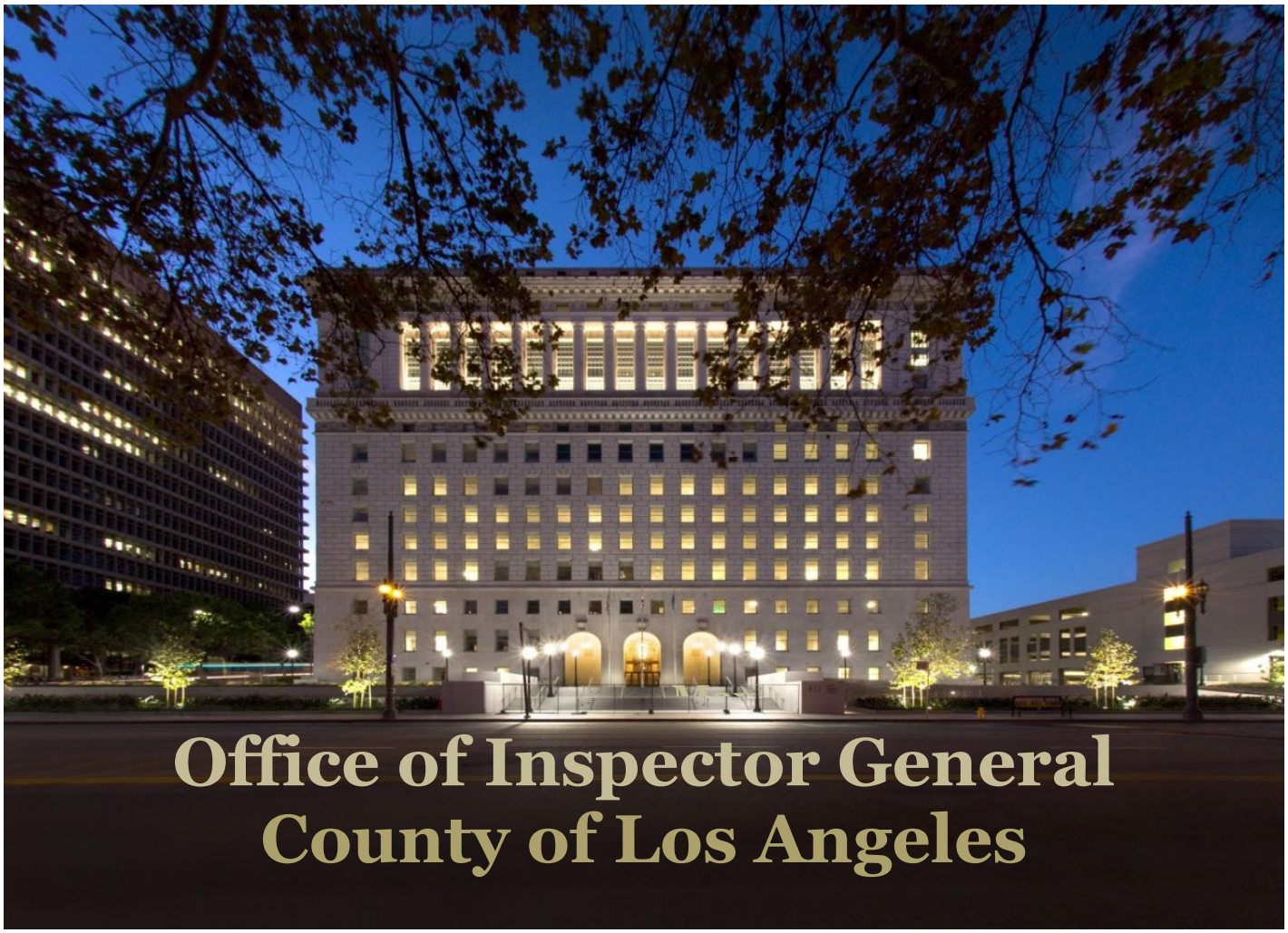

Reform and Oversight Efforts: Los Angeles County Sheriff's Department

July through September 2025

Issued November 19, 2025

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ABOUT QUARTERLY REPORTS

Quarterly reports provide an overview of the Office of Inspector General's regular monitoring, auditing, and review of activities related to the Los Angeles County Sheriff's Department (Sheriff's Department) over a given three-month period. This quarterly report covers Department activities and incidents that occurred between July 1 and September 30, 2025, unless otherwise noted. Quarterly reports may also examine issues of interest. This report includes special sections on the following topics:

- Sheriff's Department Policies on Eyewitness Identification – Legal Compliance
- *Rosas* Compliance
- Shower Privacy for Transgender, Gender Non-Conforming, and Intersex People at Men's Central Jail
- Correctional Health Services Mortality Review
- Custody Administrative Death Review Pre-meet

During the third quarter of 2025, the Office of Inspector General issued the following reports relating to the Sheriff's Department:

- *Sixth Report Back on Meeting the Sheriff's Department's Obligations Under Senate Bill 1421*
- *Thirteenth Report Back on Implementing Body-Worn Cameras in Los Angeles County*

MONITORING SHERIFF'S DEPARTMENT'S OPERATIONS

Deputy-Involved Shootings

Deputy-involved shootings are shootings in which a deputy intentionally fired a firearm at a human, or intentionally or unintentionally fired a firearm and a human was injured or killed as a result. As communicated in a memorandum to the Board of Supervisors dated June 11, 2025, the Office of Inspector General suspended regular rollouts to deputy-involved shootings due to staffing reduction and lack of implementation of state laws on cooperation with external misconduct investigations (*see, e.g.* Government Code 25303.7(c)(2) and Penal Code 13510.8(a)(8)).

During this quarter, there were no incidents in which people were shot or shot at by Sheriff's Department personnel. The Sheriff's Department attributes this fact to

increased Taser usage. While the goal of deploying less-lethal Tasers is to reduce the use of firearms, that claim is currently without evidentiary basis. The Office of Inspector General encourages the Sheriff's Department's Audit and Accountability Bureau to conduct a multi-year study correlating Taser and shooting statistics to support the claim and to guide future policy.

The Sheriff's Department maintains a page on its website listing deputy-involved shootings that result in injury or death, with links to incident summaries and video. Records relating to the discharge of a firearm at a person by a peace officer or custodial officer are not confidential pursuant to Penal Code section 832.7(b)(1)(A)(i).[1] Disclosures of records of deputy-involved shootings may be delayed under some circumstances, but the agency must establish in writing the basis for its "determination that the interest in delaying disclosure clearly outweighs the public interest in disclosure" and the records must be released no later than 18 months after the date of the incident as set forth in Penal Code section 832.7(b)(8). Sheriff's Department practice in releasing such information had rarely complied with this legal mandate. In March 2022, the Board of Supervisors County enacted Los Angeles County Code section 2.170.020, which sets minimum standards for the disclosure of records related to peace officers employed by the Sheriff's Department. The ordinance is only operative once the Peace Officer Records Division (PORD), the County Counsel division responsible for responding to SB 1421 requests is fully staffed. Because the unit is not yet fully staffed, the public still does not have access to information that the Board intended be publicly posted as anticipated by the ordinance timelines.[2]

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[1] Penal Code section 832.7(b)(3) states that the records that must be released pursuant to this section include "all investigative reports; photographic, audio, and video evidence; transcripts or recordings of interviews; autopsy reports; all materials compiled and presented for review to the district attorney or to any person or body charged with determining whether to file criminal charges against an officer in connection with an incident, whether the officer's action was consistent with law and agency policy for purposes of discipline or administrative action, or what discipline to impose or corrective action to take; documents setting forth findings or recommended findings; and copies of disciplinary records relating to the incident, including any letters of intent to impose discipline, any documents reflecting modifications of discipline due to the *Skelly* or grievance process, and letters indicating final imposition of discipline or other documentation reflecting implementation of corrective action. Records that shall be released pursuant to this subdivision also include records relating to an incident specified in paragraph (1) in which the peace officer or custodial officer resigned before the law enforcement agency or oversight agency concluded its investigation into the alleged incident."

[2] SB 1421 is codified in Penal Code section 832.7 and requires the release of certain records that include records relating to deputy-involved shootings. A more detailed explanation for the delay in the implementation of the County ordinance is in the Office of Inspector General's most recent report on compliance with SB 1421, *Sixth Report Back on Meeting the Sheriff's Department's Obligations Under Senate Bill 1421*.

District Attorney Review of Deputy-Involved Shootings

The Sheriff's Department's Homicide Bureau investigates deputy-involved shootings in which a person is hit by a bullet, except for deputy-involved shootings that result in the death of an unarmed civilian, which California law requires the Attorney General to investigate.[3] For those shootings it investigates, the Homicide Bureau submits the completed criminal investigation of each deputy-involved shooting that results in a person being struck by a bullet and that occurred in the County of Los Angeles to the Los Angeles County District Attorney's Office (District Attorney's Office or District Attorney) for review and possible filing of criminal charges.

Between July 1 and September 30, 2025, the District Attorney's Office posted memoranda on its website for eight findings on deputy-involved shooting cases involving Sheriff's Department's employees.[4] The District Attorney's Office declined to file charges in seven cases, as it determined that use of force was not unlawful. For the remaining shooting, the District Attorney's Office determined the deputy did not fire his service weapon, but rather the suspect's gunshot wound was self-inflicted. The memoranda may be found on the District Attorney's website page for Officer-Involved Shootings. The following are the deputy-involved shootings posted:

- The October 19, 2021, non-fatal shooting of Adrian Abelar by Deputy Yen Liu.
- The September 5, 2022, non-fatal shooting of Corey Crittenden by Deputies Michael Alburez, Terri Coats, and Brandon Vanarsdale.
- The November 3, 2022, fatal shooting of Ramiro Lozano by Deputy Adonay Molina.
- The December 22, 2022, fatal shooting of Willie Pendleton by Deputies Ervin Francois and Stephen Williams.
- The February 6, 2024, fatal shooting of Janathan Foster by Deputies Kyle Deluca, James Alvarado and Eric Torres.

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[3] In 2020, the California Legislature passed AB 1506, which requires that a state prosecutor investigate all shootings involving a peace officer that result in the death of an unarmed civilian. *See* A.B. 1506 (McCarty 2020) (codified at Govt. Code § 12525.3). The Attorney General's findings in these investigations are reported in the section of this report below entitled *California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians***.** Until the law took effect in 2021, the Sheriff's Department's Homicide Bureau investigated all deputy-involved shootings in which a person was hit by a bullet.

[4] The District Attorney's Office posts its decisions on deputy and officer-involved shootings on its website under Officer-Involved Shootings. The Office of Inspector General retrieves the information on District Attorney decisions from this webpage.

- The March 19, 2024, fatal shooting of Jose Acosta by Deputies Hector Macias and Zachary Van Der Zanden.
- The June 17, 2024, non-fatal shooting of Jason Baker by Deputy Madison Lee.
- The October 11, 2024, non-fatal shooting of Raul Martinez by Deputy Tarek Salah.
- The March 29, 2025, non-fatal shooting of himself, Jamon Allensworth, with Deputy Jairo Silva's service weapon.

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

Under California law, the state Department of Justice (CA-DOJ) investigates any peace officer-involved shooting resulting in the death of an unarmed civilian and may issue written reports or file criminal charges against a peace officer, if appropriate.[5] CA-DOJ is not currently investigating any shootings involving deputies from the Sheriff's Department. During the third quarter of 2025, CA-DOJ issued no written reports regarding shootings involving Sheriff's Department deputies.

Homicide Bureau's Investigation of Deputy-Involved Shootings

For the present quarter, the Homicide Bureau reports that it has six shooting cases involving Sheriff's Department personnel open and under investigation. At the close of the quarter, the oldest case for which the Homicide Bureau maintained an active investigation relates to a January 21, 2025 shooting in the jurisdiction of Century Station. For further information as to that shooting, please refer to the Office of Inspector General's report *Reform and Oversight Efforts: Los Angeles Sheriff's Department - January to March 2025*. The oldest case for which the Homicide Bureau completed its investigation but remains open is a 2019 shooting in the city of Lynwood, which was submitted to the District Attorney's Office and for which the Sheriff's Department still awaits a filing decision.

This quarter, the Sheriff's Department reported it sent four deputy-involved-shooting cases to the District Attorney's Office for filing consideration.

[5] Government Code § 12525.3(b).

Internal Criminal Investigations Bureau

The Sheriff's Department's Internal Criminal Investigations Bureau (ICIB) reports directly to the Division Chief and the Commander of the Professional Standards Division. ICIB investigates allegations of criminal misconduct committed by Sheriff's Department personnel in its jurisdiction, meaning for crimes occurring in unincorporated areas of Los Angeles County or in a city that is contracted with the Sheriff's Department for law enforcement services.[6]

The Sheriff's Department reports that ICIB has 80 active cases. This quarter, ICIB reports sending 9 cases to the District Attorney's Office for filing consideration. The District Attorney's Office is still reviewing 33 cases previously sent from ICIB for filing. The oldest open case that ICIB submitted to the District Attorney's Office and still awaits a filing decision relates to conduct that occurred in 2018, which ICIB presented to the District Attorney in 2019.

