



Santa Clara County Office of Correction
and Law Enforcement Monitoring

Annual Report: 2025

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Introduction

2025 marked a new level of progress for the Office of Correction and Law Enforcement Monitoring (OCLEM) in fulfilling its original mandate in Santa Clara County. Increased access and regular, meaningful communication with Sheriff's Office officials have introduced independent oversight to the daily functions of the County's law enforcement and custody operations in unprecedented ways. This has allowed us to build on the paradigm shift that followed Sheriff Jonsen's election, which involved not only the signing of a comprehensive information-sharing agreement but also an approach of cooperative engagement from the Sheriff's Office, rather than the grudging and limited compliance of our early years under the prior Sheriff.

The Sheriff's Office's heightened transparency – and OCLEM's increased opportunity to ask questions and offer insights – was apparent in the immediate aftermath of two tragic incidents in 2025. In January, an individual incarcerated at the County's Elmwood Facility was brutally murdered by other incarcerated persons. And in October, Sheriff's Office deputies were involved in a shooting incident during which a man who advanced on them with a knife was fatally wounded. Following both incidents, Sheriff's Office personnel promptly notified OCLEM and provided detailed briefings. We were subsequently included in critical incident review meetings during which our questions and comments were welcome.

The Sheriff's Office's willingness to maintain its commitments, and to be responsive to OCLEM input, seems particularly noteworthy in the face of extreme events like these. At the same time, much of OCLEM's impact is now occurring through our established participation in regular Sheriff's Office review processes. The challenge now has less to do with creating a presence and more with remaining adaptable as the Sheriff's Office continues to evolve.

OCLEM's regular participation at Major Incident Review, Internal Affairs Review, In-Custody Death Review, and Use of Force Review Committee

meetings, our access to confidential investigative reports and internal documents, and our ability to weigh in on important changes to the Sheriff's Office's policies and processes is consistent with the Board's vision of an independent entity that has the access and the voice to make a meaningful impact on the County's public safety reform efforts.

As we have become more deeply involved in these various aspects of Sheriff's Office operations and review mechanisms, we remain committed to our role as independent outsiders. This was spotlighted in important ways during the significant debate that emerged in 2025 around the Sheriff's Office's proposal to equip its deputies with Tasers.

The concerned County residents opposing Tasers are as sure that Tasers pose a significant threat to people who encounter law enforcement as the Sheriff's Office is certain that Tasers are a "tool" that is crucial to safeguarding lives. Our role is not to "take sides" on whether Tasers should be deployed in the County but to dispassionately examine the evidence, assess the quality of the review mechanisms, and present our findings to the public. We did that in our October 14, 2025 Status Report on the Sheriff's Office Taser Pilot Program, evaluating each Taser deployment during the first six months of the program, and will continue that approach as the pilot project moves forward.

In the end, the discussion around Tasers illustrates two important realities that continually impact our work, in Santa Clara County and elsewhere: the challenges of contrasting viewpoints, and the fundamental importance of transparency and independence as tools to bridge the divide.

This report is intended to provide a measure of transparency in an effort to increase public trust in the way the agency manages both basic operations and more challenging circumstances. By providing a window into the effectiveness of the Sheriff's Office's internal accountability mechanisms – and in calling out where we see areas of needed improvement – we aim to help the Sheriff's Office improve its practices while building public confidence in the fairness of its systems.

This report is also meant to inform the Board and the public on OCLEM's work over the past year, as we have become more deeply involved in those systems. The report has six parts, highlighting key areas of our contribution to issues of importance to the community. The first section discusses three critical incidents to underscore the Sheriff's Office's

evolving mechanisms for reviewing these events with an eye toward future improvement.

The second section discusses internal administrative investigations and reports favorably on the Internal Affairs Unit's diligent efforts to clear the backlog of cases that dogged it in 2024 (and earlier) without sacrificing the quality of its investigations. With that backlog diminished, the expectation is that Internal Affairs will be able to adhere to a timeline for completing cases that more closely meets best practices in this area.

Section three reports on the unfortunate deaths of people incarcerated in the County's jails and the various investigative and review processes employed by both Custody Bureau and Custody Health Services for responding to in-custody deaths. Fortunately, this section is shorter than it was in last year's report, as the number of people who died following incidents in the jails dropped from 10 in 2024 to four in 2025. There is overlap here with our discussion of the review of critical incidents, as one of these deaths was a gruesome murder of an individual at Elmwood that demanded the type of holistic scrutiny we advocate.

The report next provides an overview of OCLEM's role in reviewing use of force incidents, including an assessment of the Custody Bureau's Use of Force Review Committee (UFRC) and a recap of our involvement in evaluating the Taser pilot program as well as the Sheriff's Office's uses of military equipment and other force reporting. We are impressed by the UFRC process in general, and its embrace of a model for comprehensive review focused on growth and improvement by holding people accountable through constructive after-action measures. We look forward to participation in the new UFRC process that is set to begin soon for the Enforcement Bureau.

The fifth section is a brief update on the status of Sheriff's Protective Services Officers, pursuant to the Board's request to provide periodic reports on the development of this classification in 2023. We discuss the challenges related to hiring, retention, and staffing stability for this position and the ongoing sustainability of the program.

The final section of this report is a "grab-bag" of other activities that kept us busy throughout the year, including the important work of supporting, listening to, and advising the County's Community Correction and Law Enforcement Committee. We also summarize our collaboration with the

County's Privacy Office to evaluate important uses of surveillance equipment and the policies governing those uses. We also recap our reports on the jail reform measures stemming from the Blue Ribbon Commission's work as we concluded the audit of the large number of specific recommendations and shifted to ongoing monitoring of a more concise set of areas for reform. We also discuss Custody's Inmate Advisory Committee meetings and ideas for augmenting the way jail administrators engage with the incarcerated population.

We credit the Sheriff for his openness to outside scrutiny as he has welcomed and encouraged our participation in important review functions of the Office, challenging us to help him make the organization better.

In our Annual Report for 2024, we took care to express our appreciation to the many members of the County who have facilitated our work. This included Custody Health personnel, lawyers from the Office of County Counsel, and members of the County Executive's team – three entities whose responsiveness and patience had been consistent across our tenure in Santa Clara County. And we also cited the Sheriff's Office personnel with whom we deal most regularly, and whose cooperation had been a foundation for the contributions we have been able to make.

All of the above remains true. Accordingly, we are happy to again thank the many people from the County who assisted us in 2025, and whose continuing collaboration has been welcome in 2026.

Review of Critical Incidents

An effective process for reviewing critical incidents – including officer-involved shootings, in-custody deaths, or other incidents such as collisions following vehicle pursuits or uses of force that result in serious injury or death – not only addresses “bottom line” accountability questions, but also has other key characteristics. These include an approach that is holistic, thorough, timely, and, where applicable, leads to both formal recommendations or action items and a feedback loop to ensure that the recommended actions are completed. We reported last year on Sheriff’s Office efforts to revise its related policy to place new emphasis on conducting timely, internal, comprehensive reviews of all critical incidents. That work is ongoing, with a final policy expected to be implemented in the coming months.

While the journey toward finalization has been slow,¹ the Sheriff’s Office has conducted preliminary tests of the framework in its draft policy to review a limited number critical incidents over the past year. This initial testing of the draft policy has proven to be beneficial, in that it has given participants a concrete opportunity to evaluate aspects of the intended process and make needed adjustments to the draft policy in response.

The draft policy creates a phased process:

- A Major Incident Review (MIR) Board meeting to take place as soon as possible following an incident, ideally within 10 days. This meeting is meant to focus on organizational factors such as

¹ We first met with Sheriff’s Office leaders in mid-2024 to discuss concepts related to a new, more comprehensive policy for reviewing critical incidents. We had a number of initial meetings and discussions, including an OCLEM-facilitated site visit by Sheriff’s Office members to an agency we monitor that has a well-developed critical incident review process. The policy development process then slowed while the Sheriff’s Office negotiated a number of provisions with the associations representing impacted employees.

training, tactics, supervision, equipment, and post-incident response. The Board will create “action items” to be addressed as the review process moves forward. The goal is to identify those issues that are initially discernible, and then to make timely improvements while allowing a comprehensive investigation to proceed on its own timeline.

- An interim meeting of the MIR Board to discuss progress on action items and any other issues that need to be addressed and that may not have been evident at the time of its initial meeting.
- A Critical Incident Review (CIR) Board meeting convened after the criminal and administrative investigations are complete. This Board will examine specific causal factors as well as the actions of the individuals involved in the incident. It will issue findings and provide recommendations for specific remedial measures.

The draft policy is intended to create a review process that goes beyond the question of compliance and addresses tactical issues, lessons learned, training and equipment needs, or necessary policy updates. Topics discussed should generally include officer decision making, the quality of supervision, effectiveness of communications, review of any de-escalation efforts, equipment concerns, sufficiency of training and policy guidance, and any other potentially relevant issues unique to each scenario.

OCLEM has been engaged in the evaluation of this process throughout the year – attending and participating in preliminary trials of the Major Incident Review meeting framework and collaborating on identified policy adjustments.

We discuss below three critical incidents that occurred, or were reviewed, in 2025 and highlight the importance of the holistic, systemic review the new Major Incident policy is intended to establish. Our focus is on assessing the analytical framework applied during those reviews.

We look forward to our continued engagement with the Sheriff’s Office in working through the details of implementing the new policy once finalized and in ensuring that the review process is utilized when appropriate and as intended.

Vehicle Pursuit Ending in Fatal Crash

This vehicle pursuit at the end of November 2024 became the first incident to be reviewed, in early 2025, using the framework of the Sheriff's Office intended Major Incident Review process, which was then under development.² The pursuit unfortunately ended in fatal injuries to a passenger in the subject vehicle. As discussed below, this case highlighted opportunities to strengthen pursuit review practices, particularly the application of a risk-versus-reward analysis and informed our decision to conduct additional review of pursuit cases in the coming months to support broader, evidence-based recommendations.

Incident Summary

In the very early morning hours, a Sheriff's Office deputy observed a vehicle traveling with the rear brake light out (an equipment violation) and requested a records check. As he waited for information from dispatch, the vehicle made a U-turn and the deputy followed. Dispatch returned information that the vehicle was clear and had current registration.

However, the deputy observed that the driver had on a black hoodie and what appeared to be a ski mask covering his face, and that the passenger window was shattered, indicators consistent with a recently stolen vehicle. The deputy attempted to initiate a traffic stop; however, the driver did not yield and instead accelerated away. Based on the deputy's observations, he initiated a vehicle pursuit for failure to yield and suspected vehicle theft. The deputy broadcast that a front passenger put his arm out of the window holding a cell phone.

A second patrol unit joined and took over the radio broadcast of the pursuit. This unit also broadcast that there was at least one passenger in the vehicle.

During the pursuit, the vehicle traveled at high rates of speed, significantly exceeding posted speed limits, and committed multiple traffic violations,

² The Sheriff's Office elected to use this incident as an early opportunity to test the proposed process and assess its effectiveness as it worked to refine and create policy for the new structure.

including unsafe lane changes and failure to stop at controlled intersections.

As the road curved and rose and fell, the fleeing vehicle pulled away. The lead deputy lost sight of the vehicle. Moments later, he observed that the vehicle had been in a major traffic collision: the vehicle's bumper had detached from the vehicle and was in the roadway, and the vehicle itself had crashed into a fence. The vehicle had come to rest on its side, with extensive damage and airbag deployment. No other vehicles were involved.

Upon exiting their patrol vehicles, the deputies observed movement from the vehicle and initiated a high-risk vehicle stop.³ One of the occupants exited the vehicle, apparently injured, and cried for help. Deputies attempted to identify if there were others in the vehicle and asked if there were any weapons. This occupant reported that she was a juvenile and that there had been a total of four occupants in the car during the pursuit.

Deputies provided aid and requested a Santa Clara County Fire response. One occupant was found trapped inside the rear passenger area and was unresponsive. Despite life-saving efforts, this occupant, later determined to also be a juvenile, was pronounced deceased at the scene.

There was then considerable confusion about how many occupants had been in the car, and which one was driving. Eventually, Fire personnel located a third occupant a considerable distance from the collision site. This occupant, also determined to be a juvenile, was transported to the hospital for treatment of serious injuries along with the first juvenile to have exited the vehicle. Their parents were notified. Supervisors later responded to the hospital to attempt to obtain statements from these witness occupants, but neither provided one at that time (one refused, while the other was in critical condition).

³ A "high-risk vehicle stop" refers to a tactical vehicle stop used when deputies reasonably believe an occupant may be armed, has committed a serious offense, or otherwise presents an elevated safety risk. These stops typically involve officers unholstering lethal and less-lethal weapons from positions of cover, maintaining distance, using clear verbal commands, and controlling occupants' movements to reduce risk.

Meanwhile, deputies continued to search for additional occupants on foot and by using a drone. They located a fourth juvenile, identified as the driver, hiding in bushes in a nearby residential yard. He was taken into custody without further incident, then transported to a hospital for medical evaluation and subsequently booked into juvenile detention.

Investigators later confirmed that the vehicle involved had been stolen the previous day in a neighboring jurisdiction, but the owners had not yet reported it.

Based on observations at the scene, evidence recovered, and the post-collision investigation, the case was referred for further criminal investigation and a more detailed traffic collision investigation, including a reconstruction by a specialized unit.

