COUNTY OF LOS ANGELES

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FROM: Haley Broder
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SUBJECT: **2024 ANNUAL REPORT AND RECOMMENDATIONS ON THE LOS ANGELES COUNTY JAILS HUMANITARIAN CRISIS[1]**

In 2024, the County of Los Angeles (County) Sybil Brand Commission's (Commission) Commissioners conducted inspections of 26 county correctional facilities, court lockups, and sheriff substations. The inspections spanned multiple facilities, including Men's Central Jail (MCJ), Twin Towers Correctional Facility (TTCF), Century Regional Detention Center (CRDF), Inmate Reception Center (IRC), and Pitchess Detention Center (PDC). These inspections identified endemic systemic failures affecting the health, safety, and dignity of incarcerated individuals that have been a feature of the conditions of confinement in county jails for decades, but which demand immediate and decisive action from the County and its Sheriff's Department (Sheriff Department).

Key findings include:

- Severe medical neglect compromising inmate health and safety
- Systematic nutritional deficiencies
- Widespread sanitation and infrastructure failures
- Critical mental health care shortcomings
- Significant safety and staffing challenges

[1] All information in this report is based on findings from Sybil Brand Commission inspections, including discussions with those incarcerated at Los Angeles County Jail Facilities.

- Alarming increase in inmate deaths with racial disparities

The depth and consistency of these issues indicate system-wide failings that extend far beyond isolated incidents. This annual report outlines the patterns of ongoing problems we have consistently documented through our inspections.

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1. Deaths

There has been an alarming number of jail deaths, with 32 fatalities in 2024. A disproportionate number of the deaths were Black and Latino/a individuals, suggesting potential disparities in medical treatment or facility conditions.

In addition, the County Jail system experienced a widespread drug overdose crisis in the last quarter of 2024. A significantly increased number of men who died in the custody of the Sheriff's Department did so as a result of a drug overdose.

Cause-of-death data indicates multiple overdose incidents, pointing to insufficient contraband controls and inadequate supervision. While the Sheriff's Department responded to this acute crisis of drug overdoses by increasing the monitoring of civilians entering the jails, they have consistently refused to engage in increased screening of the Sheriff Deputies in a manner closer to that of those incarcerated.

The County's labeling of deaths remains opaque and inadequately explained to the public and the Commission. Several deaths classified as "natural" involved individuals under age 50, warranting further investigation into the quality of preventative care and medical response protocols. Finally, the Sheriff's Department and County Counsel consistently refuse to provide the Commission with the Corrective Action Plans that detail the nature of any death and the steps that the Sheriff's Department and Correctional Health Services proposes to take to address any shortcoming in health and safety that they identify. In that way, the Commission is unable to do its job to inspect the jails for positive changes made as follow-up to Corrective Action Plans. With limited oversight on deaths, there is little besides "thoughts and prayers" being done or shared.

2. Building Issues

The adequacy of the County Jails as adequate for human habitation varies across the different jail buildings. Environmental conditions within the facilities present serious health hazards. The Pitchess Facilities—North County Correctional Center, North, and South—are generally clean and well maintained, although the Commissioners still noted problems with these facilities. The women's jail, Century Regional Detention Facility, has more shortcomings than the Pitchess jails. However, by far the worst facilities are the three downtown jails, Men's Central Jail, Twin Towers Correctional Facility, and the Inmate Reception Center. All of these suffer from dysfunctional plumbing, poor maintenance, and dirty cells. The Commissioners have repeatedly documented widespread mold on cell walls and ceilings, shower areas, and communal spaces across multiple facilities, along with insect and rodent infestations in cells and eating areas.

Men's Central Jail is, however, by far the worst. Men's Central Jail is a disintegrating and poorly maintained building. As early as 2014, the Department of Justice described the living conditions at Men's Central Jail as "deficient (dimly lit, vermin-infested, noisy, unsanitary, cramped and crowded) …and create an environment that may contribute to prisoners' mental distress." Letter from U.S. Department of Justice, Mental Health Care and Suicide Prevention Practices at Los Angeles County Jails (June 4, 2014).

According to the September 3, 2015, Joint Settlement Agreement Regarding the Los Angeles County Jails; and Stipulated Order of Resolution entered into by the Department of Justice and Los Angeles County before Judge Dean Pregerson, "the County and the Sheriff will have written housekeeping, sanitation, and inspection plans to ensure the proper cleaning of, and trash collection and removal in housing…areas, in accordance with California Code of Regulations ("CCR") Title 15 § 1280: Facility Sanitation, Safety, and Maintenance." Title 15 is, however, somewhat vague. Section 1280 requires written policies and procedures that "shall provide for a regular schedule of housekeeping tasks and inspections to identify and correct unsanitary…conditions."