Internal Affairs Bureau

The Internal Affairs Bureau (IAB) conducts administrative investigations of policy violations by Sheriff's Department employees. It also responds to and investigates deputy-involved shootings and significant use-of-force cases. If the District Attorney declines to file criminal charges against the deputies involved in a shooting, IAB reviews the shooting to determine whether Sheriff's Department personnel violated any policies during the incident.

The Sheriff's Department also conducts administrative investigations at the unit level. The subject's unit and IAB determine whether an incident should be investigated by IAB or remain a unit-level investigation based on the severity of the alleged policy violations.

During this quarter, the Sheriff's Department reported opening 141 new administrative investigations. Of these 141 cases, 42 were assigned to IAB, 66 were designated as unit-level investigations, and 33 were entered as criminal monitors (in which IAB monitors an ongoing criminal investigation conducted by the Sheriff's Department or another agency). In the same period, IAB reports that 116 cases were closed by IAB or at the unit level. There are 474 pending administrative investigations, of which 333 are assigned to IAB and the remaining 141 are unit-level investigations.

[6] Misconduct alleged to have occurred in other jurisdictions is investigated by the law enforcement agencies in the jurisdictions where the crimes are alleged to have occurred.

Civil Service Commission Dispositions

The Civil Service Commission hears employees' appeals of major discipline, including discharges, reductions in rank, or suspensions of more than five days. Between July 1 and September 30, 2025, the Civil Service Commission issued final decisions in five cases involving Sheriff's Department employees. In these five cases, the Civil Service Commission sustained the Department's discipline in four cases and reduced the discharge to a thirty-day suspension in one case. The Civil Service Commission reports its actions, including final decisions, in minutes of its meetings posted on the County's website for commission publications.

The Sheriff's Department's Use of Unmanned Aircraft Systems

According to data posted by the Sheriff's Department, it deployed its Unmanned Aircraft Systems (UAS) 27 times between July 1 and September 30, 2025. Of the 27 deployments, 6 were categorized as "training exercise." The Office of Inspector General recommends that the Sheriff's Department provide more specific information regarding the use of UAS for a "high risk tactical operation." Circumstances justifying use of a UAS might include exigent circumstances, a reasonable suspicion that a crime is occurring, or execution of a search warrant. The law recognizes these exceptions to the Fourth Amendment of the United States Constitution, which does not have an exception for a "high risk tactical operation." Historically, members of the public have supported drone usage in law enforcement but have requested the activity be limited to areas of the most benefit to life and safety and that safeguards be in place to avoid usage encroaching into areas which are likely to result in excessive invasion of privacy. Imprecise categories and limited information can result in law enforcement action that undermines public trust.

Status of the Sheriff's Department's Adoption of an Updated Taser Policy and Implementation of a System of Tracking and Documenting Taser Use

Status of Taser Policy Implementation and Training

On October 3, 2023, the Board of Supervisors (Board) passed a motion instructing the Sheriff's Department to revise its Taser policies and incorporate best practices from other law enforcement agencies to ensure its policies complied with State and Federal law. The motion directs the Inspector General to include in its quarterly reports to the Board the status of the Sheriff's Department updated Taser policy, deputy compliance with updated policies and training, and documentation on the Department's Taser use.

The Sheriff's Department reported the following information regarding training and policy implementation to date:

- The Department reported that from the Phase 1 purchase of 3,197 Taser 10s, over 2,800 are currently deployed.[7]
- As reported in our previous report, according to the Weapons Training Unit (WTU), a list of approved CEWs is currently being created.[8] This list will be maintained by the Tactics and Survival Unit (TAS) and posted on the TAS SharePoint site once the data is compiled.

Tracking Taser Use

In May 2024, the Sheriff's Department launched a web dashboard reporting Taser usage by date range with options to narrow the results by practice area (such as Patrol or Custody), patrol station or facility, incident type, or city. Beginning in July 2024, the Department began including in that data the "Result of the Use of Force" (i.e., whether the use resulted in serious injury or death). The Sheriff's Department provided the following information for Taser usage for the third quarter of 2025:

- There were 242 Taser 10 field uses recorded with a reported 88% effectiveness rate.[9]
- Of the 242 field uses, the suspect was armed in 43 (18%) incidents. Of the 43 incidents, 10 involved firearms, 18 involved knives, and 15 involved other weapons.[10]
- Each Taser 10 is equipped with technology that signals the BWC to activate when a deputy turns off the Taser 10's *Safe Mode* as the deputy readies the

[7] This section on Tasers includes the information reported by the Sheriff's Department for the quarter covered in this report and does not include information reported previously. For information reported previously, we refer to our reports: *Reform and Oversight Efforts: Los Angeles County Sheriff's Department – April to June 2025* and *Report on the Sheriff's Department's Taser Policy, Training, and Usage*.

[8] The Sheriff's Department refers to Tasers by the generic name, Conducted Energy Weapons, abbreviated as CEW. The term Taser and CEW are used interchangeably in this report.

[9] According to the Sheriff's Department, effectiveness is determined by the assessment that a suspect was subdued as a result of the Taser usage.

[10] It is this low percentage of Taser uses in which a suspect is armed that causes the Office of Inspector General to continue to warn against Sheriff's Department force policies that do not sufficiently protect against improper use of *less*-lethal technology.

Taser to fire. The Department reported 27 such activations, referred to as signal activations, during this quarter.[11]

Sheriff's Department Policies on Eyewitness Identification – Legal Compliance

In 2018, California enacted Senate Bill 923, later codified as Penal Code section 859.7, to establish uniform standards for eyewitness identifications. Effective January 1, 2020, the law requires law enforcement agencies to use evidence-based procedures designed to reduce wrongful convictions. This statute replaced the prior system of discretionary practices with mandatory safeguards to ensure consistency and reliability statewide.

California Penal Code section 859.7 requires all law enforcement agencies and prosecutorial entities to adopt standardized regulations for conducting photo and live lineups with eyewitnesses. The statute's purpose is to improve the reliability and accuracy of suspect identifications.

Key provisions include:

- **Eyewitness description first:** The eyewitness must describe the suspect before any lineup.
- **Blind/blinded administration:** The officer conducting the lineup should not know the suspect's identity ("blind"), or if he knows the suspect's identity ("blinded"), he must not know what position the suspect will be placed in. If blind administration is not used, the officer shall provide a written explanation for this decision.
- **Neutral instructions:** Eyewitnesses must be informed that the perpetrator may or may not be present, that they are not required to identify anyone, and that their decision will not conclude the investigation.
- **Lineup composition:** Fillers must generally match the eyewitness description. Only one suspect can be included, and writings or information concerning any previous arrests shall not be visible to the eyewitness.

[11] Per Sheriff's Department policy, a deputy should activate their BWC in advance of enforcement or investigative contact. In those incidents where the TASER 10 was deployed but no signal activation occurred, it was because the deputy's BWC was already recording. Per a response from the Department, the signal activation feature on the TASER 10 serves as a fail-safe to account for situations that unfold rapidly, where a deputy may need to react immediately for officer safety before manually activating the BWC. It also functions as a secondary safeguard in cases where the BWC was not activated as required. The Department should review the 27 signal activations to determine if those deputies should have already activated their BWCs.

- **Separation of eyewitnesses:** Multiple eyewitnesses cannot view the lineup together.
- **No influence:** Officers must refrain from making statements that could influence an eyewitness.
- **Confidence statement:** If an identification is made, the eyewitness confidence level must be recorded in writing, verbatim, of what the witness says. The officer shall not validate or invalidate the eyewitness identification.
- **Recording requirement:** "An Electronic recording shall be made that includes both audio and video of the entire identification procedure. Whether it is feasible to make a recording with both audio and visual representations shall be determined on a case-by-case basis. When it is not feasible to make a recording with both audio and visual representations, audio recording may be used. When audio recording without video recording is used, the investigator shall state in writing the reason that video recording was not feasible."

In February 2020, the Sheriff's Department revised *Section 5-09/530.20, Manual of Policy and Procedures, Photo Arrays*, to reflect the changes in the law. The policy encompasses nearly all the key provisions required by Penal Code Section 859.7. In fact, the language of the policy often provides more detail than required by the law, thereby offering more precise guidance to its employees. However, there is one discrepancy between the law and the Department's policy regarding the recording requirement. The law is clear that an electronic recording "shall" be made (of the witness identification process) that includes both audio and video recording. When it is not feasible to have both, an audio recording may be sufficient, but a reason must be stated as to why a video recording was not feasible.

The Department's current policy does not meet this requirement. The policy states:

> Documenting an eyewitness' response shall be in writing in case notes or records; but should include an audio or video recording as well.

The Department's use of the word "should" instead of "shall" is not in compliance with the law, as it leaves the ultimate decision to the investigating employee as to whether they will or will not record. It is essential to make this requirement mandatory, rather than optional, to ensure compliance with the language and spirit of the law. Furthermore, the policy states the response should include audio *or* video when in fact the law states both audio and video must be used unless not feasible.

***Recommendation*:** The Department's policy should require and make mandatory the electronic recording that includes both audio and visual representations of the identification procedures. When it is not feasible to do both, audio recordings may be

used without video, accompanied by a written explanation as to why video recording was not feasible. The Department should provide training to ensure that personnel understand the requirements of Penal Code section 859.7, including that recording the identification is mandatory.

Outstanding Requests to the Sheriff's Department

The Office of Inspector General made the following request for information to the Sheriff's Department for which responses are still outstanding:

- An April 18, 2025 request for additional materials responsive to a subpoena duces tecum that was served in October 2024 and included a request for all documents and information relating to any Sheriff's Department surveillance of any County oversight officials; this follow-up request was made after it came to the Inspector General's attention that surveillance of a County oversight official was conducted but information relating to that surveillance, including notes and an audio digital tape of an interview, were not provided. Although the subpoena duces tecum was served on October 1, 2024, no notes have been provided regarding the work of two peace officers alleged to have engaged in surveillance. Despite repeated assurances that additional information would be provided, either by providing additional documents or acknowledging the documents that purportedly exist cannot be located, no additional information has been provided.

CUSTODY DIVISION

Rosas Compliance

An unreported use of force by a deputy (the Deputy) and a custody assistant (the CA) occurred at CRDF on January 23, 2020. Provision 13.1 of the Implementation Plan for the *Rosas* Settlement Agreement and Release[12] (*Rosas* Implementation Plan) requires

[12] The *Rosas* Settlement Agreement arose out of a federal class action lawsuit alleging a pattern of excessive uses of force in the Los Angeles County jails downtown facilities.

that the Sheriff's Department have a "firm policy of zero tolerance for acts of dishonesty and failure to report uses of force."[13] Provision 13.1 further states:

> If the Department does not terminate a member who is found to have been dishonest [or] used excessive force, … the Department should document the reasons why the member was not terminated.

Pursuant to provision 13.2, if the Department does not terminate an employee for a finding of dishonesty or excessive force, the Department should report its reasons for not terminating the employee to the Office of Inspector General.

Following the use of force on January 23, 2020, and during the administrative investigation, the Deputy and the CA denied that they used reportable force, despite substantial evidence indicating that they employed resisted control holds, used a team takedown, and that their actions "result[ed] in an injury or a complaint of pain," each of which constitute reportable force under Custody Division Manual (CDM) Section 7-06/000.00, Use of Force Reporting Procedures.

Although the Sheriff's Department sustained findings against the Deputy and the CA regarding their unreported uses of force, the Sheriff's Department's investigation concluded that it was "unresolved" as to whether the Deputy and the CA violated the Department Manual of Policy and Procedures MPP Section 3-01/040.70, False Statements, and the Deputy and the CA were not discharged from the Department. A review and analysis of the investigation by the Office of Inspector General shows that the Deputy and the CA violated MPP Section 3-01/040.70, Dishonesty/False

[13] While the use of force occurred in January of 2020, the results of the administrative investigation were reported to the Office of Inspector General during this past quarter. Per the Implementation Plan, the Department is required to report quarterly to the Office of Inspector General all findings of dishonesty, the punishment imposed, and the reasons why the department member was not terminated if the employed was not discharged. The Sheriff's Department did provide the Office of Inspector General with the results of the investigation and the discipline imposed even though the Department did not find that the Deputy and the CA were dishonest. Because the Department is only required to report findings of dishonesty and failure to report force, it is concerning that there are likely similar cases where dishonesty was alleged but not found or cases where the Department failed to alleged dishonesty at all. Such failures indicate a lack of compliance with the intent of the Settlement Agreement and the *Rosas* Implementation Plan.

Statements, by a preponderance of the evidence standard,[14] by making false statements, failing to disclose material facts related to engaging in reportable uses of force, and denying engaging in a reportable use of force, and that the Department should have found accordingly.[15] Such a finding would have required the employees to be discharged or for the Department to provide the Office of Inspector General with an explanation as to why the Department did not discharge the employees pursuant to *Rosas* Implementation plan provision 13.1.

