Date of Hearing: June 16, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 995 (Pérez) – As Amended May 14, 2026

SENATE VOTE: 39-0

SUBJECT: Involuntary residential facilities: health and safety inspections.

SUMMARY: Enacts the Masuma Khan Justice Act, which authorizes the Department of Public Health (DPH) to inspect an involuntary residential facility. Authorizes unnoticed inspections under certain conditions, and requires DPH, within 30 days of completing an inspection, to submit a report to the Legislature. Requires the operator of a facility to provide access to DPH for an inspection, to maintain all records necessary to demonstrate compliance, and to correct a violation identified by DPH. Makes a violation of this bill subject to an administrative penalty and authorizes DPH, if an operator fails to correct a violation, to issue a safety warning and require prompt corrective action by the operator. Authorizes DPH to refer violations to the Attorney General (AG) and authorizes the AG to bring a civil action for declaratory or injunctive relief. Specifically, **this bill**:

Inspection Authority

1) Authorizes DPH, notwithstanding any other law, to inspect an involuntary residential facility for the limited purpose of ensuring sanitary, hygienic, and safe conditions, using standards and inspection protocols consistent with those applied to residential health facilities pursuant to 6) of existing law below. Clarifies that this bill does not require licensure under the provisions of 6) below, or to otherwise subject an involuntary residential facility to the regulatory scheme applicable to facilities licensed under those provisions.

2) Requires DPH to implement the provision of this bill in a manner that avoids unnecessary duplication of existing state or local health and safety oversight. Authorizes DPH, in carrying out inspections pursuant to this bill, to consider prior inspections, certifications, and compliance findings, when appropriate. Authorizes DPH, in determining its inspection priorities, to consider whether a facility has already been inspected by DPH as part of its regulatory oversight of licensed or certified facilities.

3) Authorizes DPH to conduct inspections for any of the purposes described in 2) above without prior notice.

4) Requires inspections conducted pursuant to this bill to be carried out in a manner that does not unreasonably interfere with facility operations or any federal, state, or local law enforcement or security functions.

5) Authorizes, in determining whether an inspection unreasonably interferes with operations or security functions, relevant factors to include, but not be limited to, all of the following:

    a) Whether the inspection delays or obstructs emergency response or time-sensitive security operations;

b) Whether the inspection requires access to areas used exclusively for security operations, except as otherwise authorized by this bill;

c) Whether the inspection imposes requirements that are inconsistent with applicable security procedures or legal obligations; and,

d) Whether the inspection can be reasonably accommodated through scheduling, coordination, or alternative means without compromising the purposes of this bill.

6) Requires DPH, in exercising its authority under this bill, to utilize the inspection and citation protocols described in 8) of Existing Law below.

7) Prohibits internal security protocols from being used to deny inspectors access to any area where residents are housed, fed, or receive medical care. Requires DPH to comply with reasonable security procedures necessary to ensure safety and facility operations.

8) Clarifies the provisions in 7) above do not prohibit the review of deidentified or aggregate health, safety, or incident records reasonably necessary to assess compliance with this bill, if the review is conducted in a manner that protects resident privacy. Specifies those records may include, but are not limited to, aggregate or deidentified data relating to injury rates, the number of incidents involving the use of force or restraints, infectious disease, hospitalizations, and mortality.

9) Requires if, during an inspection conducted pursuant to this bill, DPH identifies conditions that may fall within the jurisdiction of another agency, DPH must refer those conditions to the appropriate state or local agency with jurisdiction over the facility for further review or action.

10) Specifies that a referral made pursuant to 9) above does not expand the authority of DPH beyond the scope of this bill and does not authorize DPH to enforce laws or regulations outside its jurisdiction.

11) Requires DPH, within 30 days of completing an inspection pursuant to this bill, to prepare a written report of its findings and to transmit the report to the Legislature.

Operator Duties

12) Requires an operator to provide access to DPH for an inspection authorized pursuant to this bill.

13) Requires an operator to maintain all records necessary to demonstrate compliance with applicable health and safety standards, including the standards adopted pursuant to 22) through 23) below, and to make those records available to DPH upon request.

14) Requires an operator to correct any violation identified by the DPH within the timeframes established by DPH.

