



Riverside County Sheriff's Office

Chad Bianco, Sheriff-Coroner

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July 31, 2026

Riverside County Grand Jury
3516 9th Street
Riverside, CA 92501

RE: The following is the response to the Riverside County Civil Grand Jury 2025-2026 Report: After a Decade of Record Deaths in County Jails, the Community Deserves Transparency through Oversight.

Dear Riverside County Civil Grand Jury,

This correspondence will provide responses to Findings #1-9 as well as responses to Recommendations #1-9 from the above referenced report.

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.

Response to Finding 1

The Respondent, Riverside County Sheriff's Office, agrees. There has never been a question about whether or not there has been an independent civilian oversight; there has not. However, "authorized" by no means requires the formation of an oversight committee. A deep dive into the need for an oversight committee was recently completed by the Executive Office that concluded with a recommendation against the formation of the committee.

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.

Response to Finding 2

The Respondent, Riverside County Sheriff's Office, wholly disagrees with the finding. The Grand Jury claimed the frequency and circumstances of in-custody deaths reflected "systemic deficiencies" in multiple facets of operations; however, the Grand Jury failed to identify any single specific "systemic deficiency." This is nothing but a presupposed opinion with nothing in the report to support such a reckless statement.

Regarding the frequency and circumstances surrounding inmate deaths, the Grand Jury failed to inquire as to how many inmate deaths were prevented in relation to those we were unable to save. To put the numbers in proper perspective, in 2022, which was the highest year of inmate deaths for the entire nation during the fentanyl epidemic, not just for Riverside, six inmates died from an overdose; however, Riverside County Sheriff's staff saved 110 lives by administering Narcan to inmates who ingested drugs. Additionally, staff intercepted drugs on 438 occasions. This means the Riverside County Sheriff's Office potentially prevented 548 inmates from a self-induced drug overdose. Similarly, while there were 3 suicides, Riverside County Sheriff's Staff thwarted 96 suicide attempts. That same year, six inmates died from natural causes, there were two homicides, and one accident (asphyxiation). While tragic, the 18 deaths compared to the 548 saved prove there is no systemic deficiency and that our proactive efforts are effective in saving lives.

Regarding the alleged "systemic deficiencies" with intake screening, staffing, medical and behavioral healthcare access, supervision protocols, and documentation processes, please see the following:

- **Intake Screening:** Every inmate undergoes an intake screening process designed to identify medical needs, mental health concerns, suicide risks, substance withdrawal risks, disabilities, and safety-related considerations. Information obtained during intake is used to guide housing, classification, observation levels, and referrals to medical or behavioral health services. Compliance with intake requirements is monitored through quality assurance reviews, audits, and supervisory oversight.
- **Staffing:** We strictly adhere to staffing plans, supervisory structures, training requirements, emergency response procedures, and operational reviews which are approved and audited by the Board of State and Community Corrections.
- **Medical and Behavioral Health Care Access:** In partnership with the Riverside University Health System, we maintain processes to provide access to unfettered medical and behavioral health services, including intake evaluations, emergency responses, medication management, ongoing treatment, crisis intervention, and specialized care. Healthcare delivery is monitored through quality assurance activities, performance reviews, and compliance audits to identify and address barriers or delays in care. Additionally, Riverside County was the first in the State to receive National Commission on Correctional Health Care accreditation and has successfully maintained its high standards and been awarded reaccreditation every year.

- **Supervision Protocols:** Custody staff follow Board of State and Community Corrections requirements, such as unannounced security checks, direct observation procedures, housing unit monitoring, and response protocols. Supervisors conduct reviews to verify compliance with these requirements and ensure appropriate actions are taken if concerns are identified.
- **Documentation Practices:** Accurate and timely documentation is a critical component of facility operations. Staff are required to document observations, actions taken, medical and behavioral health contacts, minor and critical incidents, and daily activities. Documentation is reviewed through supervisory checks, audits, and quality assurance processes to ensure records are complete, accurate, and consistent with policy requirements.