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[14] An early California case defined preponderance of the evidence: "The term simply means what it says, viz., that the evidence on one side outweighs, preponderates over, is more than, the evidence on the other side, not necessarily in number of witnesses or quantity, but in its effect on those to whom it is addressed." *People v. Miller* (1916) 171 Cal. 649, 652-653. *Skelly v. State Personnel Board* (1975) 15 Cal. 3rd 194, 204, noted in footnote 19, "the appointing power has the burden of proving by a preponderance of the evidence the acts or omissions of the employee upon which the charges are based and of establishing that these acts constitute cause for discipline under the relevant statutes."

[15] MPP 3-04/020.25 *Administrative Investigation Terminology* includes the following definitions:

- Exonerated – a complaint shall be classified as exonerated when the investigation establishes by clear and convincing evidence either (1) that the employee was not personally involved or in any other way connected with the incident or incidents or allegation in question or (2) that the allegation giving rise to the investigation was demonstrably false and brought in demonstrable bad faith or by virtue of an obvious and demonstrable mental disease or defect or (3) that the allegation in question, broadly construed and even if true, would not, in any circumstance, constitute violation of law or Department policies, rules, or procedures and is not otherwise censurable. Any disposition of exonerated must be fully documented in writing and the complete reasoning and rationale set forth;
- Founded – when the investigation that the allegation is true, and when the action on the part of the Department members is prohibited by law or Department policy;
- Unfounded – when the investigation establishes by a preponderance of the evidence that the allegation is not true; and
- Unresolved – when the investigation fails to resolve the conflict between the complainant's allegation and the Department member's version of the incident; when there is no preponderance of the evidence to support either version of the incident."

While there is no specific reference to the preponderance of the evidence standard as necessary for a finding of founded, the reference to the standard in unfounded indicates that a founded allegation is based on this legal standard consistent with case law. Proposed revisions to the Sheriff's Department *Administrative Investigations Handbook* would change the possible outcomes for two categories, changing *founded* to *sustained* and *unresolved* to *not sustained,* and would clarify that a sustained finding is based on a preponderance of the evidence standard. The standard is also defined in the proposed revisions to the handbook as follows, "Preponderance of Evidence Standard – The weight of credible evidence, when viewed as a whole, more likely than not supports the disposition." The Office of Inspector General recommends incorporating corresponding changes to the MPP.

Factual Summary

On January 23, 2020, a person in custody at CRDF refused to return to her cell after a pill call.[16]

The Deputy and CA determined that the inmate's behavior constituted insubordination and interference with module operations, and that she should be transported to discipline housing. The Deputy and the CA handcuffed the inmate to a bench pending transport to discipline. A supervising sergeant (the Supervising Sergeant), arrived in the module and was informed of the inmate's behavior. The Supervising Sergeant directed the deputy and the CA to notify him prior to beginning the inmate's transport, so that he could be present in case the inmate became recalcitrant as defined in CDM 7-02/020.00, Handling Insubordinate, Recalcitrant, Hostile, or Aggressive Inmates.

The Deputy subsequently contacted the discipline module and learned that there was no cell availability. The Deputy and the CA moved the inmate to a cell in her current module pending housing availability in discipline housing. They did not notify the Supervising Sergeant of their intent to transfer the inmate to a cell.

As the Deputy and the CA handcuffed the inmate behind her back and escorted her to the cell. The inmate verbalized non-compliance and stated that she would not enter the cell but ultimately did enter the cell without incident. Once inside the cell, the inmate resisted efforts to remove the handcuffs and a "struggle ensued."[17] After utilizing "failed control holds," the Deputy and the CA left the inmate handcuffed within the cell. Approximately 20 seconds later, they returned to the cell and spoke with the inmate through the door of the cell for just over a minute and then the Deputy and the CA entered the cell to remove the handcuffs where a secondary struggle ensued for approximately one minute and twenty-two seconds. At no point did the Deputy or CA utilize their radios, call for back-up, or request assistance from a supervisor during either the first or second use of force. It was only after the struggle in the cell that the Deputy notified the Supervising Sergeant via telephone, informing him that she had moved the inmate into a cell and that the inmate refused to relinquish the handcuffs. The Supervising Sergeant inquired as to why the inmate was moved without contacting him when he gave specific instructions to not transport the inmate unless he was present.

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[16] "Pill call is the process through which medical personnel administer prescribed medication to inmates in housing units." See MPP 5-03/050.00 Access to Health Care.

[17] Quotations in the Statement of Facts are taken directly from the Internal Affairs Investigation Summary.

When the Supervising Sergeant arrived back at the module, the inmate alleged that the Deputy and the CA had broken her arm. After observing redness on the inmate's arm, the Supervising Sergeant directed two deputies to escort the inmate to the medical clinic.[18] The Supervising Sergeant asked the Deputy and the CA at least twice if they had used force against the inmate and both denied using force.

The Supervising Sergeant contacted a Risk Management Sergeant (RM Sergeant) regarding a possible unreported use of force incident. In response to the RM Sergeant's inquiry, the CA denied using force on the inmate. The Supervising Sergeant and the RM Sergeant reviewed and evaluated CCTV video of the incident and determined that the Deputy and the CA had both utilized reportable force on the inmate. The Supervising Sergeant notified the on-duty watch commander and the RM Sergeant returned to the module to identify potential witnesses to the use of force.

Department Disciplinary Determinations

At the time of the incident, the Deputy had been working at the Department for approximately one year, was off training, and had been working on the line in CRDF modules for approximately eight months. The Sheriff's Department sustained findings that the Deputy violated MPP Sections 3-01/050.10, Performance to Standards, 3-01/030.10, Obedience to Laws, Regulations and Orders as it pertains to CDM 7-02/020.00, Handling Insubordinate, Recalcitrant, Hostile, or Aggressive Inmates, 3-10/050.16, Performance to Standards – Performance Associated with the Use of Force and CDM 7-06/000.00, Use of Force Reporting Procedures. The Department determined that the following charges against the Deputy were unresolved: MPP Sections 3-01/040.70, False Statements, MPP 3-01/040.75, Dishonesty/Failure to Make Statements and/or Making False Statements During Departmental Internal Investigations, MPP 3-01/030.15, Conduct Towards Others, and MPP 3-01/030/85, Derogatory Language.[19] The Deputy received a 10-day suspension without pay.

At the time of the incident, the CA had been working at the Department for approximately 20 years, had been working on the line in CRDF modules for approximately 14 years, and had been a training officer for approximately four years. She had been involved in 25 prior uses of force. The Sheriff's Department sustained findings that the CA violated MPP Sections 3-01/050.10, Performance to Standards, 3-01/030.10, Obedience to Laws, Regulations and Orders as it pertains to CDM 7-02/020.00, Handling Insubordinate, Recalcitrant, Hostile, or Aggressive Inmates,

[18] The Deputy who used force was not one of the deputies who escorted the inmate.

[19] The administrative investigation does not state the reason for the unresolved finding as to the Deputy.

3-10/050.16, Performance to Standards – Performance Associated with the Use of Force and CDM 7-06/000.00, Use of Force Reporting Procedures. The Department determined that the following charges against the CA were unresolved: MPP Sections 3-01/040.70, False Statements, MPP 3-01/040.75, Dishonesty/Failure to Make Statements and/or Making False Statements During Departmental Internal Investigations, MPP 3-01/030.15, Conduct Towards Others, and MPP 3-01/030/85, Derogatory Language.[20] The CA received a 15-day suspension without pay.

Analysis

MPP Section 3-01/040.70, Dishonesty/False Statements, states that "[Department] Members shall not make false statements or commit any other violations of the honesty policy, Section 3-01/040.69, when questioned, interviewed, or in reports or documents submitted. Department members who violate this section are subject to discipline up to and including discharge." Provided in pertinent part, the Department's Honesty Policy, MPP Section 3-01/040.69, reads, "[e]xamples of dishonesty and violations of trust include not only false statements, but also . . . concealment of or failure to disclose material facts, observations, or recollections, and failure to make full, complete and truthful statements when required."

CDM Section 7-06/000.00, Use of Force Reporting Procedures, defines reportable force as "any force which is greater than that required for un-resisted Department-approved . . . control holds, . . . or any action which results in an injury or a complaint of pain." CDM Section 7-06/000.00 further outlines reportable force categories, stating that "control holds or come-alongs resisted by a suspect [and] takedowns" constitute Category 1 Uses of Force.

Based on the Sheriff's Department investigation, and the standard of proof by a preponderance of the evidence, the Deputy and the CA's denials as to using force constitute dishonesty or false statements. Specifically, they each made false statements and/or failed to disclose (1) utilizing control holds on the inmate when she resisted, (2) conducting a takedown on the inmate, and (3) engaging in an action against the inmate resulting in her complaining of pain.

[20] The administrative investigation does not state the reason for the unresolved finding as to the CA.

Resisted Control Holds

Regarding the use of control holds that were resisted, is more likely than not that Deputy and the CA knew that utilizing control holds that were resisted by the inmate constituted reportable force pursuant to CDM Section 7-06/000.00.

Both the Deputy and the CA acknowledged that, immediately after escorting the inmate to a cell, they had utilized control holds, including re-directing the inmate toward the wall, to control her behavior. However, although the Deputy and the CA acknowledged that the inmate was non-compliant with their commands and refused to relinquish handcuffs, they denied that her behavior was recalcitrant or resistive, to constitute their use of control holds being considered reportable force.

All the evidence compiled in the course of the administrative investigation contradicts this claim. When interviewed by investigators, the inmate expressly realized that her resistance contributed to the use of force, stating explicitly that her "[continued] refus[al] to lock it down," lead to the uses of force, which she stated were "[her] fault." When describing this interaction, the inmate stated that the Deputy and CA "slammed" her against the wall, and utilized control holds to hold her against the wall. She stated that the Deputy and the CA "used pressure" to put her arms down and then exited the cell leaving her handcuffed behind her back. During a subsequent interview, the inmate provided consistent statements, admitting that she refused to comply with orders and resisted the Deputy and when they attempted to remove her handcuffs.

Other witness's accounts mirror the inmate's statements, with another person housed in the same module telling investigators that, during the first interaction, she observed the Deputy and the CA "roughing up" the inmate and that she observed the CA grabbing the inmate's arms during the interaction.

A deputy who heard, but did not see the incident, told the investigators that he heard the inmate being "uncooperative" and refusing to be housed in the cell, disputing the Deputy and CA's assertion that the inmate was cooperative and non-resistant during the interaction in which they utilized control holds.

A Mental Health Clinical Supervisor (Clinical Supervisor) who was present in the module, stated that she observed the Deputy and the CA on the upper tier "struggling with an inmate," and that they "were hands on with her to try and get her to comply." Describing the incident as the Deputy and the CA "tugging and wrestling" with the inmate, the Clinical Supervisor stated that she observed the Deputy and the CA utilize control holds and stated that the inmate was struggling against the Deputy and the CA's efforts to control her throughout the entire incident. The Clinical Supervisor stated that she observed the Deputy and the CA hold the inmate in what she believed was an attempt to "get a handle on the inmate."

A Psychiatric Technician III (Psychiatric Technician) also observed the first interaction, telling investigators that he heard and observed a "struggle" with the inmate and saw the Deputy and the CA attempting to control the inmate and describing the inmate as "being [physically] resistive and uncooperative," when he observed the Deputy and the CA "holding [the inmate] and then moving her towards the wall to get her to calm down."

In statements to the investigators, the Deputy admitted that the inmate was "verbally aggressive, agitated" and refused to enter the cell. The Deputy further admitted that when the Deputy and the CA attempted to remove the handcuffs, the inmate "took a step forward" in an attempt to pull away from the Deputy. The Deputy admitted that she "re-directed" the inmate toward the wall to keep the inmate from breaking free and explicitly stated that she had utilized a firm grip and control holds to place the inmate against the wall.

Despite describing these behaviors, the Deputy continued to claim that she did not perceive the inmate to be recalcitrant, because the inmate was following verbal commands despite being "verbally defiant." Seemingly contradicting this denial of the inmate's recalcitrance, the Deputy stated that prior to utilizing control holds, the CA told the Deputy they would end up going "hands-on" if they removed the inmate's handcuffs, as the inmate was agitated.[21] The fact that the Deputy and the CA initially left the inmate handcuffed in the cell also shows that the inmate was recalcitrant.

Following review of the CCTV, the Deputy admitted that the inmate was recalcitrant and that she resisted the Deputy and the CA's control holds. Nevertheless, the Deputy continued to claim that she did not perceive the inmate to be resistant at the time of the incident, stating "at the time we didn't feel the, like her being resistive. Like, it was more like we were just holding her against the wall." The Deputy expressly admitted to utilizing resisted force, stating, "looking back, yes, I did violate the use of force [policy] when it came to control holds. But at the time I didn't. But I did report my actions of the [incident] to the Supervising Sergeant."

