2025–2026

Riverside County Civil Grand Jury Report

May 7, 2026

After a Decade of Record Deaths in County Jails, the Community Deserves Transparency through Oversight

SUMMARY

The Riverside County Sheriff's Office (RCSO) administers one of the largest jail systems in California, housing pretrial detainees, sentenced individuals, and persons held under a variety of legal classifications. These facilities serve a growing population with increasingly complex medical, mental health, and substance-abuse issues.

The 2025–2026 Riverside County Civil Grand Jury (Grand Jury) initiated this investigation to evaluate the effectiveness, transparency, and accountability of RCSO operations, focusing on its jail system. Persistent concerns regarding in-custody deaths, internal investigative practices, and the absence of comprehensive independent oversight prompted the Grand Jury to examine whether existing structures adequately protect the rights, health, and safety of individuals in custody and ensure responsible stewardship of public resources.

The Grand Jury also assessed the role and performance of the Sheriff's Advisory Committee (SAC), a body intended to provide community input and some oversight-related guidance. Despite its stated purpose, the committee's activities, documentation practices, and public transparency raised significant questions about its ability to fulfill its advisory function.

Over the past decade, Riverside County's jail system has been the subject of public and media criticism, prior Grand Jury findings, and civil lawsuits.[1] While the RCSO jail system has made some operational improvements, these efforts have lacked a coordinated, countywide oversight framework that could identify systemic risk, monitor long-term trends, and ensure sustained compliance with state and federal standards.

In February 2023, the California Attorney General announced a civil rights investigation into the Riverside County jail system following a record number of in-custody deaths and allegations concerning custodial practices and inmate medical care.[2] As of early 2026, that investigation remained active without a final public report or any updates. Twenty-nine in-custody deaths, from the launch of the state inquiry through late April 2026 underscores the urgent need for structural reform independent of electoral or political timelines.[3] Oversight mechanisms based only on isolated investigations cannot substitute for permanent systems grounded in transparency and accountability.

After extensive interviews, document reviews, facility visits, and an analysis of oversight entities throughout California—including the City of Riverside—and nationwide, the Grand Jury finds that Riverside County has not established a comprehensive, independent civilian oversight structure under Assembly Bill 1185[4] and Government Code § 25303.[5] Existing oversight

[1] *Palm Springs Desert Sun*, "Amid jail deaths and lawsuits, groups urge Riverside County supervisors to rein in sheriff. Advocates want independent oversight," by Christopher Damien, November 2, 2023.
[2] California Department of Justice, Office of the Attorney General, press release, "Attorney General Bonta Announces Civil Rights Investigation into Riverside County Sheriff's Office System." (February 23, 2023).
[3] Riverside County Sheriff's In-Custody Deaths. Riverside Sheriff. Accessed April 29, 2026.
[4] Assembly Bill 1185 (2020), amending Cal. Gov. Code § 25303, authorizing county boards of supervisors to establish civilian oversight boards and inspectors general with subpoena authority over sheriff's departments.
[5] Cal. Gov. Code § 25303 (West 2024) (granting supervisory authority to county boards of supervisors over county officers).

mechanisms are fragmented, limited in scope, and largely internal to the RCSO's chain of command. This structural design restricts independent review of critical incidents, constrains systemic risk analysis, and limits public transparency.

The Riverside County Board of Supervisors (Board) appointed members of the SAC, which was created to provide community input and promote transparency.[6] The SAC has not, however, demonstrated measurable advisory output. It does not publish meeting minutes, formal findings, or written recommendations and its meetings lack public participation.

Nationally recognized standards developed by the National Association for Civilian Oversight of Law Enforcement (NACOLE) emphasize five core components of effective civilian oversight:[7]

- structural independence
- clearly defined legal authority
- investigative access
- transparency and public reporting
- professional competence

Riverside County's current framework does not incorporate these best-practice elements in a unified or systematic manner.

Comparative analysis of other California counties demonstrates that independent oversight structures—including civilian oversight boards and inspectors general with subpoena authority—are now common governance tools.[8] Counties such as Los Angeles, Sacramento, Sonoma, and Santa Clara have adopted formalized models combining investigatory authority, dedicated staffing, public reporting requirements, and clearly defined legal mandates. Riverside County remains among the largest counties in the state without a comparable, fully empowered civilian oversight entity for sheriff's operations, including the jail system.

The absence of independent oversight is not merely a policy gap; it presents measurable governance risk. Repeated in-custody deaths and allegations of systemic deficiencies expose the County to potential civil liability under federal and state law, including claims under 42 U.S.C. § 1997[9] authorizing federal investigations of institutional conditions. Beyond legal exposure, continued deficiencies may erode public trust, increase insurance and litigation costs, and divert public resources from other essential services.

This report does not presume misconduct by individual personnel. Rather, it identifies structural weaknesses that inhibit Riverside County's ability to evaluate performance objectively, detect systemic risk patterns, and implement effective corrective action. Independent oversight is a

[6] Riverside County Sheriff's website www.riversidesheriff.org/27/About-Us. Accessed March 17, 2026.
[7] National Association for Civilian Oversight of Law Enforcement (NACOLE), "Standards and Guidelines for Civilian Oversight of Law Enforcement" (latest edition).
[8] Fixin' San Mateo County Report on Civilian Oversight of Law Enforcement, August 2022.
[9] Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997a.

governance best practice—not an accusation. When properly structured, it strengthens institutions by enhancing credibility, reinforcing professional standards, and promoting continuous improvement.

The Grand Jury's Findings are listed below:

- Riverside County has not established an independent civilian oversight entity with clearly defined authority and investigatory capacity.
- Internal investigations of in-custody deaths lack structural independence and publicly accessible reporting.
- Transparent public data regarding jail operations is limited and inconsistent.
- Operational improvements have been reactive rather than strategic.
- The SAC has not fulfilled its intended advisory function.
- The Board has not adopted a unified, long-term oversight and accountability framework.