Enforcement

15) Subjects an operator that violates any provision of this bill or a regulation adopted pursuant to this bill, after appropriate notice and an opportunity for a hearing, to an administrative penalty in an amount not to exceed the following:

    a) Twenty-five thousand dollars ($25,000) for a class AA violation;

    b) Ten thousand dollars ($10,000) for a class A violation; or,

    c) One thousand dollars ($1,000) for a class B violation.

16) Allows each day a violation remains uncorrected to constitute a separate violation.

17) Authorizes DPH, if an operator fails to correct a violation within the time specified in a citation issued pursuant to this bill, to issue a safety warning that identifies the uncorrected condition and require prompt corrective action by the operator.

18) Makes a safety warning issued pursuant to this bill an administrative notice issued as part of, and subordinate to, the citation and enforcement described in 8) of Existing Law, below.

19) Specifies that a safety warning does not constitute a separate violation but may be considered in determining compliance status and the need for further enforcement action.

20) Authorizes DPH to refer violations of this part to the AG.

21) Authorizes the AG to bring a civil action for declaratory or injunctive relief to compel abatement of a hazard described in this bill.

Miscellaneous Provisions

22) Requires DPH to adopt rules and regulations necessary to implement this bill. Requires these regulations to ensure that all involuntary residential facilities comply with measurable standards for sanitary, hygienic, and safe conditions.

23) Requires regulations to establish objective, measurable standards for all involuntary residential facilities to ensure the health and safety of residents, including, but not limited to, all of the following:

    a) Standards for personal hygiene, laundry services, and the frequency of cleaning; and measurable metrics for vector and pest control, plumbing integrity, and the maintenance of sanitary common areas;

    b) Minimum requirements for indoor air quality, ventilation, and ambient temperature control to prevent heat-related illness or respiratory distress;

    c) Requirements for potable water access and dietary caloric intake, including the provision of medically necessary diets for individuals with conditions requiring dietary modification, such as diabetes, cardiovascular disease, or other clinically indicated conditions, and reasonable accommodations for religious dietary requirements;

d) Protocols for the screening, isolation, and treatment of communicable diseases;

e) Standards to prevent and respond to physical harm to residents and staff, including, but not limited to, all of the following:

i) Requirements governing the safe application of physical restraints to minimize the risk of injury;

ii) Requirements for mandatory medical evaluation and appropriate care following any incident involving the use of physical force or restraint;

iii) Documentation and reporting of incidents involving physical force or restraint;

iv) Staff training in de-escalation and safe intervention techniques; and,

v) Workplace violence prevention measures consistent with occupational safety and health standards.

24) Requires DPH, in developing the standards described in 22) and 23) above, to consult with stakeholders, including civil rights advocates, public health experts, and organizations representing the interests of persons held in involuntary residential facilities.

25) Makes the provisions of this bill severable. Prohibits, if any provision or its application is held invalid, that invalidity from effecting other provisions or applications that can be given effect without the invalid provision or application.

General Provisions and Definitions

26) Defines, for the purposes of this bill, the following terms to have the following meanings:

a) "Class AA violation" means a violation that is a substantial factor in causing a death;

b) "Class A violation" means a violation that poses an imminent risk of death or serious harm;

c) "Class B violation" means a violation that has a direct or immediate relationship to health or safety but does not constitute a class A or class AA violation;

d) "Involuntary residential facility" means a facility that meets all of the following criteria:

i) Houses 50 or more individuals overnight;

ii) Restricts residents' ability to enter or leave the facility at will, regardless of the legal authority under which the individual is housed; and,

iii) Provides onsite food service, medical care, mental health services, or residential supervision.

e) Specifies that "Involuntary residential facility" includes, but is not limited to, a secure state hospital, civil commitment facility, or a secure residential treatment program, to the

extent the facility meets the criteria described in this subdivision, and that "Involuntary residential facility" does not include a facility that is a state prison;

f) Clarifies that "Involuntary residential facility" does not include a juvenile facility that is operated by a local government, except for a secure youth treatment facility, including a secure youth treatment facility that is located within or operated in conjunction with a juvenile facility. Specifies that this bill does not authorize the inspection of any part of a juvenile facility that is not a secure youth treatment facility;

g) "Operator" means any person, corporation, partnership, nonprofit organization, or other entity that owns, leases, manages, or operates an involuntary residential facility;

h) "Resident" means any individual housed in an involuntary residential facility, regardless of legal status, custody status, or reason for placement; and,

i) "Unreasonably interfere" means conduct that materially disrupts or impedes facility operations or security functions beyond what is necessary to carry out an inspection authorized by this part.