Similarly, the CA stated that, despite the inmate's refusal to relinquish the handcuffs and follow their verbal commands, the CA believed that the inmate was not recalcitrant. The CA stated that her interpretation of a recalcitrant inmate (under CDM 7-01/020.00, Handling Insubordinate, Recalcitrant, Hostile, or Aggressive Inmates), as an "inmate

[21] It should also be noted that, immediately preceding the use of force, the Deputy authored a Behavioral Observation and Mental Health Referral (BOHMER), in which the Deputy identified the inmate as a potential danger to staff/others and stated that she was displaying "combative/hostile" and "aggressive" behavior.

[who is] hostile and refusing to follow orders or commands given," but stated that she perceived the inmate to be calm and cooperative.

The evidence contradicts the claims of both the Deputy and the CA even by their descriptions of the inmate's behavior. Additionally, the fact that they left the handcuffs on the inmate after she was placed in the cell contradicts their ***belief*** that the inmate was not recalcitrant.

Following review of the CCTV, the CA stated that she still did not recall if the incident constituted force but stated that it seemed like "[the inmate was flailing around and [the Deputy and the CA] were holding her." Despite acknowledging that CDM 7-06/000.00, Use of Force Reporting Procedures requires Department members to report force where "there's resistance involved," the CA continued to claim that despite the inmate's "flailing," the CA did not believe that that the inmate was recalcitrant or resistant.

The Deputy and the CA are the only witnesses who ever describe the inmate as being cooperative; every other individual interviewed stated that they heard or observed the inmate behaving recalcitrantly prior to and during the encounter with the Deputy and the CA. Although the Deputy immediately admitted that the inmate was recalcitrant upon viewing CCTV of the incident, the CA continued to claim that, despite "flailing around," the inmate was cooperative with the control holds. Based upon the evidence, it is more likely than not that, at the time of the incident, the Deputy and the CA were aware of the inmate's resistance to their control holds, thus requiring them to report the use of control holds pursuant to CDM 7-06/000.00, Use of Force Reporting Procedures and indicating that there statements to investigators were false.

Takedown

A takedown is also a reportable use of force pursuant to CDM 7-06/000.00, Use of Force Reporting Procedures.

In recounting their second interaction with the inmate in which the Deputy and CA attempted to remove the inmate's handcuffs, both the Deputy and the CA admitted that they had utilized control holds to place the inmate on her lower bunk prior to exiting the cell. Most of the other witnesses to the force described this action as a team takedown, which is reportable force under CDM 7-06/000.00, Use of Force Reporting Procedures.

In the summary of the incident, the Internal Affairs investigators detailed the Deputy and the CA's second interaction with the inmate as "another obvious struggle." The Investigators noted that, based on a review of CCTV footage, it appeared as though the Deputy and the CA conducted a team takedown on the inmate by forcefully placing her in a lower bunk inside the cell.

In describing this part of the incident to investigators, the inmate described that the Deputy and the CA "forced [her] down" to her bed. Recognizing that she "kept refusing, so therefore [the force] was [her] fault as well," the inmate stated that she was handcuffed behind her back when the Deputy and the CA "threw" her face-first on her bunk.

Two persons in custody who were housed in the module observed the inmate being forced to the lower bunk. One described that she observed the CA "throw" the inmate on the bed and bend the inmate's arms behind her back. The other person stated that, she heard a "fight" and observed the inmate face-down on the bed with the Deputy and the CA on top of the inmate. Similarly, the Clinical Supervisor described the second incident as the Deputy and the CA "on the lower bunk" with the inmate "to try and get her to comply."

During her interview, the Deputy was not initially forthcoming about the takedown and stated that she and the CA told the inmate to lie down on the bed. When pressed by the investigators, the Deputy eventually admitted that she and the CA "placed the inmate face down on the bunk using control holds." Contrary to the evidence and her own statements, the Deputy continued to claim that she "didn't feel as if [the inmate] was resisting."

The CA described the second incident similarly to the Deputy claiming she did not recall the inmate resisting during the interaction, and that she had directed the inmate to bend over and lean on the lower bunk. The CA told investigators that she believed that the inmate was compliant and cooperative with these instructions to lean over onto the lower bunk and that she did not believe that she forced the inmate onto the bunk.

Upon review of the CCTV footage of the second incident, the CA continued to assert that it "seem[ed] like [the inmate complied]," but also noted that the inmate was "either flailing or jerking her body around bit." Despite these observations, the CA stated that the inmate was only verbally resistive, not physically resistive and that she "didn't feel like [the inmate] was forced onto the bunk."

Given the statements of those who witnessed the use of force, including the statements of the Deputy and the CA that proved they used force to move the inmate onto the bunk despite continuing to deny it, the evidence shows likely than not that, at the time of the incident the Deputy and the CA were aware of the inmate's resistance to their attempts to take her down to the bunk, which required them to report the use of a team takedown pursuant to CDM Section 7-06/000.00, Use of Force Reporting Procedures and is evidence that shows more likely than not that the statements by the Deputy and the CA were false.

Complaints of Pain

The evidence is uncontroverted that the inmate complained that the Deputy and the CA had broken her arm. That allegation alone required the Deputy and the CA to report a use of force as required by CDM Section 7-06/000.00, Use of Force Reporting Procedures, which defines reportable force as "any action which results in an injury or *a complaint of pain*." In this case, all the witnesses interviewed in the Internal Investigation reported hearing the inmate claim that her arm was broken following the use of force. In fact, the medical evaluation found that the inmate sustained injuries as a result of the use of force. The CA correctly identified that reportable force includes instances "when there is resistance or any complaint of pain or injury," and admitted that she heard the inmate claim they broke her arm, and that she failed to report the use of force. The Deputy also admitted hearing the inmate yell that her arm was broken following the second use of force. Therefore, it is more likely than not that the Deputy and the and CA were dishonest in denying that their actions constituted reportable force based on the inmate's complaint of a broken arm. [22]

Conclusion

The evidence detailing that the Deputy and the CA engaged in force that was reportable because they used control holds to place the inmate up against the wall of the cell, that they utilized a team takedown to force the inmate onto the lower bunk, and that the inmate complained of pain after the uses of force, which required them to report the force pursuant to CDM Section 7-06/000.00, Use of Force Reporting Procedures, indicates by a preponderance of the evidence that the Deputy and the CA's claims that they did not use reportable force are dishonest. It is more likely than not that the Deputy and the CA withheld information or falsified their statements by denying engaging in a use of force, in violation of the Department's zero tolerance policy against dishonesty and failures to report a use of force pursuant to *Rosas* Implementation Plan provision 13.1. By failing to find that the Deputy and the CA were dishonest, the Department avoided discharging these employees or explaining why a decision was made not to terminate their employment as required by the *Rosas* Implementation Plan.

[22] Notably, the CA had previously received a five -day suspension for a violation of MPP section 3-01/040.75, Failure to Make Statements, and/or Making False Statements. During Departmental Internal Investigations. During the administrative interview for this incident, the CA was asked if she had ever lied in a previous administrative investigation, to which she responded, "no."

Jail Overcrowding

As previously reported by the Office of Inspector General, overcrowding in the Los Angeles County jails continues to jeopardize the ability of the Sheriff's Department to provide habitable, humane, and safe conditions of confinement as required by the Eighth and Fourteenth Amendments to the U.S. Constitution.[23]

The Los Angeles County jails have a Board of State and Community Corrections (BSCC) total rated capacity of 12,404.[24] According to the Sheriff's Department Population Management Bureau Daily Inmate Statistics, as of September 30, 2025, the total population of people in custody in the Los Angeles County jails was 12,797. As of June 30, 2025, the total population of people in custody in the Los Angeles County jails was 12,364.

The table below shows the daily count of people in custody, according to the Population Management Bureau Daily Inmate Statistics, at Men's Central Jail (MCJ), Twin Towers Correctional Facility (TTCF), Century Regional Detention Facility (CRDF), Pitchess Detention Center – East (PDC-East), Pitchess Detention Center – North (PDC-North), Pitchess Detention Center – South (PDC-South), and North County Correctional Facility (NCCF) on the last day of the previous four quarters. On these dates, three facilities (MCJ, PDC-North, and NCCF) that together account for more than half the Department's jail capacity operated over the BSCC rated capacity.

Facility	BSCC Capacity	Facility Count			
		12/31/2024	3/31/2025	6/30/2025	9/30/2025
MCJ	3512	3850	3793	3441	3751
TTCF	2432	2350	2314	2433	2403
CRDF	1708	1341	1418	1416	1496
PDC-East	926	10	11	7	17
PDC-North	830	1221	1286	1373	1348

[23] See *Fischer v. Winter* (1983) 564 F. Supp. 281, 299 (noting that while overcrowding may not be unconstitutional in itself, overcrowding is a root cause of deficiencies in basic living conditions, such as providing sufficient shelter, clothing, food, medical care, sanitation, and personal safety).

[24] The total rated capacity is arrived at by adding the rated capacity for each of the County jail facilities: MCJ 3512, TTCF 2432, CRDF 1708, PDC-East 926, PDC-North 830, PDC-South 782, and NCCF 2214. Some portions of the jail facilities are not included in the BSCC capacity ratings. When referring to the jail facilities, this report includes only the BSCC rated facilities. The rated capacity has not been recently updated and does not take into account the understaffing or the deteriorating physical plant of MCJ, meaning that the current safe capacity of the Los Angeles County jails is certainly substantially lower than the rated maximum.

PDC-South	782	462	423	546	640
NCCF	2214	2612	3010	3148	3142

Availability of Menstrual Products in the Los Angeles County Jails

On June 25, 2024, the Board of Supervisors (Board) passed a motion requesting the Sheriff's Department and directing the Office of Inspector General, Sybil Brand Commission, and the Sheriff Civilian Oversight Commission to review and report back on policies related to the availability and accessibility of menstrual products in the Los Angeles County jails, in light of recent legislation, and directing the Office of Inspector General to include the status of the availability and accessibility of menstrual products in its quarterly reports to the Board, until further notice. [25]

Between July and September 2025, Office of Inspector General staff periodically verified the availability and accessibility of menstrual products at Century Regional Detention Facility (CRDF).[26] Any issues, such as the need to restock certain products, were addressed with line personnel and resolved promptly.

In its initial report to the Board, staff from the Office of Inspector General detailed the availability of pads, tampons and panty liners for menstruating individuals—the only products available in custody at the time. In September 2025, the Sheriff's Department began piloting menstrual cups for incarcerated workers and incarcerated persons

[25] See Penal Code, § 4023.5(a). ("A person confined in a local detention facility shall be allowed to continue to use materials necessary for personal hygiene with regard to their menstrual cycle and reproductive system, including, but not limited to, sanitary pads and tampons, at no cost to the incarcerated person."); Cal. Code Regs., tit 15, § 1265. ("Each menstruating person shall be provided with sanitary napkins, panty liners, and tampons as requested with no maximum allowance."); Los Angeles County Sheriff's Department, Custody Division Manual, § 6-15/010.00 Inmate Clothing, Bedding, and Personal Hygiene. ("All menstruating inmates shall have ready access to sanitary napkins, panty liners, and tampons."); Los Angeles County Sheriff's Department, Custody Division Unit Orders, § 5-16-040 Distribution of Personal Care Items. ("Each menstruating inmate housed at CRDF shall be provided with sanitary napkins, panty liners, and tampons. All feminine hygiene products shall be readily available in a common space within each module or pod setting."); Penal Code, § 3409(a). ("A person incarcerated…who menstruates or experiences uterine or vaginal bleeding shall, without needing to request, have ready access to, and be allowed to use, materials necessary for personal hygiene with regard to their menstrual cycle and reproductive system, including, but not limited to, sanitary pads and tampons, at no cost to the person.").

[26] Staff from the Office of Inspector General visited the CRDF-Reception Center and modules 1400 (medical and mental health intake); module 1700 (Conservation Work Program housing); module 2100 (restrictive housing); module 2200 (high observation housing); and modules 2500, 2600, 2700, 2800 and 3800 (general population housing).

enrolled in rehabilitation/education programs in dedicated housing modules.[27] Office of Inspector General investigators reviewed Sheriff's Department policies, engaged in discussions with CRDF personnel, visited facilities, and attended learning sessions to gather information on the menstrual cup pilot program.

Revised protocol for searches. In August 2025, the Custody Support Services Policy Review team approved the revised Protocol for Inmate Searches Unit Order § 6-01-00. CRDF leadership disseminated the unit order and briefed line custody personnel on August 6, 2025. The unit order adds menstrual cups as an option alongside the previously available pads, tampons and panty liners, and provides guidance for personnel on how to conduct body searches when a person is menstruating.[28] Under the revised unit order, menstruating individuals are required to remove their menstrual product prior to a pat-down search and, immediately afterward, be provided a new product and underwear and allowed to sanitize their hands before proceeding through the body scanner. Building on recent enhancements to privacy and sanitation through the addition of curtains, paper towel dispensers, hand sanitizer, and trash bins in the search area, the pilot of a new menstrual product demonstrates further progress.