Despite the last decade of warnings and litigation, the problems of dimly lit, vermin-infested, noisy, and unsanitary conditions with inadequate trash collection and removal in housing dorms, last year this Commission reported to the County Board of Supervisors (Board of Supervisors) its "alarm[] and frustrat[ion] with the regularity with which it finds unsafe, inhumane, and unsanitary conditions in the jails. The recurrence of issues after this Commission brings them to the attention of responsible parties at the Sheriff's Department is evidence of problems not being adequately addressed…The Sheriff's Department's failure to maintain a sanitary facility and to conduct regular inspections of its facilities for sanitary conditions reflects an administrative orientation with a limited commitment to upholding basic values." Los Angeles County Sybil Brand Commission for Institutional Inspections Report & Recommendations on the Los Angeles County Jails Humanitarian Crisis July 2023".

Clearly, the system of relying on trustees and outside contractors to clean Men's Central Jail abjectly fails to ensure sanitary conditions in those areas of the jail occupied by incarcerated men. LASD does keep the areas of the jail occupied by Sheriff Deputies and civilian staff clean. The rest of the jail requires a concerted and consistent effort to bring up to even minimal standards of cleanliness. Since at least 2014, various groups including the Department of Justice, the Central District of California, the American Civil Liberties Union (ACLU), and the Commission have pointed out the severe, prolonged lack of sanitation in Men's Central Jail. We note that federal law establishes such conditions "constitute an infliction of pain within the meaning of the Eighth Amendment." Johnson v. Lewis, 217 F.3d 726, 731 (9th Cir. 2000)

The Board of Supervisors has acknowledged the need to close Men's Central Jail, and had planned to do so by 2024. The County's continued willingness to house human beings in Men's Central Jail is inhumane and a hazard to their physical and mental health.

Men's Central Jail

Door and lock mechanisms have failed in multiple locations, creating potential security risks. The October 2024 inspection of MCJ documented occupied cells with "doors…getting stuck" and "concerns about doors not shutting fully and concerns about attacks on deputies being possible due to open cells."

Inspections of Men's Central Jail consistently report a congenital failure to assure adequate plumbing, resulting in water that is on some occasions too hot to drink and on

other occasions too cold to shower, or no water at all. The men in multiple locations around the facility cannot use urinals because flushing causes flooding in toilet areas. Toilets do not flush, multiple modules have only a fraction of showers operational, and those that do work, constantly drip.

Cleanliness, Rats and Other Vermin

Commissioners repeatedly reported hazardous sanitary conditions that were consistently terrible across the facility on their inspections of Men's Central Jail. The cells, dorms, and communal areas (unlike the areas occupied by LASD Deputies and staff) are regularly disgusting, with dust coating the air vents, debris on the ground, mildew and mold on the sinks, showers, and even the mattresses. Rodent infestations are a persistent problem. The conditions were so concerning that "many of the men had pasted plastic over their vents to prevent rats entering. On one visit, "the rats audibly move[d] when the men bang on the toilet and back behind cells; roaches come out of the drain" which the Commissioners observed. Some had placed bottles across the front of the cells to alert them should a rat try to enter." In addition, Commissioners have observed on multiple visits that County Jail officials have placed rat traps in corridors and eating areas.

Many of the men incarcerated in Men's Central Jail complain of cockroaches and biting spiders that leave lesions requiring medical attention. Commissioners have observed cockroaches in the cells and such bite marks. In various locations around the jail, but in particular in the 2000 floor, men incarcerated in the modules suffered from insect bites that have been reported to the LASD multiple times.

Commissioners found sanitary conditions that clearly violate the Board of State and County Corrections Code, Title 15, § 1245. Kitchen Facilities, Sanitation, and Food Storage requires that "food preparation, service, and storage shall comply with standards set forth in Health and Safety Code, Division 104, Part 7, Chapters 1-13, Sections 113700 et seq. California Retail Food Code." Commissioners' inspections of Men's Central Jail have consistently found the Mess Hall littered with food scraps on tables and chairs around the Hall, and piles of food in crates around the hall surrounded by swarms of flies. Food is served often cold, and Commissioners have observed mold on freshly served items.

Mold and Air Quality Issues

Dampness from the showers spreads into the living area and contributes to the mold issues. Some showers are on constantly, never being shut off. Multiple modules have showers that are moldy and drains that are clogged. These issues increase the mental strain on those in the jail, undermining their health, safety, and security as well as the security of the Deputies who have to respond to constant complaints and frustration with the facility.