In total, the pursuit lasted approximately four minutes and traveled somewhere between five and 10 miles. Toward the end of the pursuit, the roadway was dark with no streetlights. There was light to no traffic and clear road conditions. Speeds hit an excess of 100MPH, with a high of 110MPH recorded.

Sheriff's Office Administrative Reviews

This incident was reviewed through two separate processes: the Sheriff's Office's standard vehicle pursuit review and a review based on the framework proposed for the new Major Incident Review process.

Consistent with its existing policy, the Sheriff's Office first initiated its standard vehicle pursuit review: In the days following the incident, the lead deputy completed a Vehicle Pursuit Report in the Department's BlueTeam system, which included a summary of the pursuit and related circumstances. The report was reviewed by the deputy's sergeant, who examined available reports and video evidence. The sergeant concluded that the pursuit was within policy, finding that the deputy had a reasonable belief the driver may have committed a felony offense involving a stolen vehicle. The review further noted that emergency lights and sirens were activated throughout the pursuit, required radio communications were broadcast, and deputies rendered aid to the extent possible following the collision.

The review was then forwarded to a lieutenant, who concurred with the sergeant's findings. The review noted that the pursuit lasted less than four minutes at a time when there was minimal traffic, and that although deputies briefly lost sight of the vehicle, they saw that the collision had occurred before any additional radio traffic could be broadcast, at which point the pursuit ended. Command staff concurred with the policy determination. This standard vehicle pursuit review process was completed within approximately one month of the incident.

Given the seriousness of the outcome, the Sheriff's Office also elected to review the incident using its intended framework for a "Major Incident Review" process, which was still under development. The stated purpose of the review was to better understand how the incident unfolded and to examine broader considerations such as decision-making, supervision, tactics, employee wellness, and potential community impact.

The Major Incident Review session occurred approximately three months after the incident and was intended to facilitate open discussion about both the incident and the review process itself. The presentation was led by the involved division leadership, with support from command staff who had completed the vehicle pursuit review. Participants included command staff, training personnel, and other subject matter experts.

Discussion during the session covered a range of topics, including pursuit-specific issues such as vehicle speeds, radio communications, supervisory involvement, the loss of visual contact, the presence of passengers, and potential alternative approaches. Broader topics were also discussed, including the deputy's initial perception of the scene, challenges associated with managing a complex, high-risk crash scene while providing medical aid, and considerations related to deputy wellness.

The session also included discussion of the review process itself, including supervisory analysis and the presentation of video evidence.

The Department noted that Major Incident Reviews are intended to occur within ten calendar days of an incident and prior to final policy determinations. Because the meeting here was used as a preliminary trial of the framework for the policy that was still in development, it was convened later, after the standard pursuit review had already been

completed and policy findings issued. Those findings were discussed but not contested during the Major Incident Review session.

OCLEM Review

As is our practice, we reviewed all available materials related to this incident, including the Vehicle Pursuit Report and supporting documentation, and we observed the Major Incident Review session. Based on our review, we identified opportunities for improvement in how the Sheriff's Office evaluates vehicle pursuits, both in this case and more broadly.

While the Sheriff's Office identified several factors that elevated the risk of this pursuit, those factors were generally noted without a corresponding analysis of whether they should have altered the decision to continue the pursuit or how they affected overall public safety.

We recognize that the Major Incident Review functioned as a test case for a new process; as such, unlike later sessions, it took place several months after the incident, there was no formal documentation of the discussion, nor were action items or identified takeaways captured for continued learning.⁴ We appreciate both the work-in-progress nature of that session and the opportunity to participate in the discussion.

At the same time, this review presented an opportunity to more closely examine a serious pursuit that had already been determined to be within policy, particularly given the presence of several factors warranting deeper analysis.

In particular, we found that in neither the Vehicle Pursuit Report nor the Major Incident Review did the Sheriff's Office consistently apply a risk-versus-reward analysis of the pursuit as it developed, commonly referred to as the "Balance Test." The Balance Test is intended to guide ongoing decision-making during a pursuit by weighing the evolving risks to officers, vehicle occupants, and the public against the law-enforcement

⁴ We understand, though, that some actions were taken following the Major Incident Review meeting here, including a briefing with supervisors emphasizing their role in actively monitoring pursuits and setting expectations for the deputies they supervise. We also understand the policy governing vehicle pursuits had recently been updated and will evaluate that policy in a future report.

benefit of immediate apprehension. Importantly, this analysis requires more than listing risk factors; it requires assessing whether those risks remain reasonable under the totality of the circumstances and whether continued pursuit is justified as conditions change.

In this case, there were several points at which the Balance Test could have been more explicitly applied using factors already identified in the Sheriff's Office policy. For example:

- The pursuit reached speeds far in excess of posted limits over a relatively short period of time. While these speeds were documented and presented during the review, the Sheriff's Office undertook little evaluation of whether these speeds were reasonable, how the speeds affected the fleeing driver or deputies' ability to maintain control or react to roadway conditions, or how those speeds increased the risk to occupants of the vehicle and the public. When concerns about speed were raised during the Major Incident Review, the response offered was that pursuits are often high-speed events, rather than an exacting analysis of whether the speeds observed here were reasonable under the circumstances.
- In both reviews, the Sheriff's Office also gave limited attention to the risk posed to vehicle occupants. At least one passenger was identified early in the pursuit, yet the heightened risk to non-driver occupants was not meaningfully weighed in the decision-making analysis or discussed as part of the review.
- The lieutenant's rationale in the Vehicle Pursuit Report seemed to suggest that the loss of visual contact might have been a potential termination point for the pursuit but then concluded that deputies observed the traffic collision before any radio broadcast could be made. As a result, the significance of the lead deputy losing sight of the vehicle as it accelerated away on a winding and hilly roadway was largely minimized rather than critically examined. Loss of visual contact under these conditions increases risk, and limits an officer's ability to make informed, real-time decisions about whether continued pursuit remains reasonable.

Overall, the Sheriff's Office review processes documented what occurred and identified multiple high-risk elements, but they stopped short of fully

evaluating how those risks should have informed real-time decision-making during the pursuit. A more consistent and deliberate application of the Balance Test, one that actively weighs evolving risks against the necessity of immediate apprehension, would strengthen pursuit reviews and better align them with the underlying safety principles reflected in pursuit policy.

As part of our ongoing work, we plan to review a broader sample of vehicle pursuit cases in the coming months to further evaluate the Sheriff's Office's pursuit review process and policy, and to develop formal recommendations for improvement.

Murder of Incarcerated Person

In January 2025, an incarcerated person ("IP") was brutally assaulted by other IPs at the Elmwood Correctional Facility. He did not survive his injuries. Three suspects were identified and all three have been charged with murder and torture. Those criminal charges are pending, with a trial scheduled in 2026.

Incident Summary

After being arrested and booked into jail on misdemeanor charges, the victim IP had been in custody fewer than 12 hours when he was targeted for assault by the suspect IPs. The assault took place in the minimum security barracks at the Elmwood facility and lasted 15 minutes, with some IPs keeping watch at the door while the suspects brutally attacked the victim. The suspect IPs walked out of the barracks, leaving the victim unconscious on the floor, several minutes before deputies' next scheduled routine welfare check. During that welfare check, deputies discovered the victim, called for an emergency medical response, and began lifesaving measures. The victim was transported to the hospital, where he died several days later. The Medical Examiner determined his death was caused by blunt force head trauma and ruled it a homicide.

Jail Crimes Unit (JCU) detectives conducted a comprehensive criminal investigation, assembling video footage that accounted for almost all of the victim's time in custody, including most of the assault that led to his

death.⁵ This investigation was submitted to the District Attorney for prosecution of the suspects and also formed the basis for much of the administrative review conducted by the Sheriff's Office.

Sheriff's Office Administrative Reviews

This significant incident did not prompt a "Major Incident Review." As with the vehicle pursuit discussed above, that policy and process was still under development. However, within a week of the assault and days after the victim's death, the Sheriff's Office conducted an "Executive Briefing," followed about a month later by an "Incident Review," which together met many of the expectations of a Major Incident Review meeting as anticipated by the draft policy.⁶

The Sheriff's Office provided a detailed account of the victim's time in custody, with his movement through booking to his housing at Elmwood. Because of the extensive network of cameras throughout the jail facilities, it was possible to create a timeline accounting for the entirety of his time, including who he talked to and when he slept. The briefing also presented records of the hourly welfare checks conducted at Elmwood during the time the victim was housed there.⁷

The presentation also focused on staffing issues, with an account of all the deputies on duty that day.⁸ The visual presentation included a map of where each on-duty deputy was located relevant to the location of the

⁵ Portions of the assault took place in the bathroom area, where there are no cameras for privacy reasons.

⁶ Participants included the Sheriff, Undersheriff, all Assistant Sheriffs, several Captains, investigators who had knowledge of the incident, and representatives of County Counsel. OCLEM was notified and received an in-depth briefing two days after the assault, and while the victim was still alive. We were also invited to and attended the Executive Briefing.

⁷ The review noted one check that was over 20 minutes late, when the deputy responsible for that check was otherwise preoccupied apprehending an IP who was found in possession of drugs. This late check was not close in time to the assault.

⁸ Of the 10 positions allocated to the minimum security facility at Elmwood, three were vacant on the day of the assault. Our understanding is that this was not uncommon at the time, with housing areas at the jails generally running at below what had been determined to be ideal staffing levels.

assault during the 15 minutes it was taking place, demonstrating that none of the deputies was inattentive or neglectful of their duties. As seen on video, the suspects had other allied IPs tracking deputy movement, and they ended their assault approximately five minutes before the next scheduled hourly check.

The Executive Briefing included a detailed discussion of classification issues, with an evaluation of each involved IP's criminal history and available evidence of gang affiliations in an attempt to understand whether the assailants had been mis-classified and inappropriately permitted in minimum security housing. The conclusion from this review was that the Classification unit had applied its verified and court approved classification tool appropriately and properly assigned the involved IPs to a security level that permitted housing at Elmwood's minimum camp.

The Sheriff's Office participants in the Executive Briefing concluded informally that there were no concerns about deputy misconduct that would require any investigation from Internal Affairs beyond its standard "Executive Summary," as discussed below. Participants did discuss potential opportunities to learn from the incident and possible technology and equipment improvements to the camera systems (which we discuss below).

While there were no formal written action items provided to OCLEM following this meeting, we are aware that the Sheriff's Office did take important steps to address issues identified in the aftermath of this incident. For example, Custody made significant changes to its housing configurations to more strictly limit which IPs can be housed at Elmwood's minimum camp.

The incident was assigned an Internal Affairs case number, and an IA investigator completed an Executive Summary of this incident. As is standard practice with in-custody deaths where there is no indication of deputy misconduct, the assigned investigator reviewed all existing reports, the interviews conducted by JCU detectives, and all available video. The investigator compiled this information into a summary report and concluded there were no violations of department policy related to this tragic death.

In addition to these executive reviews, the Sheriff's Office conducted a standard in-custody death review around 30 days after the victim's death.

This review was short, relative to others we've observed, and the Sheriff's Office explained that information shared during the review would be limited due to the criminal investigation. In addition, Custody Health had limited information to contribute because medical and mental health personnel had little interaction with the victim during his brief time in custody. The review covered information obtained during the intake process, the classification process and housing issues, and, importantly, evaluated the emergency response by deputies and medical staff when the victim was found unconscious. The review found no deficiencies in any of these areas.

OCLEM Review

As with all in-custody deaths, we participated in every aspect of the Sheriff's Office's review of this tragic incident. We received notification of the incident as well as a detailed briefing of the circumstances, then attended both the Sheriff's Office Executive Briefings and Incident Reviews, and the in-custody death review. We also reviewed the Executive Summary prepared by Internal Affairs.

We don't dispute the conclusions reached during these various review processes – that no negligence or misconduct on the part of deputies or responding medical staff contributed to the outcome. But given the extraordinary circumstances presented here, we believe that an additional level of formal scrutiny was warranted.

We expect that an event such as this will be subject to all phases of review laid out in the Major Incident and Administrative Review Boards policy, when that policy is finalized. That process would alleviate the lingering concerns we have around this incident in two ways: (1) creation of formal action items with target deadlines and assigned personnel and (2) completion of a full administrative investigation.

Formal action items here could have included:

- Follow up on the potential for AI systems that could monitor cameras and generate an alert to direct deputies to unexpected

movement by IPs.⁹ That seems to be a potential longer-term solution, with the technology not fully ready for deployment. We are aware that Custody personnel have discussed this technology with vendors and are tracking development of these systems.

- A quicker fix would be to at least enlarge the screens on which deputies can monitor camera activity to increase the chance that deputies working facility control might notice unusual activity in a particular housing area. Currently, the camera views are accessible to deputies, but only on very small screens that are split between hundreds of cameras. This, too, was discussed at the briefing. As of the time we write this report, this improvement to the surveillance system has not been implemented.
- An examination of how periodic safety checks are completed. Despite staffing shortages, deputies here had completed their checks in a timely, diligent way. And yet the available evidence suggests that the predictability of those checks created risk. The attack on the victim seems to have been timed by the assailants to avoid detection during scheduled checks. Custody should consider ways to make safety checks more staggered and unpredictable, while nonetheless compliant with state regulatory requirements.¹⁰

The point of formal action items is to assign the task to specific personnel and create deadlines for completion. Absent the formality, items too often fall through cracks or get delayed. We are aware that Custody staff

⁹ One major area of concern here is the fact that Elmwood – and all of the County’s jail facilities – has hundreds of cameras that are constantly recording and yet are not being monitored in real time. Given the number of cameras and the limited number of available staff, there has never been an expectation that cameras will be continuously monitored, and yet the fact that this brutal beating extended over a 15-minute span, much of which was recorded on video, makes the victim’s death even more disturbing.