To address deficiencies detailed in this report, the Grand Jury recommends that the Board establish, within twelve months as of July 1, 2026:

- An independent civilian oversight body pursuant to AB 1185, with subpoena authority or equivalent investigatory access.
- An oversight entity with independent staffing and budget, authority to review critical incidents and in-custody deaths, mandatory public reporting, and defined appointment protections.
- An independent custodial and correctional health audit.
- A quarterly public data dashboard.
- A five-year strategic jail operations plan.

The Grand Jury further recommends the Board dissolve the SAC, and formally adopt NACOLE best-practice standards as the County's oversight framework.

Oversight of a jail system housing thousands of individuals—many of whom are pretrial detainees presumed innocent—demands more than isolated reviews, as are currently conducted by the State of California.[10] It requires institutionalized transparency, independent evaluation, and measurable accountability. The Board possesses clear statutory authority to establish such oversight. Exercising that authority is not an intrusion upon law enforcement functions; it is a core governance responsibility.

The Grand Jury recognizes the complexity of jail administration and general operations of the Sheriff's Office with its budgetary constraints, and acknowledges the dedication of many professionals who work within the system. Meaningful reform, however, requires structural alignment between authority, accountability, and transparency. Without independent civilian oversight, systemic deficiencies may persist undetected, eroding public trust and escalating legal

[10] California Board of State and Community Corrections, *About the BACC*, https://www.bscc.ca.gov/; see also Cal. Penal Code §§ 6030–6031.1 (authorizing the BSCC to establish minimum standards for local detention facilities, conduct biennial inspections, and issue reports identifying noncompliance).

and fiscal risks. Failure to implement independent oversight and custodial reforms exposes the County to significant civil liability, particularly in cases involving in-custody deaths, deliberate indifference claims under 42 U.S.C. § 1997, and wrongful death actions.

Comprehensive, centralized reporting on lawsuit payouts specific to custodial deaths is limited. Available case data and reporting indicate that Riverside County has paid millions of dollars in individual settlements. Additional litigation is currently pending. The most well-documented recent case involved a $7.5 million settlement paid in 2024 to the family of Christopher Zumwalt. He died in custody in 2020 following a confrontation with deputies and alleged denial of medical care.[11]

Comparable counties (as outlined in Tables 1 and 2) have incurred settlements ranging from $1 million to over $10 million per incident involving custodial deaths or serious medical neglect.[12] The implementation of a civilian oversight entity with improved reporting and independent review processes may reduce these liabilities by demonstrating compliance, transparency, and corrective action. Investment in oversight infrastructure may therefore offset long-term litigation costs, insurance premiums, and harm to the RCSO's reputation.

The goal of this report is to promote accountability, strengthen operational practices, and support the development of effective, transparent, and sustainable oversight mechanisms within Riverside County's jail system and RCSO operations as a whole.

The Grand Jury respectfully submits this Summary in support of durable, evidence-based reform and urges all required respondents to engage substantively and promptly with the Findings and Recommendations that follow.

BACKGROUND

An alarming number of in-custody deaths, combined with questions about internal investigative practices and the absence of independent oversight, has raised ongoing concerns about safety, transparency, and accountability of Riverside County's jail operations. With regard to the internal investigative practices, an investigation was opened by the RCSO against a sergeant two days after he lodged a harassment complaint according to all available documentation.[13] Despite

[11] *Zumwalt v. County of Riverside*, No. 5:20-cv__(C.D. Cal. 2024) (settled for $7.5 million); see also, "$7.5 Million Settlement in Suit Over California Jail Death" (August 2024) (reporting settlement involving allegations of excessive force and denial of medical care).

[12] See, e.g., *Estate of Chavez v. County of Los Angeles*, No. BC512345 (Cal. Super. Ct. 2016) (settlement reported at $8 million involving in-custody death); *Rosales v. County of Kern*, No. BCV-18-102345 (Cal. Super. Ct. 2020) (settlement exceeding $6 million for failure to provide adequate medical care); and Castro v. County of Los Angeles, 833 F.3d 1060 (9th Cir. 2016) (establishing municipal liability standards for pretrial detainee medical and safety claims under the Fourteenth Amendment). See also Prison Law Office, *California Jail and Prison Condition Litigation Summary* (2022), documenting multiple county jail settlements ranging from approximately $1 million to over $10 million in cases involving custodial deaths, suicide, or serious medical neglect.

[13] *Lodes v. County of Riverside*, (Cal. Super. Ct., Riverside County, filed (lawsuit alleging civil rights violations arising from in-custody conditions within the Riverside County Sheriff's Department; case resulted in a judgment/settlement in favor of the plaintiff).

these concerns, the County has not established a comprehensive oversight structure capable of evaluating systemic risks and ensuring compliance with state and federal standards.

The SAC was created to provide community input and serve as a bridge between the public and the RCSO. Its stated purpose includes reviewing policies, offering recommendations, and enhancing transparency. However, the SAC's actual role, documentation practices, and public engagement have remained unclear. The SAC does not publish meeting minutes, findings, or recommendations. During interviews with the Grand Jury, SAC members were unable to articulate any significant, formal accomplishments. Board members who appointed SAC members, were unclear about SAC activities and accomplishments. This lack of transparency and accountability has contributed to uncertainty about the SAC's effectiveness and its ability to fulfill its intended advisory function.

The difference between the SAC and oversight aligned with AB 1185 is substantial. One is internal, advisory, and controlled by the Sheriff, while the other (AB 1185 oversight) is independent, investigatory, and accountable to the public through the Board of Supervisors.

The Board holds ultimate responsibility for establishing policy direction, funding priorities, and oversight structures for County agencies, including the RCSO. While acknowledging concerns related to jail operations in the past, supervisors have not implemented a unified or strategic framework for oversight, data transparency, or long-term operational planning. One Supervisor's advocacy for an ad hoc committee to explore independent civilian oversight failed to gain support from colleagues at a Board meeting July 2025.[14]

This Grand Jury investigation evaluated the following interconnected issues:

- the performance and accountability of the jail system
- the adequacy of internal and external oversight mechanisms
- the effectiveness of the SAC

The Background presented here provides the context necessary to understand the systemic challenges identified in the Findings and addressed in the Recommendations.