27) Makes findings and declarations including:

a) The State of California has a compelling interest in protecting the health, safety, and welfare of individuals residing in involuntary residential environments and that facilities that house large numbers of individuals in restricted settings present heightened risks related to fire safety, structural integrity, sanitation, infectious disease, environmental hazards, and worker safety;

b) The state has long exercised its police powers to regulate building safety, public health, environmental compliance, and professional licensing, and these powers apply to all facilities operating within the state, regardless of ownership or contracting entity;

c) That this bill establishes neutral, generally applicable standards for health and safety inspections of involuntary residential facilities; and,

d) That nothing in this bill is intended to regulate detention operations, security procedures, classification of residents, or any other function reserved to federal, state, or local governmental agencies.

EXISITNG LAW:

1) Defines a "detention facility" as a facility in which persons are incarcerated or otherwise involuntarily confined for purposes of execution of a punitive sentence imposed by a court or detention pending a trial hearing or other judicial or administrative proceeding. Defines a "private detention facility" as a detention facility that is operated by a private, nongovernmental, for-profit entity pursuant to a contract or agreement with a governmental entity. Excludes various types of facilities from the definition of detention facility, including a facility providing specified health services, residential care facilities, and facilities used for quarantine. [Government Code (GOV) § 7320]

2) Requires, until July 1, 2027, the AG to engage in reviews of county, local, or private locked detention facilities in which noncitizens are being housed or detained for purposes of civil immigration proceedings in California. Requires the review to include conditions of confinement and requires the Department of Justice (DOJ) to provide a written summary of findings regarding the progress of these reviews and any relevant findings. [GOV § 12532]

3) Requires each county board of supervisors to appoint a local health officer (LHO). Requires LHOs to enforce and observe orders of the board pertaining to public health and sanitary matters, including regulations prescribed by DPH, and statutes relating to public health. [Health and Safety Code Section (HSC) § 101000 and § 101030]

4) Establishes provisions for investigations of detention facilities by LHOs as follows:

   a) Requires LHOs to investigate health and sanitary conditions in every publicly operated detention facility in the county or city (including county and city jails), and all private work furlough facilities and programs, at least annually. Requires private work furlough facilities and programs to pay an annual fee commensurate with the annual cost of investigations;

   b) Permits LHOs to make additional investigations of a county jail, private detention facility, or other detention facility of the county as determined necessary;

   c) Requires LHOs to submit a report to the Board of State and Community Corrections (BSCC), the person in charge of the jail or detention facility, and to the board of supervisors or city governing board (in the case of a city that has an LHO);

   d) Requires LHOs, whenever requested by the sheriff, the chief of police, local legislative body, or the BSCC, but not more often than twice annually, to investigate health and sanitary conditions in any jail or detention facility, and submit a report to the officer and agency requesting the investigation and to the BSCC;

   e) Requires the investigating LHO to determine if the food, clothing, and bedding is of sufficient quantity and quality that at least equal minimum standards and requirements of the BSCC for the feeding, clothing, and care of prisoners in all local jails and detention facilities, and if the sanitation requirements under the California Retail Food Code, have been maintained; and,

   f) Defines "private detention facility," for purposes of these provisions, as having same definition in 1) above. [HSC § 101045]

5) Establishes the Lanterman-Petris-Short (LPS) Act to end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders, developmental disabilities, and chronic alcoholism, as well as to safeguard a person's rights, provide prompt evaluation and treatment, and provide services in the least restrictive setting appropriate to the needs of each person. Permits involuntary detention of a person deemed to be a danger to self or others, or "gravely disabled" for periods of up to 72 hours for evaluation and treatment, or for up-to 14 days and up-to 30 days for additional intensive treatment in "county-designated facilities." [Welfare and Institutions Code (WIC) § 5000, *et seq*.]

6) Licenses and regulates various types of health facilities by DPH, including general acute care hospitals, acute psychiatric hospitals, and skilled nursing facilities. Requires every health facility for which a license or special permit has been issued by DPH, to be periodically inspected by DPH. [HSC § 1250, *et seq*.]