The Grand Jury further alleged a lack of independent review. However, as mentioned above, the Board of State and Community Corrections has direct and complete oversight and authority over our jails. Per PC 6034 and SB 157, the Board of State and Community Corrections' In-Custody Death Review Division conducts independent reviews of in-custody deaths. The Board of State and Community Corrections has unredacted access to records, information, and Riverside County Sheriff's Office's property. The independent organization also performs routine and unannounced inspections of all areas of confinement, staffing, documentation, and safety measures. The results of their inspections regularly reveal sustained compliance with regulations. Notably, the Board of State and Community Corrections leadership have praised our system and relay Riverside County Sheriff's Office is the model for all county jail systems.

Through these ongoing reviews, audits, oversight mechanisms, and certifications, the Riverside County Sheriff's Office continuously evaluates its operations to ensure compliance with applicable standards and identify opportunities for improvement while exceeding the requirements of safe and constitutional care for inmates.

This finding is not substantiated in the report and directly contradicts fact and the reality of daily operations.

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.

Response to Finding 3

The Respondent, Riverside County Sheriff's Office, wholly disagrees with the finding. The Riverside Sheriff's Office's internal investigations into inmate deaths routinely identify areas for improvement which result in additional training, policy revisions, administrative investigations, and concerns which are addressed and resolved. However, as mentioned above, the Board of State and Community Corrections also performs independent reviews of inmate deaths to identify systemic risks.

Each and every jail death is investigated by the Riverside County Force Investigations Detail or other investigative unit and treated with the same level of importance as a homicide. These death investigations are the most complex, complete, and thorough cases completed by law enforcement. The investigations are provided to the District Attorney's office and also accessible in whole unredacted version by the Department of Justice.

There has never been an allegation by any outside entity about the accuracy and integrity of our investigations. The allegation is a gross misrepresentation of fact and reality with nothing presented in the report to show anything else.

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.

Response to Finding 4

The Respondent, Riverside County Sheriff's Office, wholly disagrees with the finding. The Riverside Sheriff's Office maintains consistent, transparent, and extensive reporting processes related to all in-custody deaths. Each incident is thoroughly documented, reviewed, and reported in accordance with applicable state laws, regulatory requirements, and established oversight standards, including mandated guidelines issued by the Board of State and Community Corrections and the California Department of Justice.

These processes ensure all critical incident information is accurately captured, appropriately reviewed through established administrative and investigative procedures, and submitted to the required oversight agencies in a timely manner. This structured reporting framework supports accountability, transparency, continuous quality improvement, and compliance with statutory obligations, while reinforcing public confidence in the Sheriff's Office's handling of in-custody death cases.

The Riverside County Sheriff's Office adheres to all applicable statutory and regulatory requirements, including:

- California Government Code §12525 – Requires reporting of all in-custody deaths to ensure proper state-level notification, oversight, and data collection.
- California Code of Regulations, Title 15, §1046 – Establishes requirements for medical review and evaluation of in-custody deaths to ensure appropriate clinical and operational assessment.
- California Government Code §27491 – Requires notification to the Coroner's Bureau for independent investigation and determination of cause and manner of death. Currently, San Bernardino County Coroner's Office conducts all autopsies adding another layer of

transparency to ensure the case is not done by the Riverside County Sheriff's Office.

In compliance with DOJ requirements, the Coroner's Office completes and submits the BCIA 713 In-Custody Death Report within 10 days of the death. This report is transmitted to the California Department of Justice and is also retained within Riverside County Sheriff's Office records for documentation and continuity purposes. A copy is additionally forwarded for retention and filing in accordance with Board of State and Community Corrections reporting protocols.

The Riverside County Sheriff's Office also complies with the Board of State and Community Corrections reporting requirement to submit a Notice of Death form within 10 days of the incident, along with a copy of the BCIA 713 form submitted to Department of Justice. Following this initial notification, the Riverside County Sheriff's Office is responsible for submitting an Initial Death Review Report within 60 days of the death. This report is submitted directly to the Board of State and Community Corrections and is distinct from the Department of Justice reporting requirements. All reporting is completed in accordance with Title 15, Section 1046 Death in Custody standards.

Regarding use of force reporting, the Riverside County Sheriff's Office submits comprehensive documentation to the California Department of Justice, on a monthly basis, as required.

