's back was to the SEO and throwing the youth down on a table and then to the floor. The SEO then placed his knee on the youth's head as a DSO handcuffed the youth.*

Probation Department policy permits the amount of force that "an objective, similarly trained, experienced, and competent youth supervision officer, faced with similar facts and circumstances, would deem reasonable and necessary to ensure the safety and security of youth, and staff."[22] Probation Department policy prohibits staff from throwing a youth down on a table and floor, as well as applying pressure to a youth's head or neck area during a physical intervention.[23] The video recording clearly shows the SEO slam the youth onto a table, throw him to the floor and then hold his knee on the youth's head as the DPO handcuffs the youth. However, there is no Video Review Form indicating that a facility director reviewed the video recording to determine if there was excessive or unnecessary force. The Office of Inspector General requested that this use of force be referred to IAB for review for investigation and the Department referred the case as requested.

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[20] Determination of review is determined by the presence of the Probation Department's Video Review Form, which documents the Director's review of the video recording. Sixty incidents did not have the Video Review Form. Of the 8 use-of-force incidents with video review forms provided, 6 were properly reviewed by the Department and 1 is unknown due to the lack of video recording of the incident.

[21] Use-of-force incidents in case examples: SCM Nos. LPJH 2024-4515, LPJH 2024-4758.

[22] Detention Services Bureau Policy 1005.

[23] Detention Services Bureau Policy 1005(G): The following examples are PROHIBITED USES OF FORCE AND CONDUCT: Deliberately or recklessly striking a youth's head, limbs, *torso*, or other body parts against a hard, fixed object (e.g., roadway, driveway, *floor*, wall, etc.); Applying *pressure* to and/or torquing of the head and neck. (Emphasis added).

CASE 2

A DSO (DSO 1) and a youth were engaged in an argument in a living unit. DSO 1 continued to argue with the youth and appeared to be challenging the youth to a fight. DSO 1 repeatedly had to be pushed away by DSO 2 as DSO 1 continuously attempted to move toward the youth. DSO 2 and a DPO pushed DSO 1 to the corner of the dayroom, but DSO 1 continued to argue with the youth. The youth got up from his seat and ran to DSO 1 and attempted to hit him but accidently struck DSO 2 in the face. The youth was restrained by a third and fourth DPO.

Probation Department staff are not allowed to challenge youths to a fight or engage in conduct that is considered unprofessional.[24] Again, there is no Video Review Form indicating that a facility director reviewed the video recording to determine if misconduct occurred. The Office of Inspector General requested that this use of force be referred to IAB for investigation and the Department referred the case as requested.

PRISON RAPE ELIMINATION ACT

The Office of Inspector General reviewed the Probation Department's compliance with the portions of the Prison Rape Elimination Act (PREA) designated in the Detailed Plan, including a range of requirements intended to deter sexual assault in correctional institutions, including juvenile detention facilities.

During the Reporting Period, Office of Inspector General staff inspected juvenile facilities and Probation Department camps to determine compliance with two PREA-related requirements in the Detailed Plan: (1) that the bathrooms of all units have properly installed privacy curtains, and (2) that staff announce their presence when entering a housing unit for youth of a different gender. The Office of Inspector General inspected two juvenile halls (LPJH and BJNJH) and five camps (Camp Clinton B. Afflerbaugh, Dorothy Kirby Center, Camp Vernon Kilpatrick, Camp Joseph Paige, and Camp Glenn Rockey) to determine compliance with these provisions.

As the Office of Inspector General has noted in previous reports, Camp Rockey, Camp Afflerbaugh, Camp Paige and Campus Kilpatrick each have blind spots due to tiled walls in the shower areas. As noted in the Office of Inspector General's previous report, the Probation Department planned to remodel the showers to address the blind spots

[24] DSB 2300 provides, "Staff shall work cooperatively and harmoniously with other staff. ***Physical confrontations***, vulgar language, profanity, sarcasm, or ridicule constitute a violation of this policy." (Emphasis added).

but then diverted resources for that project in order to open LPJH, and because of the BSCC determination that BJNJH and LPJH facilities were not in compliance with other Title 15 requirements.[25]

The Probation Department's PREA Coordinator informed the Office of Inspector General staff that the Department's Management Services Bureau is currently in the process of developing a plan to remove the tiled walls inside the East Camps' restrooms. The Department's plan is to install mirrors in the blind spots in the restrooms to assist staff in supervising youth during the shower and restroom periods. The Department continues to assign staff at each camp to monitor the blind spots while the youths utilize the restrooms. The Department continues to address previously noted problems of obstructed views of the youth in the showers at BJNJH and LPJH due to old and improperly installed curtains, by replacing them with the appropriate curtains, making both halls PREA compliant.