Commissioners were particularly concerned by air quality issues. In general, moldy conditions contribute to respiratory problems. In addition, Commissioners continue to

observe a clear smell of smoke throughout the jail whenever they visit. With no windows and poor circulation, the smoke renders the air quality very poor.

In June 2023, the Commissioners witnessed fires in cells and brought the issue to the attention of the Sheriff's Department in hopes they would take steps to ensure the safety of people incarcerated and working inside of Men's Central Jail. In our visits in 2024, the men in the County Jail told Commissioners that the fires were often used to heat food and to keep warm because of poor conditions (cold food and cold temperatures). Commissioners discovered that LASD has not done anything to address the issue of fires in the jail except to take away batteries from those locked up in the jail except a few people in the 1700 and 1750 units. Everywhere else, the men get very limited out of cell time and the batteries for their "radios" or MP3 players, and which also provides a channel that enables them to listen to the television. Their radios are one of the few things they can purchase to help with their mental health by providing music and entertainment while they are confined in their cell. Without batteries they are useless.

There are a variety of actions that could have been taken to ensure that fires were dealt with: frequent inspections should disclose the source of fires; providing food heaters (and warm food) and extra blankets are other options. LASD's response appears to have been taken as a form of laziness or retaliation for the Commissioners' report about the fires (which was also reported in the Los Angeles Times). This does not solve the fire issue, which Commissioners continued to observe and smell in 2024.

Mattresses and Linens

Title 15, Section 1271 requires that each man in the jail receive "one serviceable mattress which meets the requirements of Section 1272 of these regulations…Washable items such as sheets, mattress covers, and towels shall be exchanged for clean replacement at least once each week." Section 1272 requires that "Any mattress issued to an inmate in any facility shall be enclosed in an easily cleaned, non-absorbent ticking." In addition, the ACLU has an ongoing consent decree from a federal lawsuit, bedding and clothing, Rutherford v. Pitchess (1978) to ensure adequate bedding for the men incarcerated in the County jail system.

The Sheriff's Department fails to meet the minimum bedding provisions standards. Many mattresses lack proper plastic covers or have severely damaged covers. In some Modules, the mattress bottoms were covered in mold, distributed with dirt and stains and even blood on them, and some of the men reported not having any mattress at all. In addition to worn out mattresses, men in some of the Modules complained of a lack of blankets, including during the winter despite the cold temperatures. When the Sheriff's Department transferred men into different modules, it could take 1-2 days for linen to arrive. If the module is overcrowded, the new person would have to sleep on the floor for a few days until a bunk opened up or they were assigned to one, particularly if they were not able to access an upper bunk.

The Commissioners observed similar issues with the Sheriff Department's provision of clothing to men in the County Jails, including men receiving improperly sized clothing and broken shoes or no shoes at all. The Sheriff Department's continued failure to

provide people in the Jail with adequate clothing results in the men washing underwear in their sinks or toilets and drying them on lines strung up across the Modules. The Sheriff Department recognizes that this practice, referred to as “tenting” is a violation of Board of State and County Corrections (BSCC) regulations, in part because it makes it harder for Sheriffs to monitor the men’s activities in the dorms and contributes to diminished safety for the men housed there and the Deputies themselves. Rather than providing adequate linens, the Sheriff Department engages in sweeps to remove the clotheslines and may punish men for the security violation.

Hygiene

Commissioners have reported that multiple modules in Men’s Central Jail have non-functioning sinks and toilets, with "neighbors giving neighbors water in a bag to drink when their water is not working." The Sheriff’s Department regularly fails to provide the men with their basic hygiene provisions (soap, toothpaste, and toothbrush, etc.), known as “FISH kits,” as well as insufficient toilet paper. In one Module, "guards conduct lottery games to give out a limited supply of FISH kits."

Communication

The County’s promise to improve communication with families and lawyers by making telephone calls free to the men in the County Jails is consistently frustrated by phone systems that are frequently inoperable. Again, these issues increase the mental strain on the men in the jail, undermining their health, safety, and security as well as the security of the Deputies who have to respond to constant complaints and frustration with the facility.

Twin Towers Correctional Facility

Sanitary Conditions

Commissioners regularly observe inhumane unsanitary conditions at Twin Towers Correctional Facility. Twin Towers houses men with significant mental illness who cannot be housed in dorms, even with medication. Many of the men confined in Twin Towers wear blue “suicide