Menstrual cups pilot program. In early 2025, the Sheriff's Department partnered with the Los Angeles-based nonprofit, The Flow, to expand access to menstrual cups for people in custody at CRDF.[29] To date, the organization has participated in stakeholder meetings with custody personnel and Correctional Health Services (CHS) staff; conducted learning sessions with incarcerated individuals to introduce the new product and address questions; and distributed menstrual cups and informational materials.[30]

In April 2025, the Sheriff's Department and The Flow held a stakeholder meeting with custody personnel and CHS staff. Custody personnel raised concerns about security and misuse, noting that menstrual cups could potentially be used for "gassing" or to

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[27] Modules 1700 and 3600 were selected for the menstrual cup pilot program. Participants included incarcerated persons from the Conservation Work Program in module 1700 and those enrolled in rehabilitation/education programs in module 3600.

[28] Custody Division Unit Order, § 6-01-00, *Protocol for Inmate Searches*.

[29] The Flow "distributes free menstrual cups and provides bilingual education to help people manage their periods with dignity, autonomy, and sustainability." Menstrual cups are small, medical-grade silicone devices inserted into the vagina to collect menstrual fluid. Each cup can be worn safely for up to 12 hours at a time.

[30] The Flow has received menstrual cup donations from saalt, Pixie, and Diva, and funding from a number of entities including the Los Angeles Giving Circle, Sidney E. Frank Foundation, and Bloomberg Philanthropies. The organization has partnered with community organizations like A New Way of Life, CASA of Los Angeles, Los Angeles Regional Food Bank, and Women's Foundation California.

smuggle narcotics during off-site transportation such as to court or medical appointments.[31] CHS staff expressed hygiene and medical concerns, including the cleaning and sterilization of menstrual cups, overall facility cleanliness, access to handwashing, and the potential for infections or other complications, particularly given limited its reported medical staffing capacity. The Sheriff's Department and The Flow acknowledged the concerns raised and reaffirmed their commitment to piloting the product, monitoring incidents, and adjusting as needed.

In May 2025, leadership from the Sheriff's Department and The Flow met with representatives from the Office of Inspector General and American Civil Liberties Union of Southern California to review the pilot program. In September 2025, staff from The Flow and the Sheriff Department's Gender Responsive Services (GRS) conducted learning sessions for incarcerated persons in the pilot modules who chose to participate.[32] A total of four sessions were held, with 41 individuals participating, of whom 40 chose to take a menstrual cup. Participants in the pilot program completed pre- and post-questionnaires and received a menstrual cup along with instructions.[33] Sign-up sheets, which recorded full names, booking numbers and housing locations, were shared with CHS to monitor any infections or other complications.

From October to December 2025, the Sheriff's Department and The Flow will follow up with participants still in custody through additional learning sessions, Q&A, and a post-pilot survey to gather feedback and address concerns.

Response to the pilot program. Participants in the incarcerated workers' housing module have expressed appreciation for the menstrual cups, citing their usefulness for long work schedules and the difficulty of accessing a toilet to change out pads or tampons. Other pilot program participants shared similar feedback regarding off-site transportation to court and medical appointments, noting that menstrual cups allow

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[31] Penal Code, § 243.9(b) defines "gassing" as "intentionally placing or throwing, or causing to be placed or thrown, upon the person of another, any human excrement or other bodily fluids or bodily substances or mixtures containing human excrement or other bodily fluids or bodily substances that result in actual contact with the person's skin or membranes.".

[32] See Los Angeles County Sheriff's Department, Custody Division Unit Order, § 5-21-20, Education Based Incarceration: "The Gender Responsive Services Unit is responsible for providing inmate educational programs in accordance with the Minimum Standards for Adult Local Detention Facilities, Title 15, section 1061, 'Inmate Education Plan' [at Century Regional Detention Facility.]" At CRDF, Gender Responsive Services offers services in numerous housing modules, including 1700 and 3600.

[33] Pre- and post-questionnaires collected demographic information and asked about menstrual product shortages, familiarity with menstrual cups, and willingness to try them. Menstrual cups were disinfected in a boiling water dispenser prior to distribution.

them to go several additional hours without needing to empty or clean the product, unlike pads or tampons, which must be changed more frequently. Some custody personnel and CHS staff remain concerned about potential misuse or complications.

As of the end of September 2025, no incidents of infection or gassing attempts were documented. However, an incarcerated worker reported that custody personnel instructed her to remove her menstrual cup during a search conducted after she completed her work shift.[34] The menstruating individual further stated that she was denied access to a toilet and was directed to remove her menstrual cup in the designated search area in accordance with the revised unit order.[35] During the removal process, the menstrual cup slipped from the individual's grasp, resulting in spillage on her legs, clothing, and the floor.[36] The Sheriff's Department is reviewing relevant policies, operational procedures, and staff training to prevent recurrence of such incidents.

Recommendations. The incident where a person was required to remove the cup without access to a toilet, concerns raised by custody personnel about security and misuse, particularly using the cups for gassing and contraband smuggling, and concerns raised by CHS personnel about the potential for infections or other complications, highlight the need for additional policy, operational protocols, and training. The Office of Inspector General recommends that the Sheriff's Department continue collecting and incorporating feedback on menstrual cup implementation; revise directives and training as needed; re-brief custody personnel on relevant policies and unit orders; and ensure that hand sanitizer, paper towels, and menstrual products in the search area are regularly replenished.

Commissary Prices

Background

On July 9, 2024, the Board of Supervisors passed a motion directing the Sheriff's Department to report back on measures taken to ensure commissary prices in the

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[34] See Los Angeles County Sheriff's Department, Custody Division Unit Order, § 5-23-010, *Inmate Workers* states: "All inmate workers shall be escorted to the CRDF Reception Center to be searched utilizing the B-SCAN at the end of the inmate worker's shift prior to returning to their housing location."

[35] Custody Division Unit Order, § 6-01-00, Protocol for Inmate Searches states: "Inmates utilizing the menstrual cup shall be instructed to the hold the lower portion of the cup and empty the content into the biohazard container."

[36] The menstruating individual stated that custody personnel provided her with new pants but no underwear. She described the experience as humiliating and embarrassing.

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

Kosher Meal Menu and Religious Diet Agreement

People in custody who require a kosher diet may enter into a Religious Diet Agreement (RDA) with the Department that outlines the required responsibilities and conditions to remain in the religious diet program. By signing the agreement, the individual commits to consuming only the food provided through the program and agrees not to eat food from the general population meals or purchase non-compliant items from commissary. The RDA allows the Department to routinely monitor commissary purchases to ensure compliance and specifies that individuals are prohibited from giving away, trading, or selling any portion of their religious meals.

The RDA also indicates that if a person in custody violates the terms of the agreement, they will receive a written warning. A second violation results in removal from the program, and reapplication is permitted after six months. The decision to remove someone for non-compliance is made by the Office of Religious and Volunteer Services (RVS). Additionally, individuals prescribed a medical diet will be automatically removed from the religious diet program.

The current commissary price list does not designate kosher items with a "K," which is the designation for kosher products. The Department advises that they are aware of the issue and ordered updated menus that will have the proper kosher designations. In the interim, as the majority of the commissary items are the same between this and last year, the Department has provided the prior commissary price list with the kosher designations for people in custody to compare the lists to see which items are kosher before placing an order.

The Office of Inspector General received multiple complaints from people in custody at different custodial facilities participating in the kosher religious diet program because of failure of the current price list to properly designate items as kosher. Complainants stated that before they had a copy of the previous year's commissary price list, they ordered items from the new list, not knowing whether they were kosher items, and were subsequently written up for violating the terms of the RDA. Specifically, these individuals received Inmate Record Tracking System (IRTS) write ups concerning ordering non-kosher items while on the kosher diet. In response to the complaints, the

Department indicated that the IRTS entries were “Information Only” entries that were provided to the affected individuals as a reminder of the RDA, and that no one was removed from the religious diet program. However, since these individuals had no way of knowing what items on the list were kosher without access to the previous price list, the Department lacked a sufficient basis to issue the warnings. The Office of Inspector General recommends that any IRTS warning entry for a violation prior to the issuance of the updated price list with the proper kosher designations be rescinded from their records.

As part of the Office of Inspector General’s inquiry into this topic, the Department noted that kosher diets are nearly four times more expensive than general population meals. This year, Food Services has conducted two evaluations of commissary orders for people participating in the religious diet program and reports that from February to April of this year, there were 147 individuals on kosher diets and 109 of those on kosher diets (74%) ordered commissary during that time period. Of the 109, only 2 restricted their order to kosher items. The other 107 inmates ordered a variety of items that were not kosher, in violation of the RDA. During this time period, the Department reported no IRTS entries were made and none of the individuals were notified of the RDA violation, nor were any kosher diets cancelled. Food Services merely shared their findings with RVS. The Department expressed concerns regarding the excessively high number of individuals (107 out of 147) on kosher diets who ordered non-kosher commissary items.

The Office of Inspector General recommends that the Department review the RDA and evaluate the terms, including the possibility of inmates ordering non-kosher items for other inmates.[37] It is understandable that the Department limits kosher, or other specialized diets for religious purposes, only to those individuals who require it, but the RDA should be clear regarding what constitutes a violation. Additionally, the Department needs to ensure that information on commissary purchasing contains sufficient information to ensure that the inmate has notice that they are violating the agreement when the order is placed.

Vending Machine Installation Update

As previously reported, Keefe provides commissary goods and items for sale in vending machines and while Keefe completes installation of new vending machines, the contract requires the temporary sale of vending debit cards so that people in custody can

[37] The RDA should make clear that an inmate on a kosher diet may not place an order for a non-kosher item on behalf of another inmate and should also make clear that an inmate on a kosher diet may not have another inmate order a non-kosher item on their behalf. Clear rules are needed to ensure that inmates are aware of what constitutes a violation.

continue to purchase items from the vending machines before the phase out. Keefe must also advise people in custody that new machines will be operational and the temporary vending debit cards will no longer be accepted three weeks before that point.

The Department indicates that installation of the new vending machines program is moving forward in two phases for each custody facility. The first phase is to ensure the facility has the proper infrastructure to support the vending machines, including completing the required wiring and conduit. The second phase is the delivery and physical installation of the vending machines. Every machine requires a dedicated data line (ethernet, Wi-Fi) to capture transactions in real time.

The vending machine installation process will begin with CRDF, followed by TTCF. The Department reports that phase one has been completed at CRDF, with the expected to arrive beginning in mid-October and operational as soon as the end of October. The wiring installation at TTCF is in progress and the tentative arrival for the first vending machines at TTCF is mid-November 2025. Old vending machines are being moved out of the facilities in the same sequence as the new installations to maintain continuity of service as much as possible.

The Sheriff's Department states that the process will continue over the next several months by facility, until all the new vending machines are installed and operational.

Inmate Welfare Fund Update

As previously reported, the profits from the sale of goods in the County's jails go to the Inmate Welfare Fund (IWF) to support programming and services for inmates as well as funding operational expenses of the Sheriff's Department that the Department designates as related to inmate welfare. The Department provided a recap to the Inmate Welfare Fund Commission of the financial statements for Fiscal Year 2024-25 closing and the first two months of Fiscal Year 2025-26.

The IWF began Fiscal Year 2025-26 with a carryover balance of nearly $15.4 million, which is $3 million higher than anticipated in the Fiscal Year 2024-25 budget due to lower than anticipated costs to reimburse the salaries and employee benefits for Inmate Services Bureau personnel assigned to units that provide inmate programs, and higher than anticipated revenues from commissary and vending sales. All remaining encumbrances for jail facility maintenance have been cancelled and the money returned to the IWF for inmate programs.

The financial report for August 31, 2025, presents the most recently updated budget forecast for Fiscal Year 2025-26. The Department indicates that the revenue from commissary and vending profit sharing will be closely monitored for any impact resulting from the negotiated reduction in profit sharing and new menu items and pricing, and the

budget forecast will be adjusted accordingly. Future monthly financial reports will be also updated as money for inmate programs is encumbered and spent.

As previously reported, under the new contract, the revenue sharing was adjusted and now 39% (down from 51.5%) of gross commissary and vending sales will be deposited into the IWF. While the lower percentage taken by the Sheriff's Department is a theoretical improvement in the contract terms, it is not clear that this adjustment resulted in reducing the costs of commissary items The Office of Inspector General continues to recommend that the Department limit the markup of commissary items to the amount attributable to Keefe's profit and forgo the portion of the revenue generated by the contract for the IWF in order to reduce the costs of commissary items for persons in custody and their families. Funding for jail maintenance, programming, and for the welfare of persons in custody should be part of the Sheriff's Department budget allocated from County resources.

The last quarterly report of the Office of Inspector General also noted that Keefe is required to attend monthly Title 15 meetings convened by the County to present reports on various commissary issues and present annual detailed cost comparisons for all products. The Office of Inspector General requested notification of the dates and times of such meetings in order to monitor discussions on commissary pricing.

