Inspection Information

1. Location *

Century Regional Detention Facility

2. Date of Previous Inspection *

1/16/2024

3. Date of this Inspection *

2/25/2024

4. Time *

1:00pm

5. **Location**

	Courts	Jails	Sheriff Station
Location	○	◉	○

6. Commissioner(s) - (Select all that Apply) *

- [ ] Ingrid Archie
- [ ] Mark - Anthony Clayton Johnson
- [ ] Haley Broder
- [ ] Bob Frutos
- [ ] Dr. Cheryl N. Grills
- [ ] Eric J. Miller
- [ ] Norma Cumpian
- [ ] Raymond Regalado
- [ ] Alexander Sherman
- [ ] Joahanna Terrones
- [x] Mary Veral
- [x] Eric Miller

Facility Information

7. Facility Name *

Courthouse names and locations: https://www.lacourt.org/courthouse

Patrol Names and locations Stations: https://lasd.org/stations/

LA County Jail Facilities names and locations: https://lasd.org/custody/

Century Regional Detention Facility

8. Facility Address *

Courthouse names and locations: https://www.lacourt.org/courthouse

Patrol Names and locations Stations: https://lasd.org/stations/

LA County Jail Facilities names and locations: https://lasd.org/custody/

11705 S. Alameda St., Lynwood CA90262

9. Name and Title of LASD Supervisor Contacted *

Lt. Daniel J. Wade

10. Census: Capacity *

2670

11. Current Census *

1321

12. Location(s) Inspected: *

2100; 2300; 1300 (FIP-Stepdown)

13. Issues reported to *(Select all that Apply)*: *

- [ ] BOS
- [x] Officer in Charge
- [ ] LASD
- [ ] ISD
- [ ] OIG
- [ ] COC
- [ ] Other

14. Name of the person(s) issues were reported to: *

Daniel Wade

15. Contact Information of the person(s) contacted: *

DJWade@lasd.org

Conditions of Confinement

16. **Condition of Confinement:** Cells/Toilets/Sinks

- ( ) Satisfactory
- (•) Unsatisfactory
- ( ) Corrective Action Needed
- ( ) Not Applicable

17. **Condition of Confinement COMMENTS RE**: Cells/Toilets/Sinks

In 2302 (second floor of 2300) we observed two people incarcerated in the High Observation Housing unit, each of whose cell toilet was overflowing with feces. The response appeared to be that the sheriffs had placed towels outside the two cells to contain the overflow. There was a strong smell of feces in addition to the unsanitary water flow. In addition, at least two other women in 2100 and 2300 complained of problems with the water flow in their sinks, including one sink in which the water was constantly running.

18. **Condition of Confinement:** Showers (water temperature, rust, mold etc.)

- (●) Satisfactory
- ( ) Unsatisfactory
- ( ) Corrective Action Needed
- ( ) Not Applicable

19. **Condition of Confinement:** Crowding

- ( ) Satisfactory
- (●) Unsatisfactory
- ( ) Corrective Action Needed
- ( ) Not Applicable

20. **Conditions of Confinement COMMENT RE:** Crowding

The FIP-Stepdown unit in 1300 had at least 8 unused spaces, according to the Mental Health Assistants, that could have been used to house people with significant mental illness, designated P3/P4 who are currently located in high observation housing.

21. **Condition of Confinement:** Cleanliness/Graffiti

- (●) Satisfactory
- ( ) Unsatisfactory
- ( ) Corrective Action Needed
- ( ) Not Applicable

22. **Condition of Confinement:** Safety, Conflict, Tension

- ( ) Satisfactory
- ( ) Unsatisfactory
- ( ) Corrective Action Needed
- (●) Not Applicable

23. **Condition of Confinement:** Common Areas

- (●) Satisfactory
- ( ) Unsatisfactory
- ( ) Corrective Action Needed
- ( ) Not Applicable

24. **Condition of Confinement:** Air Quality/Temperature

- (●) Satisfactory
- ( ) Unsatisfactory
- ( ) Corrective Action Needed
- ( ) Not Applicable

25. **Condition of Confinement:** Deputy/Detainee Relations (Including Specific Incidents or allegations of misconduct)

- ( ) Satisfactory
- (●) Unsatisfactory
- ( ) Corrective Action Needed
- ( ) Not Applicable

26. **Conditions of Confinement COMMENT RE:** Deputy/Detainee Relations (Including Specific Incidents or allegations of misconduct)

We spoke with three Mental Health Assistants in 1300 FIP-Stepdown. There appeared to be some conflict between the Mental Health Assistants and some sheriffs and some members of Correctional Health Services. They detailed some of the issues in getting sheriff deputies to "buy into" the program, and in particular that some of the deputies did not accept the treatment orientation of the Mental Health Assistants, and took a more punitive approach. That resulted in Mental Health Assistants no longer visiting women in high observation housing to explain the FIP-Stepdown program and encourage them to join it. It also explained why FIP-Stepdown had a significant portion of spare places. In addition, the Mental Heath Assistants suggested that they had received pushback from Correctional Health Services, who were unwilling to work with them in providing mental health services to the women in the FIP-Stepdown program.

27. **Condition of Confinement:** Strip Search Issues

- ( ) Satisfactory
- ( ) Unsatisfactory
- ( ) Corrective Action Needed
- (●) Not Applicable

28. **Condition of Confinement:** Access (Drinking Water)

- ( ) Satisfactory
- (•) Unsatisfactory
- ( ) Corrective Action Needed
- ( ) Not Applicable

29. **Conditions of Confinement COMMENT RE:** Access (Drinking Water)

As mentioned earlier, we observed at least two malfunctioning sinks used for drinking water.

30. **Condition of Confinement:** Access (Mail/Reading Materials/Law Library)

- ( ) Satisfactory
- ( ) Unsatisfactory
- ( ) Corrective Action Needed
- (•) Not Applicable

31. **Condition of Confinement:** Access (Toilets for Common Room)

- ( ) Satisfactory
- ( ) Unsatisfactory
- ( ) Corrective Action Needed
- (•) Not Applicable

32. **Condition of Confinement:** Access (Toiletries, Appropriate Combs/Brushes)

- ( ) Satisfactory
- (•) Unsatisfactory
- ( ) Corrective Action Needed
- ( ) Not Applicable

33. **Conditions of Confinement COMMENT RE:** Access (Toiletries, Appropriate Combs/Brushes)

The Mental Health Associates revealed that there is a significant and persistent problem with head lice in the high observation housing units. They also detailed that the process for removing the lice on admission to FIP-Stepdown was unsatisfactory and that Correctional Health Services provided only perfunctory help treating the lice problem. It would usually take two weeks to remove lice, and usually required medication, which she Correctional Health Services would not provide because failing to conduct a close enough inspection.

34. **Condition of Confinement:** Access (Exercise, Religious Practice)

- ○ Satisfactory
- ○ Unsatisfactory
- ○ Corrective Action Needed
- ◉ Not Applicable

35. **Condition of Confinement:** Access (Legal Counsel)

- ○ Satisfactory
- ○ Unsatisfactory
- ○ Corrective Action Needed
- ◉ Not Applicable

36. **Condition of Confinement:** Access (Visitation, Correspondence)

- ○ Satisfactory
- ○ Unsatisfactory
- ○ Corrective Action Needed
- ◉ Not Applicable

37. **Condition of Confinement:** Solitary Confinement

- ○ Satisfactory
- ○ Unsatisfactory
- ○ Corrective Action Needed
- ◉ Not Applicable

38. **Condition of Confinement:** Privacy/Dignity (showers, bathrooms)

- ◉ Satisfactory
- ○ Unsatisfactory
- ○ Corrective Action Needed
- ○ Not Applicable

39. **Condition of Confinement:** Special needs populations (pregnant, non-ambulatory, hearing impaired, mentally ill, medical conditions, developmental disability)

- ( ) Satisfactory
- (•) Unsatisfactory
- ( ) Corrective Action Needed
- ( ) Not Applicable

40. **Conditions of Confinement COMMENT RE:** Special needs populations (pregnant, non-ambulatory, hearing impaired, mentally ill, medical conditions, developmental disability)

In the 2100/2300 units, we discussed the Sheriffs' and Correctional Health Service's failure to identify a woman as pregnant and who gave birth in the unit in October. The OIG report Issued February 20, 2024 discussed some of the failings that the Sheriffs identified for us, including the failure of correctional health services to follow up when the pregnant woman refused a pregnancy test on admission.

I have discussed issues raised by Mental Health Assistants in FIP Stepdown earlier in this report.

41. **Condition of Confinement:** Module Information Postings (re: time calculations, complaint, developmental disability)

- ( ) Satisfactory
- ( ) Unsatisfactory
- ( ) Corrective Action Needed
- (•) Not Applicable

42. **Condition of Confinement:** Complaint Procedure (e.g., Deputy, Medical Complaints - Confidential Procedures to SBC, OIG, COC)

- ( ) Satisfactory
- ( ) Unsatisfactory
- ( ) Corrective Action Needed
- (•) Not Applicable

43. **Condition of Confinement:** Fees Assessed/ Money on Books

- ( ) Satisfactory
- ( ) Unsatisfactory
- ( ) Corrective Action Needed
- (•) Not Applicable

44. **Condition of Confinement:** Other

45. **Condition of Confinement:** Other

- (●) Satisfactory
- ( ) Unsatisfactory
- ( ) Corrective Action Needed
- ( ) Not Applicable

Nutrition

46. **Nutrition:** Quality/Concerns

- ( ) Satisfactory
- (●) Unsatisfactory
- ( ) Corrective Action Needed
- ( ) Not Applicable

47. **Nutrition COMMENT RE:** Quality/Concerns

Mental Health Assistants in Century Regional Detention Facility complained that they were not getting hot meals that were promised to them. Instead of getting the same two hot meals as the Mental Health Assistants in Twin Towers, they received only one.

48. **Nutrition:** Access to special diets

- (●) Satisfactory
- ( ) Unsatisfactory
- ( ) Corrective Action Needed
- ( ) Not Applicable

Trustees

49. **Trustees:** Quarters

- ○ Satisfactory
- ○ Unsatisfactory
- ○ Corrective Action Needed
- ◉ Not Applicable

50. **Trustees:** Training and Selection

- ○ Satisfactory
- ○ Unsatisfactory
- ○ Corrective Action Needed
- ◉ Not Applicable

51. **Trustees:** Workload and Hours

- ○ Satisfactory
- ○ Unsatisfactory
- ○ Corrective Action Needed
- ◉ Not Applicable

52. **Trustees:** Calculation/Time Served

- ○ Satisfactory
- ○ Unsatisfactory
- ○ Corrective Action Needed
- ◉ Not Applicable

Medical Services

53. **Medical Services**

	Satisfactory	Unsatisfactory	Corrective Action Needed	Not Applicable
Access	○	◉	○	○
Wait Times	○	○	○	○
Responsiveness	○	○	○	○
TB and Other Medical Screening	○	○	○	○
Dental	○	○	○	○
Vision	○	○	○	○
Infectious Disease Protocol	○	○	○	○

54. **COMMENTS RE:** Medical

I have discussed the medical access issues in the context of an undiagnosed pregnant women and failure to adequately use FIP-Stepdown

Mental Health

55. **Mental Health Services**

	Satisfactory	Unsatisfactory	Corrective Action Needed	Not Applicable
Access	○	◉	○	○
Wait Times	○	○	○	○
Treatment Options	○	○	○	○
Assessment Procedures	○	◉	○	○

56. **COMMENTS RE:** Mental Health

We have discussed the problems for women with mental health problems to access FIP-Stepdown treatment and for Correctional Health Services to work with Mental Health Assistants elsewhere.

Telephones

57. **Telephones**

	Satisfactory	Unsatisfactory	Corrective Action Needed	Not Applicable
Access	◉	○	○	○
Functionality	◉	○	○	○

58. **COMMENTS RE:** Telephones

Education Based Incarceration Programming (EBI)

59. **Education Based Incarceration Programming (EBI)**

	Satisfactory	Unsatisfactory	Corrective Action Needed	Not Applicable
Availability	○	○	○	○
Type	○	○	○	○
Access	○	◉	○	○

60. **COMMENTS RE:** EBI Programming

Mental Health Assistants complained of being denied Education Based Incarceration programming. The OIG report, REPORT BACK ON SUPPORT FOR MENTAL HEALTH ASSISTANTS IN FURTHERING THE SUSTAINABILITY AND SUCCESS OF THE FORENSIC IN-PATIENT STEPDOWN UNIT PROGRAM dated February 21, 2024 discusses these issues.

61. **EBI:** Volunteer Services

	Satisfactory	Unsatisfactory	Corrective Action Needed	Not Applicable
Type	○	○	○	○
Access	○	○	○	○
Concerns	○	○	○	○

62. **COMMENTS RE EBI:** Volunteer Services

Clean Clothing and Bedding

63. **Clean Clothing and Bedding** (including laundry practices)

- ◯ Satisfactory
- ◯ Unsatisfactory
- ◯ Corrective Action Needed
- ◯ Not Applicable

Facilities/Maintenance

64. **Facilities/Maintenance:** Back Log Unfilled Order(s)

- ◯ Satisfactory
- ◯ Unsatisfactory
- ◯ Corrective Action Needed
- ◯ Not Applicable

Deputy Staffing

65. **Deputy Staffing:** Quality of Interactions w/Detainees

	Satisfactory	Unsatisfactory	Corrective Action Needed	Not Applicable
Use of Force (Last 30 days)	◯	◯	◯	◯
Assault on Staff (Last 30 days)	◯	◯	◯	◯
Staff Training (MH, trauma informed etc.)	◯	◯	◯	◯

66. **Deputy Staffing COMMENTS RE:** Quality of Interactions w/Detainees

67. **Detainee Complaints/Concerns COMMENTS:**

68. **Deputy Complaint/Concerns COMMENTS:**

69. **Prior Corrective Action Resolution:**

70. **Detainee Documentations** (e.g., intake/release, procedures)**:**

	Satisfactory	Unsatisfactory	Corrective Action Needed	Not Applicable
Classification	◯	◯	◯	◯
Logs	◯	◯	◯	◯
Detainee management	◯	◯	◯	◯
Exit interview - policies/procedure grievances	◯	◯	◯	◯
Generated funds	◯	◯	◯	◯

71. **Detainee Documentation COMMENTS:**

72. **Discipline Proceedings:**

- ◯ Satisfactory
- ◯ Unsatisfactory
- ◯ Corrective Action Needed
- ◯ Not Applicable

Inspection: Special Focus

73. **Inspection: Special Focus**

	Satisfactory	Unsatisfactory	Corrective Action Needed	Not Available
COC	○	○	○	○
Community	○	○	○	○
CHS	○	○	○	○
DMH	○	○	○	○
DPH	○	○	○	○
Facilties	○	○	○	○
Food Services	○	○	○	○
OIG	○	○	○	○
Other	○	○	○	○

74. Inspection: Special Focus Request *(Select all that Apply)*:

- ☐ COC
- ☐ Community
- ☐ CHS
- ☐ DMH
- ☐ DPH
- ☐ Facilities
- ☐ Food Services
- ☐ OIG
- ☐ N/A
- ☐ Other

75. Inspection: Special Focus Request Comments:

76. **Prison Rape Elimination Act (PREA) Issues:**

- ◯ Satisfactory
- ◯ Unsatisfactory
- ◯ Corrective Action Needed
- ◯ Not Applicable

INSPECTION DETAILS - ANCHORED TO SUMMARIZE #3 THROUGH #106

77. Inspection Detail for #:

78. Inspection Detail for #:

79. Inspection Detail for #:

80. Inspection Detail for **OIG** Request Related to:

81. Inspection Detail for **COC** Request Related to:

82. Inspection Detail for **Community Request** Related to:

83. **Inspection Detail:** EBI

84. **Inspection Detail:** Medical

85. **Inspection Detail:** Medical

86. **Inspection Detail:** Building and Maintenance *(Select all that apply)*

- [ ] Lawns
- [ ] Recreation Area
- [ ] Blacktop
- [ ] Asphalt
- [ ] General Condition
- [ ] Paint
- [ ] Roof
- [ ] Drains/Gutters
- [ ] Not Applicable
- [ ] Other

87. Inspection Detail: Building and Maintenance

INSPECTION DETAIL: INTERIOR OF BUILDINGS(S)

88. **Inspection Detail:** Interior of Building(s) and Maintenance *(Select all that apply)*

- [ ] Walls
- [ ] Paint
- [ ] Floors
- [ ] Drains
- [ ] Plumbing fixtures working
- [ ] Air Vents
- [ ] Windows
- [ ] Not Applicable
- [ ] Other

89. Inspection Detail **Interior of Building**:

90. Are Cleaning fluids and chemicals labeled and safely stored?

- ◯ Yes
- ◯ No
- ◯ Not Applicable
- ◯ Other

91. Weapons locker present?

- ◯ Yes
- ◯ No
- ◯ Not Applicable
- ◯ Other

92. Recreation/Sports Equipment:

93. Are the hallways clear, are doors propped open or closed?

- ◯ Yes
- ◯ No
- ◯ Not Applicable
- ◯ Other

94. Holding areas (cells/rooms), is there access to drinking water and toilet?

- ◯ Yes
- ◯ No
- ◯ Not Applicable
- ◯ Other

95. Condition of individual cells/rooms, or dormitories:

96. Beds - Type of bed and is it off the floor?

97. Adequate lighting:

98. Temperature:

Reform and Oversight Efforts: Los Angeles County Sheriff's Department

October through December 2023

Issued February 20, 2024

Table of Contents

ABOUT QUARTERLY REPORTS

Quarterly reports provide an overview of the Office of Inspector General's regular monitoring, auditing, and review of activities related to the Los Angeles County Sheriff's Department (Sheriff's Department) over a given three-month period. This quarterly report covers Department activities and incidents that occurred between October 1, 2023 and December 31, 2023, unless otherwise noted. Quarterly reports may also examine particular issues of interest. This report includes special sections on the following topics:

- Conflicts of Interest in Risk Management Bureau
- Reporting the Presence of MET Teams at Crime Scenes to Ensure *Brady* Compliance
- Semi-Annual Report on Implementation of the Family Assistance Program
- Rodent Infestation at Men's Central Jail
- Birth of a Baby at Century Regional Detention Facility
- Sticker Associated with an Alleged Deputy Gang at Century Regional Detention Facility

During the fourth quarter of 2023, the Office of Inspector General also issued the following report relating to the Sheriff's Department:

- *Third Report Back on Meeting the Sheriff's Department's Obligations Under Senate Bill 1421*

MONITORING SHERIFF'S DEPARTMENT'S OPERATIONS

Deputy-Involved Shootings

The Office of Inspector General reports on all deputy-involved shootings in which a deputy intentionally fired a firearm at a human, or intentionally or unintentionally fired a firearm and a human was injured or killed as a result. This quarter, there were three incidents in which people were shot or shot at by Sheriff's Department personnel. The Office of Inspector General staff responded to each of these deputy-involved shootings. One person was struck by deputies' gunfire, fatally. The information in the following shooting summaries is based on the limited information provided by the Sheriff's Department and is preliminary in nature. While the Office of Inspector General receives information at the walk-through at the scene of the shooting, receives preliminary memoranda with summaries, and attends the Sheriff's Department Critical Incident Reviews, the statements of the deputies and witnesses are not provided until the Sheriff's Department completes its investigation. The Sheriff's Department permits the

Office of Inspector General's staff limited access to monitor the ongoing investigations of deputy-involved shootings. The Sheriff's Department also maintains a page on its website listing deputy-involved shootings that result in injury or death, with links to incident summaries and video.

Operation Safe Streets: Non-Hit Shooting

The Sheriff's Department reported that on October 24, 2023, the Operation Safe Streets Bureau (OSS) Gang Surveillance Unit (GSU) was assisting Industry Station with an arrest warrant and surveilling a residence in attempts to locate a 24-year-old Hispanic man wanted for assault with a firearm. At approximately 1:28 p.m., a GSU deputy positively identified the suspect standing in the residence's driveway. The deputy exited an unmarked vehicle wearing a Department-issued vest and told the suspect to put his hands up. The deputy said that the suspect produced a handgun, and the deputy fired at the suspect four to five times. The suspect ran into the residence, but exited and surrendered after the GSU team conducted several minutes of call-outs. Neither the suspect nor the GSU deputies were injured. An unregistered firearm was found inside the residence. Five rounds struck the exterior of the residence and two of those penetrated to the interior. At the time of the shooting, three civilians and the suspect were inside the residence, and a fourth civilian was in the driveway. Though no one was physically struck by the gunfire, one civilian was hospitalized for stress.

The Department does not currently list this shooting on its transparency page for deputy-involved shootings.

Areas for Further Inquiry

The shooting deputy reported that he shot in response to the suspect producing a gun. However, neither witnesses nor body-worn camera video corroborate that the suspect produced a gun. Is there an explanation for this discrepancy? Was less-lethal force an option?

Lancaster Station: Hit Shooting - Fatal

On December 4, 2023, at approximately 6:08 p.m., Lancaster Station deputies were dispatched to a domestic violence call at an apartment located on East Avenue in Lancaster. The call was placed by a woman, later identified as a 27-year-old Black woman, reporting that her boyfriend was harassing her. During the call, sounds of a struggle and screaming could be heard.