¹⁰ We note that the IPs involved in this assault had coordinated lookouts monitoring deputy movement, so we do not suggest that more staggered safety checks could have prevented this tragic outcome. We also learned during the process of reviewing this report that deputies are encouraged to avoid predictable patterns when performing safety checks. The RFID tracking system can generate reports detailing the degree to which checks are staggered, and we encourage the Sheriff’s Office to use that system to regularly monitor this issue.

continue to work on these issues but suggest that the structure of a formal “action item” may assist with timely follow up.

With respect to the administrative investigation, the Executive Summary prepared by IA relied on deputies’ and supervisors’ written BlueTeam reports. The only interviews conducted were those done by JCU, and the focus of those interviews was on the criminal aspects presented, with the goal of securing a successful prosecution of the perpetrators of this assault.

A full and complete administrative investigation by IA would look beyond questions of who was “at fault” – the emphasis of a criminal case – and more holistically at a range of potential areas for improvement. This would include:

- A full written evaluation of the classification decisions made. The verbal presentation made at the Executive Briefing was detailed and decisive, but the facts presented there were not documented in any form we had access to.
- An examination of the charges the victim was arrested on, with potential follow-up questions about why he was booked into jail rather than cited and released. Custody and County leaders could use this information to guide future decisions about interactions with criminal justice system partners, including broader questions relating to overall reform of the bail system.

Recognizing its duty to protect the wellbeing of those in its custody, the Sheriff’s Office treated this tragic incident with seriousness and concern. It evaluated individual accountability issues and assessed systemic shortcomings that contributed to the environment in which this brutal attack could occur. The issues we note here relate to improvements to the process for reviewing these types of major incidents that will add a greater degree of consistency, rigor, and accountability to future reviews.

Since the time of this homicide, the Sheriff’s Office has continued to test the framework of its draft Major Incident Review process to convene reviews of three in-custody deaths: one from 2025 related to a medical emergency and two from the beginning of 2026 – a suicide and a medical emergency. Its willingness adopt the framework of its still-not-yet-final Major Incident Review process on these incidents sends a positive

message about its intent to think broadly and inclusively about its approach to evaluating significant events.

Deputy-Involved Shooting

In October 2025, during the evening, a deputy initiated a traffic stop in the City of San Jose on a car that had an expired registration. The driver initially stopped, then pulled away and continued driving, but stopped again a short time later. The driver began acting erratically, opening and closing his door, and then took steps to barricade himself in the car, placing items in the windows to block the deputy's view. The deputy notified dispatch and requested backup. Additional deputies arrived along with resources from the San Jose Police Department (SJPD).

Deputies positioned their cars to block the subject in, hoping to force him to leave the vehicle on the sidewalk side of the street. Members of the Sheriff's Psychiatric Emergency Response Team (PERT) responded to assist in communications with the subject. Deputies asked the subject to call the PERT phone number they provided. He complied and stayed on the line for more than 45 minutes.

In all, deputies tried for approximately two hours to get the individual to comply with their commands and exit the car. A lieutenant and sergeants were on scene developing a tactical plan. Ultimately, the lieutenant directed deputies to launch Pepper Ball rounds into the vehicle to force the subject to exit.¹¹ He eventually did exit the car but was armed with a knife. Deputies launched less-lethal projectiles in an attempt to get him to comply with commands to drop the knife. He ignored these commands and instead ran toward the deputies. Two deputies discharged their firearms, striking and fatally wounding the man.

Deputies moved to take him into custody, secured the knife, and began lifesaving measures while they cleared the scene for the arrival of paramedics, who were staged nearby. He was transported to the hospital where he died later that night.

¹¹ Pepperball rounds contain a chemical agent often use to saturate an area to create extreme discomfort.

Because the shooting occurred within the City of San Jose, SJPD assumed command of the scene and is leading the criminal investigation. That investigation, along with review by the District Attorney's Office, is ongoing.

Sheriff's Office Review

The Sheriff's Office notified OCLEM of this shooting the morning after it occurred and provided a briefing regarding the facts of the incident. It scheduled a Major Incident Review Board meeting, which OCLEM attended in person. That meeting provided a detailed factual account of the incident and included a productive discussion of the issues in several categories: planning and decision-making; supervision; de-escalation and tactics; training and equipment; policy considerations; and post-event considerations, including employee wellness and community impact.

The meeting produced a list of action items involving protocols for gathering evidence and policy related to communication with drone operators. Those items were assigned to specific personnel and are in progress.

At the conclusion of the criminal investigation, the Sheriff's Office will complete its administrative investigation and convene a Critical Incident Review Board, the next phase of its review process. OCLEM will provide a more detailed report on this incident once the investigation and review processes are complete.

Release of Body-Worn Camera Video

One related issue that is concerning to us is the Sheriff's Office decision to not yet publicly release the body-worn camera video of this shooting incident. California's SB 1421 makes records related to officer-involved shootings disclosable as public records, and AB 748 specifically requires disclosure of audio and video recordings of these incidents in response to a California Public Records Act (CPRA) request. The law provides some exceptions – generally around whether release would interfere with an active investigation – but sets a general expectation that video will be released, upon request, within 45 days of the incident. Most agencies routinely release video of officer-involved shootings within that 45-day

window, regardless of whether the agency has received a CPRA request for the video.

Based on conversations with Sheriff's Office officials, we understand the delay in releasing video to be based mainly on the fact that there has been no CPRA request for the video submitted.¹² It also is a product of the fact that the Sheriff's Office has few officer-involved shootings relative to other agencies and has not developed policy or procedure for how to handle public release of information.

In our view, the Sheriff's Office should follow the practice of many California law enforcement agencies and proactively release video of any officer-involved shootings or critical incidents that are required to be disclosed under the CPRA, regardless of whether a formal request is submitted. We understand this to be the Sheriff's approach to transparency issues, and also understand the video of this incident is currently being compiled and will be released shortly.

Going forward, the Sheriff's Office should create the expectation that this release would happen in a timelier way.

Recommendation 1: The Sheriff's Office should implement policy requiring timely and proactive release of all records related to critical incidents, as defined by state law, that are subject to disclosure under the CPRA, including body-worn camera and other video footage, regardless of whether a request has been filed under California's Public Records Act.

¹² The Sheriff's Office has responded to CPRA requests for other records related to this incident, but none has specifically requested the video.

Administrative Investigations and Internal Affairs Review

Our second full year of reviewing completed administrative investigations and attending Internal Affairs Review (“IAR”) Board meetings was a busy one.¹³ As Internal Affairs worked diligently to clear the backlog of cases that had built up over time, we reviewed nearly twice as many IA cases in 2025 as we did in 2024. This was positive news for the overall timeliness of IA cases, which we discuss below, and was the result of both a commendable effort by IA personnel and significant devotion of resources by the Sheriff’s Office. Importantly, we did not find the increased workload to have compromised the quality of the work.

Maintaining a consistently rigorous process for administrative investigations into allegations of misconduct or policy violations by its employees is among the most important functions of any law enforcement

¹³ OCLEM had limited access to materials during the prior Sheriff’s tenure, but the completion of a robust information-sharing agreement with the new Sheriff’s Office administration in late 2023 gave us broad access to the Sheriff’s Office system of administrative investigation.

We now receive all completed IA investigative reports (referred to as “Statements of Recommended Findings,” or “SORFs”) and an invitation to attend all Internal Affairs Review (IAR) meetings. At the meetings, OCLEM has the opportunity to weigh in to ask questions or offer suggestions or advisory recommendations. Our ability to provide outside scrutiny as well as an independent perspective are meant to be enhancements to the overall effectiveness of the review process.

As a provision of our information-sharing agreement with the Sheriff’s Office, OCLEM does not attend the subsequent Discipline Review Board meeting that is convened when the IAR results in sustained findings, or play any role in advising on or determining discipline. However, OCLEM does receive the disciplinary findings and can report on any concerns it might have about the disciplinary result reached by the Sheriff’s Office.

agency. Effectively enforcing internal standards and promoting accountability is necessary for an agency's overall operations, including the ability to identify and separate from the department those whose misconduct is serious or persistent as well as identify and correct less serious performance issues that do not comport with the agency's standards. And it is a critical element in maintaining the public's confidence.

California's privacy laws relating to peace officers' personnel records – which prohibit public access to investigations into alleged misconduct in most circumstances¹⁴ – can create suspicion about the objectivity of investigations and the legitimacy of outcomes. This understandable tension between confidentiality and the public's trust is why we view the ongoing monitoring and review of administrative investigations as one of our key responsibilities and a critically important part of OCLEM's mission. Our ability to provide outside scrutiny as well as an independent perspective, coupled with our regular public reporting, are meant to enhance the overall effectiveness of the process as well as increase public confidence in the system.

Throughout 2025, we reviewed completed administrative investigations and attended Internal Affairs Review (IAR) Board meetings in 87 cases. These completed investigations had the following elements:

- 54 involved Correctional Deputies.¹⁵ Of these, 17 cases concerned allegations surrounding deputies' use of force in the jails in 11 separate incidents.¹⁶

¹⁴ Relatively recent changes to state law created exceptions to the general confidentiality provision to grant public access through public records requests related to officer-involved shootings, use of force incidents resulting in death or serious injuries, or when there are sustained findings of dishonesty or sexual assault. In 2024, the law was further amended to allow law enforcement agencies to disclose information about terminations for cause of peace officers or custodial officers for any incident that is disclosable under the prior legislation.

¹⁵ For reference, the Sheriff's Office currently has a little over 1,100 sworn members. Of these, around 730 (65%) are Correctional Deputies and 390 (35%) are assigned to the Enforcement Bureau.

¹⁶ Some incidents involved multiple deputies, each of whom would be the subject in a separate IA case.

- Nine involved Enforcement Deputies.¹⁷
- Six cases involved allegations against Lieutenants and Captains.¹⁸
- 11 involved non-sworn (civilian) personnel.
- The remainder were divided between Reserve Deputies, Sheriff's Protective Services Officers, and Volunteers.¹⁹
- 11 of the investigations involved allegations of off-duty conduct that violated Sheriff's Office or County policy. Eight of these implicated potential violations of law that were also investigated by criminal investigators from an outside law enforcement agency.
- Nearly 65% of the cases resulted in some sustained findings of misconduct.

Our key observation from our 2024 report was that the IA process and outcomes were evolving in a positive way as the Sheriff's Office restructured the management of the Internal Affairs Unit and devoted additional resources to this important function. This constructive evolution continued in 2025, as we highlight in the sections that follow.

Timeliness

We reported last year on the importance of completing IA investigations in a timely way. In short: Addressing misconduct allegations promptly signals to public complainants that the agency takes their concerns seriously, strengthens the remedial and deterrent effect of the accountability system, minimizes the chance that poor performance

¹⁷ Four of these nine were subjects in a single case.

¹⁸ These cases all involved complaints about management made by subordinates. The County hired outside investigators who are not Sheriff's Office employees to handle each, to ensure investigations could be handled fairly without concerns about potential future career implications.

¹⁹ These are formal positions within the Sheriff's Office that require specialized skills and some degree of dedicated training. While not subject to traditional disciplinary measures, volunteers are nonetheless expected to adhere to certain policies and codes of conduct and can be the subjects of administrative investigations.

continues, and limits subject employees' stress and uncertainty about pending investigations.

When we began reviewing Internal Affairs cases at the end of 2023, the unit was significantly behind in its completion of investigations, with cases routinely completed just days or weeks before the one-year statute of limitations.²⁰ The Sheriff's Office acknowledged the need to improve on this metric and agreed with the recommendations we made in last year's annual report regarding deadlines for completing IA cases, which we recognized to be longer-term goals and not immediately attainable.

We updated the Board on this issue in our November 4, 2025 and April 8, 2026 Reports on the Status of Jail Reform Efforts Monitored by OCLEM, noting the diligent efforts made by Professional Standards and Compliance to address the backlog of cases that was largely responsible for the extended timelines. Throughout 2025, the division assigned a number of older cases to experienced investigators working in units other than IA as a temporary measure to bring down the number of pending cases assigned to each IA investigator. These investigators completed nine cases during 2025. The division also implemented a new practice of requiring investigators who leave IA for other assignments to complete their existing investigations rather than handing them off to others.²¹ And those investigators assigned to IA prioritized the efficient completion of their work while preserving standards of appropriate thoroughness and rigor.

In all, IA completed 87 formal investigations and IARs throughout 2025, nearly doubling the number of cases completed in 2024 (44). Crucially, we found that this increased productivity was achieved without sacrificing

²⁰ There are a few notable exceptions, but the California's Public Safety Officers Procedural Bill of Rights Act generally requires that notice of any discipline for a law enforcement officer's misconduct be provided "within one year of the public agency's discovery by a person authorized to initiate an investigation of the allegation." California Government Code Section 3304(d). If the notice is not provided within this time frame, the agency is unable to impose formal discipline on the employee.