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[14] Riverside County Board of Supervisors meeting minutes July 29, 2025. https://media.rivcocob.org/proceeds/2025/p2025_07_29_files/03.82001.pdf. Accessed March 17, 2026.

METHODOLGY

The Grand Jury conducted a comprehensive investigation into the operations, oversight practices, and accountability structures of the RCSO and its jail system. The investigation included multiple interviews, document reviews, facility observations, and analysis of publicly available data.

The Grand Jury interviewed personnel from the RCSO, including individuals responsible for jail operations, internal investigations, and administrative oversight. Interviews were also conducted with members of the SAC to assess the committee's role, activities, and documentation practices. Additional interviews were held with County officials and individuals familiar with prior oversight efforts.

The Grand Jury reviewed a wide range of documents, including internal policies, training materials, incident reports, publicly available data related to in-custody deaths, use-of-force incidents, and jail operations. The Grand Jury examined prior Riverside County Civil Grand Jury reports, external investigative findings, and relevant state and federal standards governing jail facilities.

Site visits were conducted at all five Riverside County jail facilities to observe operational conditions, intake procedures, medical and mental-health service areas, and general compliance with established protocols. These observations provided context for evaluating the consistency of practices across facilities.

The Grand Jury reviewed the structure, purpose, and public-facing practices of the SAC, including requests for meeting minutes, findings, recommendations, and any documentation of committee activities. The committee's inability to provide such materials was noted as part of the investigative record.

The Grand Jury reviewed the annual reports and operating structure of City of Riverside's Community Police Review Commission (CPRC) and interviewed current and former members.

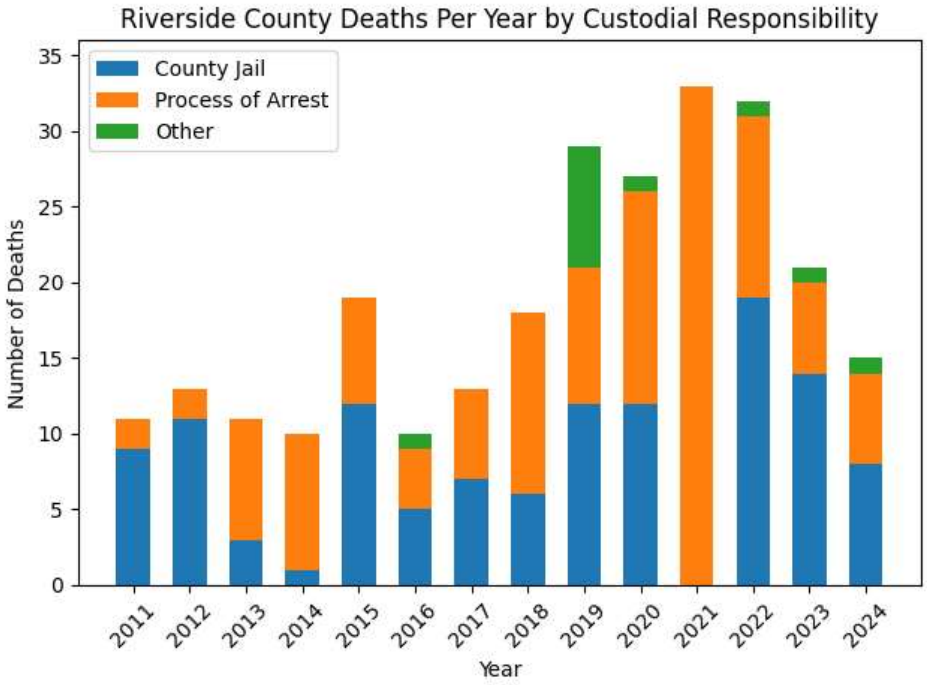
All information gathered was analyzed collectively to identify systemic issues, evaluate the effectiveness of existing oversight mechanisms, and develop the Findings and Recommendations presented in this report.

DISCUSSION

Despite repeated findings from prior Grand Jury reports,[15] external investigations, and community concerns, the County of Riverside has not implemented the structural reforms necessary to ensure consistent, safe, and constitutionally compliant jail operations. The persistence of these issues demonstrates that the problems are not isolated incidents but systemic failures rooted in inadequate oversight, insufficient transparency, and a lack of sustained institutional accountability.

The unusually high number of in-custody deaths in recent years underscores the seriousness of these deficiencies. While some deaths may be attributable to medical conditions or substance abuse, the frequency and circumstances of these incidents raise significant concerns about the adequacy of medical care, mental-health services, intake screening, monitoring practices, and emergency response procedures within the jail system. The absence of a comprehensive, independent review mechanism prevents the County from fully understanding the causes of these deaths or implementing effective corrective actions.

CHART 1



Source: California Department of Justice, Criminal Justice Statistics Center
Note: Chart recreated with pattern fills for ADA accessibility.

[15] Riverside County Civil Grand Jury, *Reports and Responses Archive*, County of Riverside, https://rivco.gov/civil-grand-jury. Accessed March 12, 2026. The Civil Grand Jury has issued multiple reports evaluating the Riverside County Sheriff's Office and Corrections Division, including findings and recommendations related to jail operations, inmate services, and oversight.

Oversight mechanisms currently in place are fragmented and insufficient. Internal investigations lack independence, and external review is limited or nonexistent. Without a dedicated oversight body empowered to monitor jail conditions, review critical incidents, and ensure compliance with state and federal standards, the County cannot meaningfully evaluate the performance of its jail operations or identify systemic risks. This lack of oversight also erodes public trust and leaves the RCSO and the County vulnerable to legal liability and reputational harm.