Upon arrival, three deputies heard yelling from inside the apartment. One deputy knocked at the door, and when no one responded, attempted to kick the door open without success. The woman then opened the door holding a knife, with her 9-year-old

daughter in front of her. The woman said she was going to stab her boyfriend for pushing her daughter. She moved back into the apartment, still holding the knife. Deputies entered the apartment and observed the woman with the knife standing next to a man. One of the deputies reported he believed that she was attempting to stab her boyfriend, at which time he fired four rounds, striking the woman and causing her to fall and drop the knife The 9-year-old daughter witnessed the entire incident. Deputies provided immediate first aid until Los Angeles County Fire Department paramedics arrived and took over. The woman was transported to a local hospital where she was pronounced dead.

A kitchen knife with an approximately 8-inch blade was recovered at the scene. No one else was injured during this incident.

The Department posted body camera video from the shooting on December 29, 2023.

Areas for Further Inquiry:

Did the deputies develop a tactical plan prior to entry into the apartment? If so, did it include a plan on the use of less lethal force? Did the deputies request a supervisor prior to attempting to forcibly enter the apartment?

Century Station: Non-Hit Shooting

On December 27, 2023, at approximately 2:00 p.m., deputies from Century Station responded to a call for service at a large two-story business complex in the city of Lynwood. The caller stated that a person had attempted to force his way into their business on the second floor of the complex, without success. A second caller reported the person had a silver handgun. Multiple deputies and a sergeant responded. Upon their arrival, the deputies began evacuating the ground floor of the building. During this process, a person came down the stairs and was detained without incident. The deputies were advised that there were people in the upstairs businesses who were afraid to come out and needed to be evacuated.

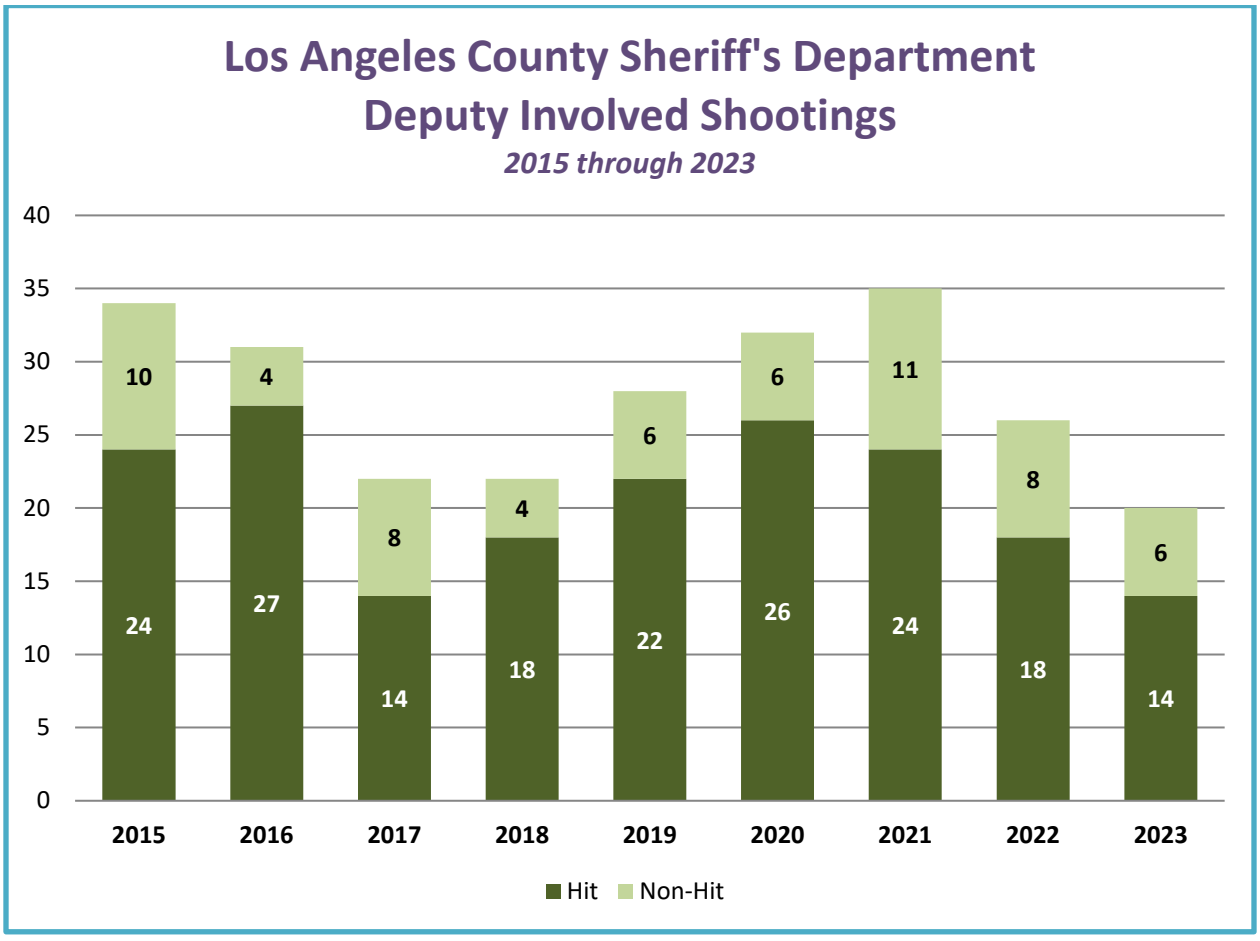
The sergeant and six deputies made their way up the stairs to the second floor and took a position at the end of a very long hallway. At the other end of the hallway, a deputy saw a person open the door from an office and peek out. From approximately one-hundred feet, the deputy saw an object in this person's hand. Believing it was a handgun, the deputy fired two rounds from a department-approved AR-15 rifle. At that time, it was unknown if the rounds struck the individual as he went back into the office. The person deputies detained when he came down the stairs upon their arrival was later positively identified as the suspect. The two rounds the deputy fired did not injure anyone. The person upon whom the deputy fired told deputies he was holding a translucent plastic drinking cup, which he showed to them. Deputies searched for a

handgun and did not find one. The shooting was captured on the deputy's body-worn camera video.

Areas of Further Inquiry:

Did the station desk ask all pertinent questions to the callers to give responding deputies the most accurate information necessary for situational awareness? Did the dispatcher give timely updates to the responding deputies? Did the responding deputies form a tactical plan and ensure every deputy on the entry team understood it? Did the deputies completely clear the first floor before making their way to the second floor? Did the deputy follow policy and training in assessing the threat and deciding to fire? Given that the sergeant was on the entry team and involved in the situation, who was the incident commander?

Comparison to Prior Years



District Attorney Review of Deputy-Involved Shootings

The Sheriff's Department's Homicide Bureau investigates deputy-involved shootings in which a person is hit by a bullet, except for deputy-involved shootings that result in the death of an unarmed civilian, which California law requires the Attorney General to investigate.[1] For those shootings it investigates, the Homicide Bureau submits the completed criminal investigation of each deputy-involved shooting that results in a person being struck by a bullet and which occurred in the County of Los Angeles to the Los Angeles County District Attorney's Office (District Attorney's Office or District Attorney) for review and possible filing of criminal charges.

Between October 1, 2023, and December 31, 2023, the District Attorney's Office issued four findings on deputy-involved shooting cases involving the Sheriff's Department's employees.

- In the August 26, 2021, non-fatal shooting of Kevin Hernandez, the District Attorney opined in a memorandum dated October 5, 2023 , that detective Albert Arevalo reasonably believed that the use of deadly force was necessary to defend against an imminent threat of death or serious bodily injury to himself and others within the meaning of Penal Code section835a(c)(1)(A).

- In the November 13, 2019, fatal shooting of Omar Garcia-Espinoza, the District Attorney opined in a memorandum dated October 16, 2023 , that there was insufficient evidence deputy Dwight Aguayo did not act lawfully in self-defense and in defense of others.

- In the April 9, 2021, non-fatal shooting of Kyle Rogers, the District Attorney opined in a memorandum dated October 25, 2023 , that deputies Aaron Agajanian and Daisy Rosales, reasonably believed that deadly force was necessary to defend against an imminent deadly threat.

- In the May 30, 2020, non-fatal shooting of Jose Martinez, the District Attorney opined in a memorandum dated November 21, 2023, that

[1] In 2020, the California Legislature passed AB 1506, which requires that a state prosecutor investigate all shootings involving a peace officer that result in the death of an unarmed civilian. *See* A.B. 1506 (McCarty 2020) (codified at Govt. Code § 12525.3). Prior to 2021, the Sheriff's Department's Homicide Bureau investigated all deputy-involved shootings in which a person was hit by a bullet. Decisions by the Attorney General are reported in the section of this report below entitled *California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians*.

deputies Nicholas Carey, Eric Slattery, Nicholas Alerich, Andrew Rosas and Bell Police Department Officer acted lawfully in self-defense.

- In the January 8, 2023 fatal shooting of Alon Foster, the District Attorney opined in a memorandum dated December 4, 2023, that deputies Adam Carreon, Zachery Corrales, Salvador Diaz, Christopher McDonald, Jonathan Soria, and Rigoberto Villa acted lawfully in self-defense and defense of others.

- In the May 24, 2022 non-fatal shooting of Gabriel Adrian Samaniego, the District Attorney opined in a memorandum dated December 7, 2023, that deputies Juan Lopez and Cesar Hernandez, as well as officers with the California Highway Patrol, reasonably believed that the use of deadly force was necessary to defend against an imminent threat of death or serious bodily injury and acted in lawful self-defense.

- In the May 10, 2019 non-fatal shooting of Alison Hart and Adolfo Cabrera-Martinez and the non-hit shooting of Dylan Lindsey the District Attorney opined in a memorandum dated December 20, 2023, that deputies Art Hernandez, Jonathan Charrette, Rene Vasquez, and David Vega, as well as officers with the Downey Police Department, acted in lawful self-defense and defense of others when they fired their weapons at Dylan Lindsey. The District Attorney additionally concluded that Mr. Lindsey died as the result of a self-inflicted gunshot wound, that the evidence does not suggest that the deputies explicitly aimed at Ms. Hart, Lindsey's accomplice, or Mr. Cabrera-Martinez, who was an innocent bystander. The District Attorney concluded that the injuries suffered by Ms. Hart and Mr. Cabrera-Martinez were due to the provocative acts of Mr. Lindsey.

Homicide Bureau's Investigation of Deputy-Involved Shootings

For the present quarter, the Homicide Bureau reports that it has eleven shooting cases involving Sheriff's Department personnel open and under investigation. The oldest case in which the Homicide Bureau maintains an active investigation is related to a November 3, 2022, shooting in the jurisdiction of Compton Station. For further information as to that shooting, please refer to the Office of Inspector General's report *Reform and Oversight Effort: Los Angeles County Sheriff's Department, October to December 2022*. The oldest case that the Bureau has open is a 2019 shooting in Lynwood, which was submitted to the District Attorney's Office and for which the Sheriff's Department still awaits a filing decision.

This quarter, the Sheriff's Department reported it sent two deputy-involved shooting cases to the District Attorney's Office for filing consideration.

California Department of Justice Investigations of Deputy-Involved Shootings Resulting in the Death of Unarmed Civilians

Under California law, the state Department of Justice (DOJ) investigates any peace officer-involved shooting resulting in the death of an unarmed civilian and may issue written reports and file criminal charges against a peace officer, if appropriate.[2] The DOJ is currently investigating three shootings involving deputies from the Sheriff's Department, the oldest of which occurred in February 2022. During the last quarter, the DOJ issued no written reports regarding shootings involving Sheriff's Department deputies.

Internal Criminal Investigations Bureau

The Sheriff's Department's Internal Criminal Investigations Bureau (ICIB) reports directly to the Division Chief and the Commander of the Professional Standards Division. ICIB investigates allegations of criminal misconduct committed by Sheriff's Department personnel in Los Angeles County.[3]

The Sheriff's Department reports that ICIB has 77 active cases. This quarter, the Sheriff's Department reports sending six cases to the District Attorney's Office for filing consideration. The District Attorney's Office is still reviewing 35 cases for filing. The oldest open case that ICIB has submitted to the District Attorney's Office for filing consideration is related to conduct that occurred in 2018, which ICIB presented to the District Attorney in 2016 and for which the Sheriff's Department still awaits a filing decision.

Internal Affairs Bureau

The Internal Affairs Bureau (IAB) conducts administrative investigations of policy violations by Sheriff's Department employees. It also responds to and investigates deputy-involved shootings and significant use-of-force cases. If the District Attorney declines to file criminal charges against the deputies involved in a shooting, IAB reviews the shooting to determine whether Sheriff's Department personnel violated any policies during the incident.

---

[2] Gov't Code § 12525.3(b).

[3] Misconduct alleged to have occurred in other counties is investigated by the law enforcement agencies in the jurisdictions where the crimes are alleged to have occurred.

Administrative investigations are also conducted at the unit level. The subject's unit and IAB determine whether an incident is investigated by IAB or remains a unit-level investigation based on the severity of the alleged policy violation(s).

This quarter, the Sheriff's Department reported opening 154 new administrative investigations. Of these 154 cases, 44 were assigned to IAB, 78 were designated as unit-level investigations, and 32 were entered as criminal monitors (in which IAB monitors an ongoing criminal investigation conducted by the Sheriff's Department or another agency). In the same period, IAB reports that 110 cases were closed by IAB or at the unit level. There are 569 pending administrative investigations, of which 359 are assigned to IAB and the remaining 210 are pending unit-level investigations.

Civil Service Commission Dispositions

There were five final decisions issued by the Civil Service Commission this quarter involving Sheriff's Department employees.[4] In all five, the Commission sustained the Department.

Four of these cases concerned sworn peace officers of the rank of deputy or higher, and one case involved a non-sworn employee. The Commission sustained three of the discharges by the Department. In one case the Hearing officer recommended the appeal of discharge be granted and instead be given a 20-day suspension, however, the Commission sustained the discharge by the Department. In two cases, the Commission sustained the fifteen-day suspension sought by the Department.

The Sheriff's Department's Use of Unmanned Aircraft Systems

The Sheriff's Department reports it deployed its Unmanned Aircraft Systems (UAS) 14 times between October 1, 2023, and December 31, 2023, in the following incidents:

- On October 3, 2023, to assist Special Enforcement Bureau with serving a high-risk search warrant in Los Angeles. The Department used the UAS to clear a majority of the location prior to law enforcement entry.
- On October 9, 2023, to assist Special Enforcement Bureau in Malibu to search regarding a vehicle accident. The vehicle collided with a telephone pole and fell over a 100-foot cliff into the canyon. The UAS successfully located the lone victim.

[4] The Civil Service Commission reports its actions, including final decisions, in minutes of its meetings posted on the County's website for commission publications.

- On October 10, 2023, in Rolling Hills to observe the interior of the location of a suspected suicide.
- On October 19, 2023, to assist in serving a high-risk search warrant in Rosamond, the Department used the UAS to visually clear the interior of location.
- On October 20, 2023, to assist in serving a high-risk search warrant in Carson, the Department used the UAS to look for the suspect at the property.
- On November 10, 2023, to assist the Homicide Bureau in Angeles Forest in a search and rescue.
- On November 12, 2023, to assist Homicide Bureau in Angeles Forest in a search and rescue.
- On December 8, 2023, to observe possible tampering of railway tracks in Los Angeles in an area bordered by freeway and off-limits to pedestrian traffic.
- On December 11, 2023, to assist Wildlife Animal Control in Malibu to search for a mountain lion and to observe the animal without need for personnel to risk injury by approaching on foot.
- On December 21, 2023, to assist K9 Services Detail in Bellflower, to search for a stolen vehicle suspect and to clear an open garage.
- On December 24,2023, to assist Special Enforcement Bureau in Hermosa Beach in successfully locating a barricaded suspect within a structure.
- On December 27, 2023, to assist Special Enforcement Bureau in Lynwood, regarding an armed barricaded suspect. The Department used the UAS to observe various rooms at a location prior to making entry.
- On December 27, 2023, to assist Special Enforcement Bureau in Los Angeles, regarding a barricaded suspect. The Department utilized the UAS to observe the interior of location prior to personnel entering.
- On December 29, 2023, to assist Special Enforcement Bureau in Whittier. The Department used the UAS to successfully locate an armed suspect barricaded within the location.

Conflicts of Interest in Risk Management Bureau

The Risk Management Bureau, part of the Office of Constitutional Policing, should be disbanded. Despite the titles “Risk Management” and “Constitutional Policing,” which

suggest reform, the Bureau's primary function is using *police* to provide litigation support to the Sheriff's Department in its defense against lawsuits. As set forth below, the Bureau has displayed a pattern of prioritizing its defense function to the point of undermining efforts to provide transparency and accountability and to identify and address long-term risks within the Sheriff's Department. As reported recently by the Los Angeles Times, payouts for the County are soaring, including significant payments for misconduct by Sheriff's Department personnel.[5] This office shares the analysis of Professor Joanna Schwartz of UCLA, quoted in the article, that the County's corrective actions after lawsuits are insufficient. A glaring example of the failure to even investigate taped evidence of dishonesty follows below.

Sheriff's Department policies charge Risk Management Bureau with "providing a Department-wide, coordinated effort to reduce the frequency of preventable accidents, minimizing the loss of Department resources and controlling liability costs" and taking "a proactive approach to prevent civil suits and limit Department liability by identifying and evaluating areas and issues of potential risk."[6] This mission should, in theory, protect constitutional rights by identifying and addressing the causes of violations of the rights of employees or members of the public and ensuring that such violations do not recur. The Sheriff's Department has placed Risk Management Bureau under the umbrella of the Sheriff's Office of Constitutional Policing, further implying that its purpose is to address past failures to abide by the Constitution and state and local laws.

In practice, however, Risk Management Bureau often adopts a highly problematic approach to liability: denying or downplaying violations in inaccurate or misleading reports, drafting analyses of incidents that deflect blame from the Department to the victim of misconduct, and using its powers to attack adverse litigants in ways that constitute retaliation against Department whistleblowers and members of the public exercising their constitutional right to petition the government for redress of grievances.[7] These problems are structural.

Risk Management Bureau's practices have always been flawed, but during the previous administration of Sheriff Villanueva they became more inappropriately aggressive and have remained so under the current administration. Further, the euphemistically named bureau corrupts the County's efforts to improve government conduct through its impact

---

[5] Rebecca Ellis and Keri Blakinger, *L.A. County legal spending skyrocketed to $1 billion last year, as Sheriff's Department settlements balloon*, Los Angeles Times (Feb. 7, 2024).

[6] Los Angeles County Sheriff's Department, Manual of Policy and Procedures, § 2 04/010.10, *Risk Management Bureau* also contains units dedicated to random drug testing, compliance with workplace safety and accessibility regulations, discovery, and handling policy bulletins and revisions to Sheriff's Department manuals, as well as a unit dedicated specifically to handling incidents and issues involving vehicle accidents.

[7] See the First Amendment to the United States Constitution, which provides for the right "*to petition the Government for a redress of grievances.*"

on other Sheriff's divisions and the other County departments it interacts with, including the Sheriff's Discovery Unit, which responds to public requests for information, and the Office of Constitutional Policing charged with managing it. The greatest impact is perhaps on County Counsel and outside counsel hired to defend the County in litigation, who rely upon the information provided, and sometimes upon the judgment of Risk Management personnel, in litigation strategy to the detriment of the County's efforts at reform.

Moreover, the use of law enforcement resources for a unit that seeks to protect the Sheriff's Department from citizens exercising their right to seek government redress, including taking action against internal whistleblowers, is a misuse of government resources that were allocated based on the representation that they would be used to improve the legality of operations and runs contrary to the Department's stated mission "to partner with the community[,] … proactively prevent crime, enforce the law fairly and enhance the public's trust through transparency and accountability."

The following examples illustrate the pitfalls of having the Risk Management Bureau assist with litigation against the Department.

Patterns of bias in reporting officers for decertification under SB 2

Risk Management Bureau has demonstrated troubling inconsistencies in the way it handles reporting of misconduct allegations to the state of California under the system for decertification of peace officers recently established by California's Senate Bill 2 (2021) (SB 2).

The Department assigned these reporting duties to the Risk Management Bureau, in the Office of Constitutional Policing. The Sheriff's Department's first six months of referrals to POST show troubling instances of quick reporting to POST for allegations against a whistleblower and slower reporting of other department employees, as detailed below.

Civil deposition in Banditos litigation. In January 2023, outside counsel for the County deposed a deputy who is a plaintiff ("Deputy A") in a lawsuit brought by several deputies against the Sheriff's Department, alleging that the Department knowingly failed to protect them from the Banditos deputy gang and retaliated against them for reporting concerns with Banditos. In the deposition, much of the County's questioning focused on Deputy A's prior testimony, during two depositions in 2020 and 2022, about reports he had made to the FBI about possible criminal and law enforcement gang activity by deputies at the Sheriff's Department, in an apparent effort to show that some of his prior testimony was inaccurate.