²¹ Past practice had been for IA to re-assign all pending cases being worked by sergeants who got promoted or left for a different assignment to others who remained in the unit. This practice created obvious inefficiencies and, over years, contributed to a backup of pending investigations.

the quality of the investigative work. Investigations remained thorough and complete, with well-written reports and an IA review process that was methodical and thoughtful. The Sheriff's Office – and Internal Affairs in particular – should be commended for their conscientiousness and strong effort.

The cases completed in 2025 represented a crucial clearing of the backlog of old IA cases and left the unit with a reasonable number of pending cases to manage in 2026. We are hopeful that IA will be in a position to meet the goal we recommended in last year's annual report: to complete investigations within 120 days and the review process and disposition within 180 days.²² We will continue to monitor and support the Sheriff's Office in its efforts toward achieving it.

Investigations and Review

When a Sheriff's Office deputy or other employee has potentially violated department or County policy, the Sheriff's Office initiates an administrative investigation into the alleged conduct.²³ The Internal Affairs (IA) Unit generally handles these investigations when the allegation may lead to formal discipline.²⁴ When the investigation is complete, the investigator prepares a Statement of Recommended Findings that includes a recitation of the allegations, detailed summary of the investigative steps taken and evidence gathered, and an analysis of the facts that leads to a recommended finding on each allegation. That Statement of Recommended Findings is forwarded to the IAR Board, which convenes to discuss the case and the proposed findings.

²² We recognize that there may be times when an investigation may need to extend beyond these internal limits such as when a subject employee is not available to be interviewed. In such cases, any "extension" of the internal deadline should be approved at the lieutenant or captain level.

²³ If that alleged conduct also potentially violates State law, a separate criminal investigation may be conducted concurrently with the administrative investigation. The two investigations move on parallel paths and the outcome of one is not necessarily determinative of the other.

²⁴ Less serious complaints for which non-punitive corrective action (such as directed training or documented counseling) is appropriate may be handled less formally at the division level.

Overall, we remain impressed with the general quality and objectivity of investigations conducted by IA. They are thorough, gathering all relevant and necessary materials and interviewing all witnesses. This observation is particularly notable given the quantity of cases completed last year.

Investigations we reviewed in 2025 were also scoped appropriately, with all possible subjects and policy violations identified and evaluated. For example:

- In one case, multiple deputies were involved in one incident. The IA investigation was initially authorized with one subject deputy, relating to potential dishonesty in report writing. As the investigator began work on the case, though, he identified conduct by the other involved deputies that was also problematic and potentially out of sync with policy. He addressed his concerns with IA and Sheriff's Office leadership and the investigation ultimately involved four subjects and a range of allegations from unprofessional language to inappropriate muting of body-worn cameras and untruthfulness.
- In one case, the investigator identified and meticulously documented, investigated, and analyzed 14 possible policy violations for 22 separate allegations of misconduct involving a range of issues surrounding a deputy's performance of regular duties.
- In one case involving a complex set of allegations regarding a workplace relationship involving, among other things, potentially threatening conduct, IAR participants questioned whether the subject may have engaged in additional, potentially criminal conduct. The IAR decided to suspend its deliberations while the IA sergeant investigated the potential additional conduct. The IAR panel then reconvened and made appropriate findings and referrals for additional investigation.

Along with the above example, alleged criminal conduct was involved in a small but not insignificant number of cases completed and reviewed in 2025. Some examples of these include:

- Six cases involved allegations of (off-duty) family violence.

- One particularly serious case began when an IP submitted an anonymous grievance about the conduct of a non-sworn employee, alleging he was bringing drugs into the facility and providing them to female IPs in exchange for sexual favors. The allegation was sent to the Jail Crimes Unit (JCU) for investigation. JCU quickly corroborated the allegations through a surveillance operation, and the Sheriff's Office placed the employee on administrative leave. Further investigation and a search of the employee's locker revealed that this conduct was part of a prolonged pattern.²⁵

Criminal charges – both for sexual activity with a confined adult and for bringing a controlled substance into a correctional facility – remain pending. But the Sheriff's Office proceeded with its administrative investigation and terminated the subject's employment with the County without waiting for the conclusion of the criminal case.

The range of other, non-criminal allegations of misconduct²⁶ (aside from uses of force in custody, which we discuss below) included:

²⁵ Shortly after this IA case was completed, OCLEM received an anonymous complaint alleging that particular Sheriff's Office leaders had been aware of complaints about this employee's misconduct for more than a year but failed to act to protect his female victims. We met with the Sheriff's Office about this complaint, which is the subject of a pending IA investigation.

²⁶ Another category of alleged misconduct that does not typically result in a formal IA investigation are complaints that initiate outside the Sheriff's Office. If the complaint is made by an incarcerated person, it is addressed through Custody Bureau's Grievance system, which we discuss later in this report. If it is made by a member of the public and is unrelated to the jails, it is categorized as a "Citizen Complaint" and is assigned to an IA investigator. The investigator completes an initial inquiry into the facts behind the complaint and unless there is evidence to suggest a deputy violated Sheriff's Office policy, the complaint is resolved informally. If the evidence suggests misconduct, the Sheriff's Office will open a formal IA investigation. We are interested in learning more about the process for investigating these complaints and pursuing this issue as a topic in a future report. While we realize the term "citizen's complaint" is commonly used and referenced in state law, we note that use of the term "citizen" in this context is underinclusive and recommend the Sheriff's Office adopt new terminology for these complaints.

- On-duty accident in a County-owned vehicle and subsequent lack of truthfulness about the circumstances
- Various employment-related allegations, such as leaving work early, failure to report for overtime shifts, unauthorized secondary employment, and other abuses of overtime and leave policies
- Sexual harassment and related supervisory failures²⁷
- A variety of workplace issues involving inappropriate text messages and unharmonious interactions
- Inattentiveness during a hospital transport that permitted an incarcerated person to briefly escape (the individual was caught within minutes)
- A member of the public complained about the conduct of a deputy who attempted what the deputy believed to be a practical joke but was interpreted by the community member as potentially stalking behavior. Notably in that case, we recommended a commendation for the sergeant who initially responded to the complainant. The sergeant forwarded the allegation through the chain of command and it ultimately was investigated by IA. When the IA investigator interviewed the complainant, she emphasized that she was impressed with the sergeant's responsiveness and sensitivity to her concerns.
- One case involved allegations of workplace discrimination but ended up turning on whether the subject's disputed comments were protected by principles of free speech. The investigator did a commendable job interviewing all witnesses to the subject's comments and found they related to political views. While others disagreed with those views, the investigator found the statements were not intended to discriminate against any individual. The investigator and IAR reviewers effectively balanced the impact of the statements against First Amendment protections and found the allegations unfounded.

²⁷ These cases were completed in collaboration with the County's Equal Opportunity Division, which concurred with the findings.

Some cases reflected a commitment to maintaining high standards for investigating incidents in the jails and protecting incarcerated persons. For example:

- An IP reported to a Correctional Deputy that he had been slapped by another IP. The deputy did not report this allegation to a supervisor, but instead tried to handle the dispute informally and discouraged the victim IP from reporting the incident. The IP eventually reported the incident to another staff member, and Custody initiated an investigation into the initial deputy's failure to take appropriate action. The assault had not resulted in any injury to the IP and the deputy had not ignored the situation (he had talked to the assailant to learn more about the motivation for the assault and attempted to mediate the dispute). Nonetheless, the Sheriff's Office addressed the violation of policy and protocol with appropriate seriousness, given the potential pitfalls of minimizing assaults and discouraging reporting in the custody setting.
- A Correctional Deputy performing safety checks discovered an IP with an injury to his face. He questioned the individual about the source of the injury and the IP responded he'd fallen off his bunk. His cellmate said he did not know what happened. The IP requested to be left alone. In his verbal report to a supervisor and to the deputy on the next shift, the subject deputy downplayed the extent of the injury to the IP's face, so that no further action was taken until around six hours later when the IP came out of his cell and was observed to have a significant laceration, dried blood, and bruising on his face. The IP reported he'd been assaulted. Review of surveillance camera footage suggested the assailants were other IPs, and not the cellmate.

The IA investigator meticulously examined all of the available video and written reports and conducted thorough interviews with all relevant witnesses and involved individuals. In reaching an appropriate resolution to this case, the Sheriff's Office decision makers noted their expectation that a deputy in these circumstances – where an assault is or should have been suspected – will take any necessary steps to speak with the IP alone and ensure his safety.

- A deputy working in a courtroom was alleged to have allowed an IP who was designated as “PC” (for “protective custody”) to walk in front of a member of a gang known to have a “standing order” to assault PC IPs. The incident was fully and thoroughly investigated to determine whether the deputy’s conduct was the result of negligence or carelessness and not intended to cause the IP harm.
- Some IA cases resolved in 2025 stemmed from concerns about the timeliness or quality of safety checks that arose following in-custody deaths we reported on in 2024. We found these cases to be fairly and objectively investigated with appropriate findings regarding all potential subjects.

Again, we found the investigations into these allegations to be effective for the most part: thorough, rigorous, and scrupulously analyzed, with well-written investigative reports. Where there were gaps in the original investigative reports, we found them to be acknowledged and addressed during the IAR process.

At IAR meetings, Sheriff’s Office leadership²⁸ meet to discuss the facts of the case and the findings recommended by the IA investigator. We have generally been impressed with the rigor of these discussions. Participants are well-prepared with follow-up questions and comments and candidly share their opinions about the recommended findings. Ultimately, decisions about outcomes rest with the Assistant Sheriff, but he or she gives due respect to the views expressed by the rest of the panel before reaching a conclusion.²⁹

²⁸ The IAR Board consists of an Assistant Sheriff, the Personnel Captain, and a Captain and Lieutenant in the subject’s chain-of-command. OCLEM attends each of these meetings and has the opportunity to weigh in at any point to ask questions or offer suggestions or advisory recommendations.

²⁹ For each alleged policy violation, the Assistant Sheriff makes one of four findings: “Sustained” (the allegations are true by a preponderance of the evidence and that the conduct at issue is a violation of agency policy); “Not Sustained” (the allegations cannot be proven true or untrue by a preponderance of the evidence); “Unfounded” (the allegations are not true); or “Exonerated” (the conduct at issue occurred but is not a violation of agency policy).

There were a number of cases where the IAR panel disagreed with recommended findings proposed by the investigator, and sometimes with each other. The thoughtful exploration of differing perspectives contributed to the soundness of the final result. To us, this is a sign of a vigorous process, and we appreciate the independent thinking and commitment to accountability shown in these cases.

Our role in these meetings is advisory in nature. We are not an official member of the IAR panel and do not have a “vote” in the outcome, but we do have the opportunity to offer suggestions and provide our independent, outside perspective in a way that is intended to make the review process more comprehensive and effective. We frequently raise questions and provide our views on the facts of a case and how policy should be interpreted in light of those facts. For example:

- In several use of force cases, we questioned the interpretation of the Custody use of force policy around strikes to the head or face and the extent to which a deputy’s intent should impact findings.
- In a case involving allegedly inappropriate texts between co-workers, we raised questions about the impact of rank and whether different standards applied to supervisors in their interactions with deputies.
- In a use of force case, we noted that a subject deputy’s interview statements about report writing indicated a need to revisit training on this issue.
- Also in a use of force case, we had questions about the deputy’s understanding of de-escalation tactics, which again indicated a need to examine training issues.
- In another case, we raised the need to reexamine policy around escorting an individual who had been the subject of a use of force to apply to a broader set of circumstances.

We appreciate that we have been welcomed into the IAR process and that our perspective on these cases is valued. This openness to outside scrutiny is an important indicator of a comprehensive review process.

Another sign of a healthy administrative investigation and review process is the willingness to look beyond the specific allegations and address

broader issues raised by the circumstances of a given case and meriting attention, even if non-disciplinary in nature. We saw this repeatedly in cases we reviewed last year.

In some cases, the panel identified training updates or management issues that needed to be addressed. For example, a few cases involved allegations of performance issues, and the panel recognized that earlier intervention by first-level supervisors might have prevented these concerns from escalating into IA investigations. In those cases, captains and lieutenants were directed to counsel those supervisors. In other cases, the panel identified laxity around informal practices for adjusting the start and end times of shifts that led to later abuses and again directed counseling for involved supervisors.

Recognizing – and acting upon – the additional opportunities for improvement that often emerge from close review is a hallmark of an effective discipline process, and one we have endorsed in Santa Clara County and many other jurisdictions. It is encouraging to see the Sheriff's Office put this concept into practice during the investigations from 2025.

Intersection between Internal Affairs Review and Custody Use of Force Review

Custody Bureau convenes a Use of Force Review Committee (UFRC) meeting every two weeks, taking an in-depth look at every significant use of force in the jails. As we detailed in our last annual report and discuss further below, we have generally been impressed with the thoroughness and rigor of these reviews. Where it appears that a deputy using force may have violated a policy with the possibility of significant formal discipline, jail leaders reviewing the incident generally recommend initiating an IA investigation. Sometimes this happens prior to a UFRC meeting, and sometimes the recommendation stems from the UFRC review.