The Office of Inspector General found generally consistent opposite-gender staff announcing their entry into the living units and therefore finds the Probation Department in compliance with this requirement of the Detailed Plan.

ROOM CONFINEMENT AND ACCESS TO PROGRAMMING

The Detailed Plan requires that the Probation Department create and implement an internal system to identify and track room confinements. This system must promptly notify juvenile hall superintendents of room confinements that violate Department policy or state law. It must also facilitate the swift implementation of remedial measures to address any identified deficiencies. The Detailed Plan further requires that the Department create an approved internal process to provide the Office of Inspector General with documentation of identified violations of room confinement policy or state law as well as the remedial measures taken in response to these violations. The Department has created an electronic system that will track room confinements and is in the testing phase and is awaiting approval by the monitor. The Department therefore remains out of compliance with the room confinement tracking system requirement of the Detailed Plan.

The Probation Department uses written forms and the electronic safety logs to document safety checks and re-engagement for room confinements. The Detailed Plan provides that when the Department determines that a youth constitutes a threat to the

[25] October 14, 2024, the Board of State and Community Corrections found Los Padrinos Juvenile Hall not suitable for the confinement of juveniles pursuant to Welfare Institutions Code section 209, subdivisions (a)(4) and (d).

safety and security of the facility, it need not make programming, access to recreational activities, large muscle exercise, outside time, religious services, visitation, phone calls ("Required Activities") or schooling available to that youth, but must make findings supporting that determination in writing at least 90% of the time.

The Office of Inspector General reviewed written documentation for all the reported room confinements during this Reporting Period — 109 at BJNJH and 29 at LPJH. In both facilities, staff sufficiently documented findings that a youth posed a threat to the safety and security of the facility in writing in 100% of the incidents, making the Probation Department in compliance with this provision.

The Detailed Plan requires Probation Department staff to notify superintendents of the juvenile halls promptly when room confinements do not comply with Welfare and Institutions Code section 208.3. Based on a review of the available documents, none of the room confinements the Department identified during the Reporting Period violated policy or state law in a way that warranted notification to the superintendent. The Detailed Plan also requires that in 90% of the incidents determined to be out of policy or not compliant with the law, the Department implement subsequent remedial measures. The Department still lacks sufficient internal processes, including a computerized database as required by the Detailed Plan, to ensure that all non-compliant room confinements are identified and documented thoroughly. Additionally, inconsistencies between Department, Board of State and Community Corrections (BSCC), and Probation Oversight Commission (POC) data continue to raise doubts as to whether the Department identified and documented in writing all out-of-compliance room confinements. As of January 2025, the Office of Inspector General has commenced weekly visits to BJNJH and LPJH to better assess the documentation and will report the findings in future reports.

The Detailed Plan requires that the Probation Department provide youths activities such as programming, access to recreational activities, large muscle exercise, outside time, religious services, visitation, and phone calls, as noted above. In addition, the Department has volunteers and outside vendors that provide non-required activities to youth. The Department must provide Required Activities to all youth unless it determines that a youth poses a threat to the safety or security of the facility or if the youth self-separates or refuses to participate in the Required Activities.[26]

[26] The Probation Department provides outside vendor activities to the youths, although not required by the Detailed Plan. These activities may also be limited when Department staff determines that a youth poses a threat to the safety or security of themselves or the facility, or if a youth refuses to participate.

For compliance, the Detailed Plan requires that the Probation Department provide Required Activities each day for at least 93% of youth who do not pose a threat to the safety or security of the facility or themselves ("eligible youth").[27] To determine compliance, the Office of Inspector General reviews written Title 15 programming exception logs, as well as supporting documentation, that are required by the BSCC when youths miss required programming. For this Reporting Period, the Department did not include cancelled programming as part of the Title 15 log programming documentation, nor on its exception log used to track programming, which is provided to the Office of Inspector General. As a result, the Office of Inspector General cannot determine the Department's compliance with the Detailed Plan for programming this Reporting Period.

As noted in the Office of Inspector General's last report, the Probation Department is working on developing a computerized data system that will automatically generate the required report with compliance information for Required Activities, to the Office of Inspector General. The Department is developing two electronic data systems, the Youth Activity Tracking System (YATS) and the Institutional Programs and Calendar Application (IPCA.) The YATS will track all daily movement of youths within the facilities including religious services and visitation. However, it is not able to be implemented due to the lack of Wi-Fi at the facilities. The Department has not provided an expected implementation date due to costs involved with procuring the required Wi-Fi support system.

The IPCA system will track all daily youth programming, including self-separations and room confinements, provide weekly and monthly event calendars, alerts for canceled events and track any changes made to youths' records which will enhance the Department's auditing and reporting capabilities. This system is in phase two with implementation and testing expected in the very near future. The Department reported that is not able to provide an expected completion date due to the complexity of integrating existing electronic systems with the new system.

[27] The Detailed Plan originally applied to BJNJH and Central Juvenile Hall (CJH). However, on July 17, 2023, the Probation Department transferred all youths housed at CJH to LPJH.

YOUTH GRIEVANCES

State law requires the Probation Department to provide a process for youths to file grievances for youth complaints relating to care at a juvenile hall.[28] The Probation Department implemented its electronic grievance management system (GMS) in February 2023, which allows youths to file their grievances from their individual computer laptops and operates as a mailbox for the Department staff to retrieve and review the filed grievances.[29] In June 2024, the Department reported that the GMS electronic system had a technological problem that the Department's IT could not remedy without taking the system offline. The Department expects GMS to be fully functional in 2025. In the meantime, staff and youth, and LACOE, have been informed that the paper grievances are available for youth to report problems as was done prior to the electronic system. Grievances can also be sent to the Office of Inspector General as well as the Department's Office of the Ombudsman. The Office of Inspector General continues to communicate as needed with the Office of the Ombudsman regarding complaints received by the Office of Inspector General.

The Probation Department indicated that it had still not procured the grievance kiosks for youths to file their grievances and recently reported that it is discussing the maintenance needs of the kiosks with its Management Services Bureau (MSB). Once an agreement is finalized with MSB, the agreement with the vendor will be finalized. The Department does not have an expected completion date.

A review of the Probation Department's Grievance Log showed that the Department resolved 90% of grievances at LPJH and BJNJH in accordance with the Department's current policies.

For BJNJH, the Office of Inspector General found that of the total 316 grievances documented between July 1, 2024, and December 31, 2024, 24% (75 of 316) related to programming, 3% (11 of 316) related to visitation, 3% (11 of 316) related to phone calls, less than 1% (1 of 316) related to recreation, and no grievances related to religious services. The review of these areas indicated that generally youths were being provided

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[28] Calif. Code of Reg., Title 15, section 1361 provides, "The facility administrator shall develop and implement written policies and procedures whereby any youth may appeal and have resolved grievances relating to any condition of confinement, including but not limited to health care services, classification decisions, program participation, telephone, mail or visiting procedures, food, clothing, bedding, mistreatment, harassment or violations of the nondiscrimination policy."

[29] GMS is an electronic grievance management system used for tracking and distribution system of grievances, which replaced the previous system JIGS that was an email method of distribution that was flawed therefore replaced.

access to telephone calls, religious services, recreation and family visitation. The balance of the grievances addressed areas that are not subject to the Detailed Plan.

For LPJH, the Office of Inspector General found that of the total 441 grievances documented between July 1, 2024, and December 31, 2024, 7% (31 of 441) related to phone calls, 5% (21 of 441) related to programming, 2% (9 of 441) related to recreation, 1% (2 of 441) related to religious services or recreation, and less than 1% related to visitation. The review of these areas indicated that generally youths were being provided access to telephone calls, religious services, recreation and family visitation. The balance of the grievances addressed areas that are not subject to the Detailed Plan.

RECOMMENDATIONS

The Office of Inspector General continues to recommend that legal action be considered to compel timely use-of-force investigations and to prohibit the use of OC spray without decontamination. The recommendations set forth in its *Second Report on the Probation Department's Compliance with the Department of Justice Settlement Agreement on Juvenile Halls (December 30, 2022)* that have not been implemented should be implemented. The Office of Inspector General also continues to recommend a change in the process of investigating and determining whether staff engaged in misconduct, as well as re-assignment of Probation Department field staff to the juvenile facilities to provide appropriate supervision of the youths.