Six days later, the Sheriff's Department reported Deputy A to POST for potential decertification on grounds that his testimony constituted "[d]ishonesty relating to the reporting, investigation, or prosecution of a crime, or relating to the reporting of, or investigation of misconduct by, a peace officer." Cal. Code Regs., tit. 11 § 1205(a)(1); *accord* Penal Code 13510.8(b)(1). The Sheriff's Department's report to POST stated that Deputy A "admitted under oath he was dishonest, withheld information, and provided false statements during prior deposition which occurred in 2020 and 2022."

The Office of Inspector General reviewed the deposition transcript. Deputy A never admitted he was dishonest. While Deputy A gave different accounts in several places from prior testimony, and admitted *one* prior answer "wasn't accurate," he never admitted to making a false statement or omitting information intentionally. The Sheriff's Department's characterization of his testimony to POST is inaccurate, significantly overstating the evidence.

The Office of Inspector General brought its concern about the reporting of the incident involving Deputy A as possible retaliation to the Sheriff's Department repeatedly, beginning in March 2023. In July 2023, the Department finally supplemented its submission to POST with an entry indicating that the original synopsis had, "while relying on a summary of the testimony from legal counsel, overstated the potential dishonesty," and that the Department had concluded there was insufficient evidence to support a finding of dishonesty. Unfortunately, this "correction" is inconsistent with the Department's previous representation to the Office of Inspector General that Department personnel had reviewed the transcript in question in preparing the report to POST rather than merely relying on the description conveyed to them. Also, in this case POST seemed to have trouble identifying the dishonesty, as it specifically asked for clarification after receiving the inaccurate description. The Sheriff's Department submitted a detailed response that demonstrated a *second* review attempting to support its claim but which identified no admission of dishonesty.

Additionally, when the deputy in question later resigned while under investigation for other matters, the Department incorrectly reported to POST that the deputy had resigned pending an investigation that included dishonesty.[8] Counsel for the deputy contacted the Department and the Inspector General noting that dishonesty was never alleged nor was there a finding of dishonesty in the investigation. In response, rather than addressing that the POST report was in error, attorneys for the Sheriff's Department falsely accused counsel of unethical behavior and directed him not to

[8] SB 2 requires that law enforcement agencies report separations from employment of peace officers and the circumstances of those separations, including whether the officer resigns during a pending investigation for misconduct that could lead to decertification. Penal Code § 13510.9(d).

contact the Department directly. Following counsel's complaint, and an inquiry regarding the complaint by the Inspector General, the Department subsequently sent a formal correction to POST removing the reference to dishonesty.

This aggressive approach to SB 2 reporting as to a whistleblower is in sharp contrast to the approach the Department takes in other cases, particularly those raising claims against management:

- A high-ranking member of the Sheriff's Department testified in a civil trial that sworn testimony that they had previously given to the COC during that body's investigation into deputy gangs was inaccurate. The same litigation liaison from Risk Management Bureau who attended Deputy A's deposition and facilitated SB 2 reporting for dishonesty was present at the trial but did not initiate a report. Risk Management Bureau generated a report to POST only after the Inspector General pointed out the admission of prior inaccuracy to Department staff. Even then, although the Inspector General expressly noted that he was only reporting the testimony and did not know what was accurate and what was not, the Department reported that the Inspector General alleged the member made false statements.[9]

- In testimony in the same civil trial, a Sheriff's Department member admitted to having a tattoo known to be associated with a deputy subgroup and identified a number of other deputies with the same tattoo. The member also identified several deputies with a different tattoo associated with a different subgroup. Both the plaintiff and the county made allegations supporting possible law enforcement gang membership but the Sheriff's Department has not reported them to POST.

- During an investigation of a lieutenant for allegedly misusing County property, members of the handling investigative bureau complained that their commanding officer, with express approval from leadership in the previous administration, ordered that documents that tended to show the allegations were fabricated be removed from the investigation. One investigator even alleged potential criminal conduct by these Sheriff's officials. These officials hold positions in the command staff of the current administration. The Sheriff's Department appears to have reported one allegation regarding an administration official to POST, but held the other without reporting to POST, pending an outside legal analysis, for approximately four months. As set forth below, the Department informs the Office

[9] This approach might seem benign in isolation, but it continues a practice from the Villanueva administration of dismissing evidence of misconduct as coming from an unreliable source used in conjunction with the Sheriff Department's campaign to discredit civilian oversight through means documented elsewhere.

of Inspector General that this delay resulted from its effort to select and retain outside counsel to review such allegations to determine whether they require reporting to POST, the process of which it has now completed.[10]

- In reviewing Sheriff's Department records, Office of Inspector General staff noticed a number of instances in which the Department had received allegations that employees belonged to known subgroups that had been publicly alleged to have engaged in misconduct, but the Sheriff's Department's SB 2 team had not reported those allegations to POST. SB 2 requires agencies to report any allegations "that could render a [deputy] subject to" decertification and specifies membership in a "law enforcement gang" as grounds for decertification.[11] The Office of Inspector General raised this matter with the SB 2 team, which explained that because the law defines a "law enforcement gang" as a group that engages in "a pattern of on-duty behavior that intentionally violates the law or fundamental principles of professional policing," the Department reported an allegation of subgroup or gang membership only if it included a specific allegation of other misconduct. The Office of Inspector General questioned this limiting approach as a misstatement of the law. In response, the SB 2 team adjusted their approach to report allegations of a violation of the Sheriff's Department's employee group policy if they arise from a request for an IAB investigation or other allegation from within the Department of a policy violation. The Sheriff's Department informs the Office of Inspector General that it adjusted its practices and now submits to POST allegations of deputy-gang membership made by members of the public.

- The Sheriff's Department has adopted a practice of having allegations against high-ranking management reviewed by attorneys outside the Department to determine if they should be reported to POST, rather than having the SB 2 team review them. The Department's adopted this practice on grounds that outside review avoids an appearance of favoritism for high-ranking employees. While the goal is laudable, the Department presently holds 26 allegations against department executives that remain "pending legal analysis," some of which have lingered in this state for several months — far outside the timeline of SB 2, which requires reporting of allegations within 10 days. The Department informs the Office of Inspector General that the process of selecting and contracting with outside counsel took some time during which a backlog of such cases built up, but that the Department began substantive consultations with outside counsel in

[10] During this time the Sheriff's Department used outside counsel multiple times without delay, primarily to dismiss evidence of misconduct inquired of by the Office of Inspector General.
[11] Penal Code §§ 13510.8(b)(7), 13510.9(a)(2).

September 2023 and completed review of the backlog of cases by November 2023. Furthermore, the Office of Inspector General has documented the Office of Constitutional Policing failing to provide critical relevant information to outside counsel and the result being consistent validation of the Sheriff's Department's failure to report rather than impartial analysis that would cause an independent observer to have faith in the process.

- In October, the County Equity Oversight Panel sustained two separate complaints alleging that former Sheriff Alex Villanueva, while he was still in office, violated the County's Policy of Equity (CPOE) by engaging in racially discriminatory and harassing behavior. The Panel found that Sheriff Villanueva violated the policy of equality by behavior that constituted discrimination, discriminatory harassment, third person harassment, and inappropriate conduct – in one instance against the Inspector General, based on national origin and ethnicity, and in another against a Supervisor's Senior Justice Deputy, based on gender and ethnicity. Under SB 2, such findings of bias by a peace officer constitute "serious misconduct" that may trigger decertification and must be reported to POST.[12]

  Risk Management Bureau's SB 2 team only reported the matter after the Inspector General's Office inquired whether it had done so and only reported the sustained findings to POST as ***allegations,*** although it later noted in the SB 2 referral that the findings had been sustained.[13] The eventual report to POST following the Inspector General's inquiry was the first report to POST about Sheriff Villanueva's conduct despite the fact that these allegations were reported to the Sheriff's Department during the Sheriff's tenure and by law should have been reported to POST at latest by July 1, 2023.

  When a Los Angeles Times reporter submitted a Public Records Act (PRA) request expressly seeking the findings of a CPOE investigation involving Sheriff

[12] Both the statute and POST's implementing regulations define decertifiable "serious misconduct" under SB 2 to include "bias on the basis of race, national origin, religion, gender identity or expression, housing status, sexual orientation, mental or physical disability, or other protected status in violation of law or department policy or inconsistent with a peace officer's obligation to carry out their duties in a fair and unbiased manner." Penal Code § 13510.8(b)(5); Cal. Code Regs., tit. 11 § 1205(a)(5).

[13] The County Equity Oversight Panel made findings on October 17, 2023, as to the two investigations of Sheriff Villanueva's behavior toward the Inspector General and a Supervisor's Justice Deputy. A commander in the Sheriff's Department authored two memoranda of the findings on that same day and noted that a Sheriff's Department Chief virtually attended the proceedings. On October 20, 2023, the Office of Inspector General inquired as to whether a POST referral was made by the Sheriff's Department. By email dated October 23, 2023, the same commander who authored the October 17 memoranda responded that the SB 2 team was notified of the ruling on October 23, 2023. The SB 2 unit reported the investigations and findings to POST on October 23.

Villanueva, the Sheriff's Department's Risk Management Bureau incorrectly asserted that no such documents existed in a letter signed on behalf of the Risk Management Bureau's Captain. While the misrepresentation in the letter was due to a mistake, had the requester not been in possession of information that such documents existed, that error would have gone unchecked. Both this office and the Board of Supervisors have previously identified systematic failures by the Sheriff's Department to respond to PRAs, and although the Board of Supervisors directed County Counsel to assume responsibility for responding to certain PRAs, that shift in responsibility has been delayed by the Sheriff's Department's denial of access to its records.[14] Additionally, the Sheriff's Department masks some records in its employee personnel record database (PRMS) by limiting access in such a manner that a person searching would simply not find those records and would never know they existed, rather than indicating there is a record but access is limited.[15] Had County Counsel been able to assume responsibilities for some PRA responses as the Board of Supervisors directed, the failure to identify and turn over these records might have been avoided.

The incorporation of police powers into litigation defense, the aggressive approach to whistleblower reporting taken by the Sheriff's Department, and the protective approach taken to reporting documented conduct of favored employees, results in a misuse of the SB 2 process and a possible violation of California Labor Code section 1102. The Office of Inspector General brought these concerns to the attention of Department leadership, and the Department claims that the use of outside counsel will address the problem. Based upon the Sheriff's Department's history of misuse of outside counsel, that seems unlikely.

Inaccurate and Biased Analysis of First Amendment Violations against a Reporter

On Tuesday, November 7, 2023, the Board of Supervisors approved a $700,000 settlement in a civil rights lawsuit filed by KPPC reporter Josie Huang for assault and false arrest. The Office of Inspector General provided an analysis of Ms. Huang's arrest in our *Report Back on Unlawful Conduct of Los Angeles County Sheriff's Department* in December 2020, specifically the section entitled *Conduct Suppressing the Exercise of First Amendment Rights*.

---

[14] See the Office of Inspector General's *Third Semi-Annual Report Back on Meeting the Sheriff's Department's Obligations Under Senate Bill 1421* (Jan. 17, 2023).

[15] This systemic violation was brought to the attention of the Sheriff's Department almost five years ago, resulted in false allegations of criminality against this office which are still pending, and yet has been maintained by the *current* administration after protest from this office.

This settlement arises out of an incident on September 13, 2020, when deputies arrested Ms. Huang while she was attempting to film an arrest of a protester. Despite Ms. Huang having clearly identified herself as a reporter, the Sheriff's Department transported her to jail, cited her for violating Penal Code section 148, and conducted a follow-up investigation in an effort to persuade the District Attorney to prosecute her. During a press conference after her arrest, the Sheriff's Department made claims about the arrest that were false based upon video taken by Ms. Huang and others at the scene. The video shows Ms. Huang visibly wearing press identification on a lanyard and clearly yelling that she is a reporter and the call letters of the local radio station for which she was reporting. The District Attorney's Office declined to prosecute, citing video evidence obtained from the internet to contradict the Sheriff's Department's claims, including evidence that a deputy acknowledged that she is a reporter, that she was filming in a public area, was given little if any time to comply, and was not intentionally interfering with the deputies. Penal Code section 148, obstructing a public officer, specifically provides that recording video of a police officer is not obstruction. On May 19, 2023, a court granted a petition for finding of factual innocence thus finding that Ms. Huang was factually innocent of the charges filed relating to her September 13, 2020 arrest.

More than two years later, in July 2023, Risk Management Bureau prepared a Summary Corrective Action Plan (SCAP) as part of the process of seeking approval for a settlement of Ms. Huang's action against the County. The SCAP included a seven-page statement of the facts of the case, which it indicated reflected "a culmination of various sources to provide an abstract of the incident." These facts reflected an uncritical recitation of the accounts of the deputies involved in the incident, notwithstanding a judge's finding of Ms. Huang's factual innocence, the District Attorney's citation of evidence contradicting the Sheriff's Department's account in its decision not to prosecute, and the Office of Inspector General's analysis. Shockingly, the SCAP did not even include the court finding of Ms. Huang's innocence. In other words, Risk Management Bureau presented an account of the incident that three separate, independent bodies found was contradicted by video evidence, without ever mentioning the contradictory evidence or the findings of the court, the District Attorney, or the Office of Inspector General.

Additionally, Risk Management Bureau's CAP ***blamed Ms. Huang*** in two of the six "root causes" it identified for the lawsuit: that Ms. Huang failed to comply with deputies and physically resisted attempts to detain her, as well as failing to have a department-issued press pass. And it named these root causes despite video clearly contradicting them, showing that she wore press credentials and that deputies threw her to the ground without giving her an opportunity to comply with their directives. The only "root causes"

Risk Management Bureau identified that in any way suggested responsibility on the part of the Sheriff's Department were:

- that one deputy "gave verbal commands" and "did not allow [Ms. Huang] time to comply with his orders,"
- one deputy's "attempt to detain [Ms. Huang], which led to a use of force,"
- another deputy's "failure to safeguard [Ms. Huang's] personal property (a cell phone),"[16] and
- that the deputies "did not have the equipment (Body-Worn Camera) to video record their contact with [Ms. Huang] to prove or disprove her allegations."

None of these causes reflect the actual and very serious problems in this arrest: that deputies arrested a person clearly displaying a press pass, who they appeared to understand was press, when that person had committed no crime, and then wrote reports that were proven factually wrong by video evidence; that supervisors made a carefully considered decision to arrest her and submit false charges for filing; or that the Sheriff of Los Angeles County publicly and falsely accused her repeatedly despite the evidence.

Finally, the SCAP noted that an administrative investigation of the incident had determined that "there were no concerns" regarding the deputies' "tactics, decision, or planning during the use of force and arrest," although "appropriate administrative action was taken regarding … the handling of [Ms. Huang's] personal property (a cell phone)." The SCAP also noted that Century Station supervisors conducted a use of force investigation in which they concluded the force used was objectively reasonable and noted various trainings Century Station and the Department had administered on crowd control and the news media, as well as the fact that the Department had issued Century Station personnel body-worn cameras. The SCAP recommended no additional corrective action.

For these reasons, Risk Management Bureau's SCAP in the Huang case is neither complete nor objective. It presents a factual summary of the incident that the court, the District Attorney, and the Office of Inspector General all found was contradicted by video evidence, without either acknowledging those findings or attempting to reconcile the contradictory evidence. The SCAP also misrepresents the "root causes," by omitting relevant facts and continuing to blame the victim. Without identifying any underlying

[16] This description is particularly ironic, as the deputy stepped upon the device which recorded the Sheriff's Department's misconduct. Fortunately, the act did not destroy the evidence, which directly contradicted submitted reports and public claims by the County that Ms. Huang was to blame.

causes or conditions that led to the incident, the SCAP cannot propose meaningful solutions to prevent a similar incident from recurring. Finally, as a result of this superficial treatment, it presents an analysis that utterly fails to engage with the core problems of the incident: that deputies violated the First and Fourth Amendment rights of a member of the press and then filed factually inaccurate reports about it. And while the administrative investigations into the incident occurred during the administration of the previous Sheriff, who publicly criticized Ms. Huang at the time,[17] Risk Management Bureau prepared its analysis in July 2023, under the current administration.

This SCAP provides a clear example of the central problem with Risk Management Bureau. In its creation of a Summary Corrective Action Plan, a role where its primary function should be identifying and addressing the causes of Sheriff's Department misconduct to prevent it from recurring, the unit adhered to a litigation approach of suppressing evidence of Sheriff's Department misconduct and shifting blame to the complainant. This example also illustrates the need for the Department to discontinue the use of police power for litigation support and using the Office of Constitutional Policing solely for its budgeted purpose: constitutional policing.

Handling of Litigation Regarding the Destruction of Photographs Taken by Sheriff's deputies at the Kobe Bryant Crash Site

After the Villanueva administration ordered the destruction of evidence during an investigation into inappropriate photographs taken of the crash site where Kobe Bryant died, Sheriff Villanueva and top aides, including one in a prominent position under the current administration, were caught on tape lying to a reporter to conceal the matter.[18] This evidence was presented in the trial of the lawsuit by Vanessa Bryant in response to outside counsel calling Alex Villanueva as a witness. The result was a thirty-five-million-dollar judgment against the County. There was no investigation into the conduct of the top aides who lied to the Los Angeles Times reporter and no disciplinary or corrective action was taken. The outside law firm that represented the County in the Vanessa Bryant litigation works closely with Risk Management Bureau, including in current litigation arising from claims that the Department knowingly failed to protect deputies from the Banditos deputy gang and retaliated against them for reporting concerns with Banditos as discussed above. This same law firm, in conjunction with the Risk Management Bureau, was involved in falsely alleging that Deputy A was dishonest in two instances of reporting to POST, also discussed in the subsection entitled, *Civil deposition in Banditos litigation supra*. Although Risk Management Bureau personnel

---

[17] *See, e.g.*, Brittany Martin, *Josie Huang Arrest Defended by Sheriff Villanueva*, Los Angeles Magazine (Sept. 17, 2020).

[18] The Los Angeles Times posted the recording of this interview on its website. *Sheriff's officials denied knowledge of a complaint about a deputy sharing crash photos*, Los Angeles Times (Dec. 21, 2021).

had an opportunity to manage risk, the Office of Inspector General has confirmed that they have taken no action regarding the tape recording, either under the Villanueva administration or to this day under the Luna administration.

Recommendation: Disband the Risk Management Bureau

The Sheriff's Department itself recognizes the inherent conflict in having Risk Management involved in reporting SB 2 complaints and litigation strategy. This tacit acknowledgement is seen by its revision to its process for reviewing allegations of misconduct against employees engaged in litigation against the County, by having them reviewed by outside counsel in order to guard against SB 2 reporting in retaliation for litigation or in order to gain a litigation advantage. But if the Sheriff's Department recognizes the inherent conflict in having the same unit responsible for both assisting the Department in litigation and reporting the potential misconduct of litigants, it should disband the Risk Management Bureau. There is no necessity that a Department have an internal Risk Management Bureau and strong public policy reasons for it not to use police powers to suppress evidence of government misconduct. County Counsel, on its own or through the retention of outside counsel, handles all County litigation, including claims and lawsuits against the Sheriff's Department. To the extent that County Counsel needs assistance with preparing for litigation, it can provide an appropriate structure for litigation support at the Sheriff's Department that does not include a team of deputies providing strategy to protect the Department that includes the suppression of legitimate claims and that thwarts the County's goals of transparency, accountability, and enhancing the public's trust.

The Sheriff's Department and County Counsel's Responses to *Conflicts of Interest in Risk Management Bureau*

Attached to this report are letters of objection from the Sheriff and County Counsel. This report was not made lightly, being issued only after a year of confidential efforts at collaboration. Facts developed in our Law Enforcement Gang investigation required this recommendation be made publicly. On February 7, the Office of Inspector General provided a draft of this report explicitly asking for a dialogue in advance of February 15. We received no response other than the attached letters. The transmitting email from county counsel referred to "inaccuracies" identified in their letter but we found none. The Sheriff accuses the Inspector General of "gratuitous attacks on Department personnel," continuing a longstanding narrative which demonstrates the importance of this recommendation. The Office of Inspector General is charged with public reporting and does not believe the failure of LASD to investigate the information in this report does not make the reporting of the conduct gratuitous. The report does not name personnel because to do so *would* be gratuitous. The mission of the Office of Inspector General is

systemic reform and we have repeatedly confirmed the conduct described is not contrary to command directives.