7) Licenses and regulates psychiatric health facilities (PHFs) and mental health rehabilitation centers (MHRCs) by the Department of Health Care Services (DHCS). PHFs provide 24-hour inpatient care for persons under the LPS Act. MHRCs are 24-hour programs that provide intensive support and rehabilitative services to assist adults with mental disorders who would have been placed in a state hospital or another mental health facility to develop skills to become self-sufficient. [WIC § 4080 and § 5675]

8) Establishes a civil penalty structure for long term care (LTC) facilities, which include skilled nursing facilities and intermediate care facilities, among others, categorized into Class "AA," "A," and "B" violations: "A" violations are where DPH determines that the violation presents either imminent danger of death or serious harm, or a substantial probability that death or serious harm to residents would result; "AA" violations (the most severe) are those that meet the criteria for a class "A" violation that DPH determines was a substantial factor in the death of a resident of an LTC facility; and, "B" violations are those that DPH determines have a direct or immediate relationship to the health, safety, or security of LTC facility residents, but do not meet the criteria for A or AA. [HSC § 1424]

FISCAL EFFECT: According to the Senate Appropriations Committee, unknown ongoing General Fund (GF) costs for DPH for state administration and enforcement activities. No significant fiscal impact for the DOJ. Unknown, potential cost pressures to the courts related to additional enforcement mechanisms provided in this measure (Trial Court Trust Fund, GF). While the courts are not funded on a workload basis, an increase in workload could result in delayed court services and would put pressure on the GF to fund additional staff and resources.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, large involuntary residential facilities, including secure treatment facilities, secure state hospitals, and privately operated detention facilities, house thousands of people who depend on the facility for shelter, food, medical care, and basic safety. Because individuals in these settings cannot freely leave, the state has a responsibility to ensure that conditions are safe, humane, and consistent with basic health and safety standards. Private immigration detention facilities are one example where this responsibility has often fallen short. People held in these facilities are suffering and, in some cases, are being treated inhumanely. An unprecedented number of people died in detention in 2025, and that number could be surpassed in 2026, with eight deaths already recorded in January. Despite this troubling trend, there are plans to expand detention capacity nationwide, including converting large facilities and warehouses into new detention sites, making the need for stronger oversight more urgent.

2) **BACKGROUND**.

   a) **Immigration detention facilities in California**. The federal government contracts with private detention facilities across the country to house federal inmates and immigration detainees. There are currently seven private detention facilities operating in California:

i) Adelanto ICE Processing Center in San Bernardino County (capacity 1,940);

ii) Desert View Annex in San Bernardino County (capacity 750);

iii) California City in Kern County (capacity 2,560);

iv) Golden State Annex in Kern County (capacity 700);

v) Mesa Verde ICE Processing Center in Kern County (capacity 400);

vi) Otay Mesa Detention Center in San Diego County (capacity 1,994); and,

vii) Imperial Regional Detention Facility in Imperial County (capacity 704).

b) Deaths in detention. CoreCivic operates the Otay Mesa and California City facilities, Management & Training Corporation operates the Imperial Regional Detention Facility, while the remainder are operated by the GEO Group. According to a February 6, 2026 article in the *Sacramento Bee*, at that time roughly 6,400 people were being held on a given day in these private facilities, which was more than double the figure from the prior year. Part of this growth was the opening of the California City Immigration Processing Center in 2025, which is now the largest immigration detention center in the state.

According to a research report by *KFF*, as of March 18, 2026, U.S. Immigration and Customs Enforcement (ICE) reported that 46 people died while in their custody or detention facilities since the start of the second Trump administration in January 2025. The number of deaths of people in detention during 2025 exceeded the highest seen in over two decades, and deaths in 2026 are on track to meet or exceed that number. On March 30, 2026, *The Los Angeles Times* reported that a detainee at Adelanto ICE Processing Center died on March 25, which was the fourth fatality at Adelanto since September of last year. Nationwide, the death toll in ICE custody in just the last three months was 14 people.

c) Response to the federal intergovernmental immunity challenge. This bill establishes an inspection and enforcement program that applies to "involuntary residential facilities," which are defined to include both unlicensed private detention facilities (those operated by ICE contractors), and licensed behavioral health facilities. The definition in the bill is a facility that houses 50 or more individuals overnight, and restricts residents' ability to enter or leave the facility at will. With the exception of prisons and jails; the only types of facilities that would meet this definition, other than private detention facilities, would be facilities licensed and approved to accept patients who are involuntarily detained for mental health reasons, typically under the LPS Act.

