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

April through June 2024

August 28, 2024

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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 April 1 and June 30, 2024, unless otherwise noted. Quarterly reports may also examine particular issues of interest. This report includes special sections on the following topics:

- An Evaluation of an ICIB and IAB Investigation into Allegations of Criminal Conduct and False Statements by a Sworn Member of the Sheriff's Department
- Attorney and Professional Visitor Access Issues for people in custody
- Out-of-Cell Time at Century Regional Detention Facility (CRDF)
- Pregnant People in Custody at Century Regional Detention Facility

During the second quarter of 2024, the Office of Inspector General also issued the following reports relating to the Sheriff's Department:

- Review of Contracts by School Resource Deputies with Elementary and Middle School Students

MONITORING SHERIFF'S DEPARTMENT'S OPERATIONS

Deputy-Involved Shootings

The Office of Inspector General reports on all deputy-involved 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. This quarter, there were four incidents in which people were shot or shot at by Sheriff's Department personnel. The Office of Inspector General's staff responded to each of these deputy-involved shootings. Three people were struck by deputies' gunfire, one fatally. The information in the following shooting summaries is based on the limited information provided by the Sheriff's Department and is preliminary in nature. While the Office of Inspector General receives information at the walk-through at the scene of the shooting, receives preliminary memoranda with summaries, and attends the Sheriff's Department Critical Incident Reviews, the statements of the deputies and witnesses are not provided until the Sheriff's Department completes its investigation. The Sheriff's Department permits the Office of Inspector General's staff limited access to monitor the ongoing investigations of deputy-involved shootings. 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.

Industry Station: Hit Shooting – Non-Fatal

On May 3, 2024, at approximately 1:17 a.m., deputies from Industry Station responded to a call for service related to a domestic disturbance in La Puente. Upon arrival deputies parked their vehicles and walked towards the suspect's wife standing outside of the residence crying and screaming. Deputies could hear the suspect arguing with his son and based on their observations updated the call classification to a priority.

As the deputies approached the suspect and attempted to speak to him, he became confrontational, bent forward, and picked up a paint roller. The deputies backed away and commanded him to "drop it," but the suspect did not comply. A deputy then sprayed the suspect in the face with oleoresin capsicum (pepper) spray. As the suspect became increasingly agitated, he appeared to position himself to throw the paint roller, while the deputies continued to command him to put it down. The suspect threw the paint roller towards the deputies, striking one deputy in the abdomen. The deputy who was struck then discharged his handgun three to four times wounding the suspect in his lower body. According to the Sheriff's Department, deputies waited to render aid until the arrival of additional units because the suspect's family members refused to obey their verbal commands. Aid was rendered, then the Fire Department transported the suspect to the hospital, where he was treated for the gunshot wound.

The deputy struck by the paint roller reported redness and soreness to his abdomen.

The Sheriff's Department posted a Critical Incident Briefing on its website with video from body-worn cameras and a surveillance camera.

Areas for further inquiry

Only three casings identified, but the Department stated there may have been four rounds discharged. Why is there a discrepancy?

Was the shooting concurrent with the throwing of the paint roller, or did the shooting occur after the paint roller had made contact with the deputy's abdomen?

Did the deputies view the paint roller as a deadly or dangerous weapon?

Were family members or neighbors in the backdrop or line of fire?

Did deputies issue any warnings prior to firing?

Was MET contacted for assistance?

East Los Angeles Station: Non-Hit Shooting

On June 7, 2024, at approximately 10:10 a.m., deputies from the East Los Angeles Station responded to a call that an adult man was at his parents' home in violation of a restraining order. Two responding deputies contacted the suspect in an alley behind the home. The suspect refused to comply with deputy's commands and ran into the family home's rear yard. The responding deputies waited for backup and then proceeded into the rear yard, where they located the suspect and his father along a narrow, paved, side yard between the house and a cinderblock wall. The suspect held a metal folding chair and waived it as if he might strike his father. Several trash bins, plastic chairs, and other items blocked the side yard between the suspect and deputies.

The deputies formed a tactical plan in which they assigned one deputy to use a less-lethal 40mm baton launcher; another deputy to use a Taser; and another to provide a lethal force option using his department-issued firearm. The deputies approached the side yard with the deputy handling the 40mm launcher in the lead and the deputy with the firearm immediately behind. They spoke for several minutes with the suspect, who did not comply with their orders to put down the chair, although he allowed his father to leave. After several minutes, the suspect threw a barbeque grill over the trash bins at the deputies, nearly striking them. At this point, the deputy assigned to use lethal force drew his firearm and pointed it in the direction of the suspect and the deputy equipped with the 40mm launcher fired a single round from the device.

The suspect then picked up a large squeegee mounted on the end of a wooden pole, waved it about, and threw it down the side yard toward the deputies. As the squeegee sailed through the air toward the deputies, the deputy with his firearm drawn discharged a single round at the suspect but did not hit him.

Deputies continued to order the suspect to drop the chair, as they cleared items from the side yard to get to the suspect. The deputy with the 40mm launcher fired a second round toward the suspect and another deputy fired a Taser as they closed in on the suspect and took him into custody.

The suspect was taken to a local hospital and treated for a contusion to his lower left abdomen from the 40mm round. The deputies suffered no injuries.

The deputy who fired his weapon did not announce that he fired it at the time it was discharged. Only after the suspect was in custody, did the deputy indicate that he may have fired his weapon, expressing some uncertainty. The supervisor on scene ordered him to review his body-worn camera video to confirm whether he had fired.

The Department reported that IAB will investigate the incident as a non-hit shooting unless it determines that the deputy discharged his firearm accidentally.

Areas for further inquiry

Did the deputies have any information indicating that mental health issues may have played a role in the suspect's behavior?

After the suspect released his father, did the deputies on scene consider retreating to a position of safety and contacting a MET team?

Did the deputy fire accidentally or intentionally?

Did the deputy have to review the body worn camera video to determine whether he fired, or could he have just checked his service weapon?

Did the deputy follow Sheriff's Department policy and training when drawing and handling his firearm?

Did the deputies and supervisor on scene follow procedures for a non-hit shooting and timely notify IAB?

Compton Station: Hit Shooting – Fatal

On June 13, 2024, at approximately 7:46 p.m., Compton station received a call stating that the brother in-law of the caller was firing several shots into the air and that he might be under the influence of an unspecified substance. The caller also stated that her children were inside an adjacent home, and she was fearful for their safety.

When the first deputy arrived, he spotted the suspect through a side gate and called for his surrender, but the suspect retreated into the backyard. As the first deputy awaited backup, he evacuated the family members who were still inside the adjacent building. Deputies then called for an Aero Unit, Canine Unit, and a MET team to respond to the location. A few minutes later, the suspect appeared on the roof of the building inhaling from an aerosol canister. When the Aero unit arrived, they informed the deputies below that there was a shotgun near the suspect.

While on the roof, the suspect fired several rounds and the Aero unit reported that the helicopter had been hit. Two deputies repositioned inside an adjacent house where they could see the suspect on the roof through a living room window. They called for the suspect to surrender, but he did not, at one point yelling "shoot me, shoot me." Shortly afterward, the suspect again aimed the shotgun at the hovering helicopter and the two deputies inside the house responded by firing their .223 and 9mm caliber weapons, striking the suspect.

After deploying a flashbang device and observing no response from the suspect, deputies advanced and assessed the situation safe enough for the nearby fire department to provide assistance. The suspect died at the scene. A helicopter

inspection determined that it had been hit with one pellet shot. At the conclusion of the incident, a loaded shotgun with a pistol grip and a box of ammunition were found next to the suspect. No deputies were injured.

The Sheriff's Department posted a Critical Incident Briefing on its website with video from body-worn cameras.

Areas for further inquiry

Were all deputies who responded provided with a body-worn camera, if not, why?

Had the MET team arrived and attempted to de-escalate the situation?

Were there any attempts to de-escalate the situation?

Did Aero unit follow best practices and department policy by remaining overhead while being fired at?

Could a UAS (drone) have been deployed instead?

Did deputies follow the standard protocols and tactics involving an armed suspect on a roof?

Palmdale Station: Hit Shooting – Non-Fatal

On June 17, 2024, at around 7:52 p.m., deputies from Palmdale station received a call regarding a man wielding two knives (later described as 3-inch pocketknives) attempting to carjack three vehicles. Following the failed carjackings, the suspect proceeded towards a nearby apartment complex where, he allegedly broke the window of a ground-floor apartment.

Shortly afterward, deputies arrived at the scene, initiating a standoff with the suspect, who still held both knives and refused to surrender despite attempts by deputies to de-escalate the situation. Deputies fired 40mm rounds which failed to subdue the suspect. Subsequently, one deputy discharged two rounds from a handgun as the suspect approached them with the knives still in his hands. The suspect was struck by one round. He was transported to the hospital for medical attention and was listed in stable condition.

The Sheriff's Department posted a Critical Incident Briefing on its website with video from body-worn cameras.

Areas for further inquiry

The shooting occurred in front of an apartment building at night, did the deputies consider evacuating residents prior to the shooting?

Since MET was on-scene at the time of the shooting, did they play a role in the de-escalation efforts?

Were other less lethal alternatives considered prior to the decision to employ lethal force?

Did deputies form a tactical plan before engaging with the suspect?

How many deputies were assigned lethal force? If more than one, why did only one deputy fire?

Was there adequate communication between deputies?

Was there a sergeant at the scene? If so, was there sufficient command and control of the incident?

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. 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 which 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 January 1, 2024, and June 30, 2024, the District Attorney's Office issued twelve findings on deputy-involved shooting cases involving the Sheriff's Department's employees.[1]

- In the March 5, 2020, non-fatal shooting of Jessa Allan Janto, the District Attorney opined in a memorandum dated April 16, 2024, that the shooting by deputies Matthew Bistline, David Chavez-Cruz, Andrew De La Rosa, Jonathon Livingston, Collin Reddy, and Ryan Thompson was not unlawful.
- In the October 6, 2020, fatal shooting of Nicholas Burgos, the District Attorney opined in a memorandum dated February 20, 2024, that there

[1] The District Attorney's Office posts its decisions on deputy and officer-involved shootings on its website under Officer-Involved Shootings, and the Office of Inspector General retrieves the information on District Attorney decisions from this webpage. The District Attorney's Office published the twelve memoranda listed here on its website between April 1 and June 30, 2024, although seven of the memoranda are dated prior to April 1.

was insufficient evidence Deputy Dalia Gonzalez did not act lawfully in self-defense and in defense of others when she fired her duty weapon.

- In the March 3, 2021, non-fatal shooting of Deputy Andrew Toone, the District Attorney opined in a memorandum dated February 28, 2024, that the shooting was accidental and Deputy Donald McNamara is not criminally responsible.

- In the April 23, 2021, non-fatal shooting of Miguel De Los Santos, the District Attorney opined in a memorandum dated March 29, 2024, that deputies Erasto Granados and Daniel Velasco acted in lawful self-defense and the defense of others when they fired their duty weapons.

- In the November 12, 2021, fatal shooting of Wendy Carolina Flores De Roque and the non-fatal shooting of Franklin Moran, the District Attorney opined in a memorandum dated June 7, 2024, that the use of deadly force by Deputy Dominguez was not unlawful.

- In the December 15, 2021, non-fatal shooting of Juan Angel Marquez, the District Attorney opined in a memorandum dated May 30, 2024, that the deputies Ernest Hernandez and Joshua Corrales each reasonably believed that deadly force was necessary to defend against an imminent deadly threat.

- In the March 3, 2022, fatal shooting of Edgar Ortiz, the District Attorney opined in a memorandum dated February 12, 2024, that there was insufficient evidence deputies Gabriel D'Souza and Erin Herring did not reasonably believe, based on a totality of the circumstances, that deadly force was necessary to defend against a deadly threat when they fired their weapons.

- In the March 13, 2022, fatal shooting of Samuel Nunez, the District Attorney opined in a memorandum dated May 20, 2024, that the District Attorney's Office cannot prove beyond a reasonable doubt that Deputy Melton acted unlawfully.

- In the August 31, 2022, fatal shooting of Agustin Flores, the District Attorney opined in a memorandum dated May 20, 2024, that the deputies Jasen Tapia, Timothy Garcia, Julio Chavez-Ruiz, and Raymond Romero-Soto acted reasonably believing that deadly force was necessary to defend against an imminent deadly threat.

- In the January 26, 2023, fatal shooting of Miguel Lopez, the District Attorney opined in a memorandum dated June 5, 2024, that the deputies acted reasonably believing that deadly force was necessary to defend against an imminent threat.