The RCSO has made some operational improvements in response to the 2024-2025 Grand Jury report, including facility upgrades and expanded training initiatives with plans for enhanced contraband screening. However, these efforts remain reactive rather than strategic. The County of Riverside has not adopted a long-term plan for jail oversight, data transparency with respect to in custody deaths, or coordinated interagency collaboration (with the noted exception of the County of San Bernardino conducting autopsies for RCSO in-custody deaths). As a result, improvements are inconsistent and do not address the underlying structural issues that contribute to operational failures.

The Grand Jury finds that meaningful reform requires an independent oversight entity with the authority to review policies, investigate critical incidents, and monitor compliance. Such a body would provide transparency, promote accountability, and support the RCSO in implementing best practices. Without independent oversight, Riverside County cannot ensure that its jail system operates safely, effectively, or in alignment with community expectations and legal obligations.

The California Department of Justice (DOJ) investigation into the Riverside County jail system that began in 2023 was prompted in part by a record number of inmate fatalities—including eighteen deaths in 2022, the highest one-year total in decades—and concerns raised by civil rights organizations, community advocates, and the media regarding medical care, supervision, and custodial practices in County jails.

Nearly three years after the investigation began, the DOJ has not yet released a final public report or definitive findings. As of late April 2026, the investigation remained active, even as the County experienced twenty-nine in-custody deaths since March 2023.[16] The continued occurrence of in-custody deaths during the DOJ inquiry has underscored ongoing operational and oversight challenges within the Riverside County jail system, and it raises questions about the immediacy and responsiveness of reform efforts tied to the state review.

The lack of a timely public report has also given rise to public commentary and political scrutiny. Leadership at RCSO [17] has publicly characterized the DOJ investigation as politically motivated rather than focused on operational accountability.[18]

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[16] In-Custody Deaths, Riverside County Sheriff. www.riversidesheriff.org/m/newsflash?cat=25. Accessed April 29, 2026.

[17] *The Press-Enterprise*, "Riverside County Sheriff Chad Bianco announces California governor run in 2026. Outspoken Republican goes public with plans Monday morning in downtown Riverside," by Jeff Horseman, February 17, 2025.

[18] *The Press-Enterprise*, "Riverside County sheriff's oversight debate continues despite supervisors' inaction," by Madison Hart, August 1, 2025.

The protracted state investigation, coupled with ongoing in-custody deaths, highlights the importance of establishing transparent, independent oversight mechanisms that operate with clear mandates and deadlines. These mechanisms can provide sustained public accountability independent of politics.

The Grand Jury learned through interviews conducted during this investigation that leadership at RCSO has expressed opposition to structured civilian oversight pursuant to AB 1185. Leadership at RCSO has stated that such oversight could become an anti-law-enforcement activist committee rather than an objective accountability entity. Leadership at RCSO also has communicated oversight opposition to members of the Board. Leadership at RCSO contended that oversight structures lacking clear guardrails, professional standards, and defined authority could evolve into politically driven forums rather than constructive partners in institutional improvement.

At the same time, leadership at RCSO has expressed support for the Civil Grand Jury process and has acknowledged its role as a legitimate oversight institution. This distinction is significant. The Grand Jury operates with defined procedural standards, including confidentiality, and produces findings grounded in investigation and documented evidence. RCSO leadership's recognition of the Grand Jury's oversight function and their cooperation with its investigations suggests that opposition may be directed not at oversight itself, but at concerns regarding structure, composition, and perceived bias.

This dynamic indicates the potential for broader institutional acceptance if the Board crafts an independent oversight entity consistent with nationally recognized best practices, including those identified by NACOLE, and aligned with the recommendations contained in this report.

A commission designed with structural independence, professional qualifications, clear investigatory authority, balanced membership criteria, and formalized reporting obligations may address concerns regarding politicization while preserving the essential goals of transparency and accountability. Properly structured oversight is not inherently adversarial; when grounded in objective standards and clear governance frameworks, it can function as a collaborative mechanism that strengthens public confidence and institutional credibility.

Oversight from AB 1185 differs significantly from both the SAC and the Grand Jury in both structure and function. AB 1185 allows counties to create ongoing, independent civilian oversight bodies (with tools like inspector general, subpoena power if granted, and continuous auditing of sheriff's office operations). These bodies can monitor patterns, review policies, and issue regular public reports**,** creating sustained accountability.

By contrast, a Grand Jury is temporary and advisory, empaneled annually under the authority of the California Superior Court. It conducts limited investigations and issues reports with recommendations, but it lacks continuous oversight authority and typically cannot enforce reforms. In short, AB 1185 enables permanent, proactive oversight, while Grand Juries provide periodic, retrospective review.

NACOLE, established in 1995, provides training, research, and professional standards for civilian oversight of law enforcement agencies. Instead of mandating a single model of oversight, NACOLE identifies core principles and structural elements that contribute to effective, credible, and sustainable civilian review systems. These best practices are widely referenced by counties (as referenced in Tables 1 and 2) and municipalities seeking to strengthen transparency and accountability.

NACOLE emphasizes structural independence as a foundational element of effective oversight. Oversight bodies should operate independently from the law enforcement agency's chain of command and should have clearly defined authority established by ordinance or charter. Independence also refers to an absence of real or perceived influence from law enforcement, political activists, and other special interests looking to affect oversight operations. Independence includes control over staffing, budget allocation sufficient to perform assigned duties, and protection from arbitrary removal of members or leadership. Without structural safeguards, oversight entities may lack the capacity or credibility to perform meaningful review functions.

Another core principle is clearly defined authority and scope of review. NACOLE guidance recommends that oversight bodies have access to relevant documents, data, and personnel necessary to evaluate complaints, critical incidents, policy compliance, and systemic trends. While specific powers vary by jurisdiction, effective oversight structures commonly include the authority to review internal investigations, audit policies and procedures, make formal recommendations, and issue public reports. Transparency in both process and outcomes is considered essential to maintaining public trust.

NACOLE also highlights the importance of transparency and public reporting. Oversight committees should conduct meetings consistent with open meeting laws, maintain written minutes, publish findings and recommendations, and issue periodic reports summarizing activities, trends, and systemic concerns. Public accessibility of information—while respecting confidentiality laws—reinforces accountability and demonstrates that oversight is substantive rather than symbolic.

