PREVIOUS INSPECTION: _____ Location: _____

Sybil Brand Commission for Institutional Inspections

Courts_____ **Jails** MCJ **Sheriff Stations**_____

COMMISSIONER(S): Sherman, Regalado **TIME** 01:00 **DATE** 12/13/22

FACILITY NAME:	Men's Central Jail
ADDRESS:	441 Bauchet St **/ LASD SUPERVISOR CONTACTED:**
Census:	**Capacity: (_____) Current Census: (_____)**
Location(s) Inspected:	6000, 3400, 5000, Roof
Issues Reported to:	○ BOS ○ Officer in Charge ○ LASD ○ ISD ◉ OIG ○ COC

RATING: S = Satisfactory U = Unsatisfactory CA = Corrective Action Needed N/A = Not Applicable

ITEMS	RATING	COMMENTS
1.Conditions of Confinement		
Cells/Toilets/Sinks		
Showers (water temperature, rust, mold etc.)		6503-3: No water pressure in shower
Crowding		
Cleanliness/Graffiti		6503-3: Water leaking
Safety, Conflict, Tension		
Common Areas		
Air Quality/Temperature		
Deputy/Detainee Relations (incl. specific incidents or allegations of misconduct		
Strip Search Issues		
Access (Drinking Water)		
Access (Mail/Reading Materials/Law Library)		
Access (Toilets (for common room)		
Access (Toiletries, Appropriate Combs/Brushes)		
Access (Exercise, Religious Practice)		
Access (Legal Counsel)		
Access (Visitation, correspondence)		
Solitary Confinement		
Privacy/Dignity (showers, bathrooms)		
Special needs populations (pregnant, non-ambulatory, hearing impaired, mentally ill, medical conditions, developmental disability)		
Module Information Postings (re: time calculations, complaint procedures, messages to SBC		
Complaint Procedures (e.g., Deputy, medical complaints – confidential procedures to SBC, OIG, COC)		
Fees Assessed/Money on Books		
Other: _____		
2. Nutrition Quality/concerns		
Access to special diets		
3. Trustees		

Quarters		
Training & Selection		
Workload and Hours		
Calculation/Time Served		
4. Medical Services (Access, wait times, responsiveness, TB and other medical screening, dental, vision; infectious disease protocol)		See notes
5. Mental Health Services (Access, wait Times, treatment options, assessment procedures)		See notes
6. Telephones Access/Functionality		
7. EBI Services Availability/Type/Access **Volunteer Services** (Type, Access, Concerns)		
8. Clean Clothing and Bedding (Including laundry practices)		
9. Facilities/Maintenance		
Back Log Unfilled Order(s)		
Kitchen/ Laundry		
Chemical exposure (kitchen, laundry, trustee duti		
10. Deputy Staffing		
Quality of Interactions w/Detainees		
Use of Force (Last 30 days)		See notes
Assault on Staff (Last 30 days)		
Staff Training (MH, trauma informed etc.)		
11. Detainee Complaints/Concerns		
12. Deputy Complaints/Concerns		
13. Prior Corrective Action Resolution		
14. Detainee Documentation (e.g., intake/ release, procedures: classification, logs, detainee management files, Exit interview – policies/procedure grievances. generated funds, classifications)		
15. Discipline Proceedings		
16. Emergency Preparedness/Systems (e.g., fire extinguishers, air pack tags, emergency evacuation routes, control centers, emergency lighting fixtures, safety drills, First Aid and Suicide kits)		
17. Grounds (conditions, unlawful postings on exterior grounds (e.g., if ever been convicted cannot visit a detainee, etc.)		
18. Inspection: Special Focus **OIG:**_____ **COC:**_____ **Community:**_____		
19. COVID-19: _COC Request_____		
20. PREA Issues:_____		
21. Other: _____		

3400-B: Medically unsupervised detoxification

Upon inspection of 3400-B, we came upon a man who appeared to be in agony as he was experiencing what appeared to be symptoms of a medically unsupervised withdrawal from opioids. When I walked up to him, he immediately begged me for help. I was told he had gone man down three times in the few days he was there, and he was ultimately told to detox in his own cell on the row. I was told he had originally been housed with cell mates on the row, but when his symptoms of withdrawal caused him to vomit on his cell mates, he was given his own cell nearby. An additional complication is the fact that the row is on a quarantine order, although there was no signage on the row alerting me to that prior to my entry, and nobody was wearing masks, including the deputy. I referred this matter to Medical for immediate attention.