- In the January 31, 2023, non-fatal shooting of Mario Bustillos, the District Attorney opined in a memorandum dated February 22, 2024, that the deputies Edwin Barajas, Leonel Leon, Victor Garcia, Timothy Cho, Chase Morales, and Steven Medina acted in lawful self-defense and defense of others at the time they fired their service weapons, reasonably believing, based on the totality of the circumstances, that deadly force was necessary to defend themselves and others against an imminent deadly threat.

- In the February 10, 2023, fatal shooting of Everett Byram, the District Attorney opined in a memorandum dated March 29, 2024, that Deputy Blake Runge acted lawfully in self-defense and defense of others when he fired his weapon.

Homicide Bureau's Investigation of Deputy-Involved Shootings

For the present quarter, the Homicide Bureau reports that it has fourteen shooting cases involving Sheriff's Department personnel open and under investigation. The oldest case in which the Homicide Bureau maintained an active investigation at the end of the quarter relates to a June 19, 2023, shooting in the jurisdiction of Walnut Station. For further information as to that shooting, please refer to the Office of Inspector General's report. The oldest case that the Bureau has open is a 2022 shooting in the city of Compton, 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 one deputy-involved shooting case to the District Attorney's Office for filing consideration.

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

Under California law, the state Department of Justice (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.[2] As of the

[2] Gov't Code § 12525.3(b).

end of the second quarter, the DOJ is investigating three shootings involving deputies from the Sheriff's Department, the oldest of which occurred in February 2022. During the last quarter, the DOJ issued no written reports regarding shootings involving Sheriff's Department deputies.

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 Los Angeles County.[3]

The Sheriff's Department reports that ICIB has 79 active cases. This quarter, the ICIB reports sending one case to the District Attorney's Office for filing consideration. The District Attorney's Office is still reviewing 29 cases 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 or use of force, IAB reviews the evidence 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.

This quarter, the Sheriff's Department reported opening 143 new administrative investigations. Of these 143 cases, 40 were assigned to IAB, 77 were designated as unit-level investigations, and 26 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 152 cases were closed by IAB or

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

at the unit level. There are 526 pending administrative investigations, of which 320 are assigned to IAB and the remaining 206 are unit-level investigations.

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 April 1 and June 30, 2024, the Civil Service Commission issued final decisions in three cases involving Sheriff's Department employees.[4]

Employee Position	Date of Department action	Case number	Department actions	Date of Civil Service Hearing	Civil Service decision
Deputy Sheriff	**5-13-15**	**15-185**	**Discharge**	**4-10-24**	**Commission sustained discharge, but Superior Court ordered reinstatement**
Custody Assistant	**12-9-21**	**21-251**	**Discharge**	**4-24-24**	**Commission overruled the Department and imposed a 30-day Suspension**
Deputy Sheriff	**10-6-21**	**21-212**	**Discharge**	**5-22-24**	**Commission did not sustain the Department's decision to discharge**

Two cases concerned sworn peace officers of the rank of deputy and one concerned a custody assistant. In all three cases, the Sheriff's Department had discharged the employee. In one case, the Civil Service Commission sustained the deputy's discharge, but the deputy sought review in the Superior Court, which overturned the discharge and ordered the deputy reinstated on grounds that the Department had not imposed discipline within the one-year statute of limitations required by the Public Safety Officers Procedural Bill of Rights Act, Govt. Code § 3304(d). Another case overruled the Department's decision to discharge and imposed a 30-day suspension. In the last case, the Commission did not sustain the Department's discharge.

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) nine times between April 1 and June 30, 2024, as summarized in the chart below.

DATE	OPERATION TYPE	LOCATION	SUMMARY
4-29-24	Barricaded Suspect	Whittier	SEB K9 services assisting Norwalk station with barricaded suspect. UAS utilized to monitor location. Suspect Surrendered.

[4] The Civil Service Commission reports its actions, including final decisions, in minutes of its meetings posted on the County's website for commission publications.

5-12-24	Search and Rescue	Monrovia Peak	SEB responded to location regarding a barricaded suspect. UAS used to view interior of location. Suspect surrendered.
5-13-24	Barricaded Suspect	Los Angeles	SEB personnel served a high-risk search warrant related to a murder investigation. UAS used to search attic space for suspect.
5-17-24	High Risk Tactical Operations	Compton	UAS used to observe train rail tracks bordered by freeway. High risk area off limits to pedestrian danger.
5-22-24	Search and Rescue	Malibu	SEB personnel assisted Montrose Search and Rescue with a missing hiker. Hiker not located.
5-26-24	High Risk Tactical Operations	Compton	UAS used to assist SEB with a barricaded suspect who used a sharp object to assault deputies. UAS used to locate suspect inside location and monitor while arrest team took suspect into custody.
6-15-24	High Risk Tactical Operations	Compton	SEB personnel serving arrest warrant for murder suspect. UAS used to search interior and attic for suspect.
6-22-24	High Risk Tactical Operations	Palmdale	SEB personnel responded for inspection and removal of potential blast hazard. UAS used to gather information on two unstable and over-pressured heavy equipment tires.
6-24-24	High Risk Tactical Operations	Palmdale	SEB personnel responded for inspection and removal of potential blast hazard. UAS used to gather information on two unstable and over-pressured heavy equipment tires.

Evaluation of an ICIB and IAB Investigation into Allegations of Criminal Conduct and False Statements by a Sworn Member of the Sheriff's Department.

The Office of Inspector General reviewed ICIB and IAB investigations into an allegation that a sworn member of the Sheriff's Department engaged in illegal gambling activity. The review found that neither ICIB nor IAB followed up on significant investigative leads uncovered during the ICIB investigation, including evidence that the subject may have been receiving large amounts of money from an unknown person in connection with gambling. Neither investigation examined the deputy's financial or business dealings to determine if the deputy was engaged in activities that violated criminal laws or County or Sheriff's Department policies. Although the deputy made statements during the IAB investigation that were inconsistent with evidence gathered during surveillance of the deputy, the Department chose not to pursue an investigation into whether those statements were intentionally false. In response to Office of Inspector General inquiries, the current administration explained the decision not to pursue an investigation into possible false statements on grounds that the passage of time may explain the deputy's failure to recall certain events. The length of the ICIB investigation along with the failure to investigate the deputy's financial records made it difficult to prove that the deputy's statements to IAB that were inconsistent with evidence gathered during surveillance of the deputy were false. In previous reports, the Office of Inspector General identified

issues with the Department's failure to conduct thorough investigations, investigatory delays that may lead to memories fading, the loss of evidence, leaving a lack of sufficient time for follow-up interviews before the expiration of the one-year Peace Officer Bill of Rights statute of limitations and neglecting to impose discipline on sworn personnel for making false statements during misconduct investigations.[5]

In March 2021, ICIB began investigating a complaint to the Sheriff's Department alleging that a sworn member of the Department was hosting illegal high-stakes poker events. ICIB investigated for approximately ***two years*** before concluding that they lacked evidence to file criminal charges.[6] In June 2023, ICIB closed its investigation without submitting the case to the District Attorney's Office and referred the matter to IAB for investigation into possible administrative policy violations. In April 2024, IAB completed its investigation, based on which the Sheriff's Department found the allegations "unresolved."

During the course of the ICIB investigation, investigators overheard a conversation at a casino between the subject deputy and an unidentified male who discussed wiring the subject a monthly five-figure sum of money and mentioned a player cheating at the poker events. The conversation ended with the unidentified male asking the subject to send him wire instructions to send the deputy a five-figure sum of money.

The ICIB and IAB case files reviewed by the Office of Inspector General indicate that neither ICIB nor IAB made any efforts to identify and interview the man talking about the wire transfer with the subject deputy. The investigators did not request surveillance recordings from the casino where the deputy and the man had the conversation. Nor did ICIB or IAB make any attempt to determine whether the deputy received a wire transfer consistent with that described by the man, or any unexplained large transfers of money and, if so, what services the subject provided for those payments. County rules require

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[5] See Los Angeles County Office of Inspector General, *Los Angeles County Sheriff's Department: Review and Analysis of Misconduct Investigations and Disciplinary Process* (Feb. 2021).

[6] The Sheriff's Department did not submit the case to the District Attorney's Office and relied upon its own determination that criminal activity could not be proven based on the ICIB investigation. There are multiple advantages in submitting criminal cases to the District Attorney for filing consideration. One, of course, is that the District Attorney's office, in its independent review of the case, may determine that it justifies filing. The District Attorney's office may also suggest areas for further investigation, including recommending securing a search warrant or suggestions for additional investigation to support the statement of probable cause to obtain a search warrant, or can initiate a grand jury investigation to gather additional evidence on its own. Finally, submitting the case to the District Attorney's office provides the prosecution with information regarding the subject deputy for inclusion in a *Brady* database to comply with the constitutional requirement that potentially exculpatory information be provided to defendants in criminal cases.

that employees inform the County of outside employment activities, including conducting a personal business, yet the investigation does not state whether the investigators even checked if the subject disclosed any outside employment. ICIB investigators do not appear to have obtained any search warrants during their investigations to investigate the subject's finances to corroborate the sums discussed.[7] Nor was the deputy asked to voluntarily provide financial records to ICIB or IAB investigators.[8] Neither ICIB nor IAB investigators provided any explanation in the case files reviewed by the Office of Inspector General as to why they did not attempt to further investigate the lead generated by the Department's own investigation.

In March 2024, the IAB interviewed the subject on two separate occasions. During the interviews, IAB investigators asked the subject about the conversation with the unidentified man, and the subject denied that the conversation took place, contradicting the evidence in the Department's possession. Under the Department's Manual of Policy and Procedures (MPP), "false statements and any other form of dishonesty during an official Department internal investigation or inquiry shall, absent extenuating

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[7] The Department has stated to the Office of Inspector General that ICIB investigators did not believe there was sufficient evidence to support probable cause to obtain a search warrant. The Office of Inspector General disagrees with this assessment.

[8] If the subject had failed to comply with such a request in the IAB investigation, they would potentially face punishment under the Sheriff's Department's Manual of Policy and Procedures (MPP) § 3-01/040.76. Under this section, employees of the Department "shall not take any action that could interfere with, delay, obstruct, distort or unduly influence any investigation." While employees of the Sheriff's Department are required to cooperate in a criminal investigation as stated in MPP § 3-01/040.85, employees may assert their rights under the Fourth and Fifth Amendment of the United States Constitution and discipline could not be imposed for a valid assertion of a constitutional right. The assertion of a constitutional right during an IAB investigation, once ordered to answer, may be considered to be a failure to cooperate and an employee may be disciplined, up to and including discharge from the Sheriff's Department. See MPP § 3-01/040.75, which states, "[f]ailure or refusal to make statements when ordered during Department internal investigations constitutes insubordination and shall, absent extenuating circumstances, result in discharge." While Government Code § 3308 states that a public safety officer shall not be required or requested to disclose income or sources of income in a personnel action, there is an exception when the information "tends to indicate a conflict of interest with respect to the performance of his official duties." There is no published case on what constitutes a "conflict of interest with respect to the performance of his official duties." In one court decision, on an *ex parte* application for a temporary restraining order in Los Angeles County, a court ordered that deputies not be compelled to answer financial questions and could not be punished for failing to answer ***but allowed the questions to be asked of the deputies***. See *Khounthavong, et al. v. County of Los Angeles*, Los Angeles Superior Court Case No. BC603263. Engaging in illegal gambling activities while employed as and therefore performing one's official duties as a sheriff's deputy is arguably a conflict of interest as intended by the statute. Section 3308 applies only to personnel actions and would not prevent ICIB from inquiring into the subject's financial records as part of its criminal investigation, nor from including the results of that investigation in its file for IAB to review.

circumstances, result in discharge."[9] But the Department never initiated an administrative investigation into the subject's possibly false statements because it concluded at the outset that the deputy's failure to recall certain events could be explained by the passage of time. Had the Department actually conducted a thorough, evidence-based investigation, it might have gathered sufficient evidence to determine whether or not the deputy's statements to IAB investigators were false.[10]

The Sheriff's Department ultimately found that the allegation was "unresolved," and as a result, the deputy was not disciplined. As of this writing, the subject remains on duty with the Department. The Department's handling of the ICIB and IAB investigations here exhibit the issues identified previously by the Office of Inspector General, that investigations of employees are not always evidence-based, thorough, or timely. These problems increase the possibility that misconduct goes unpunished.