This bill is intentionally crafted to be "nondiscriminatory" with regard to federally-regulated activities. Under the doctrine of intergovernmental immunity, which is derived from U.S. Constitution's Supremacy Clause, state laws are invalid if they "regulate the United States directly or discriminate against the federal government or those with whom it deals" (*Boeing Co. v. Movassaghi*, 768 F.3d 832 (9th Cir. 2014)). To avoid a claim that California is "discriminating" against the federal government or imposing a burden on federal activity that is more onerous than what we are imposing on a similar activity by the state, the state needs to demonstrate it is treating the federal activity the same as it is

treating the state activity. Therefore, this bill is structured in a way to apply an investigation and enforcement process for any "involuntary residential facility," whether it is a licensed acute psychiatric hospital or other type of licensed facility approved for LPS patients or other civilly committed residents, or it is a nonlicensed private detention facility. Both are holding people on a civil detention overnight and are required to ensure that residents are cared for safely. While state-licensed facilities are already subject to a more advanced regulatory scheme, given that they are also licensed specifically to provide medical and behavioral health care, this bill would allow DPH to inspect, with enforcement ability, all types of involuntary residential facilities under the standards established by this bill.

d) **California DOJ inspection report and standards for access to care at detention facilities**. In 2017, during the first Trump administration, legislation was passed (see AB 103 in "Prior Legislation" below) that authorized the Attorney General to conduct inspections and make reports of private immigration detention facilities. This law was challenged in court, and while one provision relating to the ability of the DOJ to review the circumstances of an individual's detention was blocked, the 9th Circuit Court of Appeals upheld the remainder of the law, including the ability to inspect and review the conditions of confinement. Pursuant to this authority, the DOJ has reviewed and reported on private detention facilities, with the fourth and most recent report published in April of 2025. The 2025 report focused on mental health, including the prevalence of mental health conditions, and the availability and quality of mental health services in the facilities. The DOJ, for this report, inspected the six facilities that were in operation at the time (California City had not yet begun operation when inspections were being conducted).

   According to the DOJ report, immigration detention facilities are supposed to operate in accordance with applicable standards, including standards for the provision of health care services. Such standards include constitutional requirements, federal and state law requirements, federal detention standards, and applicable professional standards. The DOJ states that the contracts for these facilities include language requiring them to follow applicable federal and state laws. The DOJ states that all immigration detention facilities are also bound by ICE's Performance-Based National Detention Standards (PBNDS), issued in 2011 with revisions in 2016, and that ICE has contractual authority to enforce its detention standards but has faced criticism for its failure to do so. The PBNDS address both general health and mental health care. Under the PBNDS, each facility must provide "medically necessary and appropriate medical, dental and mental health care and pharmaceutical services." These services include "comprehensive, routine and preventive health care as medically indicated, emergency care, specialty health care, timely responses to medical complaints, and hospitalization as needed within the local community."

   The DOJ report identified inadequate mental health care services, with detainees experiencing high rates of depression, anxiety, and post-traumatic stress disorder, increased likelihood of self-harm behavior, and negative changes in self-perception. DOJ also found that issues identified in its 2019 and 2021 reports persisted, and new areas of concern emerged. Key findings include that medical recordkeeping at all six facilities were deficient, identified disproportionate use of force practices against individuals with mental health diagnoses, and, that facilities were not conducting the mental health

reviews required by ICE's detention standards before imposing discipline or segregation. The Trump Administration's decision to reduce or eliminate oversight is concerning and makes the DOJ's facility reviews even more crucial.

e) **LHO inspections of detention facilities in California**. LHOs serve a number of public health functions at the local level, including to implement infectious disease control, emergency preparedness and response, and maternal, child, and adolescent health, through 61 legally-appointed physician LHOs in California (one from each of the 58 counties and the three cities of Berkeley, Long Beach, and Pasadena). California law has long required annual inspections of health and sanitary conditions in a county jail (or in the case of a city jail, where there is a city health officer) and publicly operated detention facilities by the LHO. Inspection checklists for minimum standards are divided by Adult Court and Temporary Holding Facilities, Adult Jail Facilities, and Juvenile Facilities; and, into three sections: environmental, nutritional, and medical/mental health. All three sections must be completed at each inspection. The BSCC follows up on items of noncompliance, as LHOs have no enforcement duties. The BSCC publicly posts the inspection reports, and existing law (Penal Code § 6031.2) also requires the BSCC to submit a report to the Legislature showing results of its biennial facility inspections and monitoring of compliance with training standards (including non-compliance items from LHO investigations).