A further best practice involves professional qualifications and training for oversight members. NACOLE recommends that committee members possess diverse professional backgrounds and receive ongoing training in constitutional law, correctional standards, investigative procedures, and ethics. Clear appointment criteria and vetting processes help ensure independence, competence, and community confidence in the oversight body's work.

Finally, NACOLE emphasizes community engagement and policy impact. Effective oversight mechanisms serve as a bridge between the public and law enforcement agencies by soliciting community input, identifying systemic concerns, and providing evidence-based policy recommendations. Oversight bodies are most effective when their findings result in documented policy review, measurable corrective action, and follow-up evaluation.

Collectively, these best-practice principles—independence, defined authority, transparency, professional competence, and meaningful policy influence—form the framework for civilian

oversight systems capable of improving institutional accountability while strengthening public trust.

TABLE 1

COMPARISON OF COUNTY AB 1185 OVERSIGHT STRUCTURES IN CALIFORNIA

COUNTY	YEAR OPERATIONAL	SUBPOENA POWER	INSPECTOR GENERAL	IG IS COUNTY EMPLOYEE	CIVILIAN OVERSIGHT BOARD	BOARD MEMBERS
Santa Clara	2020	✓	✓	-	✓	9
Sonoma	2015	✓	✓	✓	✓	11
Sacramento	2015	✓	✓		✓	11
Los Angeles	2014	✓	✓	✓	✓	9
San Francisco	2021	✓	✓	✓	✓	7
San Diego	1990	✓	-	-	✓	11
Orange	2008	✓	✓	-	-	-

Source: Fixin' San Mateo County Report on Civilian Oversight of Law Enforcement.

TABLE 2

HIGH-LEVEL COMPARISON OF COUNTY AB 1185 OVERSIGHT

COUNTY	CIVILIAN OVERSIGHT BODY	INSPECTOR GENERAL/SIMILIAR	STATUS OF SHERIFF OVERSIGHT
Riverside	None (efforts failed)	None	No formal independent oversight
Los Angeles	Yes—Civilian Oversight Commission	Yes—Office of Inspector General	Mature, formal oversight structure
San Diego	Yes—Citizens' Law Enforcement Review Board	Limited IG-style staff	Established civilian review of sheriff
Orange	Yes—Office of Independent Review	Functions like oversight/IG	Independent review of sheriff and district attorney
San Bernardino	None	No	More oversight than Riverside, less than Los Angeles/San Diego

Sources: County reports, county board of supervisors' records and proceedings reflecting oversight structures and implementation under California Assembly Bill 1185 (2020).

The City of Riverside Community Police Review Commission (CPRC) was established in 2000 by city ordinance[19] and later codified in the city charter[20] following a successful ballot measure in 2004. The Grand Jury reviewed the operation and effectiveness of the CPRC due to its longevity, proximity to RCSO's jurisdiction, and shared jail facility in Riverside. The purpose of this review was to highlight areas where the CPRC has successfully adopted NACOLE best practices as well as where they have fallen short of NACOLE recommendations.

The CPRC[21] was created in response to community concerns about Riverside Police Department (RPD) accountability and alleged institutional racism. The main catalyst for establishing the independent civilian oversight commission was the 1998 fatal shooting of Tyisha Miller, a 19-year-old African American woman killed by four Riverside Police officers who were later fired but not criminally charged.[22] The Riverside Coalition for Police Accountability played a significant role in advocating for the CPRC's creation which voters approved through the charter amendment process.

The CPRC is composed of nine citizens appointed by the Riverside City Council to four-year terms, with each ward in the city represented by at least one member. Members serve without compensation and are supported administratively by staff funded in the city manager's office. The CPRC's mandate includes promoting public confidence in the police, independently reviewing citizen complaint investigations, offering recommendations on departmental policies, conducting outreach, and, when appropriate, initiating independent investigations into complaints against officers. The CPRC also has statutory subpoena power for witnesses and documents in its investigations, a significant attribute that distinguishes it from purely advisory committees.

The CPRC provides a community-based perspective on internal police investigations, publicly issues findings and policy recommendations to both the RPD and the Riverside City Council, and publishes annual reports. The CPRC offers a formal mechanism through which public concerns about police conduct can be documented and reviewed outside of the internal affairs processes of the department. However, the CPRC's effectiveness depends on the degree to which its recommendations are adopted and implemented by city leadership and RPD command staff.

While the CPRC represents a significant step toward structured civilian oversight, its impact is contingent upon sustained community engagement, consistent resourcing, and formal integration of its findings into departmental policy reform processes. Although the CPRC has authority to review completed internal investigations and may initiate independent investigations in certain

[19] Riverside Municipal Code, Chapter 2.76, Community Police Review Commission.
[20] City of Riverside Charter Amendment § 810 (2004) establishing the Community Police Review Commission.
[21] https://www.riversideca.gov/cityclerk/boards-commissions/community-police-review-commission/about. Accessed March 17, 2026.
[22] See *Tyisha Miller Shooting* (Dec. 28, 1998) (fatal police shooting of a 19-year-old African American woman in Riverside, California, by four Riverside Police Department officers; the incident prompted widespread public protest and calls for reform, leading to the establishment of the City of Riverside's independent civilian police review commission); see also U.S. Department of Justice, *Civil Rights Division Review of the Riverside Police Department* (2001) (examining policies and practices following the shooting); Richard Marosi, "Officers Fired in Riverside Shooting," *Los Angeles Times*, Jan. 1999; and subsequent reporting confirming that the officers were terminated but not criminally charged.

circumstances, its findings and recommendations are advisory to the police chief and city manager. The CPRC does not routinely control the intake, direction, or evidentiary scope of internal affairs investigations. Community activists have suggested that when CPRC and RPD disagree on allegations and investigations, they can be resolved by arbitration.

The CPRC relies on administrative support provided through the city manager's office rather than maintaining fully independent staffing infrastructure. Best-practice oversight models often emphasize dedicated professional investigators and independent legal counsel to reduce reliance on the agency under review or general city administration.