Semi-Annual Report on Implementation of the Family Assistance Program

The Los Angeles County Board of Supervisors established the Family Assistance Program (Family Assistance), first in 2019 as a one-year pilot that it later made permanent, with the aim of improving compassionate communication and providing trauma-informed support to families of those who died following a fatal use of force by a Sheriff's Department employee or while in the custody of the Sheriff's Department. The Office of Inspector General reports semi-annually on Family Assistance in its quarterly reports on the Sheriff's Department.

Family Assistance Status

On February 8, 2024, the administration of Family Assistance officially transitioned from the Department of Mental Health (DMH) to the Office of Violence Prevention (OVP)

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[9] MPP § 3-01/040.75, *Dishonesty/Failure to Make Statements And/Or Making False Statements During Departmental Internal Investigations*.

[10] The Department stated to the Office of Inspector General that due to the passage of time between the October 2021, conversation and the March 2024, IAB interview of the subject, "it was deemed reasonable that the subject may have forgotten aspects of visits to gambling establishments [they] frequented after this significant period of time."

within the Department of Public Health, pursuant to the plan to make Family Assistance permanent as recommended to the Board in 2022.[11]

As previously reported, the Chief Executive Office approved four positions requested by DPH in the FY 2023-2024 budget to support Family Assistance. OVP reports that it filled the Clinical Social Worker Supervisor II position on September 1, 2023, and the Clinical Social Worker position on March 22, 2024. OVP continues to work in collaboration with the Department of Medical Examiner (DME) to fill the two Psychiatric Social Worker II (PSWII) positions, both of which will be assigned to work on-site with the DME.[12]

OVP reports that it has prepared a draft Memorandum of Understanding (MOU) outlining the terms of the agreement, funding provisions, and the respective duties and responsibilities of DPH, OVP, and DME. OVP reports that the draft MOU has been submitted to DME for review and will likely require modifications. OVP reports that it anticipates meeting with the DME to further clarify roles and responsibilities regarding next-of-kin identification and death notifications, managing communications with mortuaries/funeral homes, and the process for impacted families to claim decedents' personal effects and property.

In March 2024, OVP formed a multidisciplinary work group that meets monthly to discuss program design and implementation, protocols, eligibility criteria, and reviews cases. The work group includes representatives from the Sheriff's Department, DME, the Office of Inspector General, the Sheriff Civilian Oversight Commission (COC), Los Angeles County District Attorney Office, DMH, Los Angeles County Correctional Health Services, and Los Angeles Office of the County Counsel.

Family Assistance Service Data

OVP reports that from January 1, 2024, to June 30, 2024, OVP was notified of 21 incidents where an individual died following a fatal use of force by a Sheriff's Department employee or while in the custody of the Sheriff's Department. OVP successfully contacted 20 families. Of those, all 20 families accepted services and assistance from OVP Family Assistance Advocates. OVP distributed burial expenses to

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[11] *See Office of Inspector General's Semi-Annual Report on Implementation of the Family Assistance Program and Report Back on Permanent Support for Families Affected by Los Angeles County Sheriff's Department: Identifying Sustainable Funding for and Streamlining the Family Assistance Program (Item No.14, Agenda of July 9, 2019 and Item No. 9, Agenda of October 19, 2021)* (Feb. 22, 2022).

[12] The Clinical Social Worker Supervisor II position was originally classified as Mental Health Clinical Supervisor and the Clinical Social Worker position was originally classified as PSWII.

14 families, with expenses ranging from $1,393 to $7,500, totaling approximately $68,785 for the period.

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

On October 3, 2023, the Board of Supervisors directed the Sheriff's Department to revise its Taser use policies to incorporate best practices from other law enforcement agencies, ensure compliance with State and Federal legal standards, and consider recommendations by other law enforcement and advocacy groups.[13]

The Board of Supervisors also directed the Office of Inspector General to include in its quarterly reports to the Board an "[u]pdate on the status of the LASD's adoption of an updated Taser policy, the status of training personnel on the updated Taser policy, and deputy compliance with updated policies, once adopted, consistent with LASD trainings until full compliance;" and "[d]ocumentation and tracking on the Department's Taser use, including those that result in serious injury or death, in patrol and custody."

Updated Taser Policy

In its previous quarterly report, the Office of Inspector General reported that the Sheriff's Department had not completed bargaining with labor associations and had not finalized a revised policy on Taser use. The Department did not finalize a policy during this reporting period. However, on July 11, 2024, shortly after the reporting period ended, the Sheriff's Department provided the Office of Inspector General with a finalized version of the updated Taser policy. The Office of Inspector General will review the language of the updated policy in its next quarterly report to the Board in accordance with the Board's directive and to examine how the Department addressed Office of Inspector General comments on its draft Taser policy, including the clarity of its standards for authorized Taser use, the potential for use against passive resistance, the policy provisions limiting multiple applications of Tasers, and the extent to which the policy adequately conveyed the potential risks of Taser use.

Documenting and Tracking Taser Use

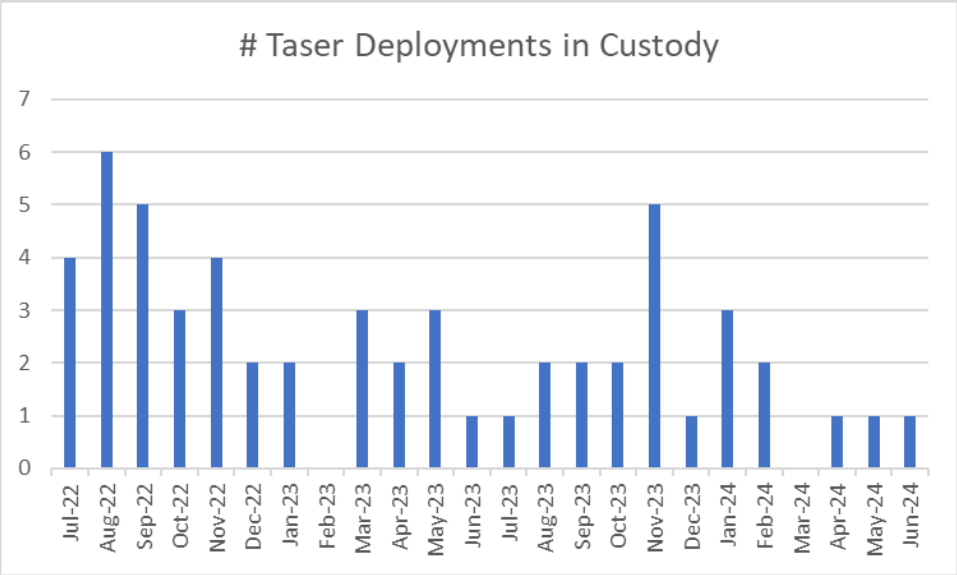
In May 2024, the Sheriff's Department launched a web dashboard reporting Taser usage after April 1, 2024, by patrol station or facility, date, and subject description. Beginning in July 2024, the Department began including in that data the "Result of the

[13] Transparency, Accountability, and Oversight of Los Angeles Sheriff's Department's Taser Use Policy, Agenda No. 15 (Oct. 3, 2023).

Use of Force" (i.e., whether the use resulted in serious injury or death) for all incidents that occurred on or after July 1, 2024.

Taser Use in Custody

The following chart reflects the number of use-of-force incidents in custodial settings over the past two years in which deputies employed a Taser, according to the *Monthly Force Synopsis* that the Sheriff's Department produces and provides to the Office of Inspector General each month:



CUSTODY DIVISION

Attorney and Professional Visitor Access Issues

The Office of Inspector General received several complaints of jail visitation staff refusing to allow people in custody to meet with members of their criminal defense team in attorney visit areas, despite valid court orders directing such access.[14]

[14] Some attorneys who spoke with Office of Inspector General staff advised that they will at times preemptively obtain a court order directing access to their clients in an effort to avoid being denied access.

The Sheriff's Department jail facilities have dedicated visiting areas for attorneys and professional visitors, such as social workers, paralegals, law enforcement officers, and private investigators, to meet with people in custody. Each facility is responsible for developing and implementing policies for providing attorneys and professional visitors with reasonable access to people in custody, which, as discussed below, has resulted in inconsistencies between the policies of the facilities.[15] Depending on the facility, the Department requires certain types of professional visitors to obtain a court order to meet with a person in custody in the attorney visiting areas. The Department also requires attorneys and professional visitors who wish to meet face-to-face with a person in custody without a physical barrier separating them to obtain a court order.[16] Legal and professional representatives may submit court orders to a facility's legal unit for prior approval or present the court order to visitation staff upon arrival to the visit area. Visitation staff work closely with their respective facility's legal unit to validate visitors' credentials and process court orders.

In August 2022, an attorney complained to the Office of Inspector General that visitation staff at Twin Towers Correctional Facility (TTCF) refused to allow him to meet with his client in a private visiting room. The attorney reported that he presented TTCF visitation staff with a valid court order to meet confidentially with his client, and that visitation staff wrote "not possible" on the court order in black marker, ostensibly due to the Tower 2 elevators being inoperable.[17]

In September 2023, an attorney complained that Sheriff's Department staff refused to allow a member of her legal team to meet with a client at Men's Central Jail (MCJ) in the attorney visiting area, despite a valid court order signed by a judge directing that the legal team, including an investigator, be granted visits with their client to assist with legal representation.

In November 2023, a legal clinic complained that, although it had obtained a court order to have a licensed social worker conduct a social history assessment of the client who was housed at MCJ, visitation staff denied the social worker access to meet confidentially with the client in an attorney visiting room on grounds that the social worker was not employed by the County. Office of Inspector General staff spoke with Custody Division personnel regarding this incident, who stated that MCJ staff did not

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[15] *See* Los Angeles County Sheriff's Department, Custody Division Manual, § 5-10/030.00, *Attorney Room Visits*.

[16] *Id*.

[17] The attorney visiting area in Tower 2 can be accessed via either stairs or via the elevators for Tower 1, and the Department did not explain why the attorney could not use these alternatives.

comply with the court order partly due to staff training issues. However, the Department had denied the clinic's legal team court-ordered access to clients on prior occasions as well. The clinic obtained a court order granting a law student access to interview a client housed at MCJ. The supervising attorney accompanied the law student and presented the court order to visitation staff. Visitation staff refused to comply with the court order on the basis that the law student was not certified as required by Department policy and that Department policy superseded the court order.[18] The court order did not require that the law student be certified to access the client.

The Office of Inspector General reviewed unit orders related to accessing attorney visit areas from MCJ and TTCF and noted several concerns:[19]

No clear directive to comply with court orders. The unit orders fail to emphasize the importance of ensuring that the Department adhere to court orders. California Penal Code section 166(4) provides that "[w]illful disobedience of the terms, as written, of a process or court order or out-of-state court order, lawfully issued by a court" constitutes a misdemeanor. Yet, it appears as though some Department visitation staff are unaware that non-compliance with court orders may constitute a criminal offense, and Department policy does not outline the legal significance of court orders.

MCJ's unit order instructs visitation staff that when visitors bring in court orders, "Legal Staff shall be contacted for approval to comply with the order" or "[i]n their absence, the Watch Sergeant or Watch Commander shall be contacted."[20] Requiring approval in order to comply with a court order suggests that the default course of action is non-compliance. This raises serious concerns given that adhering to court orders is mandatory. In contrast, TTCF's unit order requires that visitation staff notify either a supervisor or, in their absence, the watch commander, for verification, logging, and processing.

No time frame for complying with court orders. MCJ's unit order also lacks a time frame for visitation staff to process court orders. In contrast, TTCF Unit Order # Unit

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[18] The State Bar of California's Practical Training of Law Students Program certifies law students to provide legal services permitted by rule 9.42(d) of the California Rules of Court under the supervision of an attorney. The program is also governed by Title 3, Division 1, Chapter 1 of the Rules of the State Bar.

[19] The Office of Inspector General reviewed the following unit orders: (1) Men's Central Jail Unit Order 5-15-041, *Attorney Room Procedures,* (2) Men's Central Jail Unit Order 4-03-020, *Procedures for Handling Court Orders*, (3) Twin Towers Correctional Facility Unit Order 5-15-020, *Attorney and Other Professional Priority Visits*, and (4) Twin Towers Correctional Facility Unit Order 4-08-010, *Court Orders*.

[20] Men's Central Jail Unit Order 5-15-041, *Attorney Room Procedures*.

Order #: 5-15-020, *Attorney and Other Professional Priority Visits*, provides, "[w]hen an attorney, or other professional, presents TTCF Visiting staff with a court order, the deputy personnel shall *immediately* [emphasis added] notify the Visiting bonus deputy, who shall forward a copy of the court order to the TTCF Legal Unit for verification, logging, and processing. If the Visiting bonus deputy is not available and the court order is of an exigent nature, the handling deputy shall forward the order to the on-duty watch commander . . . ." The lack of timeframe in MCJ's unit order may impact the facility staff from processing court orders as expeditiously as possible.