In last year's report, we noted some internal conflicts between the UFRC process and IA investigations, largely stemming from timing issues and "siloing" of these two review mechanisms in relation to each other. The Sheriff's Office was responsive to these issues as we raised them throughout the year, and these concerns have been alleviated. IA

investigators now have access to records that the UFRC generates, so they are fully aware of the concerns raised by committee members that led to the IA referral. And at the conclusion of the IA case, there is now a protocol for returning the matter to UFRC for any potential further action. While UFRC participants cannot learn all the details of the IA process because of privacy concerns, they are advised of the outcomes and, where charges are not sustained or unfounded, have the opportunity to direct non-disciplinary remedial measures (generally additional training on areas of concern).

In 2025, 17 of the 87 completed IA investigations involved custody use of force incidents. Most of these incidents involved strikes to an IP's face or head or some type of pressure on an IP's neck, tactics which are severely constrained pursuant to Custody's use of force policy. Other cases related to policies requiring deputies to attempt to de-escalate situations before using force, and some involved deputies' failure to appropriately report their use of force.

We found the investigation of these cases to be thorough, and the discussion during the IARs more spirited and robust than most others, with detailed parsing of various sections of relevant policies regarding the necessity of force and de-escalation and how those policies overlap and intersect. In a few of these cases, the IAR panel disagreed with investigators' recommended findings. While there were cases we might have decided differently with respect to some particular findings, we had the opportunity to express our views and felt that our perspective was valued. The ultimate decisions made were the result of thoughtful consideration and principled deliberation. Further, where there were findings that a policy was not technically violated, we found the Sheriff's Office leadership nonetheless recognized problematic tactics or conduct and initiated appropriate remedial measures. All of these factors point to the integrity of the internal review system.

The positive shifts we began to see in 2024 and commented on in last year's annual report continued through 2025. IA has cleared its backlog of older cases and is now completing cases in a much more timely way. Investigations remained thorough and objective, even as investigators responded to this time pressure. The IAR process likewise retained its rigor, even as participants were called on to review and resolve twice as

many cases. We appreciate our role in this process and look forward to continuing to engage with the Sheriff's Office on these critically important issues as the agency maintains its forward momentum.

In-Custody Deaths

In 2025, three individuals died while in the custody of the Sheriff's Office and a fourth died following an incident in the jail (though the individual had been released from custody while hospitalized). These four deaths represent a significant decrease from the 10 in-custody deaths that occurred in 2024. Those 10 deaths were the highest number in a single year since at least 2006. The four deaths last year, conversely, are on the low end of the average (between 2006 and 2023, the average number of in-custody deaths per year was close to six).

The circumstances around the four deaths following incidents in the jails in 2025 were unique and varied: one person was murdered;³⁰ one died by apparent overdose; two were determined to be of natural causes. There were no suicides in the jail last year.

The youngest incarcerated person who died in 2025 was 23 years old. The oldest was 56. The other two were in their 30s. All were men. Two of the individuals were housed at Main Jail at the time of the events that led to their deaths and two at the Elmwood facility. Two individuals had been in custody for fewer than two days. Two others had been in the jail for eight and ninth months, respectively.

Two of the four deaths actually occurred outside of the jail, after individuals had been transported from the jail and admitted to the hospital. In fact, one of these deaths was not, by definition, an "in-custody death" as the individual was released from custody shortly after he was admitted to the hospital. Commendably, both the Sheriff's Office and Custody Health Services (CHS) did not allow this definitional technicality to prevent them

³⁰ As noted above, this incident was evaluated in depth by Sheriff's Office executives during multiple review meetings, and final conclusions and reporting on the incident are being deferred until the criminal cases against the alleged assailants conclude.

from investigating, reviewing, and assessing the incident as they would an in-custody death, convening both Major Incident Review and Root Cause Analysis meetings to examine the underlying circumstances.

When we questioned the fact that this incident does not appear among the in-custody deaths on the Transparency page of the Sheriff's Office website, we learned that the Sheriff's Office had based its decision on communication with the California Department of Justice (DOJ). After the Sheriff's Office provided what it believed was the required notification of an in-custody death, the state DOJ responded by indicating the incident was not, in fact, reportable because it did not meet the criteria to be counted as an in-custody death. Despite this technicality, we nonetheless believe the Sheriff's Office should include such incidents on its Transparency page, to fully inform the public about the range of deaths among incarcerated persons.

Recommendation 2: When an individual dies following an incident that occurred while incarcerated in the County's jails and where the incident was related to the cause of death, the Sheriff's Office should report the incident on its Transparency Portal, even if the person was released from custody prior to the time of death.

The decrease that occurred in 2025 is encouraging on its face. However, as we wrote in last year's report, it is difficult to draw meaningful conclusions from this "bottom line" counting alone; too many variables influence individual outcomes, and pattern identification can be elusive across limited examples. Accordingly, the careful analysis of each fatality takes on added significance as a vehicle for issue spotting and potential adjustments.

The protocols followed by Custody and CHS in the wake of a death in the jails are reflective of this commitment to thoughtful review. They work together to scrutinize the facts of each incident with an eye toward potential accountability and identification of any necessary improvements to training, policy, equipment, or operational protocols with the goal of preventing any future similar outcomes.

Reviewing Deaths in Custody

We wrote in detail in last year's annual report about the review process that Custody and Custody Health engage in every time a person dies while in custody. Thankfully, we had many fewer opportunities to engage in these processes in 2025 than in 2024.

CHS convenes a Death Review meeting within 30 days of the death, and often sooner. This meeting is attended by Sheriff's Office personnel as well as many members of the CHS staff. For two of these four incidents – the murder and one “natural causes” death – the Sheriff's Office also convened its own executive review processes, with the emphasis on its internal systems and protocols and the performance of the involved deputies. OCLEM attended all of these meetings, with the opportunity to ask questions and make any relevant suggestions.

We remain impressed by the scope, thoroughness, and rigor of these internal reviews. Participants are consistently well-prepared, having collected and reviewed all of the relevant written records and video evidence.

The tone of the meetings is collaborative and constructive, with an overall focus on identifying any potential areas of improvement or other lessons learned and creating a list of corrective actions. Some of the issues addressed in 2025 reviews include the following:

- An individual's profound mental illness seemed to contribute to his inability to engage with medical professionals about what turned out to be the very serious medical condition that led to his death. While the death review participants evaluated the various medical issues presented, as well as Custody personnel's role in completing safety checks and performing appropriate life-saving measures, the greatest emphasis was placed on the individual's record of psychiatric care and broader questions about how the system cares for those who are unable or unwilling to engage in addressing their own needs.

While broader conversations about working through these difficult situations are ongoing, in December 2025, CHS updated its policy providing guidance to its medical professionals on managing and documenting patient refusals for medical and nursing services. The

policy requires specific action and documentation by nurses and other medical providers when a patient refuses care, with stepped-up intervention measures for successive refusals. The objective of the detailed policy provisions is to ensure that patients are not overlooked because they do not want to participate in their treatment while also respecting patient's autonomy and ability to make informed decisions about their own care.

- Following one incident, jail officials discovered that the emergency call lights in one of the Main Jail's housing unit were not working properly. Though this was determined to have not played any role in the individual's death or the timeliness with which deputies discovered him, officials undertook a facility-wide check of the call lights and discovered that many were malfunctioning. Within a couple of months, work orders had been placed and completed to ensure these lights are functioning properly. Custody is developing a new policy for addressing malfunctioning call lights and concerns about misuse of the lights by IPs, particularly in areas of the jail housing those with the most severe mental illnesses.³¹
- One incident highlighted some confusion about the extent to which CHS personnel should automatically take over the lead in performing CPR once they arrive on scene. The degree to which Custody and Custody Health staff work together most effectively to provide aid in emergency situations has been a subject of prior corrective actions initiated after in-custody deaths. These corrective actions have included training for all staff on improving coordination during emergency medical response.

The confusion around who takes the lead doing CPR in this 2025 incident highlighted the need for additional corrective measures. Custody personnel reported that discussions with CHS regarding additional training and clarification of policy and procedure are ongoing.

³¹ The Sheriff's Office reports that incarcerated persons, particularly those in mental health housing areas, often press their emergency call buttons repeatedly, with no emergency to report. This creates a "crying wolf" scenario, with deputies inclined to eventually ignore the alert coming from a particular cell.

- In one case where an individual had a long history of incarceration, death review participants examined in depth his mental health treatment while in custody. Though this treatment history was not directly related to the issues surrounding his ultimate death, CHS personnel nonetheless used the death review process to identify multiple areas of improvement in both individual performance and overall systems and processes.

Our involvement in this process is intended to focus on the processes and the extent to which participants are paying careful attention to any potential learning opportunities and areas of improved performance. We continue to appreciate the level of detail, and the care and sensitivity we have witnessed in the County's in-custody death review process.

Drug Intervention and Overdose Prevention Efforts

While just one in-custody death from 2025 was the result of a drug overdose, this is a subset of jail deaths that warrants a particularly rigorous evaluation, with questions that inevitably arise about the adequacy of policies and procedures intended to prevent the introduction of narcotics or other controlled substances into the custodial setting. Beyond the obvious concerns around unintentional overdoses, the presence of drugs in the jails can create and exacerbate substance use problems and have other implications for safety and security.

Controlled substances make their way into the jails in numerous ways: through the mail, visitors, packages thrown over the fence at the Elmwood facility, and, sometimes, staff. In the case of the individual who died as the result of an overdose last year, it was discovered that he brought the drugs into the jail inside a body cavity and the Medical Examiner determined that his ingestion of them was accidental.

Custody and the Investigations Bureau have taken additional recent steps to combat the introduction of drugs into the jails. These include increased use of surveillance technology, a renewed emphasis on conducting

thorough cell searches to locate contraband,³² increased use of canine-assisted searches to identify narcotics in the facility or arriving in the mail, and improved communication between Custody and Investigations to identify and disrupt the source of controlled substances that are intercepted. In 2023, the Custody Bureau found drugs in its facilities in just over 100 incidents; in 2025, this number had increased to over 300 incidents owing to these augmented interdiction efforts.

In recent press releases, social media posts, and articles posted on its website, the Sheriff's Office has taken an increasingly deliberate approach to publicizing its efforts.³³ These reports describe several successful efforts to locate controlled substances inside the jails, resulting in the seizure of nearly 400 grams of suspected methamphetamine during January 2026 alone.

As part of its overall effort to limit illegal substances coming into its facilities, the Sheriff's Office should consider additional measures to address the introduction of contraband by staff. We noted in our section on Internal Affairs one case involving a civilian employee who provided drugs to female incarcerated persons in exchange for sexual favors, and are aware of other ongoing efforts to address concerns about the smuggling of controlled substances into the jail.

We appreciate the seriousness with which the Sheriff's Office approaches information it receives concerning allegations against staff. Diligent investigation of any tips about employee involvement in smuggling contraband is critical. But beyond increased searches and proactive investigative measures, the Sheriff's Office should also examine ways to limit employees' opportunity to engage in this type of misconduct. For example, policies that prevent staff from being alone with incarcerated

³² Sheriff's Office data show the Custody Bureau completed more searches year-over-year between 2023 and 2025, with a corresponding increase in the seizure of drugs.

³³ For example: <https://sheriff.santaclaracounty.gov/deputies-thwart-multiple-drug-smuggling-attempts-santa-clara-county-jail-facilities> and <https://sheriff.santaclaracounty.gov/one-paw-ahead-k9s-lead-fight-against-jail-drug-smuggling>

persons, particularly in areas not covered by surveillance cameras, could help avoid the scenario presented in the IA case we discussed.

In addition, the Sheriff's Office should consider the possibility of more intensive background investigations for non-sworn staff and others working or volunteering with the incarcerated population, greater rigor in hiring practices, and enhanced training for civilian personnel who will have contact with IPs.

Recommendation 3: The Sheriff's Office should examine ways to address concerns about the smuggling of controlled substances and other contraband by staff members, including expanded searches, policy measures to limit one-on-one encounters between personnel and incarcerated persons in areas not subject to surveillance, and enhanced rigor in the hiring and training of civilian staff.

Access to Naloxone (NARCAN)

While all efforts should be made to limit the presence of controlled substances in custody, it is not a zero-sum game. High demand, significant profit motives, and the considerable interest in accommodating visitors³⁴ makes total elimination of drugs in custody more a lofty ambition than an achievable objective. In light of that reality, the County's commitment to widespread access to naloxone (commonly known as NARCAN) as a way to reverse the effects of an opioid overdose is notable and commendable.

In 2025, 43 people in custody in Santa Clara's jails received naloxone as part of an overall response to a suspected overdose incident. All but one of those individuals survived.³⁵ The awareness around naloxone has

³⁴ Visitation with family members and other loved ones is crucial for IP's emotional support, stress reduction, and successful re-entry. Visitation policies must balance these interests against the need to control contraband, providing clear and transparent guidance to visitors without overly-restrictive rules or potentially intimidating or traumatizing search protocols.

³⁵ The in-custody overdose death noted above occurred despite what was determined to be the timely administration of NARCAN, likely because the drugs the individual ingested were not opioids.

become the norm in Custody, with the expectation that deputies and clinical staff will deploy this life-saving medication when appropriate. The hope is that its use can go down as drug interdiction efforts continue to improve, but its presence and availability remain a vital backstop.