Shower Privacy for Transgender, Gender Non-Conforming, and Intersex People at Men's Central Jail

The Prison Rape Elimination Act (PREA) standards include specific protections aimed at protecting transgender and intersex people in custody "based on the unique risks these populations face while incarcerated."[38] Subsection (f) of the PREA Standard 115.42 requires that transgender and intersex people in custody be given an opportunity to shower separately from other people in custody. The National PREA Resource Center states that facility layout will inform the best practices in implementing this standard, and that this standard "may be accomplished either through physical separation (e.g., separate shower stalls) or by time-phasing or scheduling (e.g., allowing an inmate to shower before or after others)."[39]

The Department's Office of PREA Compliance (OPC) is responsible for screening transgender, gender non-conforming, and intersex (TGI) people in custody in

[38] National PREA Resource Center, PREA Standards: § 115.42 Use of screening information and Placement of residents.

[39] National PREA Resource Center, *PREA Standards in Focus*: 115.42 Use of Screening Information.

Los Angeles County Jails. TGI people in custody assigned female at birth are generally housed at Century Regional Detention Center and TGI people in custody assigned male at birth are generally booked into custody through the Inmate Reception Center (IRC) and housed in the K6G dorms, which house gay, bisexual, transgender, queer, and intersex people at Men's Central Jail (MCJ).[40] While the OPC offers TGI people the opportunity to request to be re-housed at the facility that conforms with their gender identity through the Gender Identity Review Board (GIRB), the GIRB has often denied TGI people's request to be rehoused in their gender-conforming facility. Even where the GIRB has affirmed a TGI person's request to be rehoused, GIRB meetings are conducted monthly, meaning that TGI people in custody are often housed in a gender non-conforming facility for over one month prior to being re-housed.

Transmasculine, gender non-conforming, and intersex people housed at CRDF have access to individual shower stalls, consistent with PREA Standard 115.42. Transfeminine, gender non-conforming, and intersex people housed in K6G dorms at MCJ have access to a dormitory shower that does not afford TGI people in custody the opportunity to shower alone as required to PREA Standard 115.42. Although the Office of Inspector General recommended that the Sheriff's Department "utilize housing that will give TGI people in custody an opportunity to shower separately from others," the OPC has not developed a solution to achieve compliance with PREA Standard 115.42 for TGI people housed in K6G dorms.[41]

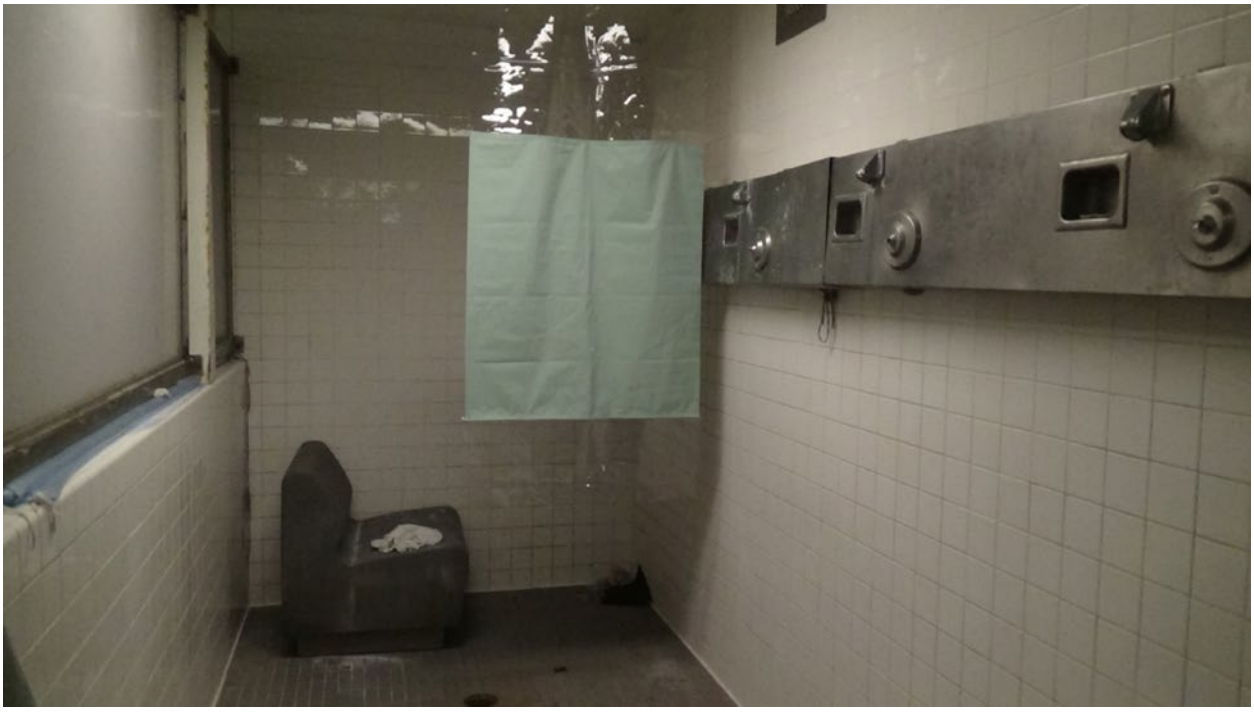
The Department's Custody LGBTQ+ Committee, which is chaired by Custody Services Division: Specialized Programs command staff and is attended by representatives from the Office of Inspector General and the American Civil Liberties Union (ACLU), began developing a plan to allow TGI people housed in K6G dorms to shower alone during the second quarter of 2025. The Committee chair recommended that MCJ install shower partitions within K6G dorm showers and implement a "shower time," during which TGI people housed in K6G dorms may individually utilize dorm showers. The Committee chair additionally proposed a draft unit order outlining expectations for TGI shower times at MCJ, specifically requiring that staff assigned to K6G dorms at MCJ announce the shower time to the dorm, ensure that the shower is only occupied by a single occupant and clear of on-lookers, and log that the shower time allotment was completed in the electronic Uniform Daily Activity Log (e-UDAL).

MCJ has not implemented the unit order, nor has the facility began implementing TGI shower times at MCJ, stating that it would be difficult for staff assigned to K6G to execute and monitor. Citing infrastructure concerns, MCJ staff has not made progress

[40] K6G houses cisgender, transgender, and gender-non-conforming people in custody.

[41] See *Report Back on the Sheriff's Department's Compliance with the Prison Rape Elimination Act*.

with installing partitions and has instead opted to install shower curtains, pictured in the photograph on the next page, in K6G dorms.



The Office of Inspector General recognizes that the installed shower curtains have the potential to afford TGI people housed in K6G dorms more privacy than previously afforded. However, the cloth paneling in the shower curtains that were installed by the Department, depicted in this photograph, does not obstruct a person's genitals, buttocks, and breasts, rendering them useless at affording TGI people in custody shower privacy. Even if installed shower curtains cover an individual's body, the installation of a shower curtain alone does not fulfill PREA standard 115.42, as other people housed in K6G dorms may still access the shower while a TGI person is utilizing it. Additionally, Office of Inspector General staff conducted a site visit at the K6G dorms, and opposite gender staff who entered K6G dorms did not announce their presence to allow people in custody to cover their genitals, buttocks, and breasts, which is required by PREA Standard 115.15(d).

MCJ command staff noted that they requested that the NCCF print shop make signs for the K6G dorms designating shower times but to date these designated shower times have not been implemented.

In-Custody Deaths

Between July 1 and September 30, 2025, fifteen people died in the care and custody of the Sheriff's Department. The Department of Medical Examiner's (DME) website currently reflects the manner of death for eleven deaths: eight natural, one accidental,

two suicides, and one homicide that was attributed to an officer-involved shooting by the Los Angeles Police Department. For the remaining three deaths, the DME findings have been deferred.[42] Two people died at MCJ, one person died at CRDF, one person died at Lancaster Station jail, five people died at TTCF, and six people died at hospitals after being transported from the jails. The Sheriff's Department posts the information regarding in-custody deaths on a dedicated page on the Inmate In-Custody Deaths on its website.[43]

Office of Inspector General staff attended the Custody Services Division Administrative Death Reviews for each of the fifteen in-custody deaths. The following summaries, arranged in chronological order, provide brief descriptions of each in-custody death:

Date of Death: July 4, 2025
Custodial Status: Pre-Trial
On June 28, 2025, CHS and custody staff at CRDF discovered an unresponsive person in a single-person intake cell during nursing rounds. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered three doses of Narcan. The person was transported to Long Beach Medical Center for a higher level of care, where the person was pronounced dead on July 4, 2025. Areas of concern include CCTV being non-operational at the time of the incident and custody staff failing to utilize a handheld camera during a medical emergency. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, the cause of death as diabetic ketoacidosis, and an "other significant condition" as effects from methamphetamine and cocaine.

[42] In the past, the Office of Inspector General has reported on the preliminary cause of death as determined by the Medical Examiner, Correctional Health Services (CHS) personnel, hospital personnel providing care at the time of death, and/or Sheriff's Department Homicide investigators. Because the information provided is preliminary, the Office of Inspector General has determined that the better practice is to report on the manner of death. There are five manner of death classifications: natural, accident, suicide, homicide, and undetermined. Natural causes can include illnesses and disease and thus deaths due to COVID-19 are classified as natural. Overdoses may be accidental, or the result of a purposeful ingestion. The Sheriff's Department and Correctional Health Services use evidence gathered during the investigation to make a preliminary determination as to whether an overdose is accidental or purposeful. Where the suspected cause of death is reported by the Sheriff's Department and CHS, the Office of Inspector General will include this in parenthesis.

[43] Penal Code § 10008 requires that within 10 days of any death of a person in custody at a local correctional facility, the facility must post on its website information about the death, including the manner and means of death, and must update the posting within 30 days of a change in the information.

Date of Death: July 11, 2025

Custodial Status: Pre-trial

On July 11, 2025, custody staff conducting Title 15 safety checks at TTCF found an unresponsive person in a single-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody and CHS staff administered three doses of Narcan. The person died at the scene. Areas of concern include timeliness of the emergency response. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death as acute asthma exacerbation and chronic bronchial asthma.

Date of Death: July 12, 2025

Custodial Status: Pre-Trial

On July 12, 2025, custody staff conducting Title 15 safety checks at TTCF discovered a person bleeding from both arms on the floor of their cell. Sheriff's Department staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered four doses of Narcan. The person died at the scene. Areas of concern include the emergency response (moving the patient from the cell before initiating CPR),[44] the quality and timeliness of Title 15 checks, boarding of the cell,[45] and an inquiry into how the person was able to obtain razor blades. Preliminary manner of death: Suicide. The DME website reflects the manner of death as suicide, and the cause of death as incised wounds to bilateral upper extremities.

Date of Death: July 20, 2025

Custodial Status: Pre-Trial

On June 28, 2025, a person was admitted to Los Angeles General Medical Center (LAGMC) after suffering from multiple gunshot wounds following an officer involved shooting by Los Angeles Police Department. The Sheriff's Department took custody of the person while he was hospitalized on July 5, 2025, and the person was pronounced dead on July 20, 2025. The DME website reflects the manner of death as homicide, and the cause of death as gunshot wounds.

[44] The Department reported that emergency response concerns related to removing a person from a cell prior to initiating CPR were addressed through "man-down" drills conducted jointly by the Sheriff's Department and CHS.

[45] Boarding is the term used when people in custody obstruct cell windows to inhibit custody staff from observing inside their cell.

Date of Death: July 21, 2025
Custodial Status: Pre-trial
On July 21, 2025, custody staff conducting Title 15 safety checks at TTCF found an unresponsive person in a single-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered five doses of Narcan. The person died at the scene. Areas of concern include the timeliness of the emergency response and CHS's evaluation of the decedent's mental health. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death as acute bronchopulmonary pneumonia.

Date of Death: July 31, 2025
Custodial Status: Sentenced
On July 13, 2025, a person in custody with a pre-existing medical condition was transported from Correctional Treatment Center (CTC) to LAGMC for a higher level of care. On July 31, 2025, medical staff detected no pulse, and the person was pronounced dead. Areas of concern include missed/cancelled and rescheduled specialty clinic appointments at LAGMC. Preliminary manner of death: Natural. The DME website reflects the manner of death as natural, and the cause of death as pulmonary thromboembolism.

Date of Death: August 5, 2025
Custodial Status: Partially Sentenced
On August 5, 2025, custody staff conducting Title 15 safety checks at MCJ found an unresponsive person in a multi-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered four doses of Narcan. The person died at the scene. Areas of concern include CCTV being non-operational at the time of the incident and custody staff failing to utilize a handheld camera. Preliminary manner of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death is sequelae of respiratory viral infection (Covid-19 and human rhinovirus/enterovirus).

Date of Death: August 14, 2025
Custodial Status: Partially Sentenced
On August 14, 2025, CHS staff at TTCF found an unresponsive person in a single-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody and CHS staff administered three doses of Narcan. The person died at the scene. Areas of concern include the medical evaluation of the person at IRC and the failure to conduct a body scan of the person at IRC. Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: August 15, 2025
Custodial Status: Sentenced
On August 15, 2025, custody staff at MCJ responded after a person in custody yelled "help me" from a single-person cell. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered three doses of Narcan. Areas of concern include referrals to Addiction Medicine Services and timely application of the Automated External Defibrillator (AED). Preliminary manner of death: Unknown. The DME website reflects the manner of death as accidental, and the cause of death as methamphetamine intoxication.