Through adherence to statutory requirements, regulatory standards, and internal review processes, the Riverside County Sheriff's Office continues to provide thorough documentation, regulatory compliance, operational accountability, and ongoing compliance with mandated standards.

Again, this finding is a gross misrepresentation of fact and can not be substantiated by this report.

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.

Response to Finding 5

The Respondent, Riverside County Sheriff's Office, wholly disagrees with the finding. The Riverside County Sheriff's Office's Quality Assurance and Compliance Unit's mission is to ensure consistency, compliance with Title 15 requirements, legislation, and policies. Rather than responding after incidents occur or deficiencies are found as alleged by the Grand Jury, this team continuously evaluates jail operations, identifies potential areas of concern, and implements corrective actions to reduce liability, improve consistency, and enhance safety and security. The Quality Assurance and Compliance Unit develops, reviews, and revises policies to ensure compliance with legislation, regulatory changes, court decisions, and industry best practices.

Annual audits are conducted on approximately 235 corrections policies, operations based on policies and policy revisions, training, documentation, and compliance with state mandated requirements.

This proactive process allows the Quality Assurance and Compliance Unit to identify training needs, reinforce policy knowledge, and promote operational consistency throughout the Corrections Division. The Quality Assurance and Compliance Unit also collaborates with Sheriff's Offices throughout the state regarding best practices. Quarterly Corrections Compliance Committee meetings are held with representatives from every facility to review inspection trends, discuss regulatory updates, share best practices, and ensure consistent application of policies and procedures across the Corrections Division. Through continuous inspections, policy management, training, audits, legislative monitoring, and compliance oversight, this unit serves as a proactive resource for the Sheriff's Office, which is dedicated to improving operations, maintaining compliance, reducing organizational risk, and the highest professional standards across all county jail facilities.

Again, this finding is a gross misrepresentation of fact and defies the reality of daily operations.

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.

Response to Finding 6

The Respondent, Riverside County Sheriff's Office, wholly disagrees with the finding. As a result of prior Grand Jury reports, the Sheriff's Office reviewed noted areas for improvement and immediately addressed deficiencies. The aforementioned elaborate internal oversight exists, and extensive external oversight is in place by means of the Board of State and Community Corrections, the Department of Justice, and court appointed experts.

This finding is once again a gross misrepresentation of fact and defies the reality of daily operations and existing extensive internal and external oversight deliberately designed to ensure the safety and security of inmates and their care

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.

Response to Finding 7

The Respondent, Riverside County Sheriff's Office, wholly disagrees with the finding.

The Sheriff's Advisory Committee has accomplished and is meeting its intended purpose: community involvement in the operations of the Sheriff's Office. The inability of this report to distinguish between the advisory committee and an oversight committee lends more to the belief the only intention of this report was to document a predetermined outcome. It also shows the incomplete and completely inadequate "investigation" supposedly conducted to produce this report.

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.

Response to Finding 8

The Respondent, Riverside County Sheriff's Office, wholly disagrees with the finding. The National Association for Civilian Oversight of Law Enforcement is nothing more than an activist organization with no legitimate authority, expertise, or ability to direct policy. What was left out of the Grand Jury's report is a study from the National Institute of Justice that concluded that civilian oversight rarely if ever has a positive benefit or the ability to effect change. What it found was exactly the opposite. The NIJ has concluded that civilian oversight boards create more divide and mistrust within government and the citizenry.

While the report indicated cities/counties with oversight, there was never any insight or evidence those committees were successful. To the contrary, common knowledge tells us those cities do not have the positive government relationships with residents that Riverside County has always enjoyed. The small group of activists in Riverside County currently demanding oversight in no way represents the overall positive opinions of residents about the operations of the Sheriff's Office.

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.

Response to Finding 9

The Respondent, Riverside County Sheriff's Office, wholly disagrees with the finding.

The Sheriff is an elected official representing the entire population of Riverside County. Being transparent is exactly why he was elected twice. His straightforward and sometimes blunt and factual statements contribute to his popularity amongst residents. His comments are nothing but the truth and are in direct contradiction to the opinions and emotions of the activist groups demanding oversight. The comments of the Sheriff in no way influence members of the Board of Supervisors or the Executive Office. It is obvious those decisions were made from factual studies absent politics or the constant noise from activists which appear to have motivated this grossly inaccurate report.