We will continue to view in-custody deaths – and the efforts by Custody and Custody Health to employ meaningful review processes following these incidents – as a high priority aspect of our oversight responsibilities. In 2025, we continued to observe a willingness to engage in meaningful self-examination, along with a degree of proactivity in identifying both remedial measures and systems-based solutions, that is both commendable and exemplary. We appreciate the ongoing cooperation and collaboration with the Sheriff's Office and CHS on these important issues.

Use of Force Review

Review and monitoring of the use of force by Sheriff's Office personnel has been a significant part of OCLEM's responsibilities since its inception. In 2025, though, these tasks rose to increased prominence in our work and public reporting because of the Sheriff's Office's introduction of Conducted Energy Devices ("CEDs," commonly referred to as "Tasers") as a pilot program among a group of Correctional Deputies. The public debate over the introduction of Tasers highlighted the various circumstances under which law enforcement officers are authorized to use force and how the force options available to them impact the outcome of these incidents.

In October 2025, we reported to the Board and the Community Correction and Law Enforcement Monitoring Committee on the first six months of the Taser pilot program, providing a detailed account of the first nine Taser deployments as well as a sample of those incidents where a deputy's unholstering of the Taser (without actual deployment) was sufficient to end the threatening behavior at issue. We continue to comprehensively review these incidents and will report again on the status of the pilot program later this year.

OCLEM also interacts with the Sheriff's Office use of force review systems in several other ways. We review and provide our independent assessment of the Sheriff's Office Annual Use of Force Report as well as its Annual Report on the Use of Military Equipment, following up on specific aspects of these reports as directed by the Board. We also attend the biweekly meetings of Custody's Use of Force Review Committee and, as we describe above, we review use of force incidents that are assigned to Internal Affairs for a formal administrative investigation.

For the past several years, the majority of this review work has focused on the Custody Bureau. This makes sense, given the high frequency of contentious interactions – among incarcerated persons as well as

between IPs and staff – as well as the importance of oversight given the inherently insular nature of the custody environment. The history of violence in the jails and the existence of the federal consent decree also necessitate a particularly robust internal review process for each force incident in custody.

The Custody Bureau’s thorough documentation, assessment, and accountability when its personnel use force is serving as a model for the Enforcement Bureau’s own Use of Force Review Committee (UFRC). We discussed in last year’s report plans to develop a UFRC process for the Enforcement Bureau. Unfortunately, the pace of that development has been slower than expected. We understand the Sheriff’s Office will convene its first Enforcement UFRC meeting in the coming weeks, and we look forward to participating in that process and reporting next year on our review of use of force incidents in the field.

The dynamics of force used in the field differ in some significant ways from those in a custodial facility, but the importance of a standard emphasis on accountability, and the impact of an incident that goes awry, are the same. Maintaining the public’s trust requires the Sheriff’s Office to thoroughly review each use of force with a willingness to engage in meaningful self-scrutiny and identify areas of improvement.

Custody Use of Force Review Committee

The Use of Force Review Committee for Custody meets every-other week to review a selection of recent force incidents in the jails. The Committee formally includes the Assistant Sheriff, Professional Standards and Compliance Captain, and the Division Commander of Elmwood and Main Jail (with each voting on incidents from the other’s facility), but many others also attend UFRC meetings – including sergeants and supervisors from each facility, Professional Standards and Compliance Unit (PSAC) personnel, representatives from Training, a Mental Health clinician, and County Counsel. OCLEM has been participating in these meetings since the end of 2023.

The UFRC process is a methodical one. Operational Standards and Inspection Unit personnel are responsible for gathering all materials, including all surveillance and body-worn camera video, and organizing the review meetings. Before beginning review of each incident, personnel

present tables and charts showing year-to-date and month-by-month use of force data, by facility, housing area, and type of force, with a comparison to the prior year. Any increases or decreases are discussed so participants can identify any concerning trends or issues that need to be addressed by jail management.

The list of cases for review includes every force event classified as “Category 2 or 3” plus a random selection of “Category 1” force incidents,³⁶ generally involving the use of chemical agents, with a focused approach on incident involving individuals with mental health diagnoses. For each incident, the UFRC panel determines whether the event was appropriately classified and whether all aspects of the incident were consistent with policy. UFRC participants also assess and make recommendations around any operational changes or training needs.

The Sheriff’s Office convened 26 UFRC meetings in 2025, during which 124 force incidents were reviewed. The Sheriff’s Office tracks data on a wide range of metrics regarding each of these cases:

- 65 of the 124 incidents took place at Main Jail; 44 occurred at the Elmwood Complex Men’s Facility; 15 occurred at Elmwood’s Women’s Facility.

³⁶ UFRC procedures are specified in Policy 514: Use of Force Reporting, Investigation, and Review. Specifically, the force categories include:

Force Category 1: Pain compliance control holds, chemical agents, pressure point controls, and takedowns.

Force Category 2: Personal body weapon strikes, Compressed Air Launcher, impact weapons, and Conducted Energy Device (CED).

Force Category 3: Less lethal and munitions; Force Category 2 involving force to a person’s head, neck, sternum, spine, groin, or kidneys; discharge of a firearm; deadly force; and non-authorized use of force techniques and/or force options.

Injuries are also categorized:

Injury Category 1: Transitory Pain

Injury Category 2: Injury

Injury Category 3: Serious Bodily Injury or Death

- 69 of the reviewed cases were classified as Category 1 uses of force; 48 of these were uses of chemical agents, almost always OC spray.³⁷
- 20 cases were classified as Category 2 uses of force (Taser and Compressed Air Launcher deployments and “personal weapon” – fists, hands, or feet – strikes to non-vital areas).
- 30 were deemed to be Category 3 uses of force; 26 of these involved “personal weapon” strikes to a person’s head, neck, spine, groin, or kidneys.
- The remaining five cases involved “de minimis” force that was reviewed because the incident nonetheless resulted in an injury to the incarcerated person.
- 33 of the 124 reviewed cases involved an injury categorized as greater than “transitory pain” to the incarcerated person; Six of these individuals were transported to the hospital for treatment.
- 48 deputies were injured in 32 of the reviewed incidents.
- 50 incidents involved an incarcerated person housed in an area of the jail designated for those with serious mental illness.
- 100 of the reviewed incidents resulted in some sort of required corrective action, which most often consisted of some type of directed training for the involved deputies. Professional Standards and Compliance personnel collect evidence that the after-action was completed and report back to UFRC on any pending or outstanding action.

Personnel carefully track all uses of force, and the presentation at the beginning of each meeting allows UFRC participants to identify concerning trends and discuss ways to address them. Along with the close scrutiny of individual cases, the consistent format of these reviews makes patterns of

³⁷ “OC” is short for oleoresin capsicum, the active ingredient in pepper spray and derived from the naturally occurring compound in chili peppers.

conduct easily identifiable and provides the panel the opportunity to address them.

As we reported last year, the rigor of the discussions at UFRC and the willingness to be self-critical and acknowledge where performance was less than ideal is a commendable aspect of this force review process. As we did last year, we noted many cases where UFRC participants assessed de-escalation measures, critically evaluated deputies' choices about force options, and identified issues tangential to the force that nonetheless warranted attention. Indeed, it is the rare case at UFRC where there is no issue identified for discussion as a possible opportunity for improvement.

We offer the following examples in an effort to show how the UFRC process works and provide some depiction of the types of issues discussed at these meetings.

- A deputy engaged in a combative way with an IP who was harming himself, giving him commands and threatening to spray him with OC rather than displaying compassion and seeking a way to help alleviate the crisis. The deputy ultimately used OC spray on the IP. UFRC participants expressed frustration at the deputy's seeming inability to recognize the signs of a mental health crisis and respond with a greater degree of patience. The deputy received documented corrective action.
- In contrast, one case prompted acknowledgement of deputies' excellent work in addressing a person in mental health crisis who was engaging in self-harm and needed involuntary medication. The individual was not following a deputy's orders to allow him to be handcuffed with his hands behind him, but was showing some effort to comply with commands. Rather than force compliance, deputies handcuffed the individual in front and effectively removed him from his cell – a commendable exercise of discretion and flexible thinking.
- In a case involving a protracted struggle with an IP who was under the influence of "pruno" (jail-made alcohol), UFRC participants were critical of the deputies' threat assessment and decision making. Deputies engaged with the IP without calling a supervisor, one deputy failed to activate the body-worn camera, and one deputy

briefly had a hand on the IP's neck in an effort to control him. Deputies received appropriate counseling and formal training on de-escalation tactics and force options.

- Following an incident where an IP assaulted deputies, injuring three of them, one deputy received counseling on the difference between a "control hold" and "pain compliance" and the importance of properly documenting this distinction.

This response was notable because of the seriousness of the assault on deputies and the fact that the force was found to be within policy. Even within this challenging context, the reporting details were not overlooked and corrective action was nonetheless given.

- A deputy conducting a welfare check noticed that an IP was harming himself by jabbing his wrist with a pencil. The deputy instructed him to stop and when the IP did not, the deputy opened the door and sprayed OC into the cell. The IP then charged at the deputy, who deployed more OC spray and then tackled the IP to the ground. While the deputy's identification of concerning behavior during a welfare check was creditable, the decision to open the door without initiating any radio communication with others was quickly identified by his supervisors as problematic. The deputy also neglected to activate his body-worn camera before engaging with the IP. Jail leadership initiated corrective action to address these shortfalls.

We saw a few other cases throughout the year where the UFRC participants identified similar concerns about deputies engaging with IPs in situations where a better option would have been to wait, call for a supervisor and additional deputies, and attempt to gain the IPs voluntary compliance. Those cases all resulted in some form of corrective action.

Sometimes questions regarding sergeants' performance arise during a UFRC meeting, with the panel directing counseling for those sergeants:

- Questions about report writing, where sergeants showed a tendency to provide an explanation or justification for deputies' conduct rather than simply describing it

- Issues around the timing and quality of sergeants' interviews with IPs who were the subject of the use of force

Some cases addressed unique challenges around the use of force:

- Deputies responded to a fight between IPs and used OC spray to disrupt and end the fight. As they were securing the IPs in handcuffs, they realized one was wearing a brace on his wrist. Deputies attempted to place the cuff around the brace but ultimately removed the brace to secure the IP. Discussion at UFRC resulted in development of training on alternative ways to use handcuffs to accommodate braces or casts.
- A deputy performing routine welfare checks interrupted a conflict that was on the brink of erupting into a physical fight. One IP aggressed toward the deputy who backed up while he struggled to unholster his OC spray. This was a challenge because he was holding the RFID device³⁸ used for scanning to record welfare checks. Deputies generally do not wear holsters for the RFID devices, so that both of the deputy's hands were full as he confronted the antagonistic IP. In this incident, the OC was effective at stopping the IP's aggression. UFRC participants used the event to discuss alternatives for holstering the RFID scanners.

One specific aspect of UFRC we find valuable – and unique – is the presence of the mental health clinician at these review meetings. The clinician is available to answer any questions that arise about interactions between Custody and Mental Health personnel and can often provide some background on the individual's treatment that gives context to their behavior and helps custody staff consider ways to adjust future interactions. Sometimes the UFRC panel asks for follow-up information as part of an after-action plan, and requests that the incident be discussed again at a subsequent meeting. And the feedback loop to Mental Health staff is critically important. While Custody could provide a written report of these incidents back to clinicians, having a clinician in attendance at the review provides a much more detailed level of feedback in real time. The

³⁸ When performing welfare checks and logging other activities, deputies use handheld scanning devices that use Radio Frequency Identification (RFID) technology to record their checks.

clinician watches the videos and listens to Custody staff discuss the incident, providing a degree of context for the potential impact of clinical decisions. A couple of cases stood out as good examples of this open communication and collaboration:

- In one incident, a female IP was returning to the women's facility from the unit at Main Jail housing those with the most serious mental health concerns (the Acute Psychiatric Unit or APU), where she had spent just 24 hours. She was agitated and turned and moved aggressively toward the deputy escorting her. The deputy took her to the ground to control and secure her. She was returned to the APU, where she stayed for several days. Custody staff – while also addressing their own staffing and escort concerns – questioned why the individual had been discharged so quickly from the APU. The clinician attending UFRC committed to discuss the incident with the attending psychiatrist, and the incident was again discussed at a subsequent UFRC meeting.
- In one case, a mental health patient got agitated with deputies' directions during pill call and eventually lunged at a nurse. The mental health clinician attending UFRC questioned whether clinicians were doing enough to communicate with custody staff about the things that are triggers for some patients and acknowledged that was an area of potential development that he would work with other clinicians to improve.

Overall, we have been impressed with Custody's UFRC process – the inclusiveness of its scope and the rigor of its review. Eighty percent of the cases reviewed last year resulted in some type of corrective action. We also appreciate the emphasis on follow-through: as noted above, the completion of "action items" that emerge from the process is documented and confirmed at subsequent meetings.