Date of Death: August 15, 2025
Custodial Status: Pre-Trial
On August 15, 2025, custody staff conducting Title 15 safety checks at Lancaster Station jail found an unresponsive person in a single-person cell. Custody personnel and paramedics rendered emergency aid, but did not administer Narcan. The person died at the scene. Areas of concern include the quality and timeliness of Title 15 safety checks, the timeliness of the emergency response, housing medically fragile people at station jails, and custody staff's failure to administer Narcan. Preliminary cause of death: Unknown. The DME website reflects the manner of death as natural, and the cause of death as coronary artery atherosclerosis.

Date of Death: August 23, 2025
Custodial Status: Pre-Trial
On August 20, 2025, a person in custody with a pre-existing medical condition was transported from CTC to LAGMC for a higher level of care. On August 23, 2025, the person was pronounced dead. Preliminary manner of death: Natural. The DME website reflects the manner of death as natural, and the cause of death as acute cardiac dysfunction and atherosclerotic cardiovascular disease.

Date of Death: August 25, 2025
Custodial Status: Sentenced
On August 25, 2025, custody staff and nursing staff conducting vitals checks at CTC found an unresponsive person in a single-person cell with a ligature around his neck. Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff administered three doses of Narcan. The person died at the scene. Preliminary manner of death: Suicide. The DME website reflects the manner of death as suicide, and the cause of death as asphyxia.

Date of Death: August 29, 2025
Custodial Status: Pre-Trial
On August 29, 2025, a person in custody at CRDF alerted custody staff that her cellmate was “man down.” Custody staff, CHS staff, and paramedics rendered emergency aid, and custody staff and CHS staff administered four doses of Narcan. The person died at the scene. Areas of concern include delays in medical treatment despite the person making multiple requests for medical care. Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: September 10, 2025
Custodial Status: Pre-Trial
On August 19, 2025, a person in custody in a single-person cell at the San Fernando Superior Court alerted custody staff that he was in medical distress. Custody staff requested paramedics who transported the person to Olive View Medical Center. On September 10, 2025, the person was pronounced dead. Areas of concern include the quality and timeliness of Title 15 safety checks, the timeliness of the emergency response, the lack of appropriate care by custody staff in moving the person, the person being involved in three uses of force approximately three months prior to his death, potential medical and mental health misclassification, and the person retaining contraband. Preliminary manner of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: September 17, 2025
Custodial Status: Pre-Trial
On September 3, 2025, a person in custody with a pre-existing medical condition was transported from TTCF to LAGMC for a higher level of care. On September 17, 2025, the person was pronounced dead. Preliminary manner of death: Natural. The DME website reflects the manner of death as natural, and the cause of death is as sequelae of abdominal aortic aneurysm with rupture.

Correctional Health Services Mortality Review

Office of Inspector General staff attend the Custody Services Division (CSD) Administrative Death Reviews for every in-custody death. Prior to this quarter, Correctional Health Services (CHS) and the Sheriff’s Department jointly engaged in the Death Review process. In August of 2025, CHS began conducting a separate “Mortality Review,” lead by the Chief Medical Officer with participation limited to medical personnel, the quality assurance team, Office of Inspector General staff, and the two Sheriff’s Department CSD Chiefs.

According to the Chief Medical Officer, CHS conducting a Mortality Review separate from but in addition to the Sheriff's Department's Administrative Death Review aligns with national best practices. The National Commission on Correctional Health Care (NCCHC), a non-profit organization that seeks to "improve the quality of health care in jails, prisons, and juvenile facilities," established a standard procedure in the event of an in-custody death.[46] In addition to working with custody staff to assess the "correctional and emergency response actions surrounding an [in-custody] death" in an administrative review, NCCHC compliance indicators establish that correctional health authorities should conduct a clinical mortality review, defined as an "assessment of the clinical care provided and the circumstances leading up to an [in-custody] death," within 30-days of an in-custody death.[47]

Similarly, in a lawsuit filed by the California Attorney General against the County of Los Angeles, the Sheriff's Department, and CHS regarding conditions of confinement in the Los Angeles County Jails, the Attorney General noted that "CHS fail[ed] to conduct its own death review or morbidity-and-mortality review process."[48] To address the allegation in the lawsuit, to align with the NCCHC standards, and to mitigate CHS concerns about health related information being adequately protected by custody staff, CHS began conducting Mortality Reviews to analyze the medical and mental health care provided to each person who has died in Sheriff's Department custody, with particular focus on the care provided to the individual during the intake process and the peri-death period.[49]

To achieve this, CHS nursing, mental health, and medical providers conduct an independent review of each in-custody death. Corrective Action Plans (CAPs) that CHS develops at Mortality Reviews will be reviewed every two weeks until completed, and CHS plans to track CAPs longitudinally as a long-term improvement project. CAPs developed at Mortality Review are provided to the Custody Compliance and Sustainability Bureau (CCSB) death team at each 30-day Administrative Death Review and documented in the CCSB death book. The Chief Medical Officer continues to attend each custody Administrative Death Review to address issues that involve both CHS and custody.

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

[47] National Commission on Correctional Health Care, Standards for Health Services in Jails, Procedure In The Event Of An Inmate Death (J-A-09) (2018).

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

[49] CHS defines the peri-death period as six-months prior to an individual's death.

Custody Administrative Death Review Pre-Meet

This quarter, CSD executives also modified the Administrative Death Review process so that issues that do not have a direct nexus to an in-custody death would be raised outside of Administrative Death Reviews. Thus, CSD executives developed a "pre-meet," where staff from the Office of Inspector General and County Counsel meet with the custody team to review each incident and may raise these systemic issues more effectively.

Where issues identified in the pre-meet are directly related to an in-custody death, they are addressed during the Administrative Death Review and tracked by the CCSB death review team. If issues identified in the pre-meet are not directly related to an in-custody death but present systematic concerns, a CAP will be developed by the General Population or Specialized Programs chief's aide and tracked by Custody Support Services (CSS).

CSD executives reported that the changes to the Administrative Death Review process are preliminary, and that the department is building an electronic database to track pre-meet CAPs. CSD executives articulated that implementing these changes will keep Administrative Death Reviews focused on issues directly related to each in-custody death, and that the Department aspires to develop meaningful corrective actions within both the Administrative Death Review and the Administrative Death Review Pre-Meet.

In-Custody Overdose Deaths in Los Angeles County Jails

On December 19, 2023, the Board of Supervisors passed a motion directing the Sheriff's Department to "[c]ollect and track data outlining narcotics recovery in county jail facilities to evaluate the efficacy of drug detection interventions and provide information to the OIG," and [s]trengthen existing policy on increasing and conducting more comprehensive searches of the belongings of staff and civilians who enter the facility, beyond visual inspections." The Board also directed the Office of Inspector General to report quarterly on the Sheriff's Department's progress on these mandates, including progress or any recommendations included in Office of Inspector General reports, as well as on the number of in-custody deaths confirmed or assumed to be due to an overdose, and on any additional recommendations related to in-custody overdose deaths.

Of the fifteen people who died in the care and custody of the Sheriff's Department between July 1 and September 30, 2025, the medical examiner's final reports, including toxicology assessments, confirm that one person died due to an accidental overdose. Toxicology results remain pending for four of the fifteen deaths and may indicate an additional overdose deaths once completed. As of this report, the DME has confirmed

that eight individuals have died this year due to accidental overdose through the third quarter of 2025.

Tracking Narcotics Intervention Efforts

With regard to the directive to the Sheriff's Department to track narcotics recovery and evaluate drug detection interventions, as previously reported the Sheriff's Department does not presently track narcotics detection in a format that allows data to be analyzed and reports that it does not have the capacity to build a mechanism to track narcotics seizure by drug detection mechanism, nor is it able to compile extractable data collected in the Los Angeles Regional Crime Information System (LARCIS) to evaluate the efficacy of drug detection intervention. Instead, the Sheriff's Department takes the position that constructing an all-encompassing jail management data system would best support the Sheriff's Department's efforts to track narcotics recovery and evaluate the efficacy of drug detection interventions. The Office of Inspector General continues to recommend that the Sheriff's Department examine ways to comply with the Board's directive by standardizing search procedures division-wide, improving reporting requirements for staff, and compiling data on detection interventions and seizures using existing technologies.

Improving Searches of Staff and Civilians

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

Since last quarter, the Office of Inspector General has engaged with the Department to discuss potential ways to improve search procedures for employees of the Department and CHS and professional employee visitors, such as independent contractors and vendors, entering secured custodial facilities. The Department asserts that greater resources, including funding for more staff and equipment, are needed in order to implement more thorough search procedures. The Department emphasized that the current practice is to focus narcotics detection resources on incarcerated persons as the Department believes these individuals to be the primary source of narcotics and contraband entering the facilities. For example, the Department has seventeen new body scanners coming into their facilities that will be operational once staff complete the required training on how to use them, however, the machines will only be used to

screen people in custody. There are also thirteen K-9s employed by the Department that perform property scanning only. Although the K-9s are used at facilities upon request when available, they are mostly reserved for custodial areas.

Unless employees and professional employee visitors are searched and screened at the same frequency and thoroughness as those in custody and the civilians entering for visitation, it is difficult to determine how much contraband enters the facility via employees and professional visitors.

The Department described several proposals that could support enhanced narcotics interdiction, including (1) establishing a single point of entry and exit, (2) restricting allowable personal property, (3) monitoring traffic in the security/transportation compound, and (4) enhancing security and monitoring.

Establishing a single point of entry and exit. Employees and professional employee visitors at Twin Towers Correctional Facility and Men's Central Jail can use multiple entrances and exits with minimal screening, and although random searches are permitted, they are rarely conducted. The Department indicated that ideally there would be a single point of entry and exit with thorough, airport-like screenings. This plan would require 24/7 staffing, with the Department estimating that employee shifts would be extended by two hours in order to compensate employees for the time spent in the screening process and to change into their uniforms before starting their duties. The Department maintains that due to current staffing and budget conditions these screenings are operationally unfeasible but agrees that the potential for random screenings at this level would act as a deterrent.

Restricting allowable personal property. Another proposal includes further restricting the items that employees may bring into secure areas, such disallowing food items. As discussed above, the Department maintains that its current staffing and budget are insufficient to thoroughly examine employee property entering the secure facilities. Additionally, this proposal raises concerns with how the Department would accommodate employee special dietary and medication needs and would likely require the Department to negotiate with its employee labor unions.

Monitor traffic in the security/transportation compound. One area of interest at Twin Towers is the transportation security compound area situated behind the building, essentially a gated parking lot that is particularly vulnerable due to high vehicle and foot traffic with minimal monitoring remotely via cameras. There is significant traffic in and out of this area for inmate medical appointments, court transports, vendor deliveries, and maintenance and custodial service work. The Department indicated there are challenges to preventing contraband flowing in this area, particularly with inmate workers (trustees) and unsupervised external contractors. Indeed, at the September 27, 2025 Public Safety Cluster Agenda Review Meeting, when discussing

an agendized Board Letter to execute a contract for custodial services at six of the Department's jail facilities, members of the Department and the public expressed concern about an outside vendor contract for cleaning jail facilities because of the potential for smuggling in narcotics. Based on current search practices, this is a legitimate concern.

Enhancing security and monitoring. Another possibility is using independent contractors to manage security operations, or armed, non-sworn Sheriff Security Officers (SSO), which could improve accountability and allow for stricter and more consistent enforcement without taxing Department resources. Such contractors would be responsible for staffing and would not be impacted by internal departmental staffing challenges. Of course, an independent contractor may have the similar hiring challenges as the Department. Using K-9s to sweep employee parking lots, and installing license plate readers to monitor vehicle access, are other ways to potentially combat the flow of narcotics.

Despite the Department indicating they do not believe employees and professional employee visitors to be the main source of narcotics entering secured facilities, the Department recognizes it does occur. Employees are encouraged to report anomalies, and the Department does investigate credible tips. The process typically involves initial inquiry by the facility, followed by referral to internal bodies such as ICIB or IAB if sufficient evidence exists. However, Custody Investigative Services (CIS) generally does not investigate staff, and the Department reports that ICIB lacks the resources to pursue full investigations unless CIS has already confirmed potential criminal activity.

Recommendations. The Office of Inspector General recommends that the Sheriff's Department continue to assess the feasibility of the discussed proposals and explore allotting funds from its current budget to implement some of these strategies. Adopting these measures will improve staff/civilian accountability and assist in determining whether searches are both conducted as required and effective at deterring or intercepting contraband.

Department Search Statistics

As previously reported, the comprehensiveness of the searches varies across facilities as does the minimum requirement per week. The table on the following pages details the staff search practices at all jail facilities from July 1 to September 30, 2025. The data regarding the number of staff searches and searches with K-9 illustrated in the table was supplied by CSSB. CSSB extracted the data on searches from the Custody Watch Commander's Log (CWCL) on October 7, 2025. K-9 data was obtained from the Custody Investigative Services (CIS) Searches of Custody Personnel Report on October 7, 2025. The Office of Inspector General was unable to verify the data provided by CSSB without additional information.