Reporting the Presence of MET Teams at Crime Scenes to Ensure *Brady* Compliance

In September of 1991, the Sheriff's Department worked with the Department of Mental Health (DMH) to develop the nation's first law enforcement mental health collaborative co-response teams handling mental health crises.[19] These teams evolved into the current-day Mental Evaluation Team (MET) program, which provides crisis assessment, intervention, and targeted case management services to help de-escalate potentially violent situations involving people suffering from mental illness.[20] MET units usually consist of a deputy sheriff and a Department of Mental Health licensed clinician who is *Lanterman-Petris-Short Act* designated to initiate involuntary psychiatric hospitalizations in accordance with the California Welfare and Institutions Code (WIC) sections 5150 and 5585.[21] In recent years, the number of mental-health-related calls for service has steadily increased, with some estimating that, nationally, 20% of police calls for service involve mental illness, and that from 25% to more than 50% of fatal encounters with law enforcement involve individuals with mental illness.[22]

The implementation of the MET program as a response to this need has been well received. By responding to Sheriff's Department incidents involving mental health issues, the Sheriff's Department reports that MET units have reduced uses-of-force and avoided unnecessary incarcerations of people with mental illness. In response, the Board of Supervisors funded the expansion of the MET to 23 teams in 2017.[23] In 2018, the Civilian Oversight Commission recommended that the County expand MET to 60 regional teams.[24] MET had expanded to 33 regional teams by 2019, and currently

---

[19] See, *Status Report of the Sheriff Civilian Oversight Commission Regarding the Mental Evaluation Team Program of the Los Angeles County Sheriff Department*, (2017) and *LASD Mental Evaluation Teams Annual Report* (2019).
[20] See, LASD Mental Evaluation Team website.
[21] The *Lanterman-Petris-Short Act* (Welfare and Institutions Code §§ 5000 *et. seq.*) established a right to prompt psychiatric evaluation/treatment of individuals suffering from mental health disorders and set out strict due process protections governing the involuntary commitment of people with mental health disorders. *See* Disability Rights California, *Understanding the Lanterman-Petris-Short (LPS) Act* (2018).
[22] Eric Westervelt, *Mental Health And Police Violence: How Crisis Intervention Teams Are Failing*, NPR (Sept. 18, 2020); Sarah DeGue, Katherine A. Fowler, and Cynthia Calkins, *Deaths Due to Use of Lethal Force by Law Enforcement Findings From the National Violent Death Reporting System, 17 U.S. States, 2009–2012*, 51 Am. J. Preventive Medicine 5 supp. 3, S173-S187 (Nov. 2016).
[23] Maya Lau, *L.A. County supervisors vote to expand sheriff's mental health teams*, Los Angeles Times (Jan. 11, 2017).
[24] *Report of the Sheriff Civilian Oversight Commission Regarding the Mental Evaluation Team Program of the Los Angeles County Sheriff Department* (Feb. 15, 2018), at 4.

operates approximately 35 teams that respond to incidents from 14 regional offices throughout the County.[25]

Apart from their effectiveness in addressing mental health issues, the use of MET teams can raise new issues for the Department. This section addresses how the Department's handling of MET teams can trigger constitutional issues stemming from the requirements of the United States Supreme Court case of *Brady v. Maryland*.[26] In *Brady*, the Supreme Court established that prosecution teams have an ethical and constitutional responsibility to disclose exculpatory evidence to the defense.[27] When a MET unit observes, interacts with, and evaluates the mental state of a suspect, and the MET clinician then writes a report documenting these observations and conclusions, this information falls under the *Brady* rule because a suspect's mental state may reduce their culpability for a given crime or provide a potential basis for sentencing mitigation or diversion.[28] A failure to disclose the presence of a MET team, whether intentional or unintentional, deprives defense counsel of this information and results in a possible *Brady* violation with potentially severe consequences to the prosecution up to and including the reversal of a conviction.

Current Sheriff's Department policies only require that handling deputies record the presence of a MET unit when a person is subject to involuntary psychiatric hospitalization pursuant to WIC 5150 or 5585.[29] When a person suffering from a mental illness is not involuntarily hospitalized, Sheriff's Department policies ***do not require*** that

---

[25] *Mental Evaluation Team Integrated Report* (Apr. 2023) at 10; *Los Angeles County Sheriff's Department Mental Evaluation Team (MET) Update* (July 20, 2023) and *Statement of Proceedings for the Regular Meeting of the Sheriff Civilian Oversight Commission Held on January 20, 2022*.

[26] In *Brady v Maryland*, (1963) 373 U.S. 83, the United States Supreme Court established that a criminal prosecutor has an ethical and constitutional responsibility to disclose exculpatory and impeachment evidence to the defense. Brady evidence includes any evidence that is favorable to the defense. "Evidence is 'favorable' if it either helps the defendant or hurts the prosecution. . . ." (*In re Sassounian* (1995) 9 Cal.4th 535, 544.)

[27] The duty to disclose *Brady* evidence applies to information known to police investigators as well as prosecutors. (*Kyles v. Whitley* (1995) 514 U.S. 419, 437.) The California Supreme Court case of *In re Brown* (1998) 17 Cal.4th 873, explained the duties of Sheriff's Department personnel with respect to potentially exculpatory evidence. In *Brown*, the Orange County Sheriff's crime lab unintentionally failed to communicate a defendant's positive results of a laboratory drug test to the prosecution. Nevertheless, the *Brown* court held that the Orange County Sheriff's Department was part of the "prosecution team" and therefore, the *Brady* rule was violated because the nondisclosure prevented the defendant from presenting a credible defense of diminished capacity, thereby denying him a fair trial. (*Id.* at p. 891.)

[28] A person suffering from a mental illness or developmental disability may not be able to form the criminal intent necessary to be found guilty of committing a particular crime. Pursuant to California Penal Code section 28(a), evidence that a defendant suffers from a mental disease, mental defect, or mental disorder is admissible "on the issue whether or not the accused actually formed a required specific intent, premeditated, deliberated, or harbored malice aforethought, when a specific intent crime is charged."

[29] See, Los Angeles County Sheriff's Department, Field Operations Directive 16-003, *Calls for Service Involving Allegedly Mentally Ill Persons*; Los Angeles County Sheriff's Department, Manual of Policy and Procedures, § 4-16/0.10.00, *Mentally Ill Persons*.

handling deputies record the presence of a MET team. When a MET team makes a referral for jail psychiatric services, those records are not generally part of the package provided to prosecutors for consideration in filing decisions and to review for *Brady* material. The following case study involving the arrest of a person suffering from mental illness demonstrates how this policy gap may result in violations of the *Brady* rule.

Case Study: Sheriff's Department MET Policy and *Brady* Issues

In March of 2021, the Sheriff's Department received a 911-call reporting that a man was outside of a residence holding gasoline cans and yelling, "I'll burn this place down." According to Sheriff's Department incident reports, two deputies drove to the location and observed a man standing in the driveway of the residence. The man began pacing back and forth in the driveway, yelling at the deputies "come test me!" and "I'm ready," with profanities interspersed. The deputies stayed back and requested additional units, while the man continued pacing and yelling at them.

Deputies spoke with a resident of the house who reported that the man had been living inside a trailer in the backyard and had become upset earlier in the day when the property owner advised him that he was being evicted. This resulted in an argument between the man and the owner, during which the resident heard the man yell threats to kill the owner and burn the house down.

According to the incident report, after a sergeant and three other deputies arrived, the man walked into a garage on the property. Deputies heard thudding sounds coming from the garage. The resident warned them that the man was breaking a wooden gun safe in the garage containing numerous firearms and ammunition and urged them to do something.

The deputies approached the garage and detained the man pending a criminal threats investigation. After waiving his *Miranda*[30] rights, the man told deputies he was upset because his family was kicking him out of their house. The man said he was aware of the firearms and ammunition inside the wooden safe and told the deputies, "You're lucky, you guys were cool. I was ready to die in a gun fight [*sic*] today."

MET Evaluation Not Documented in Arrest Reports

The narrative above comes from the original "Incident Report" and follow-up reports prepared by the deputies involved in this incident. In those reports there is no mention of the presence or involvement of a MET unit. However, MET records indicate that a

[30] The United States Supreme Court case of *Miranda v. Arizona* (1966) 384 U.S. 436 mandated that a criminal suspect be given warnings to protect the suspect's Fifth Amendment right to avoid self-incrimination during a police interrogation.

MET team responded to the incident. The MET team gathered information from handling deputies, interviewed the man and collateral sources, consulted with the MET Triage Desk Clinician, completed a risk evaluation tool, completed suicide screening assessment, and evaluated whether the man met the requirements for California Welfare and Institutions Code section 5150.[31]

According to MET team records, the man made various statements to the MET clinician regarding his mental health. The MET clinician noted the man was unable to regulate his emotions and admitted to having suicidal thoughts, including planning how to kill himself and having some intention of acting on those suicidal thoughts. Based upon these assessments, the MET clinician advised the handling deputies that the man met the criteria for a 72-hour mental assessment at a mental health treatment facility pursuant to California Welfare and Institutions Code section 5150. Given the circumstances, the handling deputies decided to arrest the man and keep him in custody rather than take him to a mental health treatment facility. The MET deputy advised the handling deputies that MET would send a referral to the Twin Towers Psychiatric Ward for a mental health evaluation of the man in jail. The man was subsequently charged with felony criminal threats and misdemeanor battery.

Because the handling deputies did not mention the MET unit in the original Incident Reports, neither the District Attorney's Office nor the man's attorney, in this case an attorney with the Public Defender's Office, had notice of the potential mental health issues in the man's criminal case. Neither the prosecution nor defense had notice that a MET clinician had evaluated the man on the scene and opined that he presented a danger to himself or others pursuant to WIC 5150, a fact that could have affected the District Attorney's decision to file the case and the defense attorney's strategies, including defenses based on the man's ability to form the required mental intent to commit the crime of felony criminal threats, which requires a specific intent when making the threatening statements.

The man remained in custody for over seven months before the court granted him a mental health diversion and released him to a treatment center. Given the charges filed and the disposition, the man's mental health status was relevant and material to his criminal case. As a result, the Public Defender's Office requested that the Sheriff's

[31] California Welfare and Institutions Code section 5150(a) provides that "[w]hen a person, as a result of a mental health disorder, is a danger to others, or to himself or herself, or gravely disabled . . . designated members of a mobile crisis team, or professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services."

Department determine why the responding deputies did not note the presence of the MET team in the Incident Report or any of the follow-up reports.

Sheriff's Department Investigation

The Sheriff's Department investigated why the handling deputies did not identify the presence of the MET unit in the Incident Reports.[32] That investigation concluded that the deputies omitted any mention of MET because the MET unit did not witness the man's criminal conduct nor was it involved in the detention of the man. The handling deputies did not believe that it necessary to note the presence of the MET unit in their reports because the MET deputy told them that the MET team would make a referral for jail psychiatric services for the man, and the handling deputies believed the MET referral provided sufficient notification and documentation of the subject's mental health issues. The Sheriff's Department found that the handling deputies had not intentionally or maliciously excluded presence of the MET team from the Incident Report. In addition, the station commander invited the Public Defender's Officer to attend deputy briefings to train deputies on their *Brady* obligations with respect to documenting the presence of MET units in their reports.

Analysis and Recommendation

The example above shows how a MET team's actions—even their mere presence—will often be relevant to criminal charges against the subject. A MET team's interview, observation, and evaluation of the subject of a call, set forth in the MET clinician's report, will very likely be *Brady* material because it can relate to a person's ability to form the required intent for a given crime. It may also be relevant to charging decisions and sentencing mitigation. Omissions as to a person's mental state at the time they engaged in criminal behavior can result in the reversal of otherwise valid criminal convictions or in the filing of criminal charges when alternatives to incarceration offer better treatment options to persons experiencing mental health challenges.

This policy gap is easy to remedy. The Office of Inspector General recommends that Sheriff's Department amend its policies to require that handling deputies always document the presence of a MET unit at a crime or arrest scene in Sheriff's Department incident reports and require that the documents prepared by the MET team be included in the filing packet presented to the prosecutorial agency to be provided to the defense. Specifically, we recommend that the Department amend Field Operations Directive 16-003, *Calls for Service Involving Alleged Mentally Ill Persons* and Manual of Policy and

[32] Watch Commander Service Comment Report 257057.

Procedures, § 4-16/0.10.00, *Mentally Ill Persons* to include language that requires documentation of the presence of a MET unit at any Sheriff's Department incident.

Semi-Annual Report on Implementation of the Family Assistance Program

On July 9, 2019, the Los Angeles County Board of Supervisors adopted a motion establishing a Family Assistance Program (Family Assistance), aimed at improving compassionate communication and providing trauma-informed support to families of those who died following a fatal use of force by a Sheriff's Department employee or while in the custody of the Sheriff's Department. The Board of Supervisors' motion established Family Assistance as a one-year pilot program administered by the DMH and instructed the Office of Inspector General to report back quarterly in the first year and semi-annually thereafter. On July 5, 2023, the Office of Inspector General submitted its second semi-annual report-back for 2023, reporting on available data from January 1, 2023, to May 31, 2023. The Office of Inspector General also reported that future report-backs will be incorporated into the Office of Inspector General's quarterly reports on *Reform and Oversight Efforts: Los Angeles County Sheriff's Department* on a semi-annual basis. This is the Office of Inspector General's first report-back for 2024.

On February 22, 2022, the Office of Inspector General, the Sheriff Civilian Oversight Commission, and the Office of Violence Prevention of the Department of Public Health (OVP), in consultation with other County departments, submitted to the Board of Supervisors a report setting forth recommendations to make Family Assistance permanent, administered by the Department of Public Health (DPH), comprising a design and implementation plan, an annual budget, a data tracking system, and a plan for quickly processing payments to affected families for burial assistance.[33] To allow sufficient time for DPH to properly staff the program, DMH currently administers burial assistance services, provides mental health services to families, and connects families to available services. DMH is working with DPH to transition the work to DPH, at which time, OVP will assume responsibility for the distribution of funds for burial services to the affected families.

Family Assistance Status

As previously reported, the Chief Executive Office approved four positions requested by DPH in the FY 2023-2024 budget to support Family Assistance: one Clinical Social Worker Supervisor II position, one Clinical Social Worker position, and two Psychiatric

[33] *Office of Inspector General's Semi-Annual Report on Implementation of the Family Assistance Program and Report Back on Permanent Support for Families Affected by Los Angeles County Sheriff's Department: Identifying Sustainable Funding for and Streamlining the Family Assistance Program (Item No.14, Agenda of July 9, 2019 and Item No. 9, Agenda of October 19, 2021)* (Feb. 22, 2022).

Social Worker II (PSWII) positions.[34] OVP reports that it filled the Clinical Social Worker Supervisor II position on September 1, 2023 and is interviewing for the Clinical Social Worker and two PSWII positions, which it anticipates it will fill by April 2024.

OVP reports that it continues to work towards transitioning the administration of Family Assistance from DMH and DPH. OVP retained a consultant in September 2023 to assist with designing and implementing the transition plan in collaboration with County partners, developing of a scope of work with a community-based organization that will provide service navigation to impacted families, conducting best practice research, and developing protocols. In preparation for the transition, OVP staff are working closely with DMH staff to engage with and provide support services to impacted families and process burial expense reimbursements.

OVP also reports that it has met with several County partners to discuss collaborative efforts. OVP met with the Department of Medical Examiner (DME) to discuss staffing and coordination and prepare a draft Memorandum of Understanding outlining the respective duties and responsibilities of DPH, OVP, and DME. OVP met with the Sheriff Civilian Oversight Commission to discuss protocols, resources, and services. OVP met with the Office of Inspector General to provide updates and discuss ongoing collaboration. OVP has tentatively scheduled meetings with DMH and the Sheriff's Department's Homicide Bureau and Custody Services Division to discuss protocols. OVP anticipates convening all Family Assistance partners for a meeting in early 2024.

Family Assistance Service Data

Data available to the Office of Inspector General shows that from June 1, 2023, to December 31, 2023, DMH was notified of 23 incidents where an individual died following a fatal use of force by a Sheriff's Department employee or while in the custody of the Sheriff's Department. DMH successfully contacted 22 families but lacked the next-of-kin information needed to reach one family. Of the 22 families DMH contacted, seven families accepted services and assistance from DMH's Family Assistance Advocate, six families declined, and the remaining nine families have indicated they will accept services and are working with DMH so it can begin to provide assistance. Burial expenses were distributed to 4 families, with expenses ranging from $1,789.49 to $7,500, totaling a sum of approximately $18,107.49 for the period.

[34] The Clinical Social Worker Supervisor II position was originally classified as Mental Health Clinical Supervisor and the Clinical Social Worker position was originally classified as PSWII.

CUSTODY DIVISION

Rodent Infestation at Men's Central Jail

The presence of vermin and pests has been a persistent problem within Los Angeles County jail facilities.[35] Although the Department undertakes pest control mitigation efforts, including contracting with outside pest control specialists, Office of Inspector General staff have observed a notable increase in rodent feces during the previous two quarters, specifically in the restrictive housing module that houses LGBTQ+ people at Men's Central Jail (MCJ).

During the third quarter of 2023, Office of Inspector General staff observed rat traps and a significant amount of rat feces while monitoring a module that houses LGBTQ+ people in restrictive housing at MCJ. Office of Inspector General staff observed that people living in this module had attached plastic food wrappers to the bottom of their cells in an effort to prevent rats from entering, and multiple people in custody reported being bitten by rats while residing within the module. Almost every person living within the module expressed concern about rodents, and several reported that they were immunocompromised and feared that the unhygienic living conditions posed a particular hazard to their health.

Office of Inspector General staff immediately notified facility command staff of the rodent infestation and reported that people had been bitten by rats. Office of Inspector General Staff inspected the module several times in the week following notification to the Department and noted that the unhygienic conditions remained unchanged. The photograph below shows the rat feces observed within the module a day after Office of Inspector General Staff notified MCJ command staff of the rodent infestation.

[35] *See* ACLU of Southern California, *Annual Report on Conditions Inside Men's Central Jail 2008-2009* (May 6, 2010); Los Angeles Times, *Editorial: Unconscionable abuse and shameful inaction at L.A. County jails* (May 7, 2023).

The following week, Office of Inspector General staff escalated the concern to Department executive staff. The Department stated that it had contracted with a pest control agency to set approximately 20 rat traps and that MCJ Logistics personnel had cleaned, disinfected, and pressure washed the module.

Office of Inspector General staff continued to monitor the module following the Department's rodent elimination efforts. Initially, Office of Inspector General staff and people living in the module noted that cleanliness and rodent infestation had improved. However, in early December, Office of Inspector General staff observed rat droppings throughout the module and spoke with a transgender woman housed there who stated that she had recently been bitten by a rat. Office of Inspector General staff notified the facility watch lieutenant.

During subsequent monitoring visits, Office of Inspector General staff continued to observe rat feces within the module, suggesting that the rodent infestation and unhygienic living conditions are a persistent problem that require routine attention. In January 2024, nearly four months after Office of Inspector General staff notified MCJ command staff of the rodent infestation, staff documented rat feces in two individual cells in the module. Though the cells were unoccupied at the time, people were housed in neighboring cells.

The Office of Inspector General recommends that the Department immediately depopulate this housing module until it can maintain a sanitary environment to ensure that conditions do not pose a health risk to persons in custody. The Department should continue to contract with a pest control agency to ameliorate the rodent infestation and

dedicate resources from the MCJ logistics team to clean rodent droppings within the facility.

Birth of a Baby at Century Regional Detention Facility

In early October, a woman in custody at Century Regional Detention Facility (CRDF) gave birth to a baby while alone in her cell. Although she had been in the Department's custody for nearly four months, the Department had not identified her as pregnant before the birth. The Office of Inspector General staff reviewed Department reports and closed-circuit television video to investigate the Department's handling of the birth.

The woman gave birth shortly after 11:00 p.m. In the hour before, she stood at her cell window waving her arms multiple times, seemingly trying to get attention from Department staff. At about 11:00 p.m., a deputy conducting Title 15 checks spoke with her and looked inside her cell. The Department reported that the woman asked the deputy for sanitary napkins, and the deputy looked into the cell to determine whether she had been issued a pregnancy uniform because the deputy thought she appeared "big in the belly." The video shows the woman at her cell window again prior to the 11:15 p.m. Title 15 check, when the deputy conducting the Title 15 check discovered that she had given birth. The deputy radioed for assistance, left the pod, and re-entered with three deputies. The deputies escorted the person out of her cell. The video shows a substantial amount of blood on her legs and on her clothing. The deputy then handcuffed the person behind her back, escorted her down the stairs, and sat her at a table, at which point the deputies re-handcuffed her with her hands in front. After removing the woman from her cell, the deputies entered, swaddled the baby, and took the baby down the stairs. Once a gurney arrived, deputies transported the mother and her baby to the CRDF medical clinic for evaluation. After paramedics arrived, the mother was able to hold her baby, and the two were transported to the hospital for additional care.

The incident raises multiple concerns regarding the Department's systems for detecting and handling pregnancy and other medical issues.

First, Correctional Health Services (CHS) failed to detect the person's pregnancy at intake. CHS conducts medical screening of all people booked into Los Angeles County jails, and CHS policy requires that all people capable of becoming pregnant provide a urine sample to test for pregnancy. If a person refuses to provide a urine sample during booking, CHS staff refers them to the nurse clinic, where CHS staff again request a urine sample. If the person again refuses, CHS orders a blood pregnancy test. In this case, the woman's medical records show that she refused to provide an initial urine sample. CHS staff ordered a blood pregnancy test after her refusal, but no blood sample was ever taken. CHS reports that, following this birth, nursing staff is "now

tracking the [urine sample] refusals and repeatedly offering pregnancy tests in the weeks subsequent to refusal." CHS reports initiating this practice following this birth as an additional measure to prevent people from giving birth in the jail, although it has not yet formalized the practice in written policy.

Second, neither Correctional Health Services (CHS) nor the Department detected the person's pregnancy during the nearly four months they held her in custody before she gave birth. The person's medical records indicate that, although she often refused medical treatment and medication, she had routine visits with CHS medical providers. CHS prescribed her several psychotropic medications to manage her mental health needs (one of which is contraindicated with pregnancy), so she interacted frequently with pill-call nurses administering medications. Clinical staff also noted in the woman's chart that she had refused to wear clothing in her cell. The Department failed to detect the pregnancy, although it held the person in a High Observation Housing (HOH) module, where staff conducted Title 15 checks every 15 minutes and therefore interacted with her frequently. Although the person often refused to participate in indoor and outdoor recreational programming, she did infrequently exit her cell to participate in programming, including one instance four days before giving birth.