   In 2024, legislation was passed that added "private detention facilities" to these provisions of law (See SB 1132 in "Prior Legislation" below), specifically to the provision of law permitting, but not requiring, LHOs to conduct additional inspections of detention facilities. This law took effect on January 1, 2025, and with private immigration detention centers operating in four counties, those four LHOs now have the state authority to conduct inspections of these facilities. *CalMatters* published an article on October 2, 2025 stating that only one county, San Bernardino County, conducted an investigation. According to the article, a San Bernardino County inspector spent an hour at the Adelanto detention center for food and service issues, and the facility passed. The article reported that the LHO in Kern County has "no intention" of exercising authority to inspect the facilities. Imperial County said it would respond to a complaint if the facility falls within their legal authority to inspect.

   On June 3, 2026, a federal judge ordered the Otay Mesa Detention Center to allow San Diego County health inspectors access to the 1,400-bed facility. According to a *CalMatters* article published that day, San Diego County sued the Department of Homeland Security in March after two county supervisors and the health inspector were not given full access to the CoreCivic-run facility. The Southern California county is the first in the state to try to exercise the inspection authority, granted by state law in 2024. Judge James Simmons Jr. of the Southern District of California said last month that the county was likely to succeed in its lawsuit over whether it has the authority to conduct public health inspections under the state law. In his order, Simmons Jr. wrote the inspection "shall be completed as soon as practicable and no later than June 17, 2026." He also ordered CoreCivic to produce a list of policies and procedures requested by the county.

3) **SUPPORT**. This bill is co-sponsored by the Mexican-American Legal Defense and Education Fund (MALDEF), Public Counsel, the South Asian Network, and the Coalition for

Human Immigrant Rights (CHIRLA). CHIRLA states that in a report released last year, the AG reviewed six private immigration detention facilities and identified serious deficiencies, including inadequate medical and mental health care, insufficient suicide prevention protocols, a lack of transparency regarding use-of-force, and barriers to due process. These systemic failures directly impact the people detained in these facilities. For example, Masuma Khan, a 64-year-old Altadena resident who survived the Eaton fire and lived in the U.S. for nearly 30 years with her U.S. citizen family, was detained by ICE during a routine check-in appointment in October 2025. She was held without warm clothing, adequate food, or access to vital medication until a federal judge ordered her release in November. These conditions are not isolated. ICE arrested 382,540 people nationwide over the past year, and deaths in detention centers reached unprecedented levels, with eight already reported in January 2026. Although the AG provides some transparency, there is still no consistent statewide inspection or enforcement framework, and counties have not uniformly exercised their inspection authority. CHIRLA concludes that this bill establishes a uniform inspection and compliance framework for large involuntary residential facilities by requiring routine, multi-agency health and safety inspections, access to records, legislative reporting, and enforceable penalties to ensure timely correction of violations.

MALDEF notes that large facilities where individuals are not free to leave—regardless of the reason for their placement—must comply with basic standards that protect human health and safety. Facilities of this size and nature present heightened risks simply because of scale and confinement. MALDEF notes that this bill empowers DPH to create and enforce standards This is particularly important in the context of immigration detention. In 2025, the number of people in ICE custody nearly doubled from the start of the year to about 66,000, a system record. California alone holds 6,400 people daily across all seven centers, a figure expected to increase as operators expand space at two facilities in Kern County. MALDEF concludes, that at its core this bill is a public health and safety measure and ensures that California's longstanding police powers are applied consistently and that no large residential facility operating within the state falls outside meaningful oversight.