Inconsistent practices on attorney and professional visitation between jail facilities. In addition to the inconsistencies noted above regarding the handling of court orders, TTCF's unit order provides that a certified law student need not be under the direct, physical supervision of the attorney in order to use an attorney visit room. MCJ's unit order prohibits a certified law student from using an attorney visit room unless accompanied by an attorney. TTCF's unit order allows for private paralegals to access the attorney visiting area with a valid court order, while MCJ's unit order prohibits private paralegals from accessing the attorney visiting area. TTCF's unit order does not establish procedures for defense expert visits, while MCJ's unit order allows defense experts to access the attorney visit areas with a valid court order. The lack of continuity between the types of professional visitors that are able to access each facility creates confusion for legal counsel and other professional visitors.

***Inadequate documentation of refused attorney and professional visits*.** The unit orders do not require visitation staff to log instances where the Department denies attorneys, attorney representatives, and other professional visitors access to attorney visiting areas or refuses to comply with a court order's directions on the terms for a meeting. Documenting such instances will allow for periodic audits to ensure that all policies and procedures outlined in the unit orders are followed consistently.

During conversations with defense attorneys regarding the challenges with accessing their clients in TTCF and MCJ, it became apparent to Office of Inspector General staff that attorneys and other professional visitors seeking to meet with clients lacked sufficient clear information about the Sheriff's Department's policies and procedures for such visits. Office of Inspector General staff reviewed the Sheriff's Department's website and found only fragmented information about MCJ's attorney visiting area. The website does not provide clear guidance for attorney representatives or other professional visitors seeking to meet with clients in the attorney visiting area of each facility, nor does it indicate the required identification, credentials, and documentation that the Department requires from professional visitors.

The Sixth Amendment to the United States Constitution guarantees that a criminal defendant shall "have the Assistance of Counsel for his defense."[21] California Courts have recognized that incarcerated people have a constitutional right to "confidentially confer with counsel" and "have contact visits with counsel as a part of their right to meaningful access to the courts."[22] Impairing a detained criminal defendant's ability to access their legal team interferes with the right to counsel. California Courts have also made clear that "[attorney visitation] policies will not be upheld if they unnecessarily abridge the defendant's meaningful access to his attorney and the courts."[23] Furthermore, California state regulations require that jail facilities "develop written policies and procedures to ensure inmates have access to the court and to legal counsel."[24] The Sheriff's Department's inconsistent policies and practices that impose barriers on legal counsel seeking access to their clients likely fail to comply with this regulation and to pass constitutional muster.

To address these problems, the Office of Inspector General recommends the following:

- The Sheriff's Department should develop agency-wide policies related to attorney and professional visits to ensure consistency across all facilities including the types of visitors who qualify to access the attorney visit areas and the materials they may bring into the visit areas, as well as the identification, credentials, and documentation each visitor must present. Unit orders should be limited to addressing facility-specific needs.

- The Sheriff's Department should revise its policies on visitation to clearly instruct its staff to honor all court orders providing criminal defendants in custody access to members of their legal team, including experts and professionals, and create a process for visitation staff to quickly resolve questions about court orders regarding legal team access. The policy should expressly instruct staff that defendants representing themselves in propria persona ("pro per") should be afforded access to any legal experts or investigators, or professionals necessary for their defense.

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[21] U.S. Const., Amend. VI.

[22] *County of Nevada v. Superior Court of Nevada County and Jacob Michael Siegfried (2015)* 236 Cal.App.4th 1001; *see also In re Rider* (1920) 50 Cal. App. 797, 799.

[23] *Ching v. Lewis* (9th Cir. 1990) 895 F.2d 608, 609.

[24] Cal. Code Regs., tit. 15 § 1068 (2024).

- The Sheriff's Department should train visitation staff on verifying, processing, and logging routine court orders for expeditious processing.
- The Sheriff's Department should require that visitation staff log all instances in which they deny a visitor's request to access the attorney visiting area. Staff should document the visitor and the person in custody, the visitor's basis for claiming a right to access the attorney visiting area, and their reason denying access. Staff should also preserve any supporting documentation or court orders presented by the visitor or person in custody. The Sheriff's Department should periodically audit the log to ensure that staff are adhering to policies and procedures.
- The Sheriff's Department should post comprehensive information regarding professional visits on its website. The information should include the types of professional visitors who are allowed into the attorney visiting area of each facility, as well as the required identification, credentials, and documentation that professional visitors must present. There should be links to policies and unit orders of the Sheriff's Department relating to attorney visits and relating to visits by court-appointed investigators and experts for persons who are represented by counsel and for persons who are pro per. The material should also include contact information for each facility's attorney visit area and designated legal unit.

Out-of-Cell Time at Century Regional Detention Facility (CRDF)

The Office of Inspector General has received recent complaints from people housed in general population units at CRDF that restrictions on out-of-cell time have created conditions of confinement similar to those in isolation, raising concerns about compliance with Sheriff's Department policy and CRDF unit orders.

California regulations establish standards for detention and correctional facilities in Title 15 of the California Code of Regulations (Title 15), which require that county jail facilities allow people in custody "a minimum of 10 hours of out of cell time [per week]."[25] Although Sheriff's Department policy requires only that staff comply with Title 15

[25] Cal. Code Regs., tit. 15, § 1065 (2024). Under Title 15, "out-of-cell time" means "time spent outside of the sleeping area, where an individual has the opportunity to exercise or participate in recreation." "Recreation" means "the individual's ability to choose from activities that occupy the attention and offer the opportunity for relaxation and may include reading, games, socialization, entertainment, education, and programs." "Exercise" means "the opportunity for physical exertion." *Id.* § 1006.

standards,[26] CRDF established a unit order that sets a higher standard by requiring that people in custody "be allotted a minimum of two (2) hours per day of out-of-cell time" amounting to 14 hours of out-of-cell time per week.[27] CRDF's unit order further states that, "[u]nless an educational class, religious service, or a self-help group (e.g., Alcoholics Anonymous, Narcotics Anonymous, etc.) has been scheduled for the day room, all inmates shall be allowed out of their cells to use the telephones, vending machines, showers, outdoor recreation area, television, or to socialize with the other inmates housed in the same housing module."[28] Sheriff's Department policy and the CRDF's unit order both require staff record out-of-cell-time in the electronic Uniform Daily Activity Log (e-UDAL).[29]

The Office of Inspector General spoke with people in custody and Sheriff's Department personnel about their respective concerns with out-of-cell time and conducted an evaluation of out-of-cell time in a general population housing module for a two-week period from June 9 to 22, 2024. A review of e-UDAL and closed-circuit television (CCTV) video revealed inconsistencies in out-of-cell time at CRDF across three areas: amount of time out of cell, number of times out of cell, and time of day out of cell. The review also raised concerns about line personnel's broad discretion to restrict out-of-cell time and inaccurate and inconsistent documentation.

Insufficient out-of-cell time. In the two-week period reviewed by the Office of Inspector General, CRDF staff failed to provide several people in custody a minimum of two hours per day of out-of-cell time on at least three days, violating CRDF Unit Order 5-23-090.[30] Staff also failed to document in the e-UDAL the reason for not providing the minimum required out-of-cell time. On those days, CRDF staff confined several people in this general population module to their cells for approximately 23 hours a day, mirroring conditions in restrictive housing and discipline units. Research shows isolation

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[26] See Custody Division Manual, § 5-13/115.00, *Out of Cell Time*.

[27] See Custody Division Unit Orders, 5-23-090, *Inmate Out-of-Cell Time*.

[28] Custody Division Unit Order, 5-23-090, Inmate Out-of-Cell Time.

[29] Custody Division Manual, § 5-13/115.00, *Out of Cell Time* ("All out of cell time shall be recorded in the electronic Uniform Daily Activity Log (e-UDAL)."); CRDF Unit Order 5-23-090 ("All permitted out-of-cell activities shall be recorded in the electronic Uniform Daily Activity Log (e-UDAL).").

[30] Data obtained from e-UDAL entries and CCTV footage for June 10, 11, and 15, 2024.

can detrimentally impact the psychological and physiological wellbeing of people in custody and recommends that carceral institutions limit the use of isolation housing.[31]

Inconsistent amounts and schedule of out-of-cell time. The review also detailed that, on multiple dates, custody personnel allowed people out of their cell for varying amounts of time and on different shifts. For example, on June 12, custody personnel provided the lower tier of the module about three hours of out-of-cell time on the AM shift in comparison to approximately two hours of out-of-cell time for the upper tier on the PM shift. On June 21 everyone in the module was allowed out of their cell for the same amount of time but were allowed out on different shifts. People in custody have reported to Office of Inspector General staff that inconsistent out-of-cell access limits their ability to connect with people outside of custody via telephone, particularly school-aged children who can only be reached in the afternoon, and attorneys, who can often only be reached earlier in the day.

People in custody have also reported that inconsistent out-of-cell access and parity issues have contributed to perceptions of favoritism. On at least one date within the review period, June 10, custody personnel allowed one quarter of the module out of their cells at a time. Entries in e-UDAL and CCTV footage show that line staff split the lower tier into two groups and allowed them out of their cell separately for approximately an hour and half each on the morning shift. Contrary to an entry in e-UDAL, CCTV footage reveals staff did not allow any group from the upper tier out on the morning shift. On the afternoon shift, staff allowed the entire upper tier out for approximately three hours and 45 minutes. In sum, the review indicated that the Sheriff's Department allowed one quarter of the module out of their cells for nearly four hours, while they limited out-of-cell time for everyone else to approximately one and a half hours. These inconsistencies tended to average out somewhat over time – for example, over June 9 through June 15, out-of-cell time for people in the upper tier had about 16 to 16.5 hours out-of-cell time, and people in the lower tier had about 17.25 hours. Although there were significant inconsistencies on some days, and there did not seem to be any pattern that suggested CRDF staff followed a schedule or deliberately attempted to make up time lost on days with more time on following days, out-of-cell time for people in the module varied over the week by only about 6%. The difference in out-of-cell time between different people over time seems less problematic than the Department's failure on several days to provide the minimum out-of-cell time required by the unit order

Insufficient justification for restricting out-of-cell time. The review additionally showed that line personnel had broad discretion to restrict programming time without

[31] Kayla James & Elena Vanko, *Evidence Brief: The Impacts of Solitary Confinement*, Vera Institute (April 2021).

clearly articulating a security management concern. In one instance, staff cut short programming, noting, "10:35 Program upper tier start; 12:00 Upper tier program ended due to be[ing] loud and not listening to custody personnel when told multiple times to keep the peace[.]" This e-UDAL entry raises concerns about what actions and behaviors constitute legitimate security concerns that justify restricting out-of-cell access. The Office of Inspector General recommends that the Sheriff's Department prohibit custody personnel from limiting out-of-cell time for behaviors and actions that amount to minor disruptions and hold staff accountable for any violations. To do so, the Department must have clear standards governing line staff's ability to limit out-of-cell time. Decisions to lock down inmates must carry a significant and clear relationship to safety and security and, as the unit order requires, should be documented clearly and thoroughly in the e-UDAL. As the unit order affords staff broad discretion to lockdown people in custody for perceived or potential safety and security reasons, the order should more clearly require staff to document notifications about safety and security concerns to supervisors, including articulating safety concerns as opposed to unruly behavior that does not rise to the level of a safety concern, in the e-UDAL. CRDF leadership should regularly review out-of-cell time and hold floor sergeants accountable for failing to ensure all modules under their supervision meet the minimum requirements for out-of-cell time required under the unit order.

Inconsistent practices in documenting out-of-cell time. The Office of Inspector General's review further revealed inaccuracies and inconsistencies with out-of-cell time documentation. In most cases, CRDF personnel logged out-of-cell time under the "Activity Tracking" section of the e-UDAL, selecting a combination of activities such as "Indoor Rec," "Outdoor Rec," "Showers," and/or "Telephones." But some personnel logged out-of-cell time as a comment under the "Additional Information" section of the e-UDAL.[32] Neither CRDF's unit order nor Sheriff's Department policy clearly specifies where in e-UDAL out-of-cell time should be logged, creating confusion among custody personnel and resulting in inconsistent documentation.[33] The Office of Inspector General recommends that the Sheriff's Department clarify policies governing e-UDAL entries to ensure that staff log out-of-cell time consistently.