OCLEM's role at these meetings is to provide an independent perspective. We actively participate in these meetings, raising questions about tactics or decision making that preceded the use of force, or broaching concerns about some aspect of the post-incident procedures. Where there were shortcomings noted in some aspect of deputy performance, jail leaders generally have identified these even before the UFRC meeting and undertaken some type of remediation (generally debriefing, counseling

with video review, or training). Nonetheless, input from someone in OCLEM's role can often be valuable as an additional set of eyes and insights. For example:

- In a case where an IP refused to move from someone else's bunk, the deputy used minor force (control holds) that resulted in a minor injury (a small cut) to remove him. The force was justified and in policy. When we watched the video, though, we questioned whether it might have been avoided through some better communication tactics, given that the deputy and IP seemed to have been stuck in an argumentative loop. We suggested that a supervisor review the video with the deputy and discuss better ways to communicate with resistive IPs. The UFRC panel agreed.
- One case involved the Emergency Response Team deploying a Pepper Ball launcher in order to saturate an area with chemical agent during a planned use of force operation intended to forcibly remove from his cell an IP in a mental health housing area who had armed himself with a sharp-edged weapon. The chemical agents were not effective at gaining the IP's compliance, and we questioned the choice of Pepper Ball for this situation. Beyond its ineffectiveness, we were concerned that the sound of the launcher (which is similar to a gun being fired) could have a particularly negative impact in a mental health housing area. This led to a productive discussion about various force options for these scenarios that also involved input from the mental health clinician who was attending that UFRC meeting and a commitment to take these issues to the ERT leaders for further consideration in future incidents.

One issue that OCLEM raised in several meetings throughout the year related to the relative informality of remedial measures. Jail commanders regularly identify shortcomings in deputy performance or documentation following a use of force incident. This frequently results in some type of informal "corrective action," typically a comprehensive video review of the incident and debriefing, informal counseling, or a targeted session with Training staff.

This response is laudable, and vital to ongoing development – both for the individual deputies and organizational culture. We have noted a

hesitancy, though, to go beyond these types of informal corrective action and issue a more formal, documented form of corrective action in some more serious cases where we thought it was warranted. Under Sheriff's Office policy, this could take the form, in appropriate cases, of a "Record of Discussion," a "Performance Improvement Plan," or – the most severe form of remedial action that does not constitute formal disciplinary action and therefore doesn't require a full Internal Affairs investigation and decision by the Disciplinary Review Board – "Formal Written Counseling."

We have encouraged division leaders to consider formal documented counseling in those cases where a deputy's conduct warrants more significant remedial measures. We understand the Sheriff's Office's concern that discussion and documentation by the UFRC of any formal corrective actions imposed would complicate UFRC record keeping given deputies' rights under state privacy laws and restrictions on how long documented counseling can be retained in an employee's personnel file. We will continue to monitor this issue and provide specific recommendations when appropriate.

AB481 and Uses of Military Equipment

OCLEM continues its engagement with the Sheriff's Office related to the use of tools classified as "military equipment" under Assembly Bill 481 (California Government Code section 7072(a)). AB 481 requires that law enforcement agencies report to the jurisdiction's governing body on their use of military equipment in an annual report.³⁹ The statute and its ongoing approval and reporting requirements have created new levels of transparency and accountability regarding a high-profile – but often under-scrutinized – element of law enforcement operations.

The reporting period for AB481 is based on a one-year period from April 1 through March 31. In June 2025, we presented to the Board our Review of the Sheriff's Office 2024-2025 Military Equipment Annual Report, in which we documented our process for reviewing these incidents and summarized our ongoing engagement with the Sheriff's Office regarding

³⁹ AB 481 classifies any supplies, equipment, and weapons that are part of the traditional military supply chain as "military equipment."

military equipment use.⁴⁰ We will similarly report to the Board on the 2025-2026 Annual Report prepared by the Sheriff's Office.

While our upcoming report will provide a comprehensive review, it bears noting here that the Sheriff's Office's AB 481 report reflects a comparatively high level of detail and transparency relative to many agency submissions across California. And we regularly work with Sheriff's Office personnel on development of policies and procedures.

Throughout 2025, we engaged with the Sheriff's Office on development of policies for two pieces of military equipment.

The first of these was to expand the use of the Unmanned Aerial System (UAS), commonly referred to as drones.⁴¹ The Sheriff's Office's specialized teams currently own drones to be deployed in discrete, limited operations, such as barricaded subjects or to provide visual support in high-risk search warrants. However, the Sheriff's Office seeks to expand this program to use "Drones as First Responders" (DFR). DFR refers to the use of drones deployed at the outset of a call for service, often launched immediately after a 9-1-1 call, to provide real-time aerial situational awareness before deputies or other responders arrive on scene. In the law enforcement context, this use of drones can support decision-making by supplying early information about scene conditions, potential threats, and the need for additional resources. DFR is intended to complement, not replace, traditional response, and is distinctly different from the Sheriff's Office current, more limited drone uses.

Because DFR involves proactive deployment to unfolding incidents, it raises distinct operational, privacy, and oversight considerations that are commonly addressed in the County through specific use and surveillance policies and governance frameworks. For that reason, the Sheriff's Office proactively shared drafts of these policies with us and the County's

⁴⁰ <https://files.santaclaracounty.gov/exjcpb1666/2026-04/oclem-review-of-sheriff-s-office-2024-2025-military-equipment-annual-report-june-3-2025.pdf?VersionId=83IIT.K9v2NiGQHWBB4YFTphceTiZ.5b>

⁴¹ For this technology, our oversight of military equipment uses overlapped with our responsibility, in support of the Privacy Office's work, for reviewing the applicable Surveillance Use Policies, which govern how the technology may be deployed and used in the County.

Privacy Office prior to acquiring DFR technology and considered our recommended revisions. Our subsequent discussions with Sheriff's Office personnel were collaborative and productive. This approach is significant, as agencies often seek to acquire new technology before the policies guiding their use are fully developed. The early, collaborative review process allowed for meaningful incorporation of recommended revisions and resulted in a policy that establishes clear limits, promotes accountability, and aligns with recognized best practices.

The second was for the use of energetic (explosive) breaching devices, which are classified as military equipment under AB 481. These devices are specialized tools used by specialized units to create rapid, controlled access through fortified doors or barriers in limited, high-risk situations where traditional methods of breaching would be ineffective or pose greater safety risks.

Here again, the Sheriff's Office provided their policies and guiding frameworks in advance of seeking acquisition from the Board; we reviewed the policy, including authorization, training, and deployment limitations, and found that the policy aligned with best practices.

Sheriff's Protective Services Officers: Progress Report

At its January 24, 2023 meeting, the Santa Clara County Board of Supervisors directed OCLEM to monitor and periodically report on the implementation of the then-new Sheriff Protective Services Officer (SPSO) classification and the development of the Sheriff's Protective Services Division.

SPSOs are non-sworn personnel who are supervised by Sheriff's Office sergeants and operate under the command structure of the Protective Services Division lieutenant and captain. The designation was established in 2018, when the Office of the County Executive determined that some County locations, particularly those within the Health System, required more specially trained security personnel to meet the increased safety concerns at those facilities. In response, the County's Employee Services Agency, in collaboration with the Sheriff's Office, developed the SPSO classification. SPSOs are responsible for the security of County locations and assist sworn personnel. The classification requires a higher level of education, experience, and training than that of the Protective Services Officer (PSO), the position that previously staffed these County locations.

The Sheriff's Office developed effective, discrete policies to govern the SPSO program as well as an expanded training curriculum and operational policies and procedures intended to cover both basic law enforcement functions and the particular responsibilities of the position.⁴²

⁴² As we reported in our 2024 Annual Report, the Sheriff's Office had addressed foundational policy and training needs associated with the implementation of the SPSO classification. The Sheriff's Office adopted SPSO-specific General Orders, including a use-of-force policy tailored to the limited authority and non-sworn

Unfortunately, the Sheriff's Office is now facing challenges related to hiring, retention, and staffing stability for its SPSO positions.

Hiring and Retention Challenges

In the first half of 2025, the Sheriff's Office conducted two SPSO academies, graduating eight SPSOs in March and ten in June. In addition, one lateral SPSO was hired from the San José Police Department and did not require academy training. Following these two academies, however, hiring for the SPSO classification was frozen, and the Sheriff's Office has not been able to bring on additional personnel for more than six months.

At present, there are approximately 31 SPSOs actively working, representing less than half of the 75 SPSO positions originally envisioned for the program and below the 41 currently funded SPSO positions. But even this number is unstable: the program has experienced loss of personnel, including SPSOs who left after being hired into Custody and Enforcement positions within the Sheriff's Office, as well as one resignation. The Sheriff's Office has also indicated that additional SPSOs are in the process of leaving for other employment, which will further impact staffing.

Operationally, the limited number of available SPSOs has constrained the Sheriff's Office's ability to fully staff County facilities as intended. Ten SPSOs are currently assigned to St. Louise Regional Hospital, where a minimum of two officers per shift is required. An additional 24 SPSOs are assigned to the Valley Medical Center (VMC) campus. To supplement SPSO staffing, the Sheriff's Office continues to rely on "legacy" PSOs and

status of SPSOs. A comprehensive SPSO Procedure Manual was also developed to guide day-to-day operations, including setting out responses to hospital codes and how to address allegations of patient abuse. In addition, the Sheriff's Office expanded and enhanced the SPSO training program, increasing the course length, incorporating Crisis Intervention Training (CIT) and Professional Assault Crisis Training (Pro-ACT), adding report-writing and radio communications modules, and integrating scenario-based instruction led by experienced SPSOs and supervising sergeants.

supervisors who did not transition into the SPSO classification when the County developed the SPSO program.

The Sheriff's Office is pursuing some avenues for relief from this staffing shortage, which it anticipates will grow in urgency when VMC's new Behavioral Health building opens later this year. That facility is expected to generate a high volume of incidents, underscoring the need for a stable and adequately staffed protective services presence.

Even if the Sheriff's Office is authorized to hire additional SPSOs, the lengthy hiring and training process will leave a significant short-term staffing gap. The alternatives – private security contractors or other stopgap measures – are not ideal. The objective of the SPSO program, as originally conceived, was to meet security needs at County hospitals and other facilities with consistency, training, and integration with Sheriff's Office operations. Taken together, these hiring and retention challenges hinder the program's ability to meet these goals and present a substantial risk to the sustainability of the program.

Body-Worn Cameras

As OCLEM previously reported, SPSOs are not currently equipped with body-worn cameras, despite strong support from both Sheriff Office leadership and SPSOs themselves. Body-worn cameras have become a standard accountability and risk-management tool across law enforcement agencies, serving to protect both employees and members of the public by documenting encounters for later review, training, and evaluation.

Body-worn cameras are particularly important for SPSOs given the nature of their assignments: SPSOs are frequently called upon to respond to highly dynamic and sensitive incidents within hospital and behavioral health settings, including interactions with persons experiencing crisis, use of specialized restraint techniques, and coordinated responses with medical staff. Video documentation of these encounters can be critical for performance review, training, oversight, and accountability, especially when allegations arise regarding use of force, patient handling, or staff conduct.

Since OCLEM's last report, the Sheriff's Office has continued efforts to move toward equipping SPSOs with body-worn cameras but progress has

been constrained by a combination of legal, operational, and financial challenges. Pending legislation, including Senate Bill 691, is expected to provide additional statutory guidance regarding when and how recordings may occur in medical settings, which may help resolve some of these concerns.

Acknowledging all of these concerns, OCLEM reiterates its prior recommendation that stakeholders expedite the acquisition of body-worn cameras for SPSOs. While the legal and privacy considerations associated with medical settings warrant careful attention, these challenges are not unique to SPSOs and should not indefinitely delay implementation.

Recommendation 4: The Sheriff's Office and involved stakeholders should expedite the acquisition of body-worn cameras for Sheriff Protective Services Officers.

Use of Force and Reporting

As non-sworn employees, SPSOs are authorized to use force only in limited circumstances: to affect a private person's arrest, to defend against an attack, or to assist medical personnel, at the order or direction of authorized medical staff, in restraining patients. Consistent with the SPSO role's limited authority and narrowly defined use-of-force parameters, Sheriff's Office data show that reportable uses of force involving SPSOs are relatively infrequent.

The Sheriff's Office reported that SPSOs used some type of force in eight incidents. These interventions were determined to be necessary and reasonable to restrain or detain patients who were combative or assaultive toward hospital staff, as well as one patient determined to be a danger to himself.

Seven of these incidents involved low-level uses of force, such as control holds or takedowns, used to assist hospital staff in restraining and/or detaining combative or assaultive patients. Two of these incidents involved the same patient in separate encounters. Six staff members reported sustaining some form of injury as a result of the patient's actions. Two incidents resulted in minor injuries to SPSOs. One patient sustained

a minor injury as a result of the incident, though it was unclear how the injury had been sustained.

The eighth use of force involved a control hold used to restrain a patient who was being brought in on a mental health hold.

One unique challenge faced by SPSOs is balancing their use of force authority and training against expectations from hospital staff that they will intervene in ways that exceed their role. For example, hospital staff may ask an SPSO to restrain a patient to keep them from leaving the facility in a situation where there is no legal authority to do so. This inconsistent understanding of the SPSO's role is a communications challenge, particularly in fast-moving clinical environments where expectations may not be fully aligned. To that end, SPSOs and sergeants have worked to educate hospital staff about the scope and limits of SPSO authority, which reportedly reduced the frequency of requests for interventions that fell outside their lawful role.

These circumstances illustrate the complexity of the SPSO classification, which operates at the intersection of healthcare, behavioral health, and law enforcement. Effective use of SPSOs depends not only on clear policies and training within the Sheriff's Office, but also on consistent communication and shared understanding among hospital leadership and frontline staff.