Facility	Number of Staff Searches	Number of Staff Searches with K-9	Monthly Minimum Search Requirement[50]	Search Inside Security	Search Evasion Concerns	Where Searches Logged
	Q3	Q3				
MCJ	125	17	Unable to Determine[51]	No	Yes	Watch Commander Log; Searches of Custody Personnel Report
TTCF	84	1	Yes[52]	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report
IRC	77	10	Unable to Determine[53]	No	Yes	Watch Commander Log; Searches of Custody Personnel Report
CRDF	49	1	No[54]	No	Yes	Watch Commander Log; Searches of Custody Personnel Report

[50] Each jail facility's unit order regarding staff searches was used to determine whether it met its minimum search requirement by month. Where the unit order is silent regarding the minimum search requirement, the Office of Inspector General was unable to determine if the requirement was met. Also, the jail facility must meet the minimum search requirement during each of the three months in the quarter in order to be found in compliance.

[51] Los Angeles County Sheriff's Department, Custody Division Unit Orders, § 3-08-021 *Security of Personal Property* does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

[52] Los Angeles County Sheriff's Department, Custody Division Unit Order, § 3-08-010 *Security of Personal Property* states: "Watch commander shall ensure a minimum of two random searches are conducted each week of persons entering the secured area during their assigned shift".

[53] Los Angeles County Sheriff's Department, Custody Division Unit Order, § 5-23/006.00 *Security and Searches of Person Property* does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

[54] CRDF did not meet its minimum search requirement in September 2025. Los Angeles County Sheriff's Department, Custody Division Unit Order, § 3-01-090 Searches of Sworn Personnel, Custody Assistants, Professional Staff and their personal property-Approved by CSS 3/11/2024 states: "The searches shall be conducted a minimum of once per week, per shift.".

NCCF	134	4	No[55]	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report
PDC-North	52	3	Unable to Determine[56]	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report
PDC-South	38	5	Yes[57]	Yes	Yes	Watch Commander Log; Searches of Custody Personnel Report

Office of Inspector General Site Visits

The Office of Inspector General regularly conducts site visits and inspections at Sheriff's Department custodial facilities. In the third quarter of 2025, Office of Inspector General personnel completed 189 site visits, totaling 434 monitoring hours, at IRC, TTCF, CRDF, MCJ, Pitchess Detention Center North, PDC South, and NCCF.

As part of the Office of Inspector General's jail monitoring, Office of Inspector General staff attended 151 Custody Services Division (CSD) executive and administrative meetings and met with division executives for 178 monitoring hours related to uses of force, in-custody deaths, Prison Rape Elimination Act (PREA) compliance, restrictive housing, and general conditions of confinement.

Use-of-Force Incidents in Custody

The Office of Inspector General monitors the Sheriff's Department's use-of-force incidents, institutional violence, and assaults on Sheriff's Department or CHS personnel

[55] NCCF did not meet its minimum search requirement in August and September 2025. Los Angeles County Sheriff's Department, Custody Division Unit Order, § 07-145/10 *Personal Property Searches* states: "A minimum of four (4) random searches per shift per week of any personnel and/or official visitors shall be conducted at the discretion of the watch sergeant.".

[56] Los Angeles County Sheriff's Department, Custody Division Unit Order, § 3-06-010 *Security of Personal Property* does not describe a minimum number of searches per week, which makes it difficult to determine whether they met this requirement.

[57] NCCF did not meet its minimum search requirement in September 2025. Los Angeles County Sheriff's Department, Custody Division Unit Order, § 3-02-080 *Searches of Sworn Personnel, Custody Assistants, Professional Staff and Their Property on the Facility* states: "The searches shall be conducted at a minimum of once per week, per shift."

by people in custody.[58] The Sheriff's Department most recent force report is for use-of force-incidents in custody through the first quarter of this year. This report and reports for prior quarters may be found on the Sheriff's Department website's transparency section under the page for use of force.

Handling of Grievances and Comments

Office of Inspector General Handling of Comments Regarding Department Operations and Jails

The Office of Inspector General received 405 new complaints in the third quarter of 2025 from members of the public, people in custody, family members and friends of people in custody, community organizations and County agencies. Each complaint was reviewed by Office of Inspector General staff.

Of the complaints received, 372 were related to conditions of confinement within the Department's custody facilities, as shown in the chart below:

Grievances/Incident Classification	Totals
Medical	178
Personnel Issues	20
Living Condition	32
Food	26
Classification	6
Mail	9
Bedding	11
Property	5
Showers	6
Education	5
Commissary	3
Dental	17
Mental Health	7
Telephones	4
Visiting	3
Other	40
Total	372

[58] Institutional violence is defined as assaultive conduct by a person in custody upon another person in custody.

Thirty-three complaints were related to civilian contacts with Department personnel by persons who were not in custody, as shown in the chart on below:

Complaint/Incident Classification	Totals
Personnel	
Improper Tactics	5
Discourtesy	3
Discrimination	1
Neglect of Duty	4
Harassment	2
Improper Detention, Search, Arrest	2
Force	1
Off Duty Conduct	1
Other	2
Service	
Response Time	3
Other	9
Total	33

Handling of Grievances Filed by People in Custody

The Sheriff's Department has not fully implemented the use of computer tablets in its jail facilities to capture information related to requests, and eventually grievances, filed by people in custody. There are currently 73 iPads installed in jail facilities: 37 at TTCF; 12 at MCJ; and 24 at CRDF. During the third quarter, there were no new installations, four iPads were salvaged and there were two iPad replacements. The Department assures that the iPads that have been removed from circulation will eventually be redeployed. There were 156,720 automated responses provided to people in custody using the iPad application to request information.

The Sheriff's Department continues to experience technical issues with iPads primarily due to unreliable power sources. The Department reports that currently the iPads are powered through facility televisions, which are switched off every evening. As a result, the iPads lose power overnight, thereby requiring those iPads to recharge each morning. Each day, the iPads require manual connection to Wi-Fi once recharged. Facility Services Bureau (FSB) personnel have been working to install dedicated power and data lines for the iPads. The Department reports that walkthroughs have been completed at both TTCF and MCJ, with a quote received for both facilities.

The Department states that TTCF remains the most stable facility in terms of connectivity, and for this reason that facility has been prioritized. The Department noted

that once the FSB project at TTCF is complete reconfiguration and programming of the iPads will resume. Additionally, the Department states that given the unstable iPad connectivity at MCJ, a decision was made to proceed with the installation of data line drops at that facility. Afterwards, efforts will be made to identify funding to facilitate payment to FSB.

As previously reported, the Sheriff's Department implemented a policy in December 2017 restricting the filing of duplicate and excessive grievances by people in custody.[59] The Sheriff's Department reports that between July 1 and September 30, 2025, no one in custody had been placed on restrictive filing and therefore did not reject any grievances under this policy. There were however, 16 excessive filing grievances from multiple inmates who reached their maximum limit, and 860 duplicate grievances were identified in this quarter.

The Office of Inspector General continues to raise concerns about the quality of grievance investigations and responses, which likely increases duplication and may prevent individuals from receiving adequate care while in Sheriff's Department custody.

Sheriff's Department's Service Comment Reports

Under its policies, the Sheriff's Department accepts and reviews comments from members of the public about departmental service or employee performance.[60] The Sheriff's Department categorizes these comments into three categories:

- External Commendation: an external communication of appreciation for and/or approval of service provided by the Sheriff's Department members;
- Service Complaint: an external communication of dissatisfaction with the Sheriff's Department service, procedure, or practice, not involving employee misconduct; and
- Personnel Complaint: an external allegation of misconduct, either a violation of law or Sheriff's Department policy, against any member of the Sheriff's Department.[61]

[59] *See* Los Angeles County Sheriff's Department, Custody Division Manual, § 8-04/050.00, *Duplicate or Excessive Filings of Grievances and Appeals, and Restrictions of Filing Privileges*.

[60] *See* Los Angeles County Sheriff's Department, *Manual of Policy and Procedures*, § 3-04/010.00, *Department Service Reviews.*

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

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

Sheriff's Department's Response

The Sheriff's Department was provided with a draft of this report, and the following is the Department's response.

RESPONSE TO
Reform and Oversight Efforts: Los Angeles County Sheriff's Department
July to September 2025

From pages 1 and 2

Deputy-Involved Shootings

In March 2022, the Board of Supervisors County enacted Los Angeles County Code section 2.170.020, which sets minimum standards for the disclosure of records related to peace officers employed by the Sheriff's Department. The ordinance is only operative once the Peace Officer Records Division (PORD), the County Counsel division responsible for responding to SB 1421 requests is fully staffed. Because the unit is not yet fully staffed, the public still does not have access to information that the Board intended be publicly posted as anticipated by the ordinance timelines.

Response: Due to limited staffing within the PORD Unit, the unit has not yet assumed full responsibility for responding to SB 1421 requests. However, PORD staff have begun performing redactions on responsive documents the Department has provided. The Department also continues to process requests and post disclosable records to its transparency page.

From page 5

Internal Affairs Bureau

If the District Attorney declines to file criminal charges against the deputies involved in a shooting, IAB reviews the shooting to determine whether Sheriff's Department personnel violated any policies during the incident.

Response: For clarity, it would be more accurate to state that IAB reviews all deputy-involved shootings to determine whether any Department policies were violated, regardless of the District Attorney's decision to file criminal charges.

From page 10

Sheriff's Department Policies on Eyewitness Identification – Legal Compliance

Recommendation: The Department's policy should require and make mandatory the electronic recording that includes both audio and visual representations of the identification procedures. When it is not feasible to do both, audio recordings may be used without video, accompanied by a written explanation as to why video recording was not feasible. The Department should provide training to ensure that personnel understand the requirements of Penal Code section 859.7, including that recording the identification is mandatory.

Response: California penal code section 859.7 (a)(11) states: *"An electronic recording* ***shall be made that includes both audio and visual representations of the identification procedures****. Whether it is feasible to make a recording with both audio and visual representations shall be determined on a case-by-case basis. When it is not feasible to make a recording with both audio and visual representations, audio recording may be used. When audio recording without video recording is used, the investigator shall state in writing the reason that video recording was not feasible."*

The Department will review MPP Section 5-09/530.20, *Photo Arrays*, to make the necessary changes to align with the statute.

From page 10

Outstanding Requests to the Sheriff's Department

Response: The Department responded to the October 2024 subpoena by providing over 55 gigabytes of data, contained on four thumb drives, consisting of documents, emails, phone logs, and other relevant material responsive to the subpoena. Due to the April 2025 request for additional materials, the Department requested that County Counsel retain outside counsel to conduct a thorough and independent review of the materials produced and assist the Department in locating any additional materials responsive to the document request. The request to hire counsel was made soon after the April 2025 OIG request, and counsel was ultimately retained in July 2025 and continues to work on this matter.

From page 25

Availability of Menstrual Products in the Los Angeles County Jails

" The Office of Inspector General recommends that the Sheriff's Department continue collecting and incorporating feedback on menstrual cup implementation; revise directives and training as needed; re-brief custody personnel on relevant policies and unit orders..."

Response: CRDF Training staff, along with shift sergeants and Bonus I deputies, received an initial demonstration and training on the Menstrual Cup product. An email was also sent to all CRDF personnel providing information about the product and specific instructions on how searches are to be conducted. A formal training session on the Menstrual Cup product has been scheduled. Unit Order 6-01-00, *Protocol for Inmate Searches*, which includes procedures related to menstrual cups, was distributed on August 6, 2025.

From page 29

Shower Privacy for Transgender, Gender Non-Conforming, and Intersex People at Men's Central Jail

Response: In response to concerns regarding PREA Standard 115.42 and shower privacy for transgender, non-binary, and intersex (TGI) individuals housed in Dorms 9400 and 9500, Men's Central Jail has implemented the following operational measures:

1. Designated TGI Shower Times Implemented:
   MCJ established a daily designated shower period for TGI individuals from 7:00 PM – 9:00 PM in Dorms 9400 and 9500.
   a. MCJ has posted visible signage in Dorms 9400 and 9500, for the designated shower times.
   b. The booth officer makes an audible announcement at the beginning and end of this period.
   c. Only one individual is permitted in the shower during this timeframe to ensure privacy and PREA compliance.

2. Shower Curtains Installed:
   MCJ installed individual shower curtains from an approved County vendor in both dorms.
   a. The curtains are manufactured with solid-color privacy panels, with translucent sections at the top and bottom as part of the vendor's standard design.

3. Identified Height Issue and Corrective Action:
   During assessment, staff identified that the curtains were mounted too high, which resulted in the solid section not fully covering the individual's private areas.
   a. A purchase order has been submitted and approved to reposition the curtain mounts to the appropriate height.
   b. Adjusted mounting hardware is currently awaiting delivery, after which facilities staff will complete the installation.