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[32] Custody personnel logged out-of-cell time under the "Activity Tracking" section of the e-UDAL on twelve of the days reviewed and logged out-of-cell time as a comment under the "Additional Information" section of the e-UDAL on the two other days.

[33] CRDF Unit Order 5-29-090 includes a note directing that "Each module officer shall document the time of day the cell lights were turned on and off under the "Additional Information" section in the e-UDAL." A similar note does not exist specifying where in the e-UDAL out-of-cell time should be documented.

Inaccurate documentation of out-of-cell time. The review also raised concerns about the integrity of the Sheriff's Department's data on out-of-cell time. CCTV footage revealed that on three days during the two-week period,[34] when custody personnel documented not providing some people in custody any out-of-cell time, the people in question were in fact allowed out of their cells, but custody personnel failed to log the activity in the e-UDAL.[35] Other entries in the e-UDAL significantly overstate the amount of time staff allowed people out of their cells. For instance, entries for June 21, 2024, indicate the upper tier was allowed out on the morning shift for 4 hours and 10 minutes, and the entire module was allowed out on the afternoon shift for 4 hours and 10 minutes. However, CCTV footage revealed that each tier was allowed out for approximately 4 hours and 10 minutes, respectively. The upper tier was only allowed out on the morning shift, while the lower tier was only allowed out on the afternoon shift.[36] Such inaccurate documentation of out-of-cell time, whether intentional or not, casts doubt on the reliability of Department data.

The Office of Inspector General reported these issues to CRDF leadership in writing and meetings.[37] After Office of Inspector General staff emailed CRDF leadership complaints from people in custody related to out-of-cell time, Office of Inspector General staff met with CRDF leadership to discuss possible solutions. CRDF leadership reiterated the expectation that all people in custody housed in general population modules be out of cell at the same time for as much time as possible unless there is an exception to the order. CRDF leadership explained that past attempts to address noncompliance with the Department's expectation and unit order related to out-of-cell time failed to produce sustained compliance.

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[34] e-UDAL entries for Module 3800 indicate the upper tier was not allowed any out-of-cell time on June 9, the lower tier was not allowed any out-of-cell time on June 11, and the lower tier was not allowed any out-of-cell time on June 17.

[35] For example, in Module 3800, on June 9, no staff documented out-of-cell time on the morning shift, but CCTV footage reveals that the upper tier was allowed out of their cells for approximately two and a half hours. Similarly, on June 11, e-UDAL entries reflect no documented out-of-cell time for the afternoon shift, but CCTV footage shows that staff allowed the lower tier out of their cells on the afternoon shift for approximately two and a half hours.

[36] e-UDAL entries misrepresent that on June 21, everyone in Module 3800 was allowed out-of-cell time together on the PM shift from 15:10 to 19:20. CCTV reveals the upper tier was allowed out for approximately 4 hours and 10 minutes (from 9:20 to 13:30) (AM shift) and lower tier was also allowed out for about 4 hours and 10 minutes (from 15:10 to 19:20) (PM shift).

[37] Office of Inspector General staff members emailed CRDF leadership on June 10, June 11, and July 9, 2024; reported issues to CRDF leadership in person on June 10, 2024; and met with CRDF leadership on June 25, 2024.

On July 23, 2024, CRDF leadership shared with Office of Inspector General staff an out-of-cell time directive that was sent to all CRDF personnel. The directive requires that module staff allow people in moderate-observation and general population housing to program one tier at a time on the morning and afternoon shifts, respectively, and that they be offered a minimum of three hours out of their cell on each shift for a total of six hours per day. Deviation from the schedule requires the approval of the on-duty watch commander and should be documented in the e-UDAL. Module personnel are also required to document programming refusals, significant information and unusual activity related to out-of-cell time and a range of other activities in the e-UDAL. The directive also calls for the early morning Title 15 Safety Check Sergeant to conduct daily audits of the e-UDAL to ensure documentation accuracy, and log findings. CRDF leadership report that the policies and procedures in the directive will remain in effect until further notice. The Office of Inspector General recognizes that, by significantly increasing requirements for out-of-cell time, documentation, and auditing, the new directive represents significant progress. CRDF leadership recognizes that its unit order must also be revised to reflect these changes. In revising the unit order, transparency and accountability will be key to achieving compliance with Sheriff's Department policy. The Department must avoid vague and permissive language in unit orders or policy revisions. Supervisorial staff must regularly monitor out-of-cell time through direct supervision and compliance audits to ensure both that staff accurately document out-of-cell time and that they consistently provide out-of-cell time according to policy. Where audits reveal inaccuracies in documentation, supervisors must address those inaccuracies with staff to ensure future compliance. To the extent this monitoring shows failure to adhere to policies or unit orders, the Department must hold staff accountable.

Pregnant People in Custody at Century Regional Detention Facility (CRDF)

Over the past several months, the Office of Inspector General has received complaints from pregnant people in custody and their loved ones regarding prenatal diets and access to bottled water, unstructured out-of-cell time for large muscle exercise, and issues with the use of restraints.

The care of incarcerated pregnant and post-partum people poses significant challenges. In addition to the issues faced by many justice-involved people — complex histories of trauma, poor nutrition, substance use, mental illness, chronic medical conditions, low socioeconomic status, and limited social support systems — the stressors of carceral

settings increase risks of miscarriage, premature birth, cesarean section, or complex birth for pregnant people in custody.[38]

CRDF is the main housing location for incarcerated females within Los Angeles County jail system. The Office of Inspector General monitors gender responsive and reproductive justice issues at CRDF, including access to care for pregnant and post-partum people, focusing on issues including the provision of bottled water and prenatal diets, access to unstructured out-of-cell time for large muscle exercise, labor and delivery, visitation with newborns, and release to community programs. The Office of Inspector General previously addressed this issue in a 2018 report, *Services and Programs Offered to Pregnant Prisoners and Mothers* and have revisited the issue in its quarterly report to the Board on reform and oversight for the first quarter of 2022.

From April 1 to June 30, 2024, the Sheriff's Department reported housing a total of 74 pregnant people in custody at CRDF in various modules throughout the facility based on classification status. Office of Inspector General staff interviewed 32 pregnant people in custody during this timeframe.[39]

Bottled Water and Prenatal Diets

Prior to 2018, the Sheriff's Department did not provide bottled water to pregnant people in custody and required them to purchase it themselves or drink from facility water fountains and sinks in their cells. While the Office of Inspector General was preparing its 2018 report, the Sheriff's Department began providing four 16.9 oz. bottles of water per day with prenatal diets. In November 2021, the Office of Inspector General and the Sybil Brand Commission notified CRDF leadership that several pregnant people in custody complained that bottled water was missing from their meals and that the four bottles provided were often insufficient. In response, CRDF began providing each pregnant person with six bottles of water per day (two bottles distributed at each meal), enough to meet the recommended daily water intake for pregnant people.[40]

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[38] Susan Hatters Friedman, Aimee Kaempf, and Sarah Kauffman, *The Realities of Pregnancy and Mothering While Incarcerated,* J. Am. Acad. Pysch. & L. Online (May 2020).

[39] Of the 74 pregnant people identified by Correctional Health Services, 35 were released prior to Office of Inspector General staff outreach and the remaining 7 refused to be interviewed, had false positive pregnancy tests, or had early term miscarriages. The Office of Inspector General does not have the information regarding how many of the 74 persons identified as pregnant upon intake at IRC continue with the pregnancy. All 74 are classified as pregnant in this report consistent with the Sheriff's Department assigned that classification.

[40] American College of Obstetricians and Gynecologists *Nutrition During Pregnancy FAQ* (June 2023).

All pregnant persons interviewed by Office of Inspector General staff reported receiving their appropriate prenatal diet and six bottles of water per day. Some of the pregnant people interviewed reported that they received extra bottles of water if they requested them, while others reported that Department staff expressed reluctance in providing extra bottles of water absent written directives. CRDF leadership reports that they are in the process of revising unit orders to ensure that all pregnant people receive extra bottles of water upon request. CRDF leadership additionally reported to the Office of Inspector General on May 29, 2024, that the Sheriff's Department had purchased and received point-of-use water filters that were pending installation in all CRDF living modules. At the time of this report, only two living modules have had the filters installed.

Unstructured Out-of-cell Time for Large Muscle Exercise

In pregnancy, physical inactivity and excessive weight gain are recognized as independent risk factors for maternal obesity, gestational diabetes, and other complications.[41] The U.S. Department of Health and Human Services recommends at least 150 minutes of moderate intensity aerobic activity per week during pregnancy and the postpartum period.[42]

As discussed in the previous section, California regulations require that county jail facilities allow people in custody a minimum of 10 hours of out-of-cell time each week for exercise.[43] In addition, CRDF offers pregnant people an additional 45 minutes for large muscle exercise through dedicated timeslots to walk in the day room or the recreation room within their housing module.[44] Although the Sheriff's Department reports offering opportunities for this additional large muscle exercise once daily on alternating AM/PM shifts (*e.g.*, Monday 7 a.m., Tuesday, 7 p.m., Wednesday 7 a.m., etc.), several pregnant people reported having to choose between sleep or large muscle exercise in the morning, as the program was conducted as early as 7:00 a.m. and often

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[41] Committee on Obstetric Practice, American College of Obstetricians and Gynecologists, Committee Opinion No. 804: *Physical Activity and Exercise During Pregnancy and Postpartum Period* (Apr. 2020).

[42] U.S. Department of Health and Human Services. *Physical Activity Guidelines for Americans,* 2nd ed. (2018), at p.80.

[43] Cal. Code Regs., tit. 15, § 1065 (2024). Under Title 15, "out-of-cell time" means "time spent outside of the sleeping area, where an individual has the opportunity to exercise or participate in recreation." "Recreation" means "the individual's ability to choose from activities that occupy the attention and offer the opportunity for relaxation and may include reading, games, socialization, entertainment, education, and programs." "Exercise" means "the opportunity for physical exertion." *Id.* § 1006.

[44] CRDF Unit Order 5-23-090 *Inmate Out-of-Cell Time*.

prior to breakfast.[45] The Sheriff's Department reported when pregnant people refused to participate in large muscle exercise in the morning, they have to wait until the following evening to be offered large muscle exercise again, exceeding 24 hours from the initial offering. Pregnant people housed in discipline reported to the Office of Inspector General that they often were unable to participate in large muscle exercise altogether.

The Office of Inspector General analyzed entries made in e-UDAL to determine whether Sheriff's Department staff appropriately documented opportunities for large muscle exercise. The analysis showed inconsistencies in documentation during this reporting period. Only 66% of the modules that housed pregnant people documented offering large muscle exercise. Several pregnant persons reported that although they may have refused the morning large muscle exercise, some staff would allow them to walk later in the same day. However, staff did not document these accommodations.

The Office of Inspector General recommends that the Sheriff's Department offer pregnant people the opportunity to participate in large muscle exercise after breakfast is served on the AM shift or offer opportunities twice daily to ensure that pregnant persons receive the opportunity to meet their exercise needs. In addition, the Department should take steps to ensure they offer pregnant people housed in discipline or restrictive housing modules the opportunity for large muscle exercise. The Office of Inspector General also recommends that CRDF leadership audit e-UDAL entries to ensure that module staff accurately document the large muscle exercise provided to pregnant people in custody.

Release of pregnant persons from custody

The Office of Inspector General previously reported on efforts by the Sheriff's Department and the Department of Health Services Correctional Health Services (CHS) to limit the number of pregnant people confined in its facilities by supporting diversion to community-based services.[46] The Department cites several reasons related to the criminal charges or procedural status of each person's criminal case that preclude pregnant people from release. The Department also cites barriers to timely placement and release outside of its control, such as rigid placement criteria for many community-based organizations. The Department reports that from April 1 through June 30, 2024,

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[45] Proper sleep also promotes mental and physical health, and women often face greater difficulty sleeping during pregnancy. *See* *What You Should Know About Sleep* and *Insomnia*, U.S. Department of Health and Human Services, Office of Women's Health.

[46] Los Angeles County Office of Inspector General, *Reform and Oversight Efforts – Los Angeles County Sheriff's Department – October to December 2021.*

35 pregnant persons were released. Of those persons released, approximately 40% were diverted from custody through the Office of Diversion and Re-entry or other community-based rehabilitative programs; approximately 55% were released by courts on bond or following full adjudication of their criminal cases, and; approximately 5% were transferred to other jurisdictions.