Third, deputies handcuffed the person after she gave birth, in violation of California law, and the Department failed to identify their actions as violations of law or policy. California law prohibits restraining "[a] pregnant inmate in labor, during delivery, or in recovery after delivery . . . unless deemed necessary for the safety and security of the inmate, the staff, or the public."[36] Department policy creates a higher standard, prohibiting restraint of "[a]n inmate in labor, during delivery, or in recovery after delivery … unless the inmate poses an immediate threat of great bodily injury or death to herself, her fetus, or others." Even when handcuffing is justified, California law provides that "[a]n inmate known to be pregnant or in recovery after delivery shall not be restrained by the use of . . . handcuffs behind the body."[37] Department policy likewise prohibits handcuffing pregnant inmates behind the body.[38] Despite these limitations, when deputies discovered that the person had given birth in her cell, they immediately handcuffed her behind her body to escort her out of her cell, and then re-handcuffed her in front of her body. In the supervisory inquiry of the incident, CRDF staff did not identify restraining her hands behind her as a violation of law or policy or analyzing the *need* to handcuff her at all to determine a policy violation if she posed no threat. Instead, the Department stated that "the deputies' conduct should have been different as it relates to

[36] California Penal Code § 3704(b).
[37] California Penal Code § 3704(a).
[38] *See* Los Angeles County Sheriff's Department, Manual of Policy and Procedures, § 7-02/010.00, *Pregnant Inmates*.

handcuffing the inmate behind her body immediately after delivering a baby." The inquiry suggested that deputies be provided additional training on this matter due to the "particularly uncommon circumstances surrounding the incident." When Office of Inspector General staff inquired what "immediate threat or great bodily injury or death" the person posed to necessitate the postpartum handcuffing, the Department responded that, when the person in custody alerted the deputies that she had just given birth, she stated, "There is a baby in here," and did not express what the deputies perceived to be an adequate level of alarm. The Department's review of the incident failed to analyze the conduct with reference to California law and Department policy. Even when deputies face unusual circumstances, the Department must review their actions under the governing standards and take measures to ensure compliance with state law and policy going forward.

In response to this birth, the Department briefed CRDF staff on policy pertaining to the treatment of pregnant people in custody. The Department also assigned a sergeant to oversee the pregnant people in custody at CRDF and act as a liaison between pregnant people in custody and staff at CRDF.

Sticker Associated with an Alleged Deputy Gang at Century Regional Detention Facility

While conducting a site visit at CRDF on December 21, 2023, Office of Inspector General staff observed what appeared to be a sticker associated with an alleged deputy gang referred to as the Regulators affixed to the second story elevator entrance in the staff parking structure. The sticker illustrated a skeleton wearing a cowboy hat and the Roman numeral for "21."

The Regulators are affiliated with Century Sheriff's Station, the Department's 21st station, which is located adjacent to CRDF. The sticker appeared recent, and Office of Inspector General staff had not seen it previously on regular site visits to CRDF. OIG staff noted that the sticker was still affixed to the elevator entrance on January 24, 2024.

In-Custody Deaths

Between October 1, 2023, and December 31, 2023, eleven people died in the care and custody of the Sheriff's Department. The DME website currently reflects the manner of death for seven deaths: one death resulted from an accident and six deaths were natural. For the remaining four deaths, the preliminary findings suggest two resulted from accidents (suspected overdoses) and two were natural.[39] Three of these people died at Men's Central Jail (MCJ), one died at North County Correctional Facility (NCCF), one died at Century Regional Detention Facility (CRDF) and six died at hospitals where

[39] In the past, the Office of Inspector General has reported on the preliminary cause of death as determined by the Medical Examiner, Correctional Health Services personnel, hospital personnel providing care at the time of death, and/or Sheriff's Department Homicide investigators. Because the information provided is preliminary, the Office of Inspector General has determined that the better practice is to report on the manner of death. There are five manner of death classifications: (1) natural, (2) accident, (3) suicide, (4) homicide, and (5) undetermined. Natural causes include illnesses and disease and thus deaths due to COVID-19 are classified as natural. Overdoses may be accidental, or the result of a purposeful ingestion, the Sheriff's Department and Correctional Health Services (CHS) use evidence gathered during the investigation to make a preliminary determination as to whether an overdose is accidental or purposeful. Where the suspected cause of death is reported by the Sheriff's Department and CHS, the Office of Inspector General will include this in parentheses.

they had been transported from the jails. The Sheriff's Department posts the information regarding in-custody deaths on a dedicated page on Inmate In-Custody Deaths on its website.[40]

Office of Inspector General staff attended the Custody Services Division (CSD) Administrative Death Reviews for each of the eleven in-custody deaths. The following summaries, arranged in chronological order, provide brief descriptions of each in-custody death:

Date of death: October 1, 2023
Custodial Status: Sentenced.[41]
Custody personnel at MCJ performing Title 15 Safety Checks found a person in their cell making jerking movements. After four minutes elapsed, custody staff entered the cell and began administering emergency aid, including administering two doses of Narcan. CHS arrived six minutes later and assisted in administering medical aid, including administering two doses of Narcan. Paramedics arrived during the rendering of emergency aid and took over resuscitative efforts, but the person died at the scene. The decedent had a history of seizures, yet, despite being housed in general population, had been placed in a single person cell. Areas for further inquiry include the quality and timeliness of Title 15 checks and why there was a delay to inform medical of an emergency. Preliminary manner of death: Natural. The DME website currently lists the manner of death as accident and the cause of death as sudden unexpected death in epilepsy.

Date of Death: October 11, 2023
Custodial Status: Sentenced
Custody personnel at TTCF found an unresponsive person during their Title 15 Safety Checks. Sheriff's Department staff, CHS staff, and paramedics rendered emergency aid, and CHS staff administered three doses of Narcan. The person was transported to Los Angeles General Medical Center (LAGMC), where they were pronounced deceased. Preliminary manner of death: Natural. The DME website currently reflects the

[40] As previously reported, the passage of AB 2671 amended the Penal Code to include section 10008 requiring the reporting of information on in-custody deaths within 10 days of a death, including the manner and means of death, with updates required within 30 days of a change in the information, including the manner and means of the death. This law went into effect on January 1, 2023, and requires that the information be posted on the agency's website.
[41] For purposes of custodial status, "Pre-trial" indicates that the person is in custody awaiting arraignment, hearing, or trial. "Convicted, Pre-sentencing" indicates that the person is being held in custody based on a conviction, pending sentencing, on at least some charges, even if they are in pre-trial proceedings on other charges. "Sentenced" indicates that the person is being held on the basis of a sentence on at least some charges, even if they are in pre-trial proceedings on other charges.

manner of death as natural and cause of death as pulmonary embolism and deep vein thrombosis of lower extremities.

Date of Death: October 11, 2023
Custodial Status: Sentenced
On September 29, 2023, a person in custody was transported from MCJ to LAGMC after experiencing chest pains. The person was compassionately extubated and died on October 11, 2023. The person had come into custody with significant pre-existing medical conditions. Preliminary manner of death: Natural. The DME website currently reflects the manner of death as natural and cause of death as sepsis and infective endocarditis.

Date of death: October 21, 2023
Custodial Status: Sentenced
Custody personnel at MCJ were alerted to a medical emergency in MCJ medical housing. Sheriff's Department staff, CHS staff, and paramedics rendered emergency aid, and CHS staff administered three doses of Narcan, but the person died at the scene. Preliminary manner of death: Natural. The DME website currently reflects the manner of death as natural and cause of death as hypertensive cardiovascular disease.

Date of death: October 26, 2023
Custodial Status: Sentenced
On October 24, 2023, custody personnel at the Inmate Reception Center (IRC) transported a person in custody to LAGMC after they complained of shortness of breath. The person died at LAGMC on October 26, 2023. CHS conducted a peer review and inquiry into the care and treatment that the Urgent Care Clinic provided. Preliminary manner of death: Natural. The DME website currently reflects the manner of death as natural and cause of death as sepsis and group C streptococcus.

Date of Death: November 3, 2023
Custodial Status: Pre-trial
On June 21, 2023, a person with several pre-existing medical conditions was booked into LASD custody and housed in TTCF. The person was transported to LAGMC for an appointment on September 19, 2023, and was ultimately admitted. The person was compassionately extubated and died on November 3, 2023. Preliminary manner of death: Natural. The DME website currently reflects the manner of death as natural and cause of death as sepsis and pneumonia.

Date of Death: November 14, 2023
Custodial Status: Pre-Trial
On November 12, 2023, a medical provider transferred a person housed at Correctional Treatment Center (CTC) to LAGMC via ambulance for evaluation. The person came

into custody with multiple pre-existing medical conditions. The person died at LAGMC on November 14, 2023, in the presence of their family. Preliminary manner of death: Natural. The DME website currently reflects the manner of death as natural, and the cause of death is sepsis and toxic shock and group A streptococcus bacteremia.

Date of Death: November 21, 2023
Custodial Status: Pre-Trial
Custody personnel at LAGMC discovered an unresponsive person. CHS nursing personnel rendered emergency aid, but the patient died at the scene. Preliminary manner of death: Natural (cardiopulmonary arrest). The DME website does not currently reflect the manner or cause of death.

Date of Death: December 5, 2023
Custodial Status: Sentenced
People in custody alerted custody personnel of a “man down” in a dorm at NCCF. Sheriff’s Department staff, CHS staff, and paramedics rendered emergency aid, and administered five doses of Narcan, but the person died at the scene. An area of concern is several missed Title 15 safety checks prior to the medical emergency. Preliminary manner of death: Accident (suspected overdose). The DME currently reflects the manner of death as accidental and the cause of death as fentanyl and methamphetamine toxicity.

Date of Death: December 7, 2023
Custodial Status: Pre-Trial
Custody staff at CRDF found an unresponsive person during their Title 15 Safety Checks. Sheriff’s Department staff and CHS staff rendered emergency aid and CHS staff administered three doses of Narcan. Paramedics determined that lividity and rigor mortis were present and pronounced the person dead. Preliminary manner of death: Natural. The DME website currently reflects the manner of death as natural and the cause of death as acute peritonitis and perforated duodenal ulcer.

Date of Death: December 12, 2023,
Custodial Status: Sentenced
Custody staff at MCJ found an unresponsive person while conducting Title 15 Safety Checks. Sheriff’s Department staff, CHS staff, and paramedics rendered emergency aid, and administered seven doses of Narcan, but the person died at the scene. Preliminary manner of death: Accident (suspected overdose). The DME website currently reflects the manner of death accidental and the cause of death combined effects of fentanyl, acetyl fentanyl, heroin, mirtazapine, and trazadone.

Other Deaths

On October 20, 2023, a person arrested by East Los Angeles Sheriff's Station was transported to the hospital after complaining of chest pains. The person was admitted to the hospital and pronounced dead on October 22, 2023. Preliminary manner of death: Unknown. The DME website does not currently reflect the manner, and cause of death is deferred.

Office of Inspector General Site Visits

The Office of Inspector General regularly conducts site visits and inspections at Sheriff's Department custodial facilities. In the fourth quarter of 2023, Office of Inspector General personnel completed 111 site visits, totaling 319 monitoring hours, at CRDF, IRC, LAGMC, MCJ, Pitchess Detention Center (PDC) North, PDC South, PDC East, NCCF, and TTCF.[42]

As part of the Office of Inspector General's jail monitoring, Office of Inspector General staff attended 136 Custody Services Division (CSD) executive and administrative meetings and met with division executives for 171 monitoring hours related to uses of force, in-custody deaths, COVID-19 policies and protocols, Prison Rape Elimination Act (PREA) audits, and general conditions of confinement.

Use of Body Scanners in Custody

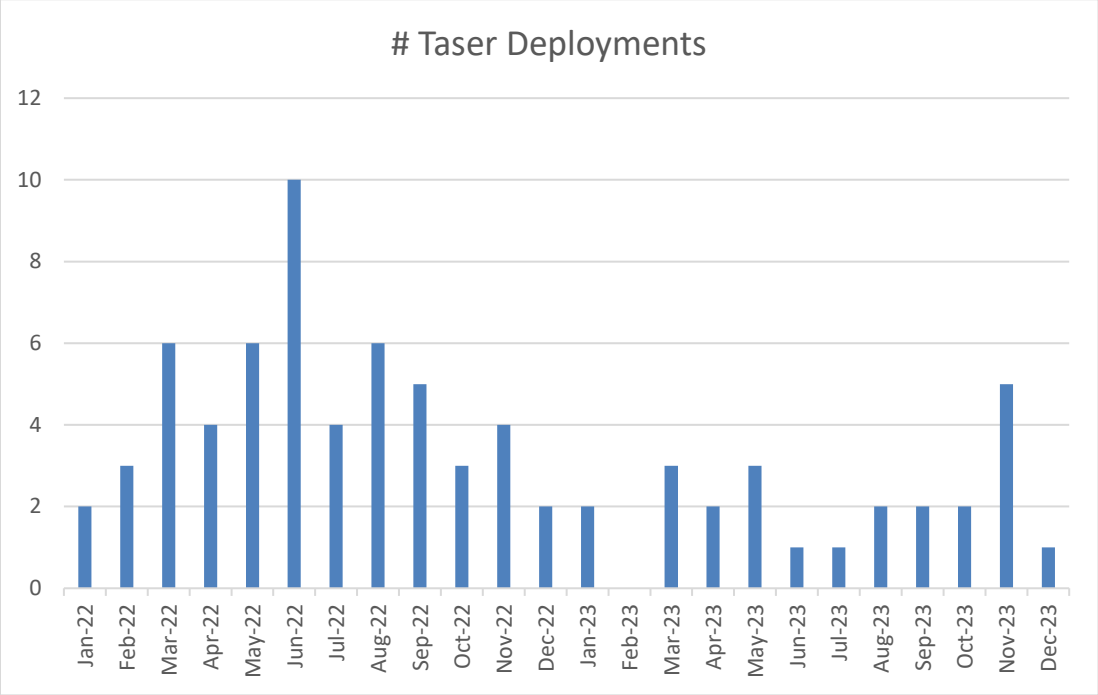
The Sheriff's Department continues to operate X-ray body scanners at MCJ, CRDF, PDC North, PDC South, NCCF, and IRC. The Sheriff's Department policy for body scanners requires each facility using screeners to maintain a unit order describing when and where inmates shall be screened, the staffing requirements to do so safely, and the logistical considerations pertaining to their facility.[43] The policy also requires handling sergeants to document the discovery of contraband into the electronic Line Operations Tracking System (e-LOTS). Although, the body scanners continue to detect anomalies that may be contraband, the Sheriff's Department reports that facility staff do not consistently complete documentation for contraband detected by body scanners. Custody Support Services Bureau reports that a division wide email has been sent to all facilities outlining the policy and correct procedures for tracking detected contraband in e-LOTS. However, there continue to be discrepancies in the data reported. The Office

[42] These figures include site visits and meetings related to monitoring for compliance with the Prison Rape Elimination Act ("PREA").
[43] See Los Angeles County Sheriff's Department, Custody Division Manual, § 5-08/020.00, *Custody Safety Screening Program (B-SCAN)*.

of Inspector General recommends that The Sheriff's Department confirm data accuracy by reviewing the entries into the e-LOTS system.

Taser Use in Custody

According to the *Monthly Force Synopsis* that the Sheriff's Department produces and provides to the Office of Inspector General each month, the following chart reflects the number of use-of-force incidents in custodial settings in which deputies employed a Taser, over the past two years:



Use-of-Force Incidents in Custody

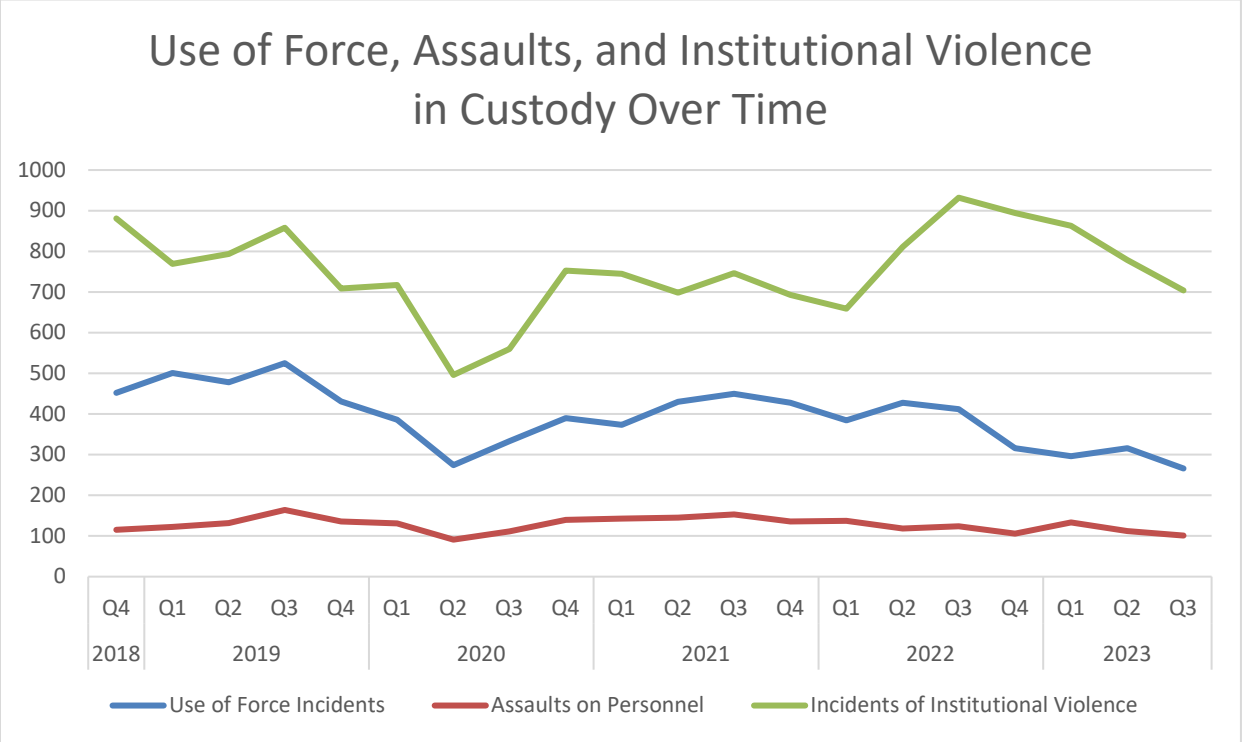
The Office of Inspector General monitors the Sheriff's Department's use-of-force incidents, institutional violence, and assaults on Sheriff's Department or CHS personnel by people in custody.[44] The Sheriff's Department reports the following numbers for the uses of force and assaultive conduct for people in its custody.[45]

---

[44] Institutional violence is defined as assaultive conduct by a person in custody upon another person in custody.

[45] The reports go through the second quarter of 2023 because the Sheriff's Department has not yet verified the accuracy of reports for the third quarter of 2023. The Sheriff's Department recently provided information to the Office of Inspector General regarding some discrepancies in the reported data based upon its internal reporting systems. The Office of Inspector General will work with the Sheriff's Department to understand the reasons for the discrepancies and to ensure accurate reporting.

		Use of Force Incidents	Assaults on Personnel	Incidents of Institutional Violence
2018	4th Quarter	452	115	881
2019	1st Quarter	501	122	769
	2nd Quarter	478	132	794
	3rd Quarter	525	164	858
	4th Quarter	431	136	709
2020	1st Quarter	386	131	717
	2nd Quarter	274	91	496
	3rd Quarter	333	111	560
	4th Quarter	390	140	753
2021	1st Quarter	373	143	745
	2nd Quarter	430	145	698
	3rd Quarter	450	153	746
	4th Quarter	428	136	693
2022	1st Quarter	384	137	659
	2nd Quarter	428	118	811
	3rd Quarter	412	124	932
	4th Quarter	316	106	894
2023	1st Quarter	296	133	863
	2nd Quarter	316	112	779
	3rd Quarter	266	101	704



HANDLING OF GRIEVANCES AND COMMENTS

Office of Inspector General Handling of Comments Regarding Department Operations and Jails

The Office of Inspector General received 101 new complaints in the fourth quarter of 2023 from members of the public, people in custody, family members and friends of people in custody, community organizations and County agencies. Each complaint was reviewed by Office of Inspector General staff.

Of these grievances, 83 were related to conditions of confinement within the Department's custody facilities, as shown in the chart below:

Grievances/Incident Classification	Totals
Medical	24
Classification	13
General Services	8
Personnel Issues	6
Living Condition	5
Visiting	3
Food	2
Education	2
Property	2
Mail	2
Telephone	2
Dental	2
Commissary	1
Showers	1
Other	10
Total	**83**

Eighteen complaints were related to civilian contacts with Department personnel by persons who were not in custody, as shown in the following chart:

Complaint/Incident Classification	Totals
Personnel	
Neglect of Duty	5
Improper Tactics	4
Harassment	2
Discourtesy	1
Discrimination	1
Off Duty Conduct	1
Service	
Policy Procedures	2
Response Time	2
Total	**18**

Handling of Grievances Filed by People in Custody

The Sheriff's Department has not fully implemented the use of computer tablets in its jail facilities to capture information related to requests, and eventually grievances, filed by people in custody. There are currently 168 iPads installed in jail facilities. However, only 22 of the 168 installed iPads are functional: 6 at TTCF and 17 at CRDF.