RECOMMENDATIONS

Recommendation 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

Response to Recommendation 1

This is a recommendation for the Board of Supervisors, not RSO.

Recommendation 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.

Response to Recommendation 2

The recommendation will not be implemented because the recommendation is not warranted. Independent correctional health and mental health experts currently conduct comprehensive audits of intake screening, medical and mental health services, supervision protocols, and emergency response procedures related to in-custody deaths. The Board of State and Community Corrections also perform this function. Additionally, independent court appointed

experts perform comprehensive evaluations and audits of all operations as they pertain to medical and mental health in relation to inmate deaths.

The Sheriff is a constitutionally elected Officer who answers to the residents of Riverside County. The Sheriff is solely responsible for the operation of the Office of Sheriff and will not and cannot be forced into policies, procedures, or hiring practices by outside entities. This grand jury report will be taken into consideration for exactly what it is: a predetermined attempt to force or intimidate the Board of Supervisors and the Sheriff to comply with the demands of activists.

Recommendation 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.

Response to Recommendation 3

The recommendation will not be implemented because the recommendation is not warranted. Independent reviews of inmate deaths are currently reviewed by and audited by the San Bernardino County Coroner, the Board of State and Community Corrections, California DOJ, and court appointed healthcare and mental health experts.

This recommendation is proof positive this report should not be taken seriously. It shows a complete lack of understanding about current operations, laws, and fact. It is once again a gross misrepresentation of fact and current operating realities.

Recommendation 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.

Response to Recommendation 4

The recommendation has not yet been implemented, but will be implemented in the future. The Riverside County Sheriff's Office maintains consistent, comprehensive public reporting on jail operations, in-custody deaths, use-of-force incidents, and compliance with mandated standards, so the Grand Jury's Finding 4 was false; however, the Riverside County Sheriff's Office will produce a quarterly dashboard containing the recommended information within 18 months of July 1, 2026.

Recommendation 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.

Response to Recommendation 5

The recommendation will not be implemented because the recommendation is not warranted. As described in the response to Finding 5, this system is already in place. Additionally, our current proactive system of auditing, training, documenting, collaboration, identification of and addressing deficiencies, and ensuring compliance is ongoing and surpasses the 5-year recommendation.

This recommendation is again a blatant disregard for current operating procedures and shows the complete bias of this supposed investigation to develop this report.

Recommendation 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.

Response to Recommendation 6

Recommendation for the Board of Supervisors, but the recommendation is not warranted as this substantial oversight already exists.

Recommendation 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.

Response to Recommendation 7

The recommendation will not be implemented because the recommendation is not warranted.

The Sheriff is a constitutionally elected official answering to the voters of Riverside County. The Sheriff is solely responsible for law enforcement operations within the County of Riverside. The Sheriff's Advisory Committee is an invaluable tool for the Sheriff to communicate with community members across our county.

NACOLE is a non-profit association that does not provide best practices for Law Enforcement Organizations. This recommendation is another example of the complete lack of understanding of fact and current reality. This shows a completely biased report simply to provide the pre-determined recommendations in an attempt to force the Board of Supervisors or the Sheriff into forming an unneeded and unwarranted oversight committee.

Recommendation 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.

Response to Recommendation 8

The recommendation will not be implemented because the recommendation is not warranted. NACOLE is civilian oversight organization that provides what they determine to be best practices. They do not have any influence, control or ability to direct operations within the constitutionally formed Office of Sheriff.

Recommendation 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.

Response to Recommendation 9

This is clearly a recommendation for the Board of Supervisors, not RSO. However, as detailed in this memorandum, it is completely obvious this recommendation is wholly based on emotion, opinion, false information, and a complete lack of understanding of Corrections. Based on current events, it is clear this report by the Grand Jury was prepared completely for political purposes from a preconceived agenda. It is completely void of fact, reality, and discounts the current state of the Riverside County Sheriff's Office.

Sincerely,

A handwritten signature in black ink, appearing to read "Chad Bianco", with a stylized flourish at the end.

Chad Bianco, Sheriff
Riverside County Sheriff's Office