Labor and Delivery

The Office of Inspector General interviewed three people housed at CRDF who delivered their babies at the hospital and remained in custody postpartum. All three reported that the Sheriff's Department provided them with time to bond with their newborn babies before returning to jail. The Sheriff's Department recognizes parent and child bonding during the initial hour following birth, commonly referred as "The Golden Hour."[47] During this time, the person in custody is able to engage in skin-to-skin contact with the newborn infant, which increases emotional bonding between mother, baby and loved ones present for the birth. By providing this dedicated time, newborn babies are provided the opportunity to benefit from the initial contact with their mother. Additionally, CHS policy states that, upon return to CRDF, all post-partum people are screened to ensure that they are provided mental health services as appropriate, to assist with the separation from their child.

During this reporting period, one person in custody experienced a miscarriage and subsequent stillbirth delivery at Los Angeles General Medical Center (LAGMC). Although the person experienced the miscarriage while at CRDF, she opted to have a delayed stillbirth delivery so that she could make necessary funeral arrangements for her infant. The Office of Inspector General reviewed patient care in response to the event and noted CHS provided adequate trauma-informed support services including chaplain and mental health services, both while the individual was notified of the miscarriage and again upon her subsequent return to LAGMC for delivery of her stillborn infant. The person reported to Office of Inspector General staff that she experienced significant emotional duress while undergoing medical treatment, and that she did not perceive Sheriff's Department staff to be "compassionate." The Sheriff's Department reported that, due to patient confidentiality concerns, non-medical staff would not be aware of the pregnancy complications that people in custody experience. The Office of Inspector General recognizes the importance of patient confidentiality for people in custody. But CHS and the Sheriff's Department should take steps to ensure that confidentiality does not pose a barrier to pregnant people (or other people with

[47] Neczypor J.L., Holley S.L., *Providing Evidence-Based Care During the Golden Hour* (Dec. 2017) 21 Nursing for Women's Health, vol. 6, pp. 462-472.

medical needs) receiving appropriate care and support. The Office of Inspector General recommends that deputies working directly with pregnant people in custody receive proper training on trauma-informed practices to best supervise the pregnant and post-partum population, as they pose higher risks for behavioral concerns stemming from emotional trauma related to their pregnancy. Both the Department and CHS should inform pregnant people that deputies will not know about even the most significant medical facts related to their pregnancy unless the person informs them directly or provides written consent to CHS to release information.

In-Custody Deaths

Between April 1 and June 30, 2024, eight 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 six deaths: five deaths were natural, and one death was accidental. For the remaining two deaths, the DME findings remain deferred.[48] Three people died at Twin Towers Correctional Facility (TTCF), one died at North County Correctional Center (NCCF), one died at Century Regional Detention Facility (CRDF), one died at Lancaster Station Jail, and two died at hospitals where they had been transported from the jails. The Sheriff's Department posts the information regarding in-custody deaths on a dedicated page on Inmate In-Custody Deaths on its website.[49]

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

Two people of the people who died this quarter were housed in CRDF pod 1400 immediately prior to their deaths. CRDF 1400 is an intake pod for individuals who

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[48] 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 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 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 (CHS) 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 parentheses.

[49] 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.

require further medical or mental health evaluation before they are assigned to permanent housing — including people undergoing drug and alcohol detox, the sudden cessation of drugs or alcohol that can lead to withdrawal in a habitual user. In the past two years, four people in custody have been housed in this module immediately prior to their deaths. In contrast, no one has died in the drug and alcohol detox pod at IRC. The Office of Inspector General recommends that the Sheriff's Department review the four deaths and protocols in the module in order to identify any changes, additional safeguards or other corrective action needed to ensure that the health and safety of people housed in CRDF 1400.

Date of Death: April 5, 2024
Custodial Status: Sentenced.[50]
Custody personnel at TTCF Correctional Treatment Center (CTC) found an unresponsive person on the floor of their cell. CHS staff and paramedics rendered emergency aid and CHS staff administered three doses of Narcan. The person died at the scene. Preliminary manner of death: Natural. The DME website currently reflects the manner of death as natural, and the cause of death as ischemic heart disease.

Date of Death: April 9, 2024
Custodial Status: Pre-trial.
Custody personnel conducting Title 15 safety checks at TTCF found an unresponsive person on the floor of his cell. Sheriff's Department staff, CHS staff, and paramedics rendered emergency aid, including administering three doses of Narcan. The person died at the scene. A review of the person's incarceration records revealed that he was transported to TTCF from a dorm in MCJ two days before he died. Closed Circuit Television (CCTV) from the dorm at MCJ showed that, immediately before the person was transported to TTCF, he was on the floor of the dorm in different positions, seemingly unable to rise, for approximately 22 hours. The video additionally showed that during hourly Title 15 safety checks people in custody appeared to wave their arms to get assistance from the staff member conducting the check, who walked to the individual and appeared to speak to him briefly before leaving. Staff did not transport the person to TTCF for a higher level of care until after he had defecated on himself. Areas of concern include the quality of Title 15 safety checks at MCJ, the quality of Title 15 safety checks at TTCF, custody personnel's emergency response, and CHS staff's

[50] For purposes of custodial status, "Pre-trial" indicates that the person is in custody awaiting arraignment, hearing, or trial. "Convicted, Pre-sentencing" indicates that the person is being held in custody based on a conviction, pending sentencing, on at least some charges, even if they are in pre-trial proceedings on other charges. "Sentenced" indicates that the person is being held on the basis of a sentence on at least some charges, even if they are in pre-trial proceedings on other charges.

medical and mental health intake assessments. Preliminary manner of death: Natural. The DME website reflects that the manner of death was natural, and the cause of death is pulmonary embolism and phlebothrombosis.[51]

Date of Death: April 10, 2024
Custodial Status: Pre-trial.
Custody personnel conducting Title 15 safety checks at NCCF found an unresponsive person on their bunk. Sheriff's Department staff, CHS personnel, and paramedics rendered emergency aid, including administering three doses of Narcan. The person died at the scene. Areas of concern include custody personnel's emergency response and the failure to renew prescription medication.[52] Preliminary manner of death: Accident (Overdose). The DME website reflects the manner of death was accidental, and the cause of death is due to combined effects of methamphetamine and heroin.

Date of Death: April 26, 2024
Custodial Status: Pre-trial.
During a routine detox assessment at CRDF, nursing staff found an individual unresponsive in her cell. Sheriff's Department staff, CHS staff, and paramedics rendered emergency aid, including administering three doses of Narcan. The person died at the scene. Areas of concern include the quality of the detox assessment, why the individual was housed in a cell rather than in the dayroom as required under detox housing protocol, custody personnel's emergency response, and the quality of Title 15 safety checks. Preliminary cause of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: May 14, 2024
Custodial Status: Pre-trial.
Three days after being booked into custody at CRDF and being placed into the detox

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[51] In response to a draft of this report, the Sheriff's Department provided the following response regarding this in-custody death: "Custody Services Division conducted an inquiry into both the frequency and quality of the safety checks. The results of the inquiry revealed the Title 15 checks were in compliance, with the exception of one late check. There was no concern for the quality of the checks. Title 15 personnel did check on and speak to the inmate on several occasions before he was transferred to Twin Towers Correctional Facility (TTCF). Although it is true that he was on the floor for several hours, the inmate was sitting and lying down during different times. He never requested medical assistance or appeared to be in distress. After he defecated on himself, a Behavioral Observation and Mental Health Referral form was completed, and he was transferred to TTCF for a higher-level of care. Additionally, the Department, thus far, has found no indication that other people in custody attempted to summon help for the decedent and were ignored."

[52] While the expired medication was not reported as a contributing factor in the death, it should still be addressed in the Sheriff's Department's corrective action plan.

unit in module 1400, a person experienced a medical emergency and was transported to St. Francis Medical Center. She returned from the hospital to CRDF and was again placed in module 1400. Seven hours after her return, custody personnel at CRDF discovered her unresponsive on her bunk and notified nursing staff of a health emergency. Sheriff's Department staff, CHS staff, and paramedics rendered emergency aid, including administering three doses of Narcan. Paramedics transported the person back to St. Francis Medical Center, where she was pronounced dead the next day. Areas of concern include an inquiry regarding the provider's plan of care and the quality of the Title 15 Safety Checks. Preliminary cause of death was unknown. The DME website reflects the manner of death as natural, and the cause of death was anoxic encephalopathy and cardiopulmonary arrest.

Date of Death: May 30, 2024
Custodial Status: Pre-trial.
On May 28, 2024, a person in custody with a pre-existing medical condition was transported from CTC to Los Angeles General Medical Center (LAGMC) for medical evaluation. On May 30, 2024, the hospital staff transitioned the person to comfort care, and he was pronounced dead. Preliminary cause of death: Natural. The DME website currently reflects the manner as natural and the cause of death as multiple organ failure and metastatic stomach cancer.

Date of Death: June 5, 2024
Custodial Status: Pending probation violation hearing.
Custody personnel conducting Title 15 safety checks at Lancaster Station Jail found an unresponsive person in his cell. Custody personnel and paramedics rendered emergency aid, including custody personnel administering two doses of Narcan. The person died at the scene. Areas of concern include custody personnel's emergency response. Preliminary cause of death: Unknown. The DME website does not currently reflect the manner of death, and the cause of death is deferred.

Date of Death: June 20, 2024
Custodial Status: Pre-trial.
Custody personnel conducting Title 15 safety checks at TTCF found a person in medical distress on the floor of his cell. Sheriff's Department staff, CHS staff, and paramedics rendered emergency aid, including administering five doses of Narcan. The person died at the scene. Areas of concern include the quality of Title 15 safety checks and custody personnel's emergency response. Preliminary manner of death: Natural. The DME website currently reflects the manner of death as natural, and the cause of death is pulmonary embolism.

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 Office of Inspector General," 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 deaths.

Of the eight people who died in the care and custody of the Sheriff's Department between April 1 and June 30, 2024, the medical examiner's final reports, including toxicology assessments, confirm that one person died due to an overdose. Toxicology results remain pending for two of the eight deaths and may indicate additional overdose deaths once completed.

Tracking Narcotics Intervention Efforts

The Board's motion directed that the Sheriff's Department "[c]ollect and track data outlining narcotics recovery in county jail facilities to evaluate the efficacy of drug detection interventions." To increase drug detection efforts, the Department must analyze data on how often it performs different interventions and when the use of the intervention resulted in the detection and seizure of narcotics. Data would allow the Department to properly evaluate what interventions are most effective at detecting narcotics, and target drug detection efforts accordingly. The Department reports that it does not presently track narcotics detection in a format that allows data to be analyzed.

According to the Sheriff's Department, custody personnel enter all narcotic seizures into the Los Angeles Regional Crime Information System (LARCIS), a database generally used to track narcotics seizures for criminal prosecution. Although LARCIS contains records of narcotics seized in the jails, LARCIS does not track the scope or duration of drug detection efforts, which would be necessary to evaluate the effectiveness of drug detection methods. Moreover, the only place Sheriff's Department personnel can enter the drug detection intervention used to discover the narcotic into LARCIS is in the narrative, so that the Department cannot search LARCIS for seizures by detection intervention and would have to manually review each entry to compile data on narcotics seized by type of intervention. The Department reports that such a review would be so

labor-intensive as to be impractical and that it therefore cannot compile the data to analyze seizures by drug detection mechanism.

However, the Sheriff's Department tracks a majority of narcotics detection efforts in multiple Department databases, as set forth in the table below. The Department reports that, because efforts are tracked in separate databases, it cannot compile data into a single dataset for analysis. Additionally, as the Office of Inspector General reported last quarter, the Sheriff's Department does not require that staff report all narcotics intervention efforts and, even when information is tracked, the Department does not impose specific requirements on data tracking, resulting in inconsistent and unreliable data on narcotics detection efforts.

Narcotics Detection Mechanism	Department Database Where Data is Tracked
Body Scanner	Electronic Line Operations Tracking System (e-LOTS)
Contraband Watch	e-LOTS
Mail Searches	Not tracked
Dorm Searches	e-LOTS, Watch Commander Log
Cell Searches	Custody Automated Reporting and Tracking System (CARTS)
K9 Assisted Searches	K9 Log, Watch Commander Log
Staff Searches	Individual Facility Staff Search Logs, Watch Commander Log
Visiting	e-LOTS, Watch Commander Log
Off-Grounds Recovery (i.e., hospital, inmate worker outside maintenance, etc.)	Not tracked

The Sheriff's Department takes the position that constructing an all-encompassing jail management data system would best support the Department's efforts to track narcotics recovery and evaluate the efficacy of drug detection interventions. The Office of Inspector General has previously recommended that the Department examine ways to comply with the Board's directive by improving reporting requirements for staff and compiling data on detection interventions and seizures using existing technologies. The

Department reports that it currently 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 LARCIS to evaluate the efficacy of drug detection intervention.