Another area of concern relates to the overall makeup and representational balance of the CPRC. While members are civilians appointed by the City Council and serve without compensation, critics have noted that the CPRC's composition has, at times, been overly represented by individuals with law enforcement backgrounds. These critics have raised questions regarding independence, objectivity, and community representation.

Best-practice models for civilian oversight by NACOLE and other organizations generally emphasize diversity of background, including members with experience in civil rights advocacy, behavioral health, legal practice, community organizing, youth services, or other disciplines that provide perspectives distinct from law enforcement culture. While prior law enforcement experience does not inherently compromise impartiality, an oversight body that lacks balanced professional and community representation may face challenges in maintaining broad public confidence, particularly in communities historically critical of policing practices.

Additionally, best-practice standards often recommend clearly defined qualification criteria and vetting processes designed to ensure independence and avoid conflicts of interest. Perceived independence is a significant component of oversight effectiveness; public trust depends not only on formal authority but also on structural neutrality.

TABLE 3

CIVILIAN OVERSIGHT BEST PRACTICES MATRIX

ATTRIBUTE	DESCRIPTION	WHY IT MATTERS	RISK IF ABSENT
Structural Independence	Operates outside the law enforcement chain of command; members protected from arbitrary removal	Ensures objectivity and public confidence	Perception of bias or agency self-policing
Clear Legal Authority	Established by ordinance, charter, or statute with defined powers and scope	Prevents ambiguity and limits jurisdictional disputes	Oversight becomes advisory without impact
Subpoena/Investigative Power	Authority to compel documents and testimony where legally permitted	Enables thorough review of critical incidents	Incomplete fact-finding; reliance on voluntary disclosure
Access to Records and Personnel	Direct access to Internal Affairs files, policies, data, and staff interviews	Allows independent verification of findings	Oversight limited to summaries or redacted reports
Dedicated Budget and Staffing	Independent funding and professional investigative staff	Supports sustained, professional operations	Oversight becomes symbolic due to resource limits
Public Reporting and Transparency	Regular public reports, open meetings, published findings	Builds public trust and accountability	Reduced credibility and limited public awareness
Defined Complaint Review Process	Clear intake, review, and disposition procedures	Ensures fairness and consistency	Inconsistent or delayed complaint handling
Policy Review Authority	Authority to review and recommend changes to policies and practices	Addresses systemic issues beyond individual cases	Repeated operational failures remain uncorrected
Mandatory Agency Response	Requirement that the law enforcement agency respond formally to recommendations	Encourages implementation and measurable reform	Recommendations ignored without consequences
Professional Training Requirements	Ongoing training in constitutional law, corrections standards, investigative practices	Promotes informed and competent oversight	Oversight body lacks subject-matter understanding
Community Representation	Diverse membership reflecting community demographics and professional backgrounds	Enhances legitimacy and inclusiveness	Perception of insularity or institutional bias
Data Transparency and Metrics	Publication of trends, use-of-force data, complaint statistics, and outcomes	Enables performance monitoring and risk identification	Systemic patterns remain undetected

Source: National Association for Civilian Oversight of Law Enforcement

Legal and Regulatory Framework

The oversight and accountability of county jail operations in California are governed by a combination of statutory authority, regulatory standards, and constitutional obligations.

Understanding this framework is essential to evaluating Riverside County's current oversight structure.

AB 1185 (2020)

Assembly Bill 1185, enacted in 2020, amended California Government Code § 25303 to expressly authorize county boards of supervisors to establish civilian oversight bodies with subpoena power over sheriff's departments and to appoint inspectors general to provide independent review of law enforcement operations, including county jail facilities. The statute affirms the authority of county governing bodies to create oversight mechanisms independent of the sheriff's chain of command. AB 1185 does not mandate a specific model of oversight; rather, it empowers counties to design structures appropriate to their operational needs while preserving constitutional separation between elected sheriffs and county governance authority. The county's limited implementation of these authorized oversight tools represents a policy choice rather than a statutory constraint.

California Government Code § 25303

Government Code § 25303 states the board of supervisors shall supervise the official conduct of all county officers, and officers of all districts and other subdivisions of the county, and particularly insofar as the functions and duties of such county officers and officers of all districts and subdivisions of the county relate to the assessing, collecting, safekeeping, management, or disbursement of public funds. It shall see that they faithfully perform their duties, direct prosecutions for delinquencies, and when necessary, require them to renew their official bond, make reports and present their books and accounts for inspection.

This section shall not be construed to affect the independent and constitutionally and statutorily designated investigative and prosecutorial functions of the sheriff and district attorney of a county. The board of supervisors shall not obstruct the investigative function of the sheriff of the county nor shall it obstruct the investigative and prosecutorial function of the district attorney of a county.

Nothing contained herein shall be construed to limit the budgetary authority of the board of supervisors over the district attorney or sheriff.

Penal Code §§ 933–933.05

California Penal Code §§ 933 and 933.05 define the authority of civil grand juries to investigate county agencies and issue findings and recommendations. These provisions require elected officials and governing bodies to respond formally to grand jury findings within prescribed timelines, stating agreement, disagreement, or proposed implementation steps. The statutory response requirement reflects the legislature's intent that grand jury investigations serve as a structured accountability mechanism. Compliance with these sections ensures transparency, formal acknowledgment of identified deficiencies, and documented corrective action planning.

Title 15 Standards (Board of State and Community Corrections)

The Board of State and Community Corrections (BSCC) establishes minimum standards for local detention facilities under Title 15 of the California Code of Regulations. These standards

govern areas including medical and mental health services, suicide prevention protocols, staffing levels, inmate classification, grievance procedures, and facility safety requirements. Counties are responsible for maintaining compliance with these regulations, and periodic inspections are conducted to evaluate adherence. While Title 15 sets minimum operational standards, compliance alone does not constitute comprehensive oversight. Effective governance requires continuous monitoring, data transparency, and systemic review beyond periodic compliance inspections.