5000: Restraint of incarcerated person with serious mental illness - incident report

This report was provided to OIG.

On December 13, 2022, Commissioner Regalado and Commissioner Sherman were in the process of conducting an inspection of various areas of MCJ, including 6000, 3000, and 5000. At around 3pm, while we stood in the watch observation deck near 5600 (or one of those 4 large dorms on 5000 that share a single deck), we heard and then later observed the removal of a person housed in an MOH dorm. We were told that he was being transferred to TTCF HOH for what was said to be a treatment-related purpose.

We observed the Sgt involved in his removal with several other deputies who walked him to the bench in the hall near the doorway to the escalators and kept him there under the watch of a number of 5-10 deputies. At that time, the person appeared to be handcuffed to the bench and behaving in a relatively calm and patient manner, even as he appeared to have a dour affect, and the deputies appeared to be relaxed. Deputies were chatting with us and offering to help us go inside the dorms to conduct an internal inspection of the dorm facilities. The situation seemed to be under control and we walked down the hall with Sgt into an office to discuss matters related to the administration of the floor.

While the incarcerated person was out of our view, I heard a verbal outburst from down the hall. I walked towards the situation to observe the incarcerated man continue to be handcuffed to the bench as he had an outburst. I was not able to make sense of his words which were generally virtiolic and did not appear to be directed at any one person. As the outburst continued, I saw deputies standing around begin to gear up with tasers, blue/black gas canisters, and eventually bring out a black canvas or kevlar wheelbarrow type of gurney. Then, a deputy told us we must leave immediately. Since Commissioner Regalado had just been speaking with the Sgt, I waited for an instruction from him. The Sgt asked us to wait where we were in the escalator vestibule.

Once in the vestibule, the floor went on lockdown as the door was locked in front of us. We attempted to view the situation through the small window of the locked door but a deputy stood there to obstruct our view. While we stood behind the locked door of the vestibule, the deputies did not appear to take action while the distressed man continued to express verbal outburst. Even though he was out of view, my belief is at that point he remained handcuffed to the bench. I did

not see any deputies use force or intentionally agitate the inmate, but they did encircle him while holding spray and tasers.

The deputies then huddled into the interior of the office adjacent to the escalator vestibule. After some time, a deputy emerged from the office and told us to leave the floor entirely. We were told the inmate had spit on a deputy, but we did not see this happen nor did we see or hear any action taken in response to the apparent spitting. I did not see the Sgt again and did not receive a follow up instruction from him. Mr. Regalado and I remained restricted from the area, behind a locked door, yet it seemed clear, as long as we remained on the floor, the deputies were not going to take any action. After some more time, Mr. Regalado and I decided to leave. We then met with the watch commander and reported the fact of the incident occurring on the floor to them. The watch commander did not ask for our observations as to what we saw.

As Commission Regalado and I left the building, we discussed our observations. The question on both of our minds was why we as commissioners conducting an inspection were not allowed to remain even behind the locked door, but also why they felt they could not do whatever it is they were going to do to effect the transfer with us being present. It is our impression we saw a situation that started as a transfer for treatment purposes, yet there were no medical or mental health personnel present to lead or monitor the transfer. This then escalated and became a potential UOF.

Later, I learned a Use of Force did occur, the person was recommended for disciplinary housing, but was instead diverted to HOH housing at TTCF.