Improving Searches of Staff and Civilians

The Board's second directive required 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 Department previously reported its current policy grants the Department broad authority to search staff and civilians entering the jails, so that no changes to existing Department policy are required to implement more comprehensive searches. The Department previously reported that it planned to implement more frequent unannounced and randomized staff searches beginning in May 2024.[53]

All jail facilities reported conducting unannounced searches during the previous quarter, beginning in May as planned, though the comprehensiveness of the searches varied across facilities. Prior to May 2024, the K9 handling team sent a briefing to jail leadership stating that they would be available upon request to assist facilities in conducting searches, and almost all facilities reported utilizing K9 units to supplement their search efforts in the second quarter. All 13 K9s are trained to detect narcotics (including fentanyl) and alcohol. Two K9s are cross trained to detect electronics and cellular phones. Each time the Department deployed K9 units to assist facility staff and civilian searches, the K9 searched Department staff, civilians, and property entering the facility.

Office of the Inspector General staff met with each facility's leadership to inquire about each facility's search efforts from April 1 through June 30, 2024, and detail what each reported about their efforts and challenges below.

[53] This report uses the term "staff search" to mean the search of all staff and civilians entering the facility during a single shift change for Sheriff's Department personnel at a facility. Such search would entail searching Sheriff's Department personnel and CHS workers.

Facility	# Staff Searches	# Staff Searches with K9	Minimum Search Requirement	Search Conducted Inside Security	Search Evasion Concerns	Where Searches are Logged
MCJ	Not Tracked	7	Yes	No	Yes	Watch Commander Log
TTCF	Not Tracked	1	Yes	Yes	Yes	Watch Commander Log
IRC	Not Tracked	2	Yes	Yes	Yes	Watch Commander Log
CRDF	Not Tracked	1	Yes	No	Yes	Watch Commander Log
NCCF	15	5	Yes	Yes	No	Watch Commander Log
PDC-North	19	0	No	Yes	Yes	Watch Commander Log & Staff Search Log
PDC-South	28	4	Yes	Yes	No	Staff Search Log

Men's Central Jail

MCJ tracks staff searches in the facility Watch Commander Log. The log indicates that the facility completed a staff search but does not denote how long the search was in effect or how many people were searched. MCJ staff report that they cannot extract search information entered in the Watch Commander Log and so cannot provide data on how many staff searches have been conducted between April 1 and June 30, 2024. Custody Investigative Services tracks searches conducted with K9 assistance and reported that the K9 assisted with staff searches seven times at MCJ between April 1 and June 30, 2024. MCJ assigns sergeants to conduct staff searches on a randomized schedule. MCJ leadership attempts to conduct staff searches as frequently as possible but requires that at least one search be conducted one time per week for each of the three shifts.[54] MCJ conducted three staff searches with K9 assistance prior to the Sheriff's Department directive requiring that facilities begin staff searches in May 2024.

MCJ provides lockers outside security for staff to store items that are prohibited in jail facilities, such as cell phones and department-issued firearms. MCJ conducts staff

[54] Custody facilities, like many units across the Sheriff's Department, schedule staff to work in three shifts: a morning or "AM" shift, an afternoon to evening or "PM" shift, and a night to early morning or "EM" shift.

searches outside security, directly in front of the sole secured entrance to the jail. Because people in custody housed at MCJ regularly walk through the facility to engage in programming and receive medical care, it is difficult for MCJ to conduct searches inside security. Yet because staff can observe searches being conducted before they enter security, they may anticipate, evade, or alert others of a search. Any employees with contraband could observe the search prior to entering the facility and simply return to their cars to leave the contraband and then bring contraband into the facility another day or after the search ended.

MCJ staff searches consist of both enforcing the clear bag policy and observing items inside clear bags. Since commencing staff searches, MCJ has not seized any contraband.

Twin Towers Correctional Facility

TTCF tracks staff searches in the facility Watch Commander Log. The log indicates that the facility completed a staff search but does not denote how long the search was in effect or how many people were searched. TTCF staff report that they cannot extract search information from the Watch Commander Log and therefore cannot provide data on how many staff searches have been conducted between April 1 and June 30, 2024. Custody Investigative Services tracks searches conducted with a K9 and reported that the K9 assisted with staff searches one time at TTCF between April 1 and June 30, 2024. TTCF conducts searches on a randomized schedule but requires that at least one search be conducted one time per week during each of the three shifts. When introducing staff searches in May 2024, the TTCF facility captain conducted staff searches alongside the sergeants tasked with conducting staff searches.

TTCF provides lockers outside security for staff to store items that are prohibited in jail facilities. TTCF conducts staff searches inside security at staff check-in, but in an area visible from outside security. Because staff can see when searches are being conducted before they enter the facility, they may anticipate, evade, or alert others of a search.

TTCF staff searches consist of both enforcing the clear bag policy and observing items inside clear bags. Since commencing staff searches, TTCF has identified several CHS workers bringing cell phones into the facility, in violation of policy. TTCF reports that when staff are identified attempting to bring electronic devices in the facility, the facility informs CHS leadership and the staff member is instructed to contain the electronic device outside of security. The Sheriff's Department did not report that any additional action was taken as far as employee discipline.

Inmate Reception Center

IRC tracks staff searches in the facility Watch Commander Log. The log indicates that the facility completed a staff search but does not denote how long the search was in effect or how many people were searched. IRC staff report that they cannot extract search information from the Watch Commander Log and therefore cannot provide data on how many staff searches have been conducted between April 1 and June 30, 2024. Custody Investigative Services tracks searches conducted with a K9 and reported that the K9 assisted with staff searches two times at IRC between April 1 and June 30, 2024. Staff searches are conducted by sergeants. IRC conducts searches on a randomized schedule but requires that at least one search be conducted one time per week per shift.

IRC provides lockers outside security for staff to store items that are prohibited in jail facilities. IRC conducts staff searches inside security at staff check-in, but in an area that is observable from outside security. Because staff can observe when searches are being conducted, they may anticipate, evade, or alert others of a search. More concerning, IRC's porous layout poses a severe barrier to searches, as IRC is connected to both MCJ and TTCF and has three unstaffed exits. Thus, while staff subject to search at other facilities may be able to evade searches by exiting the facility through a secured entry, staff at IRC are able to evade searches by walking to MCJ or TTCF, exiting the facility through a secured entry, or exiting the facility through one of three unstaffed exits. IRC staff searches consist of both enforcing the clear bag policy and observing items inside clear bags. Since commencing staff searches, IRC has identified several CHS workers bringing cell phones into the facility, in violation of policy. IRC reports that, when staff are identified attempting to bring electronic devices in the facility, the staff member is instructed to contain the electronic device outside of security. The Sheriff's Department did not report that any additional action was taken as far as employee discipline.

Century Regional Detention Facility

CRDF tracks staff searches in the facility Watch Commander Log. The log indicates that the facility completed a staff search but does not denote how long the search was in effect or how many people were searched. CRDF staff report that they cannot extract search information from the Watch Commander Log and therefore cannot provide data on how many staff searches have been conducted between April 1 and June 30, 2024. Custody Investigative Services tracks searches conducted with a K9 and reported that the K9 assisted with staff searches one time at CRDF between April 1 and June 30, 2024. Staff searches are conducted by sergeants, and CRDF conducts searches on a randomized schedule but requires that at least one search be conducted one time per

week per shift. CRDF set up check points to enforce the clear bag policy prior to the Sheriff's Department directive requiring that facilities begin staff searches in May 2024.

CRDF provides lockers outside security for staff to store items that are prohibited in jail facilities. CRDF conducts staff searches outside security, and CRDF leadership uses whiteboards to notify staff of searches while they are happening. Because staff are provided notice of searches and able to observe when searches are being conducted, they may anticipate, evade, or alert others of a search. Prior to introducing staff searches, CRDF leadership distributed a briefing directing the sergeants conducting searches to not detain staff who attempt to evade searches.

CRDF staff searches consist of both enforcing the clear bag policy and observing items inside clear bags. Since commencing staff searches, CRDF has identified several CHS workers bringing cell phones into the facility, in violation of policy. CRDF reports that, when staff are identified attempting to bring electronic devices in the facility, a note is created in the facility Watch Commander log and the staff member is instructed to contain the electronic device outside of security. The Sheriff's Department did not report that any additional action was taken as far as employee discipline.

North County Correctional Facility

NCCF tracks staff searches in the facility Watch Commander Log. The log indicates that the facility completed a staff search but does not denote how long the search was in effect or how many people were searched. . However, NCCF is in the process of working with Sheriff's Department information technology staff to develop a mechanism to track staff searches and was therefore able to report that the facility has conducted 30 staff searches between April 1 and June 30, 2024. Custody Investigative Services tracks searches conducted with a K9 and reported that the K9 assisted with staff searches four times at NCCF between April 1 and June 30, 2024. Staff searches are conducted by sergeants. NCCF conducts searches on a randomized schedule but requires that at least one search be conducted one time per week per shift.

NCCF provides lockers outside security for staff to store items that are prohibited in jail facilities. NCCF staff conducts staff searches inside security at the sole staff check-in station. Because the searches are not observable from outside security, staff cannot anticipate, evade, or alert others of a search.

NCCF staff searches consist of both enforcing the clear bag policy and observing items inside clear bags. When NCCF searching sergeants detect staff attempting to bring non-transparent bags through the facility, searching sergeants provide clear trash bags for staff to transport their belongings. NCCF reports that it has not detected contraband as a result of the searches.

Pitchess Detention Center North

Between April 1, 2024, and June 30, 2024, PDC North conducted 19 staff searches and zero staff searches with K9 assistance. Sergeants are responsible for conducting the searches, but, unlike all other facilities, PDC North does not have a schedule determining when searches should occur. Despite receiving communications from Sheriff's Department executives requiring that each facility begin conducting comprehensive staff searches in May 2024, PDC North did not complete a search until June 11, 2024, the day before Office of Inspector General staff met with PDC North leadership about staff searches.

PDC North leadership reported that their facility layout presents challenges to conducting searches. Specifically, the facility's administrative building located within security where staff can use lockers to store items generally prohibited in jail facilities, such as cell phones and department-issued firearms. Staff work modules are located across from the administrative building. Due to this design, facility leadership determined that staff searches must be conducted in open areas outside of each module so that staff were able to secure their belongings in the administrative building. The facility lacks a hard boundary between secured and unsecured areas, so that staff can anticipate and evade searches.

PDC North reported that the search consisted of enforcing clear bag policies. PDC North leadership stated that the sergeants tasked with conducting searches did not inspect or remove items inside bags because PDC leadership could not locate a table. PDC North leadership has since procured tables to allow sergeants to more thoroughly search staff property entering the jail. During the meeting with Office of Inspector General staff, PDC staff incorrectly reported that they did not have authority to search CHS workers entering the facility. Approximately five weeks after meeting with Office of Inspector General staff, PDC North reported that CHS staff were subject to search.

PDC North leadership reported that they had not detected any contraband as a result of the search. Searches conducted at PDC North are logged both in the facility Watch Commander log and in a Staff Search log.

PDC North leadership articulated resistance to deploying staff searches, stating that they were concerned that the searches may make staff "feel like criminals."

Pitchess Detention Center South

Between April 1 and June 30, 2024, PDC South conducted 28 staff searches and 4 staff searches with K9 assistance. Staff searches are conducted by sergeants. PDC South conducts searches on a randomized schedule but requires that at least one search be conducted one time per week per shift. PDC South leadership reported that the facility

consistently conducted searches prior to the Sheriff's Department directive requiring that facilities begin staff searches in May 2024.

PDC South provides lockers outside security for staff to store items that are prohibited in jail facilities. PDC South adjusted the location of its check-in point so that staff would already be inside security when searched, which prevents staff from anticipating, evading, or alerting others of a search. PDC South leadership stated that it has issued progressive discipline consistently and without exception for staff who bring prohibited items (specifically cell phones) through security. PDC South leadership reported that progressive discipline has effectively deterred staff bringing prohibited items into the jail, as PDC South has not seized any contraband since they began tracking searches in 2024.