The Sheriff's Department has publicly acknowledged this problem and noted that the iPads it uses for grievances are outdated. It also reports its intent to upgrade to a more robust tablet system for complaints, but states that such an upgrade must wait until network upgrades in the jail are complete. But the Sheriff's Department cannot fully implement the use of tablets to provide information or eventually capture complaints and grievances in the jails if 86% of them do not function. The Sheriff's Department must implement a system to commit to upgrading infrastructure where necessary, repair or replace nonfunctional tablets and commit to ensuring sufficient tablets remain operational.

As previously reported, the Sheriff's Department implemented a policy in December 2017 restricting the filing of duplicate and excessive grievances by people in custody.[46] The Sheriff's Department reports that between October 1, 2023, and December 31, 2023, zero people in custody were placed on restrictive filing. Because the Sheriff's Department transitioned grievance tracking software from the Custody Automated Reported and Tracking System (CARTS) to the Custody Inmate Grievance

[46] *See* Los Angeles County Sheriff's Department, Custody Division Manual, § 8-04/050.00, *Duplicate or Excessive Filings of Grievances and Appeals, and Restrictions of Filing Privileges*.

Application (CIGA) within the quarter, Department staff could not provide data detailing the number of grievances that it rejected under this policy.

The Office of Inspector General continues to raise concerns about the quality of grievance investigations and responses, which likely increases duplication and may prevent individuals from receiving adequate care while in Sheriff's Department custody.

Sheriff's Department's Service Comment Reports

Under its policies, the Sheriff's Department accepts and reviews comments from members of the public about departmental service or employee performance.[47] The Sheriff's Department categorizes these comments into three categories:

- External Commendation: an external communication of appreciation for and/or approval of service provided by the Sheriff's Department members;
- Service Complaint: an external communication of dissatisfaction with the Sheriff's Department service, procedure or practice, not involving employee misconduct; and
- Personnel Complaint: an external allegation of misconduct, either a violation of law or Sheriff's Department policy, against any member of the Sheriff's Department.[48]

The following chart lists the number and types of comments reported for each station or unit.[49]

INVESTIGATING BUREAU/STATION/FACILITY	COMMENDATIONS	PERSONNEL COMPLAINTS	SERVICE COMPLAINTS
ADM : NORTH PATROL ADM HQ	1	1	0
AER : AERO BUREAU	1	0	1
ALD : ALTADENA STN	6	0	0
BOL : BUREAU OF LABOR RELATIONS AND COMPLIANCE	1	0	0
CAF : COMM & FLEET MGMT BUR	1	0	0
CCS : COMMUNITY COLLEGE BUREAU	3	2	0
CEN : CENTURY STN	1	1	1

[47] *See* Los Angeles County Sheriff's Department, Manual of Policy and Procedures, § 3-04/010.00, *Department Service Reviews*.
[48] It is possible for an employee to get a Service Complaint and Personnel Complaint based on the same incident.
[49] The chart reflects data from the Sheriff's Department Performance Recording and Monitoring System current as of January 9, 2024.

INVESTIGATING BUREAU/STATION/FACILITY	COMMENDATIONS	PERSONNEL COMPLAINTS	SERVICE COMPLAINTS
CER : CERRITOS STN	4	1	0
CMB : CIVIL MANAGEMENT BUREAU	5	3	3
CNT : COURT SERVICES CENTRAL	3	3	4
COM : COMPTON STN	1	1	2
CPB : COMMUNITY PARTNERSHIP BUREAU	2	2	0
CRV : CRESCENTA VALLEY STN	12	1	1
CSB : COUNTY SERVICES BUREAU	2	3	0
CSN : CARSON STN	7	3	2
CST : COURT SERVICES TRANSPORTATION	0	1	0
ELA : EAST LA STN	0	2	0
EOB : EMERGENCY OPER BUREAU	1	0	0
EST : COURT SERVICES EAST	4	2	0
FCC : FRAUD & CYBER CRIMES BUREAU	1	0	0
HOM : HOMICIDE BUREAU	1	0	0
IAB : INTERNAL AFFAIRS BUREAU	1	0	0
ICI : INTERNAL CRIME INV BUR	1	0	0
IND : INDUSTRY STN	6	4	1
LCS : LANCASTER STN	4	20	2
LKD : LAKEWOOD STN	7	10	3
LMT : LOMITA STN	6	1	3
MAR : MARINA DEL REY STN	2	10	4
MCB : MAJOR CRIMES BUREAU	5	1	0
MCJ : MEN'S CENTRAL JAIL	1	1	0
MLH : MALIBU/LOST HILLS STN	8	6	7
NCF : NORTH CO. CORRECTL FAC	0	1	0
NWK : NORWALK REGIONAL STN	3	1	0
OCP : OFFICE OF CONSTITUTIONAL POLICING HQ	0	1	0
OSS : OPERATION SAFE STREETS BUREAU	0	2	1
PKB : PARKS BUREAU	3	0	0
PLM : PALMDALE STN	5	13	2
PRV : PICO RIVERA STN	2	2	0
RIB : RECORDS & IDENTIFICATION	1	0	0
SCV : SANTA CLARITA VALLEY STN	14	6	2
SDM : SAN DIMAS STN	15	2	0

INVESTIGATING BUREAU/STATION/FACILITY	COMMENDATIONS	PERSONNEL COMPLAINTS	SERVICE COMPLAINTS
SEB : SPECIAL ENFORCEMENT BUR	0	1	1
SLA : SOUTH LOS ANGELES STATION	3	11	2
SO : PITCHESS SOUTH FACILITY	1	1	0
SVB : SPECIAL VICTIMS BUREAU	5	3	0
TEM : TEMPLE CITY STN	6	4	2
TRP : TRAP	1	0	0
TSB : TRANSIT SERVICES BUREAU	3	3	3
TT : TWIN TOWERS	2	1	0
WAL : WALNUT/SAN DIMAS STN	3	5	3
WHD : WEST HOLLYWOOD STN	10	4	0
WST : COURT SERVICES WEST	1	1	0
Total :	176	141	50

OFFICE OF THE SHERIFF

COUNTY OF LOS ANGELES

HALL OF JUSTICE

ROBERT G. LUNA, SHERIFF

February 15, 2024

Max Huntsman, Inspector General
County of Los Angeles
Office of Inspector General
312 South Hill Street, Third Floor
Los Angeles, CA 90013

Dear Mr. Huntsman:

LOS ANGELES COUNTY SHERIFF'S DEPARTMENT'S RESPONSE TO THE OFFICE OF INSPECTOR GENERAL'S REFORM AND OVERSIGHT DRAFT REPORT – OCTOBER TO DECEMBER 2023

This letter is in response to the draft report on Reform and Oversight (October to December 2023) that my office was asked to review by February 15, 2024. First, I am deeply concerned about the recommendation that the Department's Risk Management Bureau (RMB) should be disbanded. I view this recommendation as irresponsible, given the important role of this unit, and unwarranted for several reasons outlined below.

In creating the Office of Constitutional Policing (OCP), my goal was to ensure the implementation of best practices across several Department functions, including those in the RMB. Housed in RMB are functions that are essential to the Department's commitment to transparency and accountability, as well as our obligation to prevent and appropriately report misconduct, mitigate internal and external risk, cooperate with County Counsel (and retained outside counsel) in civil litigation defense, identify and implement corrective action, increase employee safety, and support employee wellness.

Many departments, including the most comparable by size in California (such as the Los Angeles Police Department (LAPD), also house the risk management and legal affairs functions within one division and in their equivalent office to

the Department's OCP. In addition to the LAPD, the Orange County Sheriff's Department houses the civil litigation unit within a risk management bureau and under a division known as S.A.F.E. (Strategy, Accountability, Focus, Evaluation). In fact, these and other departments were the models I used in creating the newly formed Department's Office of Constitutional Policing.

The 83 sworn and professional staff who work RMB are vetted and selected based on their background, training, and experience and for their commitment to this unique role within the department. Like much of the Department, they do this work honorably and effectively despite staffing shortages.

Prior to issuing the draft report recommending that RMB be disbanded, the OIG did not conduct any specific audit or even visit with the leadership or staff of RMB in attempt to better understand the challenges and opportunities experienced by the units with the Bureau. As I understand it, it has been years since any member of the OIG staff visited RMB in an attempt to better understand their operations and to provide suggestions for improvement and guidance on best practices.

The draft report cites several anecdotal examples of actions or approaches taken by units within RMB which the OIG believes fell short in various ways. The draft report correctly acknowledges that on those occasions when you or your office raised questions or concerns, either RMB or its divisional lead OCP responded and addressed the issues and always in consultation with County Counsel.

The draft report also lists examples without any context of the roles and responsibilities, staffing levels, and work volume of the units within RMB. The draft report opines that the Bureau has "displayed a pattern of prioritizing its defense function" without providing any data to support such a conclusion but instead on a limited, selective number of examples and without the context that the Department is in fact obligated to mitigate risk, appropriately support the goal of reducing liability and ensuring root causes are identified and corrective actions are implemented.

The draft report includes gratuitous attacks on Department personnel that include assumptions about motive and intent that is not supported by any evidence or objective evaluation considering the number and types of cases handled by the units within the Bureau, including Litigation, Corrective Action, and Senate Bill (SB) 2.

The draft report discounts the use of outside counsel as a method to ensure unbiased, fair, and impartial evaluation of potential SB 2 allegations that relate to command staff or employee litigants. The draft report fails to acknowledge that reasonable legal minds might differ in their analysis based on the definitions adopted by the legislature and POST. The report summarily concludes that since the Department has a "history of misuse of outside counsel" it is unlikely the use of outside counsel will address the concerns of disparate treatment. The draft report describes the Bureau as "euphemistically named" and "corrupting of the County's efforts to improve government." Again, with limited anecdotes and conclusions. The draft report opines that nothing has changed within the Bureau since I took office and since the Bureau was placed under OCP. This, like much of the report, is speculative, unfair, and irresponsible.

The draft report's selective examples, while illustrative and often helpful to understanding areas for improvement do not paint a complete picture of the work and many successes of RMB and OCP.

For example, in the report's discussion of the Department's compliance with Senate Bill (SB) 2 and POST reporting of serious misconduct, the draft report fails to acknowledge the Department's substantial and timely compliance with the letter and spirit of the law over the last year. In just over one and half years, RMB created and implemented a new electronic reporting system to ensure compliance with the SB 2. To meet the law's requirements related to retroactive reporting of allegations of serious misconduct, 21,107 entries for potential misconduct were reviewed. As of last week, a total of 3,648 allegations of serious misconduct and a total of 2,229 unique sworn personnel entries have been reported to POST for an allegation(s) of serious misconduct. These totals include 128 allegations of law enforcement gang membership, 870 allegations of bias, 233 for dishonesty as defined by POST regulations, and 1839 for physical abuse/excessive force. These are not the statistics of a Department (or Bureau) that is attempting to thwart the letter and spirit of SB 2.

The draft report implies that timely reporting to POST is a widespread issue and notes 26 cases pending legal analysis. As reported to your office last November, the backlog was cleared early that month and since then, on average, there have been 0-5 cases pending legal analysis in any given week.

Furthermore, the data belies the draft report's implications and failure to acknowledge the successes of the Department's implementation of SB 2 by the Bureau's leadership. The SB2 team currently takes approximately 26 hours from the time of initial entry into the Department's internal system (SMART) where it is received for evaluation and determination if referral to POST is required for the employee. After the evaluation is completed, the team takes an average of 3.46 days to complete the qualifying entry into the POST system. The Unit is then responsible for providing regular every 90 days as required and responding to requests from POST.

The Department began creating the SB2 electronic system and process even before POST finalized its regulations and procedures. The Department relied on the advice of County Counsel and regularly consulted with POST to develop best practices, and when your Office was engaged in meeting regularly with the SB 2 team, those suggestions were also incorporated. I acknowledge there have been growing pains along the way, as is customary with newly implemented processes on this scale. At each step along the way, including when you or your office raised issues or concerns, the Department has promptly addressed them, even if sometimes drawing different conclusions based on review of the facts and law by County Counsel or contracted outside counsel. The SB 2 team created a dashboard solely for the OIG's use in monitoring entries and processing of potential SB 2 violations. This, like many of our efforts at collaboration and transparency, goes unnoted in the draft report.

As discussed above, it is a common practice among law enforcement agencies (especially large agencies with significant numbers of claims and lawsuits) to use the knowledge and experience of sworn members to support the assessment of claims and lawsuits and for sworn Department members to liaise with counsel to compile the documents, information, and subject matter experts that attorneys defending the Department and the County require to meet their legal and ethical obligations. While Department members (within and outside of RMB) play a critical role, in the end it is County Counsel and the contracted attorneys, and the County itself, who determine discovery, motion practice, trial, and settlement strategy.

In 2023, the Civil Litigation Unit was responsible for processing and responding to 661 civil claims and providing support to county and contracted counsel on 227 civil lawsuits. Supervisors and managers with the Litigation Unit are responsible for conducting a thorough and prompt review of all claims and lawsuits, while also ensuring any/all potential violations of

policy/procedures, as well as the law (SB2, Penal Code violations, etc.) are identified and appropriately reported in a timely manner. Personnel also assist outside entities (attorneys, members of the public, etc.) with navigation of the Department's civil liability process. None of which was acknowledged in the draft report.

Similarly, the roles and responsibilities of the Corrective Action Plan Unit are not fully captured in the draft report. In 2023, Unit members attended 28 County Claims Board Meetings. Through the Unit's work 89 settlements were approved, with settlement figures ranging between $15 thousand to $25 million. In 2023, the unit received 60 requests for corrective action plans. The unit uses a reporting format provided by the CEO's Risk Management Office and works in close consultation with both County Counsel and the CEO Office of Inspector on all CAPS/SCAPS. Draft versions are shared, feedback received, and the final version is pre-approved by the CEO RM IG as required by a 2010 directive from the CEO. In addition to the multiple department members signatures, not just the Captain of RMB, the forms included the County RM IG.

These are just some examples of the OIG's draft reports fail to acknowledge this Department's efforts over the last year. My administration remains committed to constitutional policing, as well as continuous improvement of process and procedures – whether issues come to light from the public, your office, the newest members of my administration working in the Office of Constitutional Policing or anywhere else in the Department. To accuse Department members of hindering reform based on anecdotes, without evidence and without providing this administration and our Office of Constitutional Policing the time and latitude to implement reforms is unwarranted and irresponsible.

While I intend the bulk of my response to the draft report to focus on the risk management issues because of the recommendation made, I also must address some of the issues presented in the report with respect to Custody Operations. The draft report indicates that a sticker associated with an alleged deputy gang was located at Century Regional Detention Facility. Once we became aware of the sticker, it was removed immediately. On February 12, 2024, I requested confirmation that the sticker was removed, and I received such confirmation. It would be tremendously helpful to the Department's efforts to eradicate such symbols if we were advised of their existence immediately. I do not know when your office first identified such a sticker, but any derogatory symbol

such as those reflecting a law enforcement gang are inappropriate and need to be addressed immediately.

Furthermore, a contracted pest control agency has been instructed to increase its attention to the rodent problem and to offer alternatives to prior efforts which were unsuccessful in eradicating the problem. The Department has also increased its deep-cleaning efforts. I am advised that the photo presented in the draft report is not a current reflection of the area depicted.

Finally, with respect to the iPad matter, as reported previously the Department wishes to proceed with a more robust tablet system but cannot until the network upgrade is significantly completed. As you know, the CEO's Office recently approved funding for this update. I am advised that the draft report has incorrect numbers relating to the functional iPads, and we provide updated numbers below.[1]

While the Department faces many challenges in its reform efforts, I am also extremely optimistic that we can achieve significant reform. Long-lasting reform requires effort and perseverance, but it also requires recognition of the efforts that have been successful. I intend to keep highlighting the positive changes while simultaneously recognizing more work remains to be done.

Should you have any questions, please contact Division Director Eileen Decker, Office of Constitutional Policing, at (213) 229-3096.

Sincerely,

R. Luna

ROBERT G. LUNA
SHERIFF

[1] The suggested changes with the corrected numbers are as follows: "only ~~seven~~ 22 of the 168 installed iPads are functional: ~~6~~ (5) at TTCF and ~~1~~ (17) at CRDF."

OFFICE OF THE
COUNTY
COUNSEL

County of Los Angeles

Dawyn R. Harrison
County Counsel

February 14, 2024

Max Huntsman, Inspector General
Office of Inspector General
312 South Hill Street, 3rd Floor
Los Angeles, California 90013

RE: **Response to the Office of Inspector General's February 15, 2024, Draft Report**

Dear Inspector General Hunstman:

CONFIDENTIAL:
This material is subject to the attorney-client and/or attorney work product privileges.

I am providing this letter in response to your February 15, 2024, draft report ("Report"), where the Office of Inspector General ("OIG") recommends the Sheriff's Risk Management Bureau ("RMB") be disbanded. Although we were not provided a copy of the report for the purpose of responding to its contents, we wanted to ensure some information was clarified. In making the recommendation about the RMB, the Report states County Counsel personnel "rely upon the information provided, and sometimes upon the judgment of Risk Management personnel, in litigation strategy to the detriment of the County's efforts at reform." We respectfully disagree.

County Counsel exercises its own independent legal and strategic judgment. It does not rely upon the RMB or any other bureau, unit, or department to formulate litigation strategy. County Counsel obtains information from several sources – discovery and information produced by plaintiffs, documents provided by County departments, its own factual investigation, depositions and witness statements, audio/video, input from outside counsel, and expert opinions, among others – and analyzes this information in light of the applicable law. RMB is one source of information, but certainly not the only source, for material in litigation matters involving the Sheriff, and does not play any role in litigation strategy or case assessment. We perform our own analysis and make our own decisions.

648 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012-2713

TEL 213.974.1801
TDD 213.633.0901

It is important to note that it is helpful to have a unit like RMB available to act as initial gatherer of Sheriff information about the litigation, including coordinating known witnesses. It is our understanding that RMB has not had sufficient staff to meet the influx of claims and litigation, which has resulted in additional attorney time used to gather the initial Sheriff documents. With an interest in protecting the County fisc, we believe the department itself, and a unit like the RMB, is the most efficient method of gathering initial documents as compared to attorneys who charge a much higher rate and may not be as efficient.

County Counsel is fully committed to the Board's vision of justice reform, including reforming the Sheriff's department. We have shown this through (among other things) our extensive work enforcing the OIG's subpoenas against the former Sheriff's administration, assisting the Board with preparing and placing Charter Amendments on the ballot which circumscribe the Sheriff's powers, and our creation of an innovative County Counsel division focused exclusively on law enforcement transparency. But at the same time, we have a responsibility to defend the County in litigation and protect taxpayer resources. This responsibility requires us to go beyond lawsuit allegations – including those from both plaintiff and defense witnesses – and to carefully evaluate all the facts from all relevant sources. It is this independent evaluation, along with our legal analysis, that drives our litigation strategy.

Very truly yours,

DAWYN R. HARRISON
County Counsel

By
NICOLE DAVIS TINKHAM
Chief Deputy

NDT:EM:jh

Los Angeles County Sheriff's Department

CUSTODY SERVICES DIVISION SPECIALIZED PROGRAMS CENTURY REGIONAL DETENTION FACILITY	**Unit Order: 5-00-03** **Effective Date:** 02/05/2024
Subject: Merit Master- Inmate Contact Visits (Pilot Program)	
Reference: CDM sections 5-10/010.00, 5-10/010.05, and 5-10/020.00 and UO 5-15 010, UO 5-15-020	
Unit Commander Signature:	**Date:**

PURPOSE OF ORDER:

The purpose of this order is to establish procedures for non-barrier contact visits with the Forensic Inpatient (FIP) Step Down Merit Masters inmates at the Century Regional Detention Facility (CRDF). For the purpose of this order, Leadership, Mental Health Assistant, and Peer Support Specialist inmates will all fall under the title of Merit Master.

SCOPE OF ORDER:

This order shall apply to all personnel assigned to the FIP Step Down module, CRDF Visiting Center, Main Control, Century booking, and/or working in any capacity at CRDF.

ORDER:

Non-barrier contact visits shall only be conducted in an interview room located in Century Booking. Non-barrier contact visits shall only be offered to FIP Step Down Merit Master Inmates housed at CRDF.

Non-barrier Contact Visiting Hours:

Saturday-Sunday: 0700 – 1600 hours

Each non-barrier contact visit shall be pre-scheduled to accommodate each Merit Master during the designated hours of operation. Each visit will be thirty (30) minutes in duration.

NOTE: Non-barrier contact visits shall not occur between the hours of 1300 to 1400 to allow for shift change and count without interruptions. The last visiting request for the day shall be scheduled for no later than 1530 hours.

Non-barrier Contact Visiting Schedule:

Non-barrier contact visits will be granted once a month on Saturday or Sunday.