Documentation

In last year's review, OCLEM found that SPSO physical engagements that did not rise to the level of reportable force were documented primarily through entries in the daily Sergeant's Log. While supervisors consistently recorded these incidents, the level of detail varied, and more thorough documentation was not applied uniformly. OCLEM recommended that more standardized documentation would strengthen supervisory review, clarify force determinations, and reduce uncertainty regarding SPSO actions.

In response, the Sheriff's Office implemented a new form designed to document SPSO physical engagements that do not meet the threshold for reportable force. The form provides a standardized mechanism for capturing these incidents and is completed by a supervisor based on the SPSO's actions. This change directly addresses OCLEM's prior concerns

regarding inconsistent documentation and represents a meaningful improvement in the Division's ability to track, review, and evaluate SPSO physical engagements below the reportable-force threshold.

We reviewed all available documentation for the eight reported uses of force and found that it sufficiently addressed our prior concerns. The incidents were reviewed for compliance with SPSO policy, and the supervisory reviews reflected a sufficiently robust analysis to determine that the actions were consistent with applicable policy.

OCLEM will continue to monitor the use and effectiveness of the new documentation form to assess whether it results in sustained improvements in consistency, clarity, and supervisory oversight.

Other Projects and Activities

As part of our ongoing engagement with the County and the Sheriff's Office, OCLEM was involved in a number of other projects and activities throughout 2025. Like many of the responsibilities discussed in prior sections of this report, these activities are generally ongoing, with OCLEM now an established part of the County's mechanisms for review and accountability in several areas.

Engagement with CCLEM

An important aspect of our role with the County is to work closely with the Community Correction and Law Enforcement Monitoring Committee (CCLEM). We made presentations at all eight CCLEM meetings in 2025, providing both regular updates on our work as well as special presentations on issues of concern to the Committee. For example, we gave presentations regarding our role in the review of in-custody deaths and the 10 deaths in the jail during 2024, our review of the Sheriff's Office reports on its uses of military equipment, the status of jail reforms recommendations being audited by OCLEM, and on the numerous questions surrounding the Sheriff's Office pilot program for Tasers in the jails.

We are also happy to serve as a resource to CCLEM subcommittees whose work we support in various ways. For example, we regularly receive calls from individual CCLEM members with questions about various subjects relating to subcommittee assignments, generally around Sheriff's Office protocols in relation to our experience with other agencies and what we see as best practices.

We appreciate the value that CCLEM brings to the County and to our work. Its members provide important perspectives as the voices of their respective communities. Their ideas and input help guide our approach, and their positions on important issues broaden our assessments in vital ways.

Collaboration with the Privacy Office: Surveillance Use Policies

The County's Surveillance Technology and Community Safety Ordinance serves several important purposes: protecting individuals' privacy and civil liberties by limiting information collected to only that necessary for government purposes while providing transparency and accountability through oversight and annual compliance reporting. In December 2023, the Board of Supervisors amended the ordinance to provide that OCLEM is now to work with the Privacy Office to review surveillance technologies⁴³ used or proposed by the County's various public safety and justice departments: the Sheriff's Office, District Attorney's Office, Public Defender's Office, Pretrial Services and Probation.

Since 2024, OCLEM has worked collaboratively with the Privacy Office⁴⁴ and these departments to evaluate any new Surveillance Use Policies (SUPs) and the related Annual Surveillance Reports (ASRs). In 2025, our process for reviewing these shifted with efficiency-based amendments to the ordinance that created different varying levels of review based on the classification of potential risk posed by the technology. OCLEM remains involved in the review of SUPs and ASRs, though the process has been streamlined to focus attention on technologies that pose a higher risk to individual privacy concerns.

Under the updated model, OCLEM received 27 Annual Surveillance Reports involving public safety and justice departments. Each report detailed the purpose and intended use of the technology, its effectiveness, and any incidents of data sharing. We provided feedback and worked

⁴³ Examples of surveillance technology used by law enforcement include drones, automated license plate readers, GPS technology, body-worn and other camera systems, and radio-frequency identification technology.

⁴⁴ We also wanted to acknowledge and express our gratitude to a member of the Privacy Office who participated with us on a webinar for the National Association for the Civilian Oversight of Law Enforcement on the role of Artificial Intelligence systems in law enforcement operations. His expertise and contributions were highly valued by that audience.

constructively with the Privacy Office and the departments to clarify issues that raised potential concerns.

We also received and provided feedback on Surveillance Use Policies for new technology or equipment that the Sheriff's Office sought or is seeking to acquire over the calendar year. These included policies for Unmanned Aerial Surveillance Systems (UAS, or drones) and a GPS Vehicle Tracking System. Development of policy on both of these technologies required extensive back-and-forth conversations with the Sheriff's Office. We appreciate the Office's thoughtful consideration of our edits and suggestions and found the resulting policies to fairly balance numerous, sometimes competing goals and interests.

Overall, our collaboration with the Privacy Office has been effective and constructive. Our policy review considered industry best practices, legislation, case law, and model policies to ensure that County residents' privacy interests are balanced with the need for new and ever-evolving technology in law enforcement.

Auditing of Jail Reform Recommendations

At the Board's direction, OCLEM has served since December 2020 as the auditor of the progress on implementing the set of 623 recommendations that emerged from the County's efforts to reform its jails that began in 2016. In April 2025, we presented our seventh report on the status of those auditing efforts.⁴⁵ In that report, we detailed our reasons for recommending that the auditing of the remaining specific recommendations be considered complete. Some of those recommendations have been fully implemented. For others, the recommendation was no longer relevant or applicable, or other reform efforts have fully satisfied the original intent of the recommendation. For some recommendations, the objective of the recommendation could be better achieved through other means, including ongoing monitoring by OCLEM.

⁴⁵ https://files.santaclaracounty.gov/exjcpb1666/2025-04/jail-reform-recommendations-interim-report-7-april-2025.pdf?VersionId=YLU.vcrC20_la4g.bF30hhdhfq9kdZOw

The Board approved this recommendation, consolidating the ongoing monitoring task associated with this assignment to eight areas of jail reform efforts:

- Parenting classes for incarcerated persons who have children
- The need for ombuds services or some type of observer program in the County jails, and how best to meet those needs
- Timeliness of Internal Affairs (IA) investigations
- Transparency issues surrounding IA investigations and resulting disciplinary actions
- Consideration of a disciplinary matrix to ensure consistency and fairness in the disciplinary system
- Full implementation of a robust Early Intervention System
- Implementation of the Jail Management System
- Improved communication between County and Sheriff's Office officials and family members impacted by in-custody deaths

We reported to CCLEM and the Board on these in November 2025⁴⁶ and again in April 2026.⁴⁷ As we said in both of those reports, the work of reforming the County's jails is very much "in progress." OCLEM continues to play a role in these reform efforts. And we will continue to provide the Board and the community regular updates on the Sheriff's Office progress in these areas.

Inmate Advisory Councils

We regularly attend Custody's meetings with the Inmate Advisory Councils (IACs) at both the Elmwood and Main Jail facilities. The IAC is comprised of incarcerated individuals nominated by their peers to represent each housing unit. The meetings are meant to allow these representatives to engage with facility captains and others – representatives of Food Services, the Programs Unit, Classification, Custody Health, and the

⁴⁶ https://files.santaclaracounty.gov/exjcpb1666/2026-04/report-on-the-status-of-jail-reform-efforts-monitored-by-oclem-november-4-2025.pdf?VersionId=kW3GaCYFN_EXJixerl98HH16lTkoji3s

⁴⁷ <https://files.santaclaracounty.gov/exjcpb1666/2026-04/report-on-the-status-of-jail-reform-efforts-monitored-by-oclem-april-8-2026.pdf?VersionId=fJCtHoullGcSZXb0h4LxhhOewvZsSIM3>

Grievance Unit – on issues of concern to the individual housing units and the incarcerated population as a whole.

Unfortunately, there was just one set of IACs (one meeting at each facility) convened in 2025. Those meetings are intended to be held twice or three times each year, but there is no regularly established calendar and the task of scheduling does not rest with any particular individual. When we asked about these meetings in the middle of the year, Custody apparently attempted, but was unable, to find a date that would work for both facilities within a timeframe that would allow them to hold the necessary elections in the housing units to prepare for the meeting. In conjunction with other recommendations for changing the IAC model that we discuss below, we recommend setting an established date for each IAC meeting, and then having a designated individual or individuals responsible for initiating all the steps necessary to conduct the meeting on time.

During the IAC meetings we attended in May 2025 (as well as those conducted in 2024), we found the meetings to be a productive way for incarcerated persons to connect with jail management. The facility captains meaningfully engaged with the IAC members, listening to their concerns and attempting to be responsive to their questions. The issues largely revolved around food and commissary offerings, programming opportunities, and services available on the tablets.⁴⁸

We attended the most recent meetings – in March 2026 – and found that many of the same issues were discussed. This was not surprising, as many of the responses from the captains and service providers centered on explanations of Sheriff's Office and County processes that limited the ability to fully satisfy some of the IAC requests.⁴⁹ The dissatisfaction regarding these issues persists nonetheless.

⁴⁸ Tablets provided to incarcerated persons are designed to provide some controlled access to communication, education, entertainment, and legal resources. They are provided by a third-party vendor through a contract with the County and are tailored to maintain security while also providing a valuable means of communication and connection.

⁴⁹ For example, IPs requested additional options for purchase at commissary and expanded content on the tablets. While leadership listened and expressed concurrence with the desire for increasing available options for both commissary

The captains and service providers did an excellent job of responding to the IP's concerns with empathy and frankness, and the IPs we spoke with after the meetings were appreciative of the opportunity and ability to effectively communicate with jail leaders. We made a couple of observations about the IAC meetings: There is a great deal of formality around these meetings that seemed to not always translate into meaningful engagement. At one facility, by our count, there were four IPs, 14 uniformed Sheriff's Office members, and 6 members of support units (plus OCLEM). At the other, there were five IPs, at least 16 Sheriff's Office members, and the same support unit members. There are written agendas and, at one meeting, microphones for the jail administration and other leaders.

- The effort required for the process to select the IPs who attended as housing unit representatives was cited as one reason why there were no IACs convened in 2025. The small number of IPs at each IAC raised questions for us about this selection process and whether it could be both less burdensome and more inclusive.
- The issues raised seemed capable of resolution without this level of formality. For example, one request from the IPs was for bowls in which they could make and eat the food they purchase from commissary. We learned this has been a regular, ongoing request raised in various ways. The formal answer to this request was, "no" because bowls can't be properly sanitized pursuant to regulatory requirements. There was a disconnect here, though, because the request did not have to do with meals being served by Food Services in bowls (which would require proper sterilization) but was about commissary items (like ramen noodles) being sold without a proper vessel to prepare them. Once administrators understood this issue, it seemed that a solution might be achievable.
- The incarcerated individuals who participated in these meetings were engaged, attentive representatives of their housing units. They addressed concerns that other IPs had raised with them and

and the tablets, they explained how the current limitations are based on contracts with outside vendors.

replied thoughtfully to the responses and follow-up questions from administrators.

We recommend that Custody leadership consider ways to engage with the incarcerated population more frequently, and in ways that could serve to supplement the IACs. Rather than remove certain selected IPs from the housing units to engage with a large group of administrators, jail administration should consider engaging with IPs in the housing units in an informal “town hall” format, during regular programming time. This would create the opportunity for more speedy resolution of some IP concerns and give administrators an enhanced level of connectivity with issues in their facilities. We have seen this work in other jail facilities and could work with the Sheriff’s Office to develop needed protocols.

If Custody chooses to continue with its current IAC format, it should commit to convening the IACs no less than twice a year and take appropriate measures to ensure the scheduling of these meetings is completed in a timely way.

Recommendation 5: Custody Bureau should consider new ways for its administrators and service providers to connect with the incarcerated population, to meet more frequently and with less formality than the current system of Inmate Advisory Councils.

Recommendation 6: To the extent the Inmate Advisory Councils continue to meet, Custody Bureau should take necessary measures to ensure that meetings are scheduled at least twice a year.

Recommendations

- 1: The Sheriff's Office should implement policy requiring timely and proactive release of all records related to critical incidents, as defined by state law, that are subject to disclosure under the CPRA, including body-worn camera and other video footage, regardless of whether a request has been filed under California's Public Records Act.
- 2: When an individual dies following an incident that occurred while incarcerated in the County's jails and where the incident was related to the cause of death, the Sheriff's Office should report the incident on its Transparency Portal, even if the person was released from custody prior to the time of death.
- 3: The Sheriff's Office should examine ways to address concerns about the smuggling of controlled substances and other contraband by staff members, including expanded searches, policy measures to limit one-on-one encounters between personnel and incarcerated persons in areas not subject to surveillance, and enhanced rigor in the hiring and training of civilian staff.
- 4: The Sheriff's Office and involved stakeholders should expedite the acquisition of body-worn cameras for Sheriff Protective Services Officers.
- 5: Custody Bureau should consider new ways for its administrators and service providers to connect with the incarcerated population, to meet more frequently and with less formality than the current system of Inmate Advisory Councils.
- 6: To the extent the Inmate Advisory Councils continue to meet, Custody Bureau should take necessary measures to ensure that meetings are scheduled at least twice a year.