PDC South also reported implementing strategies to improve staff transparency and morale. For example, PDC South provided additional refrigerators and microwaves to deter staff from bringing coolers and large lunch containers which can obstruct visual bag searches. In addition to enforcing clear bag policies, sergeants use a ruler to dig through and inspect items inside clear bags. PDC South has relied on the support of K9 units and require that the K9s sniff staff and property entering the facility. However, PDC South leadership stated that it would not allow K9s to search staff meals due to sanitation concerns about K9s sniffing food. While there may be some basis for these concerns, the exception for food creates an obvious vulnerability that staff could easily exploit: in 2010, a Sheriff's Department deputy attempted to smuggle heroin concealed in a burrito into a jail.[55] Searches conducted at PDC South are logged both in the facility Watch Commander log and in a customized Staff Search log.

Office of Inspector General Findings

Sheriff's Department leadership has reported that technological assistance, including the purchase and deployment of body scanners and X-ray machines, would supplement the Department's efforts to detect staff bringing contraband into the jails. Several facility leaders reported that, because staff searches presently occur during shift change, staff may still leave the facility during their shift and bring contraband into the facility when searches are not being conducted. Thus, these facility leaders recommended that the Sheriff's Department employ a fulltime security officer to search staff at each facility entrance/exit.

[55] Robert Faturechi and Jack Leonard, *Heroin in a burrito allegedly smuggled by L.A. County deputy into courthouse jail*, Los Angeles Times (Jan. 12, 2012).

Despite the Sheriff's Department's limited resources, all facilities should at least follow the efforts made by PDC South's leadership in conducting staff searches. Specifically, the Office of Inspector General recommends that each jail conducts searches at a single checkpoint inside security that entering staff cannot observe from outside security, that jail leadership issues progressive discipline to staff who bring contraband into the jails, and that each facility develop and use a staff search tracker to record data on the number of staff searches conducted and contraband detected as a result of the search, since the Department reports it cannot extract data for analysis from Watch Commander logs.

Status of Progress on Recommendations and Board Directives

The Office of Inspector General collaborated on a report with the Chief Executive Office, Chief Executive Office's report Enhancing Illegal Drug Detection in the Jails and Courts. As mentioned in the CEO's report, the Office of Inspector General's top priority to prevent overdose deaths is to reduce the jail population to a manageable level that allows for adequate care and supervision of inmates. While the population is lower than it has been historically, facility conditions and staff levels are insufficient to provide the type of care needed to prevent most or all overdose deaths.

The Office of the Inspector General previously reported on the status of the proposals made by the Sheriff's Department and referenced in both the CEO's report and the Board's motion. There has been no change in the status of any of those proposals.

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 second quarter of 2024, Office of Inspector General personnel completed 197 site visits, totaling 446 monitoring hours, at CRDF, IRC, LACMC, MCJ, Pitchess Detention Center (PDC) North, PDC South, PDC East, NCCF, TTCF and station jails located in Palmdale, Lancaster, and East Los Angeles.[56]

As part of the Office of Inspector General's jail monitoring, Office of Inspector General staff attended 171 Custody Services Division (CSD) executive and administrative meetings and met with division executives for 247 monitoring hours related to uses of force, in-custody deaths, COVID-19 policies and protocols, Prison Rape Elimination Act (PREA) audits, and general conditions of confinement.

[56] These figures include site visits and meetings related to monitoring for compliance with the Prison Rape Elimination Act ("PREA").

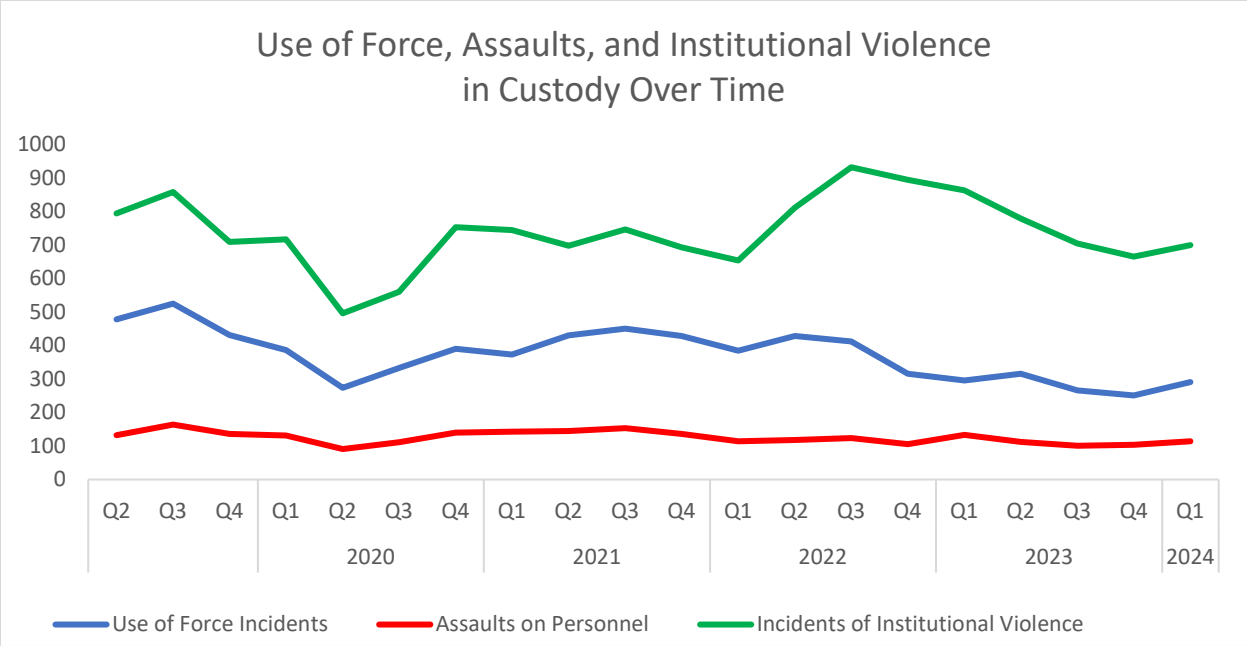
Use-of-Force Incidents in Custody

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 by people in custody.[57] The Sheriff's Department reports the following numbers for the uses of force and assaultive conduct for people in its custody.[58]

		Use of Force Incidents	Assaults on Personnel	Incidents of Institutional Violence
2019	2nd Quarter	478	132	794
	3rd Quarter	525	164	858
	4th Quarter	431	136	709
2020	1st Quarter	386	131	717
	2nd Quarter	274	91	496
	3rd Quarter	333	111	560
	4th Quarter	390	140	753
2021	1st Quarter	373	143	745
	2nd Quarter	430	145	698
	3rd Quarter	450	153	746
	4th Quarter	428	136	693
2022	1st Quarter	384	114	654
	2nd Quarter	428	118	811
	3rd Quarter	412	124	932
	4th Quarter	316	106	894
2023	1st Quarter	296	133	863
	2nd Quarter	316	112	779
	3rd Quarter	266	101	704
	4th Quarter	251	104	665
2024	1st Quarter	291	114	700

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

[58] The reports go through the quarter of 2024 because the Sheriff's Department has not yet verified the accuracy of reports for the second quarter of 2024. The Department in early 2024 noted corrected information for assaults on personnel and incidents of institutional violence for the first quarter of 2022, which is reflected here and which differs from uncorrected information reported in quarterly reports for 2022 and 2023.



HANDLING OF GRIEVANCES AND COMMENTS

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

The Office of Inspector General received 390 new complaints in the second quarter of 2024 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 these grievances, 365 related to conditions of confinement within the Department's custody facilities, as shown in the chart below:

Grievances/Incident Classification	Totals
Medical	173
Personnel Issues	39
Classification	31
Living Condition	25
Food	21
Transportation	17
Property	9
Mail	7

Bedding	6
Education	6
Showers	5
Telephones	4
Visiting	4
Commissary	1
Other	17
Total	**365**

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

Complaint/Incident Classification	Totals
Personnel	
Improper Detention	4
Improper Tactics	3
Harassment	3
Off Duty Conduct	3
Criminal Conduct	2
Dishonesty	2
Discourtesy	1
Neglect of Duty	1
Force	1
Service	
Policy Procedures	1
Response Time	1
Other	**3**
Total	**25**

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 83 iPads installed in jail facilities: 46 at TTCF; 12 at MCJ; and 25 at CRDF. During the second quarter there were 6 new installations and iPad replacements. The Department had 68 iPads reconnected during this period.

The Sheriff's Department continues to experience malfunctioning iPads and have identified power source problems as the major cause. To rectify this issue, the

Department reports that Facility Services Bureau is currently working to install dedicated data drops and power supply for the iPads. The Department also reports that outdated equipment also contributes to the problem. Custody Support Services Bureau – Correctional Innovative Technology Unit (CITU) recently acquired two new MacBooks to use to reconfigure and program the iPads. The new MacBooks are currently being prepared and programmed by Data Systems Bureau. With the MacBooks, the Department reports CITU can update applications for outdated iPads. The Department states that CITU is also monitoring the Wi-Fi connectivity issues and exploring alternative solutions to assist with strengthening the Wi-Fi signal.

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 April 1 and June 30, 2024, no one in custody had been placed on restrictive filing and it therefore did not reject any grievances under this policy.

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

[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, MPP, § 3-04/010.00, *Department Service Reviews*.

- 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]

The following chart lists the number and types of comments reported for each station or unit.[62]

INVESTIGATING BUREAU/STATION/FACILITY	COMMENDATIONS	PERSONNEL COMPLAINTS	SERVICE COMPLAINTS
ADM : CENTRAL PATROL ADM HQ	0	1	0
ADM : DETECTIVE DIV HQ	1	0	0
ADM : PROF STANDARDS ADM HQ	1	0	0
AER : AERO BUREAU	1	1	0
ALD : ALTADENA STN	1	1	0
CCS : COMMUNITY COLLEGE BUREAU	3	0	0
CEN : CENTURY STN	4	2	1
CER : CERRITOS STN	2	1	0
CMB : CIVIL MANAGEMENT BUREAU	5	4	3
CNT : COURT SERVICES CENTRAL	2	1	2
COM : COMPTON STN	1	8	3
CRD : CENTURY REG DETEN FAC	1	1	0
CRV : CRESCENTA VALLEY STN	10	4	0
CSB : COUNTY SERVICES BUREAU	4	4	1
CSN : CARSON STN	13	6	3
DSB : DATA SYSTEMS BUREAU	1	0	0
ELA : EAST LA STN	6	2	0
EOB : EMERGENCY OPER BUREAU	2	0	0
EST : COURT SERVICES EAST	0	1	0
FCC : FRAUD & CYBER CRIMES BUREAU	2	0	0
HDQ : SPECIAL OPERATIONS DIV HQ	1	0	0
IND : INDUSTRY STN	2	4	0
IRC : INMATE RECEPTION CENTER	1	0	0

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

[62] The chart reflects data from the Sheriff's Department Performance Recording and Monitoring System current as of July 1, 2024.

ISB : INMATE SERVICES BUREAU	0	1	1
LCS : LANCASTER STN	5	21	3
LKD : LAKEWOOD STN	8	8	5
LMT : LOMITA STN	4	1	0
MAR : MARINA DEL REY STN	6	2	1
MCB : MAJOR CRIMES BUREAU	2	1	1
MCJ : MEN'S CENTRAL JAIL	2	2	1
MLH : MALIBU/LOST HILLS STN	10	8	2
NCF : NORTH CO. CORRECTL FAC	0	2	0
NO : PITCHESS NORTH FACILITY	0	1	1
NWK : NORWALK REGIONAL STN	5	5	0
OCP : OFFICE OF CONSTITUTIONAL POLICING HQ	0	1	0
OSS : OPERATION SAFE STREETS BUREAU	1	1	0
PAD : PARKS & COUNTY SRVS ADM HQ	0	1	0
PER : PERSONNEL ADMIN	0	1	0
PKB : PARKS BUREAU	1	1	0
PLM : PALMDALE STN	7	23	8
PRV : PICO RIVERA STN	1	0	1
RMB : RISK MANAGEMENT BUREAU	0	2	0
SCV : SANTA CLARITA VALLEY STN	11	7	1
SDM : SAN DIMAS STN	9	1	0
SLA : SOUTH LOS ANGELES STATION	0	5	1
SSB : SCIENTIFIC SERV BUREAU	1	0	0
SVB : SPECIAL VICTIMS BUREAU	1	0	0
TB : TRAINING BUREAU	1	0	0
TEM : TEMPLE CITY STN	4	0	1
TSB : TRANSIT SERVICES BUREAU	3	3	3
TT : TWIN TOWERS	0	1	0
WAL : WALNUT/SAN DIMAS STN	1	1	1
WHD : WEST HOLLYWOOD STN	11	14	0
WST : COURT SERVICES WEST	1	7	0
Total :	159	162	44