Non-barrier contact visits shall be pre-scheduled by the CRDF Visiting Center. The FIP Step Down Merit Masters shall provide a list of potential visitors to the FIP Step Down deputies and include the following:

- Visitor's full legal name
- Date of birth
- California driver license number
- Telephone number
- Address

Once this information is obtained, FIP Step Down deputy personnel shall provide the potential visitor list to CRDF Visiting Center personnel. Visiting Center personnel shall review the information and conduct a background check of each potential visitor. After approval is granted, Visiting Center personnel shall contact the visitor and schedule a visit utilizing the Inmate Video Visitation System (IVVS).

A maximum of one adult and one child shall be allowed to participate in a non- barrier contact visit.

NOTE: Additional child visitors may be granted on a case-by-case basis as staffing levels permit.

Each visit shall be staggered so there are no more than one visit occurring at any given time. The non-barrier contact visiting schedule shall be provided to the Merit Master visitors by the FIP Step Down sergeant, or their designee, monthly. The FIP Step Down sergeant or their designee will maintain the current list of approved visitors.

NOTE: Walk-in or unscheduled non-barrier contact visits are discouraged and may be turned away.

NOTE: The Merit Master Inmates are still eligible to receive their two weekly visits per Title 15 Section 1062, "Visiting."

Contact Visitor Requirements

- Each visitor shall sign the Los Angeles County Sheriff's Department Visitation and Civil Claims Release form prior to entry.
- Juveniles under the age of 18 years must be accompanied by a parent or legal guardian and sign a waiver on their behalf. They must possess a valid form of identification and/or a birth certificate which shall be provided to Visiting Center personnel prior to entry (No Exceptions).
- Visitors shall adhere to the dress code established for non-barrier contact visits.

- ✓ The following attire is prohibited: loose-fitting or tight-fitted clothing, extra layers, bulky jackets, revealing or provocative clothing, open toed shoes, high-heel/pumps, bras with metal underwire, blue jeans, blue jacket, or gang-related attire including specific gang affiliated colors.

- Contact visitors shall be limited to the Merit Masters' parent(s), grandparent(s), spouses/fiancé, and/or children.
- All visitors shall adhere to CRDF's Code of Conduct at all times. Failure to do so could result in the visit ending pre-maturely, cancelled, or loss of visiting privileges.

Identification

- Each visitors' name shall be provided to visiting personnel for clearance/approval for the non-barrier contact visit.
- Each visitor shall be checked via the Justice Data Interface Controller (JDIC) for wants, warrants, restraining orders against the inmate, and outstanding tickets for initial approval and once again upon arrival for the scheduled visit.
- Visitors with wants or warrants, restraining orders against the inmate and/or outstanding tickets will not be allowed to participate in the visit.
- All visitors entering CRDF, except for minors, must present an authentic, current, and valid photo identification which includes any of the following:
  - State driver's license
  - State identification card
  - Interim driver's license only when accompanied by a scanned photo issued by the California Department of Motor Vehicles
  - Military identification
  - Passport
  - Resident alien identification
  - Identification Card issued by any Country Consulate's Office
  - School ID for anyone appearing to be 18 years old but representing themselves as a minor.

NOTE: Damaged/altered/expired identification cards are not accepted.

Procedures for Visitors

- Persons named on a visiting appointment for a non-barrier contact visit with the inmate must arrive at a minimum of thirty (30) minutes prior to their appointment, otherwise the visit shall be documented as a "no show" resulting in a canceled visit. The canceled visit may be counted toward the Merit Master's one contact visit for the month.
- Prior to entry, all visitors shall exchange their personal mask, disposable or reusable, for a disposable mask provided by CRDF visiting personnel. Any visitor with a reusable mask shall secure their mask in a locker with any personal items prior to entry.

- Visitors shall submit to a pat down search and are required to pass through a metal detector prior to being escorted into the Century booking interview room.
- Visitors with a pacemaker are exempt from going through a metal detector but are still required to submit to a pat down search.
- Visitors refusing to be searched shall be denied their visit and be escorted out of the facility. The visitor may still be searched prior to being escorted out of the facility. If contraband is found the visitor may be charged with violation of penal code 4573.5 P.C. (Bringing Contraband into a Jail Facility).
- Visitors shall make minimal physical contact (limited to a hug or handshake) with the Merit Master inmate at the beginning and end of the visit.
- All property shall be secured in their vehicle or stored in a locker prior to entry.

NOTE: Cell phones, hats, purses, etc. are prohibited

Visiting Area Rules

Any violation of the following rules may result in the visitor's removal from the facility and the cancellation of visiting privileges:

- Visitors shall follow all directives given by Department personnel.
- Visitors shall not engage in any activity which may violate the security of the facility or threaten the safety of Department personnel or inmates.
- Cameras, recording devices, radios, and all electronic devices are prohibited within the visiting areas.
- The use, possession of, or evidence of being under the influence of any alcoholic beverage, illegal drug, narcotic or other substance shall not be allowed in the facility and will subject the visitor to arrest.
- Visitors shall not engage in lewd conduct or indecent exposure.
- Parent/guardian shall maintain control of their child in the visiting area.
- The use of gang colors, signs, language, or any gang paraphernalia used to show gang affiliation is prohibited.
- Individuals cleared for non-barrier contact visits must comply with all rules. Violation(s) can result in the visitor being suspended from further contact visits.

Ex-felons/Parolees and Visitors on Probation

- Ex-Felons/Parolees and/or Visitors on Probation need prior approval, in writing, from the Division Chief or his/her designee to participate in contact visits.
- Anyone requesting a visit who has been incarcerated in the Los Angeles County jail system, shall not be denied visitation privileges based on their previous incarceration status.

Inmate Requirements

- Inmates have the right to refuse a visit. The inmate's refusal shall be documented in IVVS and the electronic Uniform Daily Activity Logs (e-UDAL). Refusals shall be submitted in writing on an Inmate Grievance form.
- Inmates shall be properly dressed in their issued Los Angeles County jail clothing when going to or coming from a visit.
- Inmates shall obey all facility rules and regulations. Any violation of the jail house rules shall result in the termination of the inmate's visit as well as disciplinary action.
- Inmates shall not engage in any lewd conduct or indecent exposure.

Procedures for Merit Master Inmates

- FIP Step Down module personnel may perform a visual body cavity search (VBCS) or strip search of the Merit Master inmate prior to escorting them to Century booking, if believed necessary. The Merit Master Inmates may be subject to VBCS's or strip searches upon completion of the visit to ensure no contraband was passed into the facility. A complete full body scan shall be conducted. Should a strip search or VBCS be necessary, custody personnel shall notify a supervisor and articulate the need for the search.

NOTE: All visual body cavity search protocol shall be adhered to.

Cancellation of Visits

CRDF personnel may cancel a visit at any time for the following reasons:

- Visitor(s)/inmate engage in any inappropriate behavior
- Visitor(s)/inmate refuse to be searched
- Contraband is found on the visitor/inmate
- Visitor(s)/inmate who disrupt the visiting process in any manner
- Visitor(s) shall not enter the facility under the influence of drugs or alcohol
- An inmate is on restricted status (Covid-19 related quarantine/discipline)
- Security conditions of the facility
- All visits will be immediately canceled or denied entry in the event of a facility lock down.

CRDF Personnel Responsibilities

- Visiting personnel shall ensure all contact visitors have been searched for contraband prior to entering the facility.
- Visiting personnel shall escort the non-barrier contact visitor to Main Control where they shall exchange their identification card/passport for an escort pass. Visiting personnel shall then escort the visitor to the Century booking area.

- FIP Step Down module personnel shall escort the Merit Master inmates to the Century booking interview room and shall assist with monitoring the thirty (30) minute visit.

NOTE: If additional deputy personnel are required to provide security and monitor the scheduled non-barrier contact visit in the Century booking area, the east tower supervising line deputy/or east tower sergeant shall designate appropriate personnel prior to the visit.

- All non-barrier contact visits shall be documented in the e-UDAL by FIP Step Down module personnel.

LOS ANGELES COUNTY SHERIFF'S DEPARTMENT

CUSTODY FACILITY WAIVER FORM

I, , being at least sixteen years of age, and not a member of the Los Angeles County Sheriff's Department, have made a knowingly and voluntary request to tour the **Century Regional Detention Facility.** I realize that I will be a visitor in the jail facility, and I tour at my own risk. In consideration for permission to tour the jail facility as a visitor, I understand and agree to the following:

1. I may be searched at any time while on jail property, or during or after my tour.
2. I will wear appropriate attire, as determined by the on duty Watch Commander.
3. It is a crime to bring narcotics and/or contraband into a custody facility, or to engage in unauthorized communication with any inmates during the Jail Tour. I shall not bring into the Jail Facility or on my person, any recording devices, including, but not limited to audio tapes or video tapes.
4. In the event that I am taken hostage, by anyone, no inmate will be released as a condition of my safety, and no consideration for my safety will be given to those who have taken me hostage.
5. I may be subjected to the risk of my personal safety or death, and/or damage of my property, and I accept these risks.
6. I agree that the County of Los Angeles, the Sheriff, and all Sheriff Department Employees are not liable for any injury and/or damages I sustain while on jail property, caused by inmates or anyone else.
7. In accompanying a member(s) of the Los Angeles County Sheriff's Department during the Jail Tour, I understand that I may be exposed to unlawful acts of force or violence by inmates upon staff, riot, fire, nudity, explosion, assault, or caustic chemicals.
8. I waive and release the County of Los Angeles, Sheriff, and all Sheriff Department Employees from any and all liability for personal injury, death, and/or damage or loss of my personal property occurring during my jail tour. I also waive and release any claim arising from or related to the negligent act or omission, or alleged negligent act or omission by any member, employee or agent of the Los Angeles County Sheriff's Department. I also waive and release any an all civil rights claims, including but not limited to any claims arising under 42 U.S.C. Section 1983 or 1985, that are based on or in any way predicated on any intentional, deliberate, indifferent, or conscience shocking conduct of any member, employee or agent of the Sheriff's Department, or any inmate or prisoner.
9. I also agree that myself, heirs, executors, administrators, and assigns shall defend, indemnify, and hold harmless the County of Los Angeles, the Sheriff of Los Angeles County, all members, officials and employees of the Los Angeles County Sheriff's Department, their sureties, and each of them, against any and all manner of actions, suits, debts, counts, claims, demands, or damages or liability or expense of every kind and nature, incurred or arising by reason of any actual or claimed intentional, deliberate, indifferent, negligent, malfeasance or wrongful act or omission, arising from, related to, or as a result of my touring any Jail Facility or property, assigned to the Los Angeles County Sheriff's Department, or while accompanying any member or members of the Los Angeles County Sheriff's Department during the performance of their official duties, during my jail tour.

I have carefully read and understand the contents of this document and sign it of my own free will. I also know and understand that I have the right to consult an with attorney before signing this agreement. I also can revoke this agreement at any time before my jail tour begins, but once the jail tour begins, this release cannot be rescinded.

Signature	**CDL or Social Security Number**	**Date**
Signature of parent if a Minor	**Parent's CDL or Social Security**	**Date**
Address, City, State, Zip	**Phone Number**	
	(	
Witnessing Employee or Teacher Signature	**Employee Number**	**Date**

In the event the Jail Visitor is a minor, the witnessing signature may be that of the minor's teacher.

(UTC-08:00) Pacific Time (US & Canada) - Default Tenant | Scheduling | Set Up | Profile | Log Out

Visitation Scheduling
- Create New
- Create New Ad Hoc
- Quick Connect
- Search for Visits

Visitor
- Search
- On Site Check-in
- Internet Check-in
- Check-out
- Warrant Check

Inmate
- Search

Approval
- Inmate List

Reports
- Visitation Schedule
- Visitation Statistics
- Daily Report
- Station Report
- Warrant Report

Live Visits
- Visit Maintenance

Select Date and Time of Visit

Ignore Restrictions Override Inmate Events

Visitation Location

No F

<< March 2024 >>

Sun	Mon	Tue	Wed	Thu	Fri	Sat
25	26	27	28	29	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

Time Block

07:30 AM - 08:00 AM FTF CRDF (EAST TOWER)
08:30 AM - 09:00 AM FTF CRDF (EAST TOWER)
08:30 AM - 09:00 AM CRDF (EAST TOWER)
09:30 AM - 10:00 AM FTF CRDF (EAST TOWER)
09:30 AM - 10:00 AM CRDF (EAST TOWER)
10:30 AM - 11:00 AM FTF CRDF (EAST TOWER)
10:30 AM - 11:00 AM CRDF (EAST TOWER)
11:30 AM - 12:00 PM FTF CRDF (EAST TOWER)
11:30 AM - 12:00 PM CRDF (EAST TOWER)
12:30 PM - 01:00 PM FTF CRDF (EAST TOWER)
03:30 PM - 04:00 PM FTF CRDF (EAST TOWER)
03:30 PM - 04:00 PM CRDF (EAST TOWER)
04:30 PM - 05:00 PM FTF CRDF (EAST TOWER)
04:30 PM - 05:00 PM CRDF (EAST TOWER)
[redacted]

Visitor Station

CRD-E1-02v
CRD-E1-04v
CRD-E1-06v
CRD-E1-08v
CRD-E1-ATT

Inmate Station

CRD-E1-02i

* Face to Face station selected has no recording feature.

Override Quota Quota Information

Cancel Select

MAX HUNTSMAN
INSPECTOR GENERAL

COUNTY OF LOS ANGELES
OFFICE OF INSPECTOR GENERAL

312 SOUTH HILL STREET, THIRD FLOOR
LOS ANGELES, CALIFORNIA 90013
(213) 974-6100
http://oig.lacounty.gov

February 21, 2024

TO: Supervisor Lindsey P. Horvath, Chair
Supervisor Hilda L. Solis
Supervisor Holly J. Mitchell
Supervisor Janice Hahn
Supervisor Kathryn Barger

FROM: Max Huntsman
Inspector General

SUBJECT: **REPORT BACK ON SUPPORT FOR MENTAL HEALTH ASSISTANTS IN FURTHERING THE SUSTAINABILITY AND SUCCESS OF THE FORENSIC IN-PATIENT STEPDOWN UNIT PROGRAM (ITEM NO. 10, AGENDA OF NOVEMBER 21, 2023).**

Purpose of Memorandum

On November 21, 2023, the Los Angeles County Board of Supervisors (Board) passed a motion aimed at providing support for inmate Mental Health Assistants (MHAs) to further the sustainability and success of the Forensic In-Patient Stepdown Program (FIP-Stepdown) at Twin Towers Correctional Facility (TTCF) and Century Regional Detention Facility (CRDF). The motion instructed the Office of Inspector General, in collaboration with the Los Angeles County Sheriff's Department (Sheriff's Department), Correctional Health Services (CHS), and with input from the MHAs, to provide the Board with a report back on a feasibility and implementation plan for providing support to the MHAs. In providing this report, Office of Inspector General Staff spoke with the MHAs at TTCF and CRDF, collaborated with County Counsel, and met with CHS and Department Staff.

Background

As noted in the Board motion, the FIP-Stepdown program is currently supported by MHAs, who are themselves incarcerated, working with people in custody who have complicated and severe mental health needs. The MHAs are volunteers who provide peer support, education, and motivation to engage in daily activities with the goal of

imparting skills aimed at achieving medication compliance, independence, and self-sufficiency for those persons in our jails with significant mental health challenges.[1] The Board and the United States Department of Justice have recognized the formation and expansion of the FIP-Stepdown program as a commendable action the Sheriff's Department has undertaken to provide therapeutic housing to severely mentally ill people in the Department's custody.[2] The MHAs are integral to the success of the program, as they provide necessary peer support to patients living within the FIP-Stepdown module.

Presently, the Sheriff's Department uses 13 MHAs incarcerated at TTCF and 10 MHAs incarcerated at CRDF. These MHAs live in FIP-Stepdown pods with patients, where they work to develop the patients' pro-social behavior through teaching life skills, encouraging the patients to take psychiatric medication and engage in programming, and providing meaningful peer support. As volunteers, the MHAs receive limited benefits for providing support in a challenging and physically demanding environment. The Board's motion to provide additional support to the MHAs who, in turn, provide support to people in custody suffering from mental illness, will enhance sustainability in the FIP-Stepdown program.

Additional Support for MHAs. In interviews, both MHAs and Sheriff's Department staff identified as a priority an additional source for support for MHAs not specifically mentioned in the Board's motion: dedicated, full-time custody personnel staffing for FIP-Stepdown, preferably in a dedicated unit.

Dedicated staff for FIP-Stepdown modules. Assigning full-time dedicated staff to ensure continuity between program administration and oversee day-to-day program operation would be instrumental in ensuring that the MHAs receive the support outlined in the Board motion. The Sheriff's Department reports that it has assigned specific staff to both the AM and the PM shift in all FIP-Stepdown modules. However, due to staffing shortages, the Department often rotates deputies through the facility to provide coverage to areas that need additional deputy staff, resulting in deputies staffing the FIP-Stepdown modules who do not have any prior experience with the program. The MHAs report that this inconsistent staffing impacts the functionality of the program.

---

[1] MHAs created their own training curriculum and use that to inform new MHAs of their approach to assisting the patients who are assigned to the unit.

[2] *See* Board Motion, *Supporting the Expansion of FIP Stepdown and HOH Dorm Units the Los Angeles County Jails*, (June 27, 2003); Monitor's Fifteenth Report, *United States. v. County of Los Angeles*, No. 15-05903 (C.D. Cal., July 17, 2023).

Rotating deputies often do not understand MHAs' unique role and therefore do not allow the MHAs the autonomy necessary to provide peer support to the patients within the pod, do not provide the MHAs with the benefits they receive as compensation for their role, and, in some instances, even mistake the MHAs for inmate trustees charged with providing janitorial support throughout the facility. Assigning permanent staff would both protect MHAs' role and benefits and also foster rapport between the assigned pod deputy, the assigned pod MHA, and the patients living within the pod. The Sheriff's Department reports that it will conduct briefings with facility staff to ensure that all deputies understand the operation of the FIP-Stepdown program in the event staffing needs require that they work in a FIP-Stepdown module. While these briefings will be helpful, they do not address the problems caused by the lack of continuity in deputy staffing.

Creating a unit for FIP-Stepdown. Assigning a single departmental unit to run and oversee the FIP-Stepdown program for the units at both CRDF and TTCF would provide the infrastructure necessary to ensure consistency of programming at both facilities. With the rapid expansion of the program, many Sheriff's Department staff and MHAs in the newer FIP-Stepdown units require additional training to be effective collaborators. For example, despite conducting two virtual training sessions with the seasoned TTCF MHAs in 2022, MHAs at CRDF have not received any additional or ongoing training from the MHAs at TTCF. The Sheriff's Department indicated that it would facilitate providing virtual training to the MHAs at CRDF but have not yet done so. MHAs at CRDF stress that training and mentorship from the TTCF MHAs is necessary to provide guidance on successfully managing the challenges inherent within their role. In addition to the lack of training, the MHAs at CRDF report that they also struggled to receive training materials, therapeutic living supplies, and incentives necessary for their role. Similarly, Department staff assigned to newer FIP-Stepdown units have requested training from experienced staff at established FIP-Stepdown modules to learn more about the operation and their role within this unique environment.

Unit-level oversight would facilitate peer-training opportunities and create relationships among staff at the expanding programs to ensure that all FIP-Stepdown units practice the same concepts, while also meeting the more individualized needs of patients and MHAs. Because the Sheriff's Department's sworn personnel are subject to promotion and rotation, the Office of Inspector General recommends that the Sheriff's Department assign a civilian employee position to oversee the custody supervision component of the program in order to maintain consistency between programs and to safeguard benefits afforded to the MHAs, who are general population inmates.

CHS Clinical Staff for FIP-Stepdown. Assigning a CHS clinical staff position to the FIP-Stepdown units would provide the MHAs with an on-site and available clinician to provide patient support. The flagship FIP-Stepdown module previously employed a psychiatric technician who provided support and ensured a stable line of communication between CHS providers, MHAs, and the patients. The MHAs have described this individual as essential to the program and indicated that having a psychiatric technician assigned to each FIP-Stepdown module provided effective support and expertise.

CHS reports that, while it has eight open psychiatric technician positions (with one new hire scheduled to start in February 2024), it has encountered challenges recruiting people to fill them due in large part to a national shortage of mental health workers and difficulty finding candidates willing to work in a jail environment. However, CHS reports that, while it will continue to recruit psychiatric technicians to be assigned to FIP-Stepdown modules, it is pivoting to using Mental Health Supervisors for oversight and support of the FIP-Stepdown Program. CHS has not indicated whether using Mental Health Supervisors will present similar staffing issues due to mental health worker shortages or what effects the change may have on the nature and quality of the support for the FIP-Stepdown program.[3]

Provision 1.a.

Provision 1.a. of the Board motion directs the Office of Inspector General, in collaboration with the Department, CHS, and with input from the MHAs, to provide the Board with a feasibility and implementation report back on providing incentives such as wages, food, and time credits for the MHAs.

Wages

The MHAs state that earning wages as compensation for their role would provide the strongest support, allowing them to achieve some financial independence. California Penal Code section 4019.3 provides that a county may provide credit to each prisoner confined in or committed to a county jail with a sum not to exceed two dollars ($2) for each eight hours of work within the jail. The Sheriff's Department does not currently provide monetary compensation to any inmate workers and reports that it lacks available funding as well as a proper mechanism to provide wages to the MHAs.

[3] CHS reports that these positions are filled currently. However, OIG is concerned that given persistent staffing issues there remains the possibility of future staffing shortages.

Food

The Sheriff's Department recognizes that inmate workers require increased caloric and nutritional intake based on the physical demands associated with their work. MHAs similarly report that "[h]ealthy hot meals and snacks are imperative to health, longevity, and efficient performance,"[4] especially considering that they assist with mental health crises in addition to their daily schedule of caring for and supporting the FIP-Stepdown patients.

The Department's Food Services Unit (FSU) serves three meals daily to people in custody in Los Angeles County jails and provides incentive meals to eligible inmate workers. Presently, MHAs at TTCF and CRDF receive one hot incentive meal for lunch daily and access to snacks, such as cookies, muffins, and chips. FSU reports that it plans to begin serving two hot incentive meals and healthy, high protein snacks to the MHAs by March 1, 2024. Program patients also have access to snacks, which the MHAs distribute.

FSU staff met with MHAs at TTCF and CRDF several times seeking suggestions on types of food incentives and for the MHAs to taste test some potential new products. MHAs requested of FSU an increase in the number of hot incentive meals from one to two per day as well as access to more nutritious snacks, specifically, higher-protein foods and fresh produce. They also requested access to condiments, like hot sauce, sugar, salt, ranch dressing, and BBQ sauce.

FSU reported that, at the program's current size, it can facilitate an increase to two hot incentive meals per day for MHAs at CRDF and TTCF. Readymade 'TV dinner' meals may also be used to supplement or alternate as a hot incentive meal option for lunch or dinner. FSU created three tiers of proposed snack items to pilot that would improve variety and nutrient diversity. Examples of expanded snack options are protein bars, protein shakes, yogurt, tuna/chicken salad with crackers, string cheese, jerky, almonds, pretzels, hummus, and sliced/dried fruit. Two snack items would be supplied to each MHA daily with a rotating menu each week. At least one of the snack options would be primarily protein-based.

One of the most significant hurdles FSU faces with providing food incentives is modifying current food contracts to allow for the procurement of more nutrient-dense,

[4] This quote was taken from written materials provided by the MHAs at TTCF as part of their collaboration with the Office of Inspector General in response to the Board motion.

less processed foods, with a particular focus on protein-rich foods and fresh produce. FSU currently maintains more than 30 food contracts, which allow the purchase only of specific foods. While FSU can purchase items off-contract, it does so at significantly increased costs. However, FSU reports that the additional costs may be offset by reduced food waste. County procurement policies present additional limitations on food-service providers, but most FSU contracts will expire over the next three years, giving the Department an opportunity to ensure new contracts have options for more healthful and appetizing foods. FSU already revised menus at the start of 2024 to reflect some contractual changes and plans at least two more menu revisions for this fiscal year. While supply chain issues are not as significant as during the pandemic, FSU still experiences the unavailability of or delay in receiving certain products, which could impact incentive availability and rotational options.

Labor shortages have also posed a major challenge to FSU. With fewer staff and kitchen trustees, FSU has had to rely on more pre-packaged and processed foods, due to their ease of service. Staffing and kitchen trustee shortages, if they continue, could impact the ability of FSU to fulfill hot incentive meals and snack requests. This risk is greatest at CRDF, where staffing shortages have already resulted in delays to snack orders and FSU cancelling hot meal incentives for a day or even a week. To avoid these problems, FSU requires funding to modernize its kitchen equipment to allow the Department to prepare hot meals for incentives with fewer staff.

While the focus of this report back as it relates to food is on incentives for the MHAs, the MHAs often share food with program participants, sometimes by combining various snacks into treats (e.g., using bananas, muffins, and milk to make banana milkshakes at CRDF). FSU therefore recommends all MHAs complete the basic ServSafe Food Handler course to help ensure MHAs follow food safety principles in order to minimize foodborne illness within the units. This also provides an educational opportunity as the certification is used in the hospitality industry and is valid for three years. FSU reports that it will provide the ServSafe Food Handler course to the current MHAs this quarter and will provide the ServSafe Food Handler course to future MHAs on a quarterly basis.

FSU has expressed concerns that food incentives may lead to allergic reactions and interfere with special diets. FSU estimates that about one-third of MHAs and FIP Stepdown participants have a special diet, due to food allergies, caloric needs, and medical issues (e.g., low sodium for heart or renal conditions). FSU can only provide hot incentive meals and snacks in bulk to the FIP-Stepdown modules and cannot cater the meals and snacks to the medical or religious needs of each MHA or the program

participants with whom MHAs may share their food. There are also concerns that the incentive meals and snacks together with daily meals exceed the recommended daily caloric intake. FSU is working with CHS staff and dieticians to address allergen and caloric concerns.

Finally, the Sheriff's Department states that providing enhanced food incentives presents funding challenges. Currently, the Department's budget contains no line-item budget set aside to support the FIP-Stepdown program MHAs or program participants, and high-quality snacks are significantly more expensive than the cost of the average single meal. With the program at CRDF and TTCF projected to expand, these costs are expected to rise. Of course, the Sheriff's Department could prioritize funding these incentives for MHAs over other current priorities, especially if FSU obtains some cost offset from less food waste as it reported.

Provision 1.b.

Provision 1.b. of the Board motion directs the Office of Inspector General, in collaboration with the Department, CHS, and with input from the MHAs, to provide the Board with a feasibility and implementation report back on partnering with an academic/institutional partner to provide MHAs with a certification program for future employment or academic pursuits.

Certification Program

The MHAs expressed interest in working with an academic provider to receive additional training to support their role and to obtain credentials necessary to secure post-incarceration employment. Gender Responsive Services (GRS), the unit that oversees educational and rehabilitative services at CRDF (similar to Education Based Incarceration (EBI) at TTCF, Men's Central Jail, Pitches Detention Center (PDC) East , PDC North, PDC South, and North County Correctional Facility), conducted preliminary research to determine what certifications align best with the MHAs' role and provide the strongest opportunity for post-release employment. GRS found that several certification programs would provide the MHAs with supportive education, although some require licensure that the MHAs' criminal histories would preclude.

GRS identified the CalMHSA Medi-Cal Peer Support Specialist Certification and a Drug and Alcohol Counselor Certification as the certifications most consistent with the support that the MHAs provide in FIP-Stepdown. The MHAs' criminal histories would not preclude them from obtaining employment as a Peer Support Specialist or a Drug and

Alcohol Counselor. Moreover, the MHAs' lived experience enhances their candidacy for employment in conjunction with either of these certifications. Medi-Cal recognizes Peer Support Specialists and Drug and Alcohol Counselors as billed providers, so they are common positions that could provide the MHAs with employment opportunities in the community upon release.

The Sheriff's Department has worked jointly with the CHS Mental Health Director to implement a Peer Support Specialist Certification Program for the MHAs. Volunteers associated with Tarzana Treatment Centers College (TTCC) already help to support the MHAs with training. The Department recognized that it could formalize that training with TTCC to provide MHAs with a Peer Support Specialist Certification, with course materials provided by Prism Way and with outside funding from California Department of Health Services through Continuity Consulting. TTCC is in the process of completing a Request For a Statement of Interest (RFSI), subject to the Department's review and approval, to formally provide the Peer Support Specialist Certification to the MHA.

In an effort to find additional providers, CHS reached out to all agencies approved to provide a Peer Support Specialist Certification in Los Angeles and held a meeting with eleven agencies that expressed an interest in providing the certification on January 31, 2024, where it directed all agencies interested in providing the Peer Support Specialist Certification at no cost to the Sheriff's Department to submit an RFSI.

The Sheriff's Department and CHS report they will continue to explore providing the MHAs with a Drug and Alcohol Counselor Certification. This certification requires an internship, in which each MHA would need a clinical supervisor to oversee their work and provide one hour of individual clinical supervision per week. To provide the MHAs with this certification, CHS would require budgeting an additional staff member to act as a clinical supervisor for the MHAs.

The Sheriff's Department has identified a TTCF Lieutenant to act as an interim Project Director but is still working to identify a Project Manager and additional staff, which the Department states will require additional funding.

Furthering Academic Education

Office of Inspector General staff connected with the Center for Engagement, Service, and the Public Good at California State University, Los Angeles (Cal State LA). This institute operates Project Rebound, which provides baccalaureate education to justice-impacted people in CDCR custody and assists formerly incarcerated students in

matriculating and graduating from Cal State LA. The Project Rebound Director met with several of the MHAs to discuss the opportunity for involvement with the program, both in CDCR and within the community, and volunteered to provide individual college counseling for each MHA.

Although EBI reported connecting with a local college, it did not provide additional information on the feasibility and implementation of providing post-secondary education to MHAs.

GRS currently provides limited educational opportunities to the MHAs at CRDF. For example, many MHAs at CRDF participate in college courses, life skills classes, and therapeutic activities. Due to scheduling conflicts, these offerings are not as robust as the opportunities available to students living in the educational modules. GRS reports that an analysis is underway to determine additional programs and services that may be of interest to the MHAs at CRDF and how technology could be leveraged to expand the breadth and depth of services.

Provision 1.c.

Provision 1.c. of the Board motion directs the Office of Inspector General, in collaboration with the Department, CHS, and with input from the MHAs, to provide the Board with a feasibility and implementation report back on providing consistent, frequent, and longer contact visits for MHAs to meet with family and friends.

The MHAs reported that "[contact] visits are . . . the strongest forms of support and care [the MHAs] currently receive."[5] For approximately the past two years, the MHAs at TTCF have received one 30-minute contact visit with two attendees per month. As a result of this Board motion, the Sheriff's Department likewise approved providing the MHAs at CRDF with one 30-minute contact visit with two attendees per month.

To reduce strain on the Sheriff's Department resources, the MHAs at TTCF have suggested communal visits, where several MHAs conduct their visits in a larger space. The MHAs propose that this allows for the MHAs to engage in longer visits, provide a space for MHAs and family members to offer community support, and reduce Department staffing constraints, as deputies currently transport individual MHAs to a

[5] This quote was taken from written materials provided by the MHAs at TTCF as part of their collaboration with the Office of Inspector General in response to the Board motion.

distant area in TTCF for their visits. This visiting structure mirrors that provided at CDCR, where visits generally occur in communal spaces. The Sheriff's Department reports that it has neither the space nor the infrastructure to conduct communal visits at TTCF.

The Sheriff's Department reports that it does have the resources to increase the number of 30-minute contact visits for each MHA from one per month to two per month and will begin providing the additional visits in March. The Department also reports that these contact visits remain subject to staffing levels.

Current Sheriff's Department unit orders establish that only parents, grandparents, and children are permitted to engage in contact visits. Several MHAs have reported close familial relationships with extended family members, such as nieces and nephews. The Department has indicated that it will revise this unit order, but it is unclear whether the unit order revisions will simply allow a greater number of family members at each visit or whether it will allow extended family to participate in contact visits. Similarly, several MHAs have unmarried romantic partners, and the Department has not indicated whether the policy revisions would allow partners, girlfriends, boyfriends, or fiancés to participate in contact visits. The Sheriff's Department definitively rejected the suggestion that MHAs be permitted to engage in contact visits with friends due to security concerns, despite departmental screening of all visitors prior to contact visits.

Several of the MHAs do not have family members who live locally or are able to attend contact visits. Because of this, the Sheriff's Department indicated a willingness to facilitate virtual visits for MHAs using the Inmate Video Visitation System (IVVS) that is currently used for video tele-conferencing visits. The Department reports it requires additional resources within the Correctional Innovative Technology Unit to schedule these visits.

Provision 1.d.

Provision 1.d. of the Board motion directs the Office of Inspector General, in collaboration with the Department, CHS, and with input from the MHAs, to provide the Board with a feasibility and implementation report back on providing mental health, wellness, and self-care support for MHAs.

Mental Health

MHAs currently meet individually with a volunteer from the Prism Way, who they report is instrumental in supporting their mental health. CHS reports that it could also assist in

providing mental health support to the MHAs through one-on-one counseling services with CHS interns and group meetings under a CHS Mental Health Clinical Supervisor.

Currently, CHS supervises nine psychology students from The Chicago School of Professional Psychology (CSPP) who are completing their practicum (second year internship). While the students' primary role has been to administer support groups to people in custody with mental illness, they have expressed an interest in opportunities to provide one-on-one treatment. These psychology students come from a forensic specialization within their Doctor of Psychology (PsyD) program that focuses on practice within the legal system, including with justice-involved individuals. To implement this program, each student will be matched with one to three MHAs to provide treatment. Based on availability and interest of the MHA, this treatment may be weekly or biweekly. Students providing treatment will each attend one-on-one supervision with a CHS Supervising Psychologist and engage in group supervision every other week. CHS anticipates that this program will be fully implemented in February 2024. Though the students' internship is completed at the end of the academic year, CHS is pursuing Supplemental Site status with CSPP to allow students to continue through the summer to gain required hours for their degree and provide continuity in treatment for the MHAs. CHS staff are currently interviewing students for Fall 2024, when this partnership will continue.

In addition to this one-on-one treatment, each facility will assign a Mental Health Clinical Supervisor to oversee and provide support to the MHAs. The supervisor will hold weekly meetings with the MHAs to address concerns or needs that might arise.

Wellness

The MHAs have reported that having access to proper gym equipment, including safe weights, resistance bands, and exercise machines, would help them achieve their health and wellness needs and provide stress-relief from the demands of their role. The MHAs also expressed interest in participating in health and wellness classes, namely yoga, with volunteer fitness providers.

The Sheriff's Department proposed purchasing an air strider elliptical, an elliptical cross trainer, and an exercise bike from Ripco & Associates, which manufactures institutional fitness equipment for correctional facilities. The Department states that it will not allow the MHAs access to soft weights, including slam balls and soft medicine balls, due to safety concerns. The Department will allow the MHAs access to resistance bands if they are secured and accounted for when not in use. The Department reports that it requires

funding to purchase and install exercise equipment, and that it would facilitate a Memorandum of Understanding (MOU) for fitness providers who are interested in volunteering within the facilities. EBI reports that it plans to secure a fitness provider to facilitate fitness classes with the MHAs.

The MHAs also report that their role requires heightened levels of physical activity, due to being on their feet for a substantial part of the day. Presently, the Sheriff's Department provides people in custody with plastic slippers, which also serve as shower slippers. While many of the MHAs can purchase institutionally approved sneakers, several of the MHAs are indigent and therefore do not have proper supportive shoes. The Office of Inspector General discussed this concern with an Assistant Sheriff, who indicated that the Department will not provide the MHAs with institutionally approved supportive shoes without additional funding.

Self-Care

The flagship FIP-Stepdown module in TTCF provides FIP-Stepdown Patients, MHAs, and Department staff with a clean and therapeutic environment. In this module, the Sheriff's Department replaced steel institutional fixtures with correctional furniture, allowed MHAs and patients to adorn the walls with art, and provided MHAs and patients access to books and games. The MHAs report that this environment provides a more therapeutic living space for them and the patients and recommend mirroring the flagship FIP-Stepdown environment in the expanded FIP-Stepdown modules. The Board likewise recognizes that "colorful paint, murals, aquariums, soft furniture, plants, and activity tables," serve as "key therapeutic elements [creating] a therapeutic physical space."[6] The Sheriff's Department reports that it ordered furniture for the additional FIP-Stepdown modules, and that it will supply the additional FIP-Stepdown Pods with plants, herb gardens, and institutionally safe pets (fish and turtles). The Department reports that some supplies were already ordered but that it requires additional funding to purchase ancillary therapeutic elements such as plants, herb gardens, and fish.

The MHAs report that access to basic hygiene supplies, including shampoo, soap, deodorant, and lotion, would support self-care goals for both them and the patients in the program. The MHAs explain that the stigma associating mentally ill people with a lack of hygiene negatively impacts the patients within the FIP-Stepdown program, so

[6]See Board motion: *Supporting the Expansion of FIP Stepdown and HOH Dorm Units at the Los Angeles County Jails* (June 27, 2023)

that MHAs emphasize hygiene and self-care to patients within the program and encourage hygienic practices and healthy habits in the FIP-Stepdown curriculum.

Sheriff's Department policy generally requires that people in custody supply themselves with personal care and hygiene items through the commissary, unless they are indigent.[7] Indigent people in custody who are unable to purchase personal care and hygiene items through the commissary are to be "provided the needed item upon request" from module officers, who are responsible for ensuring that "personal care items are available for distribution upon request."[8] If a person in custody requests hygiene supplies from the Department, the cost of the hygiene supplies is automatically deducted from the person's account once money is added to their account. Additionally, although the Department distributes a toothbrush, toothpaste, soap, shampoo, a comb, shaving implements, and deodorant,[9] people in custody report that distributed products are ineffective. Thus, in practice, the MHAs often share their own hygiene supplies with the patients within the program. The Department has historically supported volunteers who have distributed hygiene products to the FIP-Stepdown program at CRDF. The Department reports that it requires additional funding to distribute additional hygiene products to MHAs for distribution to the FIP-Stepdown patients.

Provision 1.e.

Provision 1.e. of the Board motion directs the Office of Inspector General, in collaboration with the Department, CHS, and with input from the MHAs, to provide the Board with a feasibility and implementation report back on providing rotational scheduling for Mental Health Assistants for respite from their responsibilities and duties, including increasing the number of MHAs to achieve this.

In addition to providing daily programming opportunities to patients within FIP-Stepdown, the MHAs' stay on-call at all times to respond to patients within their living pod experiencing a crisis. The Sheriff's Department reports that, to prevent the MHAs from being over-utilized, it will implement a schedule limiting programming hours from 8:00 am to 11:00 am and 2:00 pm to 4:00 pm each weekday. The Department

---

[7] Per Los Angeles County Sheriff's Department Policy, "[a]n inmate shall be considered indigent if he has less on account with the cashier than the standardized established price needed to purchase an indigent [hygiene] kit." *See* Los Angeles County Sheriff's Department, *Manual of Policies and Procedures,* 5-13/080/00, "Indigent Inmates."

[8] *See* Los Angeles County Sheriff's Department, *Manual of Policy and Procedures,* 5-13/090.00, "Personal Care Items and Supplies for Inmates."

[9] *See* Los Angeles County Sheriff's Department, *Manual of Policy and Procedures,* 5-13/090.00, "Personal Care Items and Supplies for Inmates."

additionally proposed an on-call rotational schedule, to provide coverage while allowing MHAs with periodic days off when they would not be on call.

It is essential that the Sheriff's Department recruit additional MHAs to provide on-call coverage to give MHAs a day off from assisting with a response to a patient crisis. The Department stated that it has circulated an MHA recruitment video across facilities to increase interest in volunteering in the program but did not provide any more specific information on an MHA recruitment plan, nor did the Department state how many persons in custody were shown the recruitment video.

Provision 1.f.i.

Provision 1.f.i. of the Board motion directs the Office of Inspector General, in collaboration with County Counsel, to include a feasibility and implementation plan for MHAs who decide to complete their prison sentences in county jail to be allowed to serve in their role and be able to receive CDCR credits for early release. County Counsel is providing its own report to the Board regarding the feasibility of MHAs remaining in county jail to complete their prison sentences. Current laws and regulations do not allow for persons sentenced to state prison to earn the same credits that accelerate their release date from state prison while housed in a county facility. We refer the Board to the report being provided by County Counsel for an overview of the program, laws that govern it, and the specifics on overcoming the challenges presented by current statutes and regulations.

Provision 1.f.ii.

Provision 1.f.ii. of the Board motion directs the Office of Inspector General, in collaboration with County Counsel, to include a feasibility and implementation plan for expansion of the County's partnership with CDCR to grant MHAs access to CDCR resources, such as the Parole Board and counselors, especially for those who have some level of involvement with CDCR, e.g.: serving a prison sentence or appealing a sentence. County Counsel is providing its own report to the Board regarding the feasibility of expanding the County's partnership with CDCR to provide MHAs access to CDCR resources while MHAs are housed in county jail. The Office of Inspector General has coordinated with the Sheriff's Department and the Board of Parole Hearings to provide virtual parole hearings for persons housed in the county jail at the time of their scheduled parole hearing. However, CDCR reported it does not have a system for providing CDCR resources or case counselors to people in local jail facilities. We refer the Board to the report being provided by County Counsel for the specifics on overcoming the challenges presented by current statutes and regulations.

Provision 2.

Provision 2. of the Board motion directs the Chief Executive Office in collaboration with OIG, Sheriff and DHS-CHS to report back, in writing, during the Fiscal Year 2024-25 Final Changes Budget, on the fiscal impact and potential funding sources for subsections a-f, including the use of AB 109 funds and other sources. Other than indicating that its current budget is insufficient to provide the incentives discussed in this report, the Sheriff's Department did not provide the Office of Inspector General with cost estimates for any of the incentives. For some of the incentives, the cost would appear to be something that the Sheriff's Department could decide to prioritize.

c: Robert G. Luna, Sheriff
Fesia Davenport, Chief Executive Officer
Jeff Levinson, Interim Executive Officer
Dawyn R. Harrison, County Counsel
Tim Belavich, Director, Correctional Health Services
Sharmaine Moseley, Executive Director, Sheriff Civilian Oversight Commission