4) **OPPOSE UNLESS AMENDED**. The Chief Probation Officers of California (CPOC) are opposed to this bill unless it is amended to clarify that the bill is not applicable to any county juvenile detention facilities, consistent with other exemptions taken in previous sets of amendments. CPOC notes that as reflected in the bill's findings and declarations section (specifically Subdivision (e) of Section 19998.1), this bill is not "intended to regulate detention operations, security procedures, classification of residents, or any other function reserve to federal, state or local governmental agencies." Consistent with the above, amendments were taken on April 6 to exclude state prisons and county jails. However, the bill has not similarly, and comprehensively, excluded all county governmental juvenile facilities. CPOC continues that amendments taken on May 14 note that "involuntary residential facility" does not include some county governmental juvenile facilities such as juvenile halls, camps and ranches, but expressly says that the bill is appliable to Secure Youth Treatment Facilities (SYTF) which are also part of county government jurisdiction and are where courts order youth and young adults who have committed the most serious and violent WIC 707(b) offenses. The current version of the bill now excludes from the definition all governmental facilities at the state (prison) and local levels (jails, juvenile halls, camps and ranches) except for SYTFs. County juvenile facilities are already subject to inspection by BSCC as well as oversight from public health, fire marshal and others. CPOC concludes that applying the provisions of this bill would layer a new, concurrent regulatory process on top

of existing inspection processes for these facilities, thereby creating disruption, confusion, and delays in existing inspection processes.

5) RELATED LEGISLATION.

a) SB 1323 (Rubio) would require health care providers to inform staff and relevant volunteers on how to respond to requests by a person who is in lawful custody by immigration enforcement to notify a family member or designated support person about their current location. SB 1323 would strengthen existing provisions of law regarding health care providers establishing procedures restricting access to nonpublic areas of the facility for immigration enforcement purposes by removing "to the extent possible," and by requiring, rather than encouraging, providers to post a notice to authorities at facility entrances regarding the visitation and access policy. SB 1323 passed the Assembly Health Committee on June 9, 2026 with a vote of 11-3.

b) SB 1399 (Durazo) would repeal the January 1, 2028 sunset date on provisions of law requiring the AG to review and report on county, local, or private locked detention facilities in which noncitizens are being house or detained for purposes of civil immigration proceedings in California, thereby making this law permanent. SB 1399 is pending a hearing in the Assembly Judiciary Committee.

6) PREVIOUS LEGISLATION.

a) SB 1132 (Durazo), Chapter 183, Statutes of 2024 clarifies that "private detention facilities," are subject to inspection by LHOs.

b) AB 263 (Arambula), Chapter 294, Statutes of 2021 requires a private detention facility operator to comply with, and adhere to, all local and state public health orders and occupational safety and health regulations.

c) AB 103 (Committee on Budget), Chapter 17, Statutes of 2017 was the public safety omnibus bill, and among other provisions, required the AG to review and report on private detention facilities in which noncitizens are being house or detained for purposes of civil immigration proceedings in California.

7) DOUBLE REFERRAL. This bill is double referred, upon passage of this committee, it will be referred to the Assembly Committee on Judiciary.

REGISTERED SUPPORT / OPPOSITION:

Support

Coalition for Humane Immigrant Rights of Los Angeles (cosponsor)
Mexican-American Legal Defense and Ed Fund (cosponsor)
South Asian Network (cosponsor)
Public Counsel (cosponsor)
Asian Americans Advancing Justice-Southern California
California Academy of Family Physicians
California Community Foundation
California Federation of Labor Unions, AFL-CIO

California for Safety and Justice
California Low-income Consumer Coalition
California National Organization for Women
California Work & Family Coalition
Central American Resource Center of California (CARECEN-LA)
Community Legal Services in East Palo Alto
Consumer Attorneys of California
County of Santa Clara
Courage California
Ella Baker Center for Human Rights
Equality California
Grace Institute - End Child Poverty in CA
Inclusive Action for the City
Indivisible CA StateStrong
Inland Coalition for Immigrant Justice
LA Forward Institute
Lawyers' Committee for Civil Rights of the San Francisco Bay Area
Legal Aid At Work
Long Beach Residents Empowered
Oakland Privacy
Orale: Organizing Rooted in Abolition, Liberation, and Empowerment
Riverside Sheriffs' Association
Santa Ana City Councilmember Jessie Lopez
Sikh American Legal Defense and Education Fund (SALDEF)
Smart Justice California, a Project of Beyond Impact
Thai Community Development Center
Vision Y Compromiso

Opposition

None on file

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