Risk Exposure and Governance Implications

The absence of comprehensive independent oversight carries measurable governance risks. Systemic deficiencies in jail operations may expose the county to civil liability under federal and state law, including claims arising under 42 U.S.C. § 1997 for alleged constitutional violations. Repeated in-custody deaths or documented operational failures increase the likelihood of federal investigation by the U.S. Department of Justice under the Civil Rights of Institutionalized Persons Act (CRIPA). In jurisdictions where systemic deficiencies persist, federal intervention has resulted in court-enforced consent decrees requiring long-term judicial oversight, mandated reforms, and substantial financial expenditures. Beyond legal exposure, sustained litigation and adverse findings may affect the county's insurance coverage, increase settlement costs, elevate risk-pool contributions, and require diversion of public resources from other essential services. Proactive implementation of independent oversight and systemic reform reduces these risks while promoting public confidence and fiscal stability.

FINDINGS

Finding 1

The County of Riverside has not established an independent civilian oversight entity, as authorized under California Government Code § 25303 and AB 1185 (2020), with clearly defined authority, investigative powers, reporting requirements, and structural independence from the sheriff's chain of command.

Finding 2

Based on Grand Jury visits to five jails, the frequency and circumstances of in-custody deaths in Riverside County reflect systemic deficiencies in intake screening, staffing, medical and mental health care access, supervision protocols, documentation practices, and emergency response procedures. The absence of independent review mechanisms prevents full identification of root causes and corrective action.

Finding 3

Internal investigations into in-custody deaths and critical incidents in Riverside County jails lack structural independence, and standardized documentation protocols, limiting accountability and systemic risk identification.

Finding 4

The Riverside County Sheriff's Office does not maintain consistent, comprehensive public reporting on jail operations, in-custody deaths, use-of-force incidents, or compliance with mandated standards, limiting transparency and public trust.

Finding 5

Operational improvements undertaken by the Riverside County Sheriff's Office are reactive, fragmented, and not part of a coordinated long-term strategy for jail oversight, data transparency, or interagency collaboration.

Finding 6

The County of Riverside has not established a unified, strategic plan to address persistent deficiencies in jail operations, oversight, and accountability, despite repeated findings from prior Grand Jury reports and external investigations.

Finding 7

The Sheriff's Advisory Committee has not demonstrated measurable advisory output. The committee failed to produce meeting minutes, written findings, formal recommendations, or documentation of deliberative processes, and members were unable to articulate specific, significant policy impacts resulting from its work.

Finding 8

The National Association for Civilian Oversight of Law Enforcement has published widely recognized guidelines describing the essential elements of effective civilian oversight of law enforcement agencies. Riverside County and the Riverside County Sheriff's Office have not incorporated these guidelines or comparable best-practice standards into the structure or function of jail oversight mechanisms.

Finding 9

Public statements by the leadership of the Riverside County Sheriff's Office characterizing civilian oversight authorized under AB 1185 as political rather than operational may influence Riverside County's implementation approach and have contributed to delayed or limited development of independent oversight structures.

Recommendation 1 (Finding 1)

The Riverside County Board of Supervisors shall, within eighteen months from July 1, 2026, establish an independent civilian oversight body pursuant to AB 1185 with:

- Subpoena authority or equivalent investigatory access
- Independent budget and staffing
- Authority to review critical incidents and in-custody deaths
- Public reporting requirements
- Defined appointment and vetting procedures
- Protection from removal without cause

Fiscal Impact:
Based on comparable AB 1185 oversight bodies, annual operating costs are estimated between $2.5 million and $6.5 million, with initial startup costs of $500K to $1.2 million.[23] Larger jurisdictions such as Los Angeles County maintain dedicated oversight commissions and inspector general functions with dozens of staff positions supporting investigative and auditing capacity.[24]

Recommendation 2 (Finding 2)

Within eighteen months of July 1, 2026, the Riverside County Sheriff's Office shall retain an independent correctional health and custodial operations expert to conduct a comprehensive audit of intake screening, medical and mental health services, supervision protocols, and emergency response procedures related to in-custody deaths. The audit findings and corrective action plan shall be publicly reported within ninety days of completion.

Fiscal Impact:
Independent correctional audits are estimated to cost $250K to $750K, with optional follow-up monitoring costs of $100K to $300K annually depending on scope and duration.

Recommendation 3 (Finding 3)

Within eighteen months of the creation of independent oversight per AB 1185, all in-custody deaths and critical incidents shall be reviewed by an independent entity separate from the Riverside County Sheriff's Office, with written findings issued and publicly released in compliance with applicable privacy laws.

Fiscal Impact:
If incorporated into the oversight body, estimated annual costs range from $500K to $1.5 million. Jurisdictions utilizing independent investigative models incur higher costs due to staffing of attorneys, investigators, and forensic experts.

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[23] County of Los Angeles, *Recommended Budget 2025–2026*, including staffing allocations for the Civilian Oversight Commission and Office of Inspector General.
[24] Assembly Bill 1185 Implementation Report (Alameda County), citing NACOLE survey data indicating most oversight bodies operate at or below 0.5% of agency budgets.

Recommendation 4 (Finding 4)

Within eighteen months as of July 1, 2026, the Riverside County Sheriff's Office shall implement a publicly accessible quarterly reporting dashboard that includes:

- In-custody deaths (with classification)
- Use-of-force incidents
- Suicide attempts and medical emergencies
- Grievance volume and disposition
- Staffing levels
- Compliance status with Title 15 and Title 24 standards

Fiscal Impact:
Estimated one-time development costs of $150K to $400K, with ongoing maintenance costs of $75K to $200K annually, consistent with transparency systems implemented in comparable counties.

Recommendation 5 (Finding 5)

Within eighteen months as of July 1, 2026, the Riverside County Sheriff's Office shall publish a five-year strategic plan for jail operations that includes measurable performance benchmarks, data transparency goals, compliance auditing procedures, and interagency coordination protocols.

