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

February 4, 2026

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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 only 21% of incidents reviewed at Barry J. Nidorf (BJNJH) and 20% at Los Padrinos Juvenile Hall (LPJH). Although there were notations regarding decontamination in 100% of incidents reviewed in either the incident review or narrative of associated PIRs at LPJH and 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).)	BJNJH: Out of Compliance. The Probation Department properly documented compliance in 21% of the incidents. LPJH: Out of compliance. The Probation Department properly documented compliance in 20% 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 Probation Department did not identify any OC spray incidents that needed training.

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: Unable to determine compliance. The Probation Department did not provide timely information for review. LPJH: Unable to determine compliance. The Probation Department did not provide timely information for review.
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. The Probation Department reported a total of 74 use-of-force incidents at BJNJH. In its review of a sample of 32 incidents, the Office of Inspector General found that 97% of the incidents reviewed provided sufficient coverage to capture the use of force and were properly video recorded. LPJH: Out of compliance. The Probation Department reported a total of 668 use-of-force incidents at LPJH. In its review of a sample of 84 use-of-force incidents, the Office of Inspector General found that only 69% of the cameras provided sufficient coverage to capture the use of force, and only 64 had video recordings.[1]

[1] In the sample of 84 use-of-force incidents, video recordings were provided for 63 use-of-force incidents, 20 incidents either occurred in an area where there were no video cameras or were missing video recordings. Included in the 63 video recordings provided to the Office of Inspector General, were 6 video recordings that failed to capture the use of force, 5 occurred at school classroom without a video camera, and the other occurred in a Control Center area out of view of the camera.

Issue	Compliance
Properly use video recordings to determine policy violations in 90% of use of force incidents. (Detailed Plan ¶ 17.)	BJNJH: In compliance. The Office of Inspector General reviewed a sample of 32 use-of-force incidents and received 32 video recordings and Video Review forms. The Department properly used the video recordings in 100% of the sampled incidents. LPJH: In compliance. The Office of Inspector General reviewed a sample of 84 use-of-force incidents and received video recordings for 63 incidents. The Probation Department provided Video Review forms for 64 of the incidents.[2] Of the video recordings and Video Review forms reviewed, the Department properly used the video recordings in 94% of the sampled incidents.
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 BJNJH. Out of compliance at LPJH. The Office of Inspector General found broken or missing toilet stall doors and multiple missing shower curtains in units.
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).)	Out of compliance at both BJNJH and LPJH. During unannounced visits conducted between January 1, 2025, and June 30, 2025, the Office of Inspector General found inconsistent compliance with opposite-gender staff announcing their entry into the living units.

[2] The Probation Department provided 64 Video Review forms but one was unsigned and excluded from compliance review.

Issue	Compliance
Room Confinements	
The County must create an internal process approved by the Monitor to 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.)	Out of compliance. During this Reporting Period, the Probation Department did not have an approved implemented 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.)	Unable to determine compliance. The Office of Inspector General is unable to verify that notification of room confinements not in compliance with policy and state law are provided promptly to the superintendent.[3]
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.)	In compliance.

[3] Although the superintendent is reportedly immediately notified of room confinements via email or text, there is no verification mechanism confirming real-time receipt.

Issue	Compliance
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 signature of the staff member, and the validation of the superintendent of the facility. (Detailed Plan ¶ 24(c)(i-iv).)	In compliance. The Office of Inspector General reviewed all 78 room confinements that occurred at LPJH and 110 at BJNJH during the Reporting Period. The Probation Department staff documented its findings that a youth posed a threat to the safety and security of the facility in writing in 99% (187 of 188) of the incidents.[4]
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 January 1, 2025, to June 30, 2025, for compliance calculations.[5]
The Detailed Plan requires that required activities are not denied as a form of punishment, discipline, or retaliation. (Detailed Plan ¶ 24(c)(i-iv).)	Out of compliance for BJNJH. The Office of Inspector General review found one incident that appeared to be punitive in nature.[6] In compliance for 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.

[4] SCM BJNJH 2025-2044.

[5] 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.

[6] Video evidence shows that three youths were left unsupervised in a hallway adjacent to an unsecured breezeway door. Two of the youths, identified by staff as known enemies, entered the breezeway for approximately 30 seconds and returned with visible injuries, strongly suggesting a physical altercation occurred off-camera. Despite no further aggression or ongoing threat observed on video, both youths were placed in room confinement more than an hour later, reportedly for being "out of bounds" (SCM BJNJH 2025-2044).This confinement appears punitive in nature, in violation of Title 15 §1354.5 and departmental policy, both of which prohibit the use of room confinement as a form of punishment. The incident also highlights significant lapses in staff supervision, including

Issue	Compliance
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.
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 (GMS) had a technological problem and was taken offline June 2024 by Probation Department IT. However, the Department recently reported that GMS testing is complete and became operational on October 13, 2025. The Probation Department still has not procured the grievance kiosks for youths to electronically file their grievances, although as previously reported, it has again reported that it is finalizing the contracts for the purchase. The Department does not have an expected completion date and, indicated that the new kiosks will not exclude the use of hardcopy grievances.

the failure to prevent known enemies from accessing an unsecured area and the delayed reporting of the incident, approximately 32 minutes after it occurred. Additionally, there was no immediate review or documentation, further compounding the concern. These deficiencies reflect a broader, ongoing failure by the Department to ensure consistent internal tracking and timely administrative responses, ultimately undermining the reliability of compliance data for this reporting period.

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).[7] 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 *Eighth Report on the Los Angeles County Probation Department's Compliance with the Settlement Agreement* covering the period from January 1, 2025 to June 30, 2025 (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.[8] 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. In some instances, documentation was not timely provided. The lack of timely producing documents to the Office of Inspector General is especially concerning in two aspects. First, this is the eighth report, and the expectation is that we would have seen substantial improvement in retaining documents and providing them pursuant to our regular requests. Second, the Reporting Period covers a sixth-month period that is not reported on until ***six months*** after the close of the period; this means that the Department is sometimes unable to provide records that were (or should have been) generated six months to a year ago. Improvements in record-keeping and in providing records to the Office of Inspector General are needed in order to achieve compliance with the Settlement Agreement.

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

[8] The Probation Department provided logs for use-of-force incidents at BJNJH and LPJH. A review of the PCMS system by the Office of Inspector General indicated a total of 74 use-of-force incidents at BJNJH and 668 at LPJH. The Office of Inspector General cannot provide an explanation for the discrepancy in the total.

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.[9] The Detailed Plan mandates that the Probation Department follow its policies and state law and properly document compliance in 90% of all incidents in which Department staff used OC spray on youths.[10]

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[9] 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 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."

[10] 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:
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> …(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.

Methodology

The Office of Inspector General requested documentation relating to all OC spray incidents, including investigations and reviews, that occurred between January 1, 2025, and June 30, 2025. In response, the Probation Department provided Physical Intervention Packages (PIPs) for 198 incidents, of which 23 occurred at BJNJH and 175 at LPJH.

The Office of Inspector General selected and reviewed a sample of 19 OC spray incidents that occurred at BJNJH and a sample of 62 incidents from LPJH.[11] 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, 21% (4 of 19) of the sampled incidents properly documented the decontamination process. At LPJH, 20% (13 of 62) of the sampled incidents reviewed properly documented the decontamination process after use of OC spray as required by policy and state law. In 100% (19 of 19) of the sampled incidents at BJNJH, and 100% (62 of 62) 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.[12] 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 third reporting period in which there was significantly more mention of decontamination procedures in the Department

[11] 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.)

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

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 continues to recommend 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.

During the previous Reporting Period, the Probation Department implemented the "Physical Intervention Packet Review Checklist" (Review Checklist). This tool organizes and reviews many of the components outlined in Section M using a checkbox format. The addition of the checklist enhances the ability to assess the accuracy and efficiency of the decontamination process, eliminating the need to sift through multiple documents to gain a clear understanding of an OC incident and its associated decontamination procedures.

The Review Checklist includes a section titled "Suggested Corrective Action," which, unlike other sections, does not feature a checkbox. This section allows reviewers to document concerns regarding staff actions and to recommend that staff review relevant policies or receive additional training. However, during this Reporting Period, training was suggested in only one instance across all completed Review Checklists. Including a dedicated checkbox for "training" would improve the visibility of training-related concerns and help ensure compliance with the training requirements outlined in the Detailed Plan.

The Review Checklist also includes a checkbox labeled "Debriefing by Supervisor," which indicates that a Probation Department supervisor conducted a debriefing with the involved staff. However, the Office of Inspector General continues to recommend that this section be amended to allow for the identification of the staff involved, as well as the documentation of any deficiencies or potential policy violations observed by the reviewing Department staff. Post-incident debriefings are a critical tool for identifying areas for improvement and ensuring accountability, and enhancing this section would strengthen the overall review process.

In this Reporting Period, the Office of Inspector General observed that the Review Checklist was used in all incident review reports. The Office of Inspector General recommends the Probation Department continue to 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.[13]

The Probation Department has reported that portable showers have been implemented; however, it still does not track key information such as the frequency of use or the

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

storage locations of the showers. According to the Department, LPJH currently has 27 portable showers, at least one in each unit, which are charged and available for use. Additionally, 485 LPJH staff completed training on the use of these showers. In contrast, BJNJH reportedly has no portable showers available, and no staff have received training. The Office of Inspector General continues to recommend that the Department maximize the utility of these decontamination resources by ensuring all staff are fully trained in the use of portable showers and that the showers are available in both facilities. Furthermore, the Department should implement a system to track both training and usage to ensure the showers remain charged, are used appropriately, and are deployed in accordance with 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 to staff decontamination of youths following the use of OC spray and to provide such support in at least 90% of cases where a need is identified. However, the Department has not complied with these requirements. This failure to meet the mandated threshold raises concerns about youth safety, and adherence to the commitments outlined in the Detailed Plan.

The Office of Inspector General examined the PIPs in the sample of 81 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 the Department did not consistently identify training needs or provide training.

SCM reviewed 100% (19 of 19 incidents in the randomized sample) of OC spray use at BJNJH during the Reporting Period. Of these, corrective action was recommended in 21% (4 of 19) of the incidents. However, only one recommendation included a specific reference to OC spray training. The Department indicated that “the facility does not have a system in place to identify training needs for staff involved in OC incidents.” The remaining recommendations were limited to emails sent to involved staff for failing to properly document facts in the PIPs and no written verification that formal training was needed or provided.

The Office of Inspector General attempted to verify whether the recommended OC spray-related training was provided to the Deputy Probation Officer involved in the sole corrective action recommendation concerning OC spray. In that case, the Probation Department identified a training need but did not provide written verification that the training was delivered. As a result, the Office of Inspector General cannot determine whether the Department is in compliance with the Detailed Plan requirement to provide support in 90% of cases where a need is identified.

Moreover, given that 21% of the incidents at BJNJH resulted in recommendations for corrective action, and considering the Probation Department's ongoing issues with incomplete and untimely reporting, at a minimum formal training on accurate and complete report writing should have been both recommended and provided in each of those cases. The consistent failure to address this training need undermines the effectiveness of corrective actions and raises concerns about the Department's commitment to accountability and improvement.

At LPJH, SCM reviewed 100% (62 of 62 incidents in the randomized sample) of OC spray use during this Reporting Period, marking a significant improvement from the previous period, during which no OC spray incidents were reviewed. In each of the prior Office of Inspector General monitoring reports, the Office of Inspector General found the Probation Department to be out of compliance with departmental policies and state law regarding decontamination following the use of OC spray.[14] These findings consistently

[14] 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 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. The seventh 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 21% at BJNJH, and 20% at LPJH followed decontamination policies and state law and properly documented the decontamination process.

identified a need for training to address the noncompliance. The Department received each of these reports, thereby receiving formal notice of the Office of Inspector General's findings and the need for corrective training. Despite this, the Department did not recommend any training related to OC spray decontamination or corrective action during the current Reporting Period. Instead, it issued 25 reminder emails to staff emphasizing the importance of adhering to policy, procedure, and documentation requirements following OC spray use. Because the Department did not identify *any* training needs in the cases from LPJH, the Office of Inspector General cannot determine if the Department is in compliance with the Detailed Plan requirement that the Department is providing support in 90% of cases where it identifies a need.

During its review of the SCM review forms provided by the Probation Department, the Office of Inspector General identified inaccurate language on page 6 of the form, which states: "Was minor decontaminated within 30 minutes of being sprayed?" This language is inconsistent with both Department policy and applicable state law, which require that decontamination occur within 10 minutes following the use of OC spray. Office of Inspector General staff brought this discrepancy to the attention of Department supervisors, who acknowledged their awareness of the error and indicated that corrective action would be taken to revise the form accordingly.

The Probation Department has not yet implemented its Early Intervention System (EIS), which is intended to identify staff in need of additional training. According to the Department, development of the EIS is ongoing, with efforts focused on creating algorithms that will incorporate Performance Incident Reports (PIRs) to help identify staff who may benefit from targeted training. The Department attributes delay in part to high turnover within the unit responsible for developing the system, and reports that it is now collaborating with the Department's Information Services Bureau to advance the project. The Department has not provided an anticipated launch date for the EIS. In the absence of this system, the Department currently lacks a mechanism to track whether recommended training is delivered to staff.

As noted in the Office of Inspector General's last report, the Probation Department's past failure to review all OC spray related incidents and to implement EIS, significantly undermines its ability to comply with the Detailed Plan's requirements.[15] Specifically, without a functioning EIS and comprehensive case review process, it is highly unlikely that the Department will be able to meet the Detailed Plan's mandate that training and support be provided in 90% of cases where a need is identified. The absence of these

[15] We refer to past compliance because during this reporting period SCM reviewed all the sampled incidents. The Office of Inspector General did not ascertain whether all incidents not included in the sample were reviewed.

systems continues to hinder the Department's ability to proactively address staff performance issues and ensure accountability.

While the Probation Department does require all employees assigned to juvenile hall facilities to complete general OC spray training, this training is not based on Departmental reviews of actual OC spray incidents or by the identification of specific training and support needs. As a result, the training lacks a targeted, data-driven approach to addressing patterns of concern or performance gaps.

During the Reporting Period, the Probation Department provided a standardized two-hour training on the proper use of OC spray and decontamination procedures to 1,306 employees. However, without integration of incident review findings or EIS data, the effectiveness of this training in addressing individual or systemic issues is cannot be ascertained.

Continuing Recommendations

The Office of Inspector General 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 spray case in which protocols were not adhered to or properly documented.

TIMELY SUBMISSION TO THE FORCE INTERVENTION RESPONSE SUPPORT TEAM

The Detailed Plan requires the Office of Inspector General to determine whether the Probation Department is accurately reporting and documenting all use-of-force incidents, and to verify that any incidents not accepted by the Internal Affairs Bureau (IAB) for review are timely evaluated by the Department's Force Intervention Response Support Team (FIRST). FIRST is responsible for ensuring that each incident complies with State law and Department policies, and the team must achieve at least a 90% compliance rate in its reviews. For this Reporting Period, the Department did not timely provide the required information for the Office of Inspector General to make an appropriate review. Because of this, the Office of Inspector General is unable to determine the Department's compliance with the Detailed Plan. As mentioned previously in this report, this documentation pertains to the first six months of 2025. Given that the Department can anticipate the requests for this information based on our previous reports, the Department should have been able to provide the information by the time it was requested.

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 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 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 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.[16]

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 reviews 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. However, for this Reporting Period, such documentation was not provided to the Office of Inspector General. Because of this, the Office of Inspector General is unable to determine the Department's compliance with the Detailed Plan.

The Probation Department's Reconfiguration of FIRST

As reported in the Office of Inspector General's Sixth Report on the Probation Department's Compliance with the Department of Justice Settlement Agreement on Juvenile Halls, on July 9, 2024, the Department's executive leadership disbanded FIRST due to significant delays in reviewing use-of-force incidents, which contributed to a growing backlog of unresolved cases. In response, the Department restructured

[16] This policy was revised in July 2025 to require the facility director to submit the PIP to FIRST within 30 days of the incident. For this Reporting Period, the Probation Department was operating according to its policy requiring incidents to be forwarded to FIRST within seven days and was reviewed by the Office of Inspector General's office accordingly.

FIRST to focus on reviewing all incidents involving the use of OC spray that generate a Preliminary Incident Notification (PIN). It also randomly selects 20% of all physical use-of-force incidents at BJNJH and LPJH that did not involve OC spray. The remaining 80% of incidents are now reviewed by the newly established Independent Force Review Team (IFRT). Additionally, the revised policy extends the timeframe for forwarding incidents to FIRST from 7 to 30 days. The Office of Inspector General will continue to monitor both FIRST and IFRT to report on the Department's compliance with the Department of Justice 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, BJNJH and LPJH. 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 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 74 use-of-force incidents at BJNJH and 668 at LPJH. The Office of Inspector General constructed a stratified representative sample which resulted in our review of 32 use-of-force incidents at BJNJH and 84 at LPJH.

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, 97% (31 of 32) of sampled use-of-force incidents had sufficient video coverage for review putting BJNJH in compliance with the Settlement Agreement Detailed Plan.

For LPJH, the Probation Department only provided video recordings for 64 of the random sample of 84 incidents. The Office of Inspector General found 69% (58 of 84) 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 435 cameras were operable with viewable video recordings. The Probation Department reported plans to install 46 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.[17]

[17] 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

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.

Barry J. Nidorf Juvenile Hall

At BJNJH, 97% (31 of 32) 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 summary shows the Department's failure to properly review a video recording to analyze the uses of force to identify violations of policy or law at BJNJH.[18]

CASE 1

A youth was suspected of having contraband and was asked by a Detention Services Officer (DSO) to submit to a strip search. The youth refused and was then taken by four DSOs to a body scanner. The body scan indicated an item secreted in the youth's rectum. The youth was informed by the DSOs that he would be taken to the medical unit for assessment if the youth did not give them the contraband. The youth refused, and two DSOs carried the youth to the medical unit where again, the youth refused to give them the contraband. After the medical staff refused to remove the item, five DSOs took the youth to a small room and DSO 1 and DSO 2 took the youth's pants off and put the youth in a prone position on the floor and separated his legs displaying the youths' buttocks. DSO 3 then removed a vape that reportedly dropped from the youth's buttocks as his legs were spread apart.

The Probation Department strip search policies are specific as to how they are to be conducted. The Department's policy specifically states, "All strip search and or visual body cavity searches shall be conducted without touching the youth's body."[19] Furthermore, a physical body cavity search is defined by Department policy as:

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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.

[18] Use-of-force incidents in case example: SCM Nos. BJNJH-2025-0379.

[19] DSB section 711.

> The physical intrusion into a body cavity or orifice for the purpose of discovering an object concealed in the body cavity. This requires a Search Warrant issued by a magistrate (judge, not a commissioner or referee) specifically authorizing the physical body cavity search. Only *medical personnel* shall conduct the search. (Emphasis added.)

As noted, the youth was initially taken to the medical unit after a body scan indicated the presence of an item inside his rectum; medical personnel declined to remove the item. Without securing a judicial search warrant, the video appears to show the DSOs utilizing force, touching the youth's body, and possibly physically intruding into the youth's body cavity to remove the vape pen. These actions violate Department policy requirements that a search warrant be obtained, that any search by non-medical staff be conducted without physically touching the youth, and that strip searches or body cavity searches be conducted only by medical staff. In fact, state law places strict limits on conducting strip searches and body cavity searches on minors and punishes any violation of the law as a misdemeanor.[20]

These actions raise serious concerns regarding compliance with departmental policy, legal standards, and the protection of youth in custody. 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] Penal Code section 4031 states in relevant part: (a) This section applies to all minors detained in a juvenile detention center on the grounds that he or she is a person described in Section 300, 601, or 602 of the Welfare and Institutions Code, and all minors adjudged a ward of the court and held in a juvenile detention center on the grounds he or she is a person described in Section 300, 601, or 602 of the Welfare and Institutions Code.

(b) Persons conducting a strip search or a visual body cavity search shall not touch the breasts, buttocks, or genitalia of the person being searched.

(c) A physical body cavity search shall be conducted under sanitary conditions, and only by a physician, nurse practitioner, registered nurse, licensed vocational nurse, or emergency medical technician Level II licensed to practice in this state. A physician engaged in providing health care to detainees, wards, and inmates of the facility may conduct physical body cavity searches….

(f) A person who knowingly and willfully authorizes or conducts a strip search and visual or physical body cavity search in violation of this section is guilty of a misdemeanor.

Los Padrinos Juvenile Hall

At LPJH, all 63 incidents for which there were videos had Video Review forms. The remaining packets did not have the form. [21] Of the 63 use-of-force incidents with Video Review forms, 94% (59 of 63) were properly reviewed by Department staff, meaning the Department was in compliance with this metric. 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.[22]

CASE 1

Two youths were fighting and a DPO (DPO 1) came from behind Youth 1 and grabbed Youth 1 and threw him behind the DPO and onto the floor. The youth nearly struck his head on the living unit table.

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."[23] Department policy prohibits staff from throwing a youth down to the floor. The video recording clearly shows the DPO flinging the youth behind the DPO to separate Youth 1 from the other youth. The Video Review Form indicated that the facility director did not believe the use of force was excessive or unnecessary. 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.

CASE 2

A DPO (DPO 1) reportedly instructed a youth to leave the living unit and return to his room. The youth refused to comply and allegedly threw a trash can at DPO 1. In response, DPO 1 lifted the youth by the waistline and carried him down the hallway. While walking down the hallway, DPO 1 appeared to intentionally drop the youth onto the floor, pushed him against the wall, and then forced the youth's head down toward

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[21] Because a determination of proper review is based in part on the Video Review form, it is the better practice to include the form with all force review packets for uniformity even if there is no video of the incident. The reviewer then can simply note on the form that there was no video of the incident.

[22] Use-of-force incidents in case examples: SCM Nos. LPJH 2025-0145, LPJH 2025-0314.

[23] Detention Services Bureau Policy 1005. This policy is consistent with California statutory law, federal statutory law and state and federal court decisions on the uses of force, which must be proportional and reasonable under the totality of the circumstances.

the floor while a second DPO (DPO 2) observed. A third DPO (DPO 3) then assisted DPO 1 in securing the youth's arms behind his back and escorting him to his room using a pain compliance technique, which involved raising both of the youth's arms in the air.

The Probation Department policy prohibits staff from throwing a youth down to the floor, as well as applying pressure to a youth's head or neck area during a physical intervention.[24] The video recording clearly shows DPO 1 carrying the youth upside down and then letting the youth drop to the floor, potentially causing head trauma to the youth. The Video Review Form indicated that the facility director did not believe the use of force was excessive or unnecessary. 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.

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 and harassment 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 (BJNJH and LPJH) and five camps (Camp 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 Glenn Rockey, Camp Afflerbaugh, Camp Joseph Paige and Camp Vernon Kilpatrick each continue to 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 but then diverted resources for that project in order

[24] 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).

to open LPJH and make improvements in response to 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 there are currently no updates or renewed plans to remodel or eliminate blind spot areas within the camp facilities. In the interim, the Department reports that staff continue to position themselves inside restrooms during shower and restroom periods to monitor these areas and reduce potential risks.

At BJNJH, Probation Department staff properly replaced outdated or missing shower curtains to maintain compliance with PREA standards. However, at LPJH, during this Reporting Period, Office of Inspector General staff observed broken or missing toilet stall doors and multiple missing shower curtains in units. These concerns were communicated to the Probation Department's PREA Coordinator, who reported that the PREA Unit is actively engaged with LPJH facility management to address the issues. The coordinator also noted that curtain shortages have occasionally resulted from backlogged orders, and to mitigate this, the Department has redistributed surplus curtains to LPJH when available. Based on the Office of Inspector General's review, BJNJH complied with the Settlement Agreement Detailed Plan, but LPJH did not.

The Office of the Inspector General observed that at both BJNJH and LPJH, staff did not consistently announce their presence when entering living units occupied by youth of the opposite gender. This concern was communicated to the Probation Department's PREA Coordinator, who was asked what measures are being taken to ensure staff compliance with this protocol. The coordinator explained that the Department is addressing the issue through multiple approaches, including posting opposite-gender announcement signage at the entrances of living units, updating the annual PREA refresher training to emphasize opposite-gender announcements, and reinforcing expectations during site visits, where PREA Unit staff routinely remind personnel to identify themselves upon entry. The coordinator emphasized that ongoing communication between the PREA Unit and facility operations is critical to improving compliance. While these measures may improve future compliance, during this reporting period the Department failed to comply with the requirements of the Detailed Plan.

The PREA Coordinator noted that the Probation Department is exploring additional strategies to standardize the announcement process and is consulting resources from

[25] On 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).

the National PREA Resource Center to help instill this practice into the culture of Department facilities.

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 Office of the Inspector General previously reported that 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 has recently reported that the Electronic Calendaring System (ECS) will be utilized to track access to room confinement and programming. However, during this Reporting Period, the Department did not have an electronic system and therefore was out of compliance with the room confinement tracking system requirement of the Detailed Plan.

The Detailed Plan provides that when the Probation Department determines that a youth constitutes a threat to the 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; there were 78 room confinements at BJNJH and 110 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 99% of the incidents, making the Department in compliance with this provision. As noted above, there was a single room confinement incident that the Office of Inspector General determined was punitive in nature and unjustified:

CASE 1

Video recordings indicated that three youths were left unsupervised in a hallway adjacent to an unsecured breezeway door. Two of the youths, identified by staff as known enemies, entered the breezeway for approximately 30 seconds and returned with visible injuries, strongly suggesting a physical altercation occurred off-camera in

the breezeway. Despite the absence of any further aggression or ongoing threat by the youths observed on video, both youths were placed in room confinement more than an hour later, reportedly for being "out of bounds." This confinement appears punitive in nature, in violation of Title 15 §1354.5 and departmental policy, both of which prohibit the use of room confinement as a form of punishment. The incident also highlights significant lapses in staff supervision, including the failure to prevent youths from accessing an unsecured area and a 32-minute delay in reporting the incident. There was no immediate documentation or review, further compounding these concerns. These deficiencies reflect a broader, ongoing failure by the Probation Department to ensure consistent internal tracking and timely administrative responses.

The Detailed Plan requires Probation Department staff to notify juvenile hall superintendents promptly when room confinements do not comply with Welfare and Institutions Code section 208.3. Based on a review of the available documents, as noted above, this one room confinement during the Reporting Period violated policy or state law, warranting notification to the superintendent. The Department does not currently have a system to verify that the superintendent actually received prompt notification of the violation as there is no requirement for electronic or written acknowledgment of receipt by the superintendent.[26] It was reported by Department staff that when a Department staff member promptly sends an email or calls the superintendent to report a room confinement, the superintendent often signs the notification form after the date of the room confinement. In addition, the date on the signature line is often noted as the date of the room confinement and not the date the form is actually signed. Based on the Office of Inspector General's review of the documentation, it could not verify that the required notification occurred as required by the Detailed Plan.

The Detailed Plan also requires that in 90% of the incidents determined to be out of policy or not compliant with the law, the Probation Department implement subsequent remedial measures. During this Reporting Period, the Department lacked 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.

[26] The current notification form sent to the superintendent is signed by the superintendent after the room confinement and does not indicate *when* the superintendent was notified.

As of January 2025, the Office of Inspector General began conducting *weekly* site visits to both BJNJH and LPJH to assess documentation practices and compliance with room confinement and programming requirements. At BJNJH, room confinement is tracked using an after-the-fact electronic system. Incidents are initially recorded on a movement control log, and this information is subsequently provided to the Room Confinement Coordinator for quality control. The documentation is reviewed for accuracy using a checklist, and once verified, the entries are entered into a tracking log. Notably, video review is not included as part of the quality control process.

LPJH follows a similar process; however, its room confinement log is updated more contemporaneously as events occur. Despite this improvement, tracking still occurs without video verification. The BSCC previously identified this as a systemic issue, citing the lack of real-time oversight and documentation errors related to room confinement at BJNJH and LPJH.[27] These findings by the BSCC mirror the Office of Inspector General's observations during this Reporting Period, confirming that deficiencies in real-time oversight and documentation persist despite incremental improvements in tracking systems.

The Office of the Inspector General has also observed that this is a systemic issue within the Probation Department and that effective oversight of room confinement processes requires a dedicated subject matter expert to ensure accuracy and accountability. Currently, the Room Confinement Coordinator receives paperwork after the fact and often resubmits corrected forms until the information appears accurate on paper. However, the documentation does not always align with what is reflected on video recordings.

During weekly visits, multiple discrepancies were noted between documentation and video evidence.[28] These inaccuracies were discussed with both the Quality Control Supervisor and the Room Confinement Coordinator. The Probation Department was responsive and asked involved Department staff to correct the documentation to reflect the events accurately.

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

[27] BSCC 2024 Report for Board Adult and Juvenile Items of Noncompliance, §1354.5, pp. 1–2.

[28] The confinements occurred on January 2, 13, and 25, 2025; February 10 and 28, 2025; and March 4 and 9, 2025.

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.

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.[29] 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 provide the room confinement log in time or in the correct format to be included in the exception log used to track programming and submitted to the Office of Inspector General. As a result, the Office of Inspector General was unable to determine the Department's compliance with the Detailed Plan for programming during this reporting period. Additionally, the Department did not provide visitor, telephone, and religious service logs as required. As mentioned elsewhere in this report, the documents requested for this compliance metric are routinely requested by the Office of Inspector General for each reporting period, meaning should anticipate these requests for information. This documentation from the first sixth months of 2025 should have been available when requested by our staff. As noted in the Office of Inspector General's last report, the Probation Department reported 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 reported developing and maintaining four primary electronic data systems to support operations within juvenile facilities. These include, (1) the Youth Activity Tracking System (YATS), which monitors and documents youth participation in daily activities, (2) the Institutional Programs and Calendar Application (IPCA), used to schedule and manage facility-based programs and events, (3) the Youth Support Systems (YSS) platform, which tracks youth support services and case management activities, and (4) the Los Angeles County Department of Youth Development (DYD) Calendar System, a scheduling tool specific to DYD. Collectively, these systems are intended to improve data collection, coordination, and oversight across key areas of youth care and facility operations.

The YATS system tracks daily movement of all youths within the facilities including religious services and visitation. The Probation Department reported that due to the lack of Wi-Fi in its youth facilities, the Department is presently unable to implement YATS and cannot provide an expected implementation date. The Department reported that

[29] 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.

procurement and installation of a facility-wide Wi-Fi network is still under review, and no implementation date has been provided due to cost and vendor coordination concerns.

During the Reporting Period the Probation Department commenced the implementation process of the IPCA electronic system which (1) tracks all daily youth programming, including self-separations and room confinements, (2) provides weekly and monthly event calendars, (3) provides an alert for canceled events, and (4) tracks any changes made to youths' records. IPCA was launched on August 5, 2025, but was replaced within weeks by the DYD Calendar System in September 2025, and was intended to serve as an upgraded scheduling and attendance-tracking tool, designed to streamline data collection for youth programming.[30] It was expected to integrate with facility calendars, track youth participation in real time, and automatically generate compliance summaries for Required Activities. However, the system remains non-functional, and the Probation Department did not provide the nature of the problem.[31] The Office of Inspector General's review found that events are not consistently entered or reviewed, rollcall and participation data are frequently missing, and inconsistent use across facilities significantly limits the system's reliability for compliance monitoring.

The YSS application is a data collection system that will assist the Probation Department to (1) centralize program data, (2) evaluate programming, (3) audit program performance, (4) work with universities and research entities to expand knowledge in the subject field, and (5) review performance, assess risk and provide operational guidance to its executive staff. This system is in its second phase with the added ability to document youth attendance at programming, which will allow replacement of logs currently used at the juvenile halls. The Department did not provide a date for the system's third and final phase which will include an automated auditing mechanism and implementation of the system.

Given the challenges with the implementation of the IPCA system and integration with the DYD Calendar system, the Probation Department recently reported the implementation of the Electronic Calendar System (ECS).[32] The ECS is designed to integrate the functions of the IPCA and the DYD systems, reportedly enabling the Department to track daily participation in activities such as large muscle exercise, indoor

[30] The reason for utilizing an outside agency's data system instead of the IPCA system that the Probation Department developed was not provided to the Office of Inspector General staff.

[31] The Office of Inspector General inquired regarding the reason the system remains non-functional but was not provided a response.

[32] The Probation Department reports that the IPCA system will no longer be operational and there is no data currently produced by the IPCA system.

recreation, classes, and court appearances. It will also allow outside stakeholders to access youths' calendars to assist in scheduling programming for the youths. The Department attributed the switch to the new ECS system because it allows integration of the IPCA and DYD systems, and it is currently "live and accessible."

Currently, room confinement logs are reviewed retrospectively, with superintendents receiving notifications of four-hour confinements via email or text message, but without an automated system to verify timeliness or trigger alerts. There is also no dashboard for real-time monitoring of potential Title 15 violations. The Office of Inspector General continues to recommend the development of a comprehensive compliance platform that integrates PCMS, SCM, and Title 15 data to enable automated alerts and real-time oversight. Once fully implemented, these electronic systems are expected to enhance transparency, improve the accuracy of documentation related to programming and room confinement, and help the Probation Department meet the tracking and reporting requirements outlined in the Detailed Plan and Title 15.

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.[33] 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.[34] 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 has since resolved the issue and confirmed that, as of October 2025, the GMS is fully operational, with restored functionality for data entry, tracking, and resolution documentation. The Office of Inspector General has verified that staff at both BJNJH and LPJH have resumed the electronic entry of new grievances into the system.

[33] 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."

[34] 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 and therefore replaced.

The Department reported that training has been completed, and GMS is fully functional as in October 2025. Staff, 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 has reported completion of the procurement process for electronic grievance kiosks, which are intended to enable youth to submit grievances directly into the GMS without staff assistance. The vendor contract was approved in late September 2025, and installation is expected to begin during the fourth quarter. In the meantime, staff continue to rely on paper grievance forms to maintain continuity in grievance reporting. However, because the kiosk component has not yet been implemented and is not accessible in all housing units, the Department is only partially compliant with the Detailed Plan's requirement for a youth-accessible electronic grievance submission portal.

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

For BJNJH, the Office of Inspector General found that of the total 295 grievances documented between January 1, 2025, and June 30, 2025, 25% (75 of 295) related to programming, 2% (5 of 295) related to visitation, 1% (4 of 295) related to phone calls, 2% (7of 295) related to recreation, and less than 1% (1 of 295) related to religious services. 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.

For LPJH, the Office of Inspector General found that of the total 514 grievances documented between January 1, 2025, and June 30, 2025, 4% (18 of 514) related to programming, less than 1% (1 of 514) related to visitation, 5% (26 of 514) related to phone calls, 1% (5 of 514) related to recreation, none related to religious services. 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 review 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. Based on the review of the force packets, the Office of Inspector General additionally recommends that the force review packet include a Video Review form even if the incident was not recorded. 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.