Fiscal Impact:
Estimated one-time cost of $100K to $300K, primarily for consulting and staff time.

Recommendation 6 (Finding 6)

Within eighteen months as of July 1, 2026 the Riverside County Board of Supervisors shall develop and adopt a countywide RCSO oversight and accountability framework defining:

- Oversight authority boundaries
- Reporting obligations
- Data transparency requirements
- Budgetary review standards
- Interdepartmental coordination roles

Fiscal Impact:
Estimated one-time cost of $75K to $250K, with minimal ongoing costs absorbed within existing administrative functions.

Recommendation 7 (Finding 7)

The RCSO shall dissolve the Sheriff's Advisory Committee and replace it with a formally authorized civilian oversight body meeting the National Association for Civilian Oversight of Law Enforcement's best-practice standards within twelve months as of July 1, 2026.

Fiscal Impact:
No significant independent cost. Fiscal impact is incorporated within Recommendation 1.

Recommendation 8 (Finding 8)

The County of Riverside shall formally review and adopt the National Association for Civilian Oversight of Law Enforcement's best-practice standards as the operational framework for civilian oversight, incorporating independence, authority, transparency, community engagement, and investigatory capacity principles within eighteen months as of July 1, 2026.

Fiscal Impact:
Estimated cost of $25K to $75K for training, policy alignment, and implementation support.

Recommendation 9 (Finding 9)

The Board of Supervisors shall exercise its statutory authority under AB 1185 to implement independent oversight of all RCSO operations, irrespective of policy disagreements, and shall publicly affirm its governance responsibility for accountability of said operations within eighteen months as of July 1, 2026.

Fiscal Impact:
No direct fiscal impact beyond those identified above.

TABLE 4

FISCAL IMPACT ANALYSIS OF RECOMMENDATIONS

Recommendation	One-Time Cost	Annual Cost	Notes
Rec. 1	$500K–$1.2M	$2.5–$6.5M	Full oversight body
Rec. 2	$250K–$750K	$100K–$300K	Audit
Rec. 3		$500K–$1.5M	Independent review
Rec. 4	$150K–$400K	$75K–$200K	Dashboard
Rec. 5	$100K–$300K	Minimal	Strategic plan
Rec. 6	$75K–$250K	Minimal	Framework
Rec. 7	Negligible	Included	Replacement
Rec. 8	$25K–$75K	Minimal	NACOLE
Rec. 9	None	None	Policy only

CONCLUSION

The Riverside County Civil Grand Jury's investigation reveals systemic deficiencies in the oversight, transparency, and operational practices of the Riverside County Sheriff's Office (RCSO) and its jail system. Despite years of public concern, repeated findings from prior Grand Jury reports, and ongoing scrutiny related to in-custody deaths and internal investigative practices, the county has not implemented the structural reforms necessary to ensure safe, accountable, and constitutionally compliant jail operations.

The absence of independent civilian oversight remains a critical gap. Without a body empowered to review policies, monitor conditions, and evaluate critical incidents, Riverside County cannot meaningfully assess the performance of RCSO operations or identify patterns that place individuals at risk. Internal processes alone have proven insufficient to ensure transparency or accountability.

Oversight of the RCSO is not about assuming wrongdoing. When done well, this strengthens the agency. Independent oversight shows transparency, which builds credibility especially after controversial incidents. When people believe the system reviews itself fairly, cooperation improves.

The Sheriff's Advisory Committee, intended to provide community input and some oversight-related guidance, has not fulfilled its stated purpose. Its lack of documented findings, absence of meeting minutes, and failure to maintain public transparency underscore the need for a restructured or alternative mechanism capable of providing meaningful civilian engagement.

The Board of Supervisors, as the County of Riverside's governing authority, plays a central role in establishing oversight structures, setting policy direction, and ensuring that public safety operations reflect community expectations and legal obligations. Its leadership is essential to implementing the reforms recommended in this report.

The Grand Jury's Findings and Recommendations are intended to support long-term improvements that enhance safety, strengthen accountability, and restore public trust. Meaningful reform will require sustained commitment, transparent practices, and coordinated action among County leadership, the RCSO, and any future oversight entities. The Grand Jury urges all responsible parties to take prompt and substantive steps to address the issues identified in this report and to ensure that RCSO operates with integrity, professionalism, and respect for the rights and dignity of all individuals in its care.

Independent oversight is not premised on an assumption of misconduct. Rather, it is a governance best practice recognized nationally as a means of strengthening institutional integrity, promoting transparency, identifying systemic risk, and improving public confidence in law enforcement operations. Effective oversight protects both the public and the agency by ensuring accountability mechanisms function consistently and objectively.

REQUIRED AND INVITED RESPONSES

Pursuant to California Penal Code §§ 933 and 933.05, the following elected officials and agencies are required to respond to the Findings and Recommendations contained in this report. Each response must address the specific Finding or Recommendation as indicated, stating whether the respondent agrees, disagrees, or will implement the recommended action, along with an explanation and timeline where applicable.

The Sheriff must respond to findings related to the Riverside County Sheriff's Office within sixty days. The Riverside County Board of Supervisors must respond to findings addressed to it within ninety days.

REQUIRED RESPONSES

Who	What	When
Riverside County Sheriff	Respond to Findings 1–7 and Recommendations 1–7 addressing operational deficiencies, oversight gaps, internal investigation practices, data transparency, training standards, and the functioning of the Sheriff's Advisory Committee.	Within 60 days
Riverside County Board of Supervisors	Respond to Findings 1–9 addressing governance responsibilities, establishment of independent oversight, transparency measures, long-term strategic planning, and evaluation of the structure and performance of the Sheriff's Advisory Committee.	Within 90 days

INVITED RESPONSES

Who	What	When
Sheriff's Advisory Committee	Respond to Finding 7 and Recommendation 7 explaining the lack of documented findings, absence of meeting minutes, failure to provide public transparency, and addressing recommendations to restructure or replace the committee to fulfill its intended oversight role.	Within 90 days

Report Issued Date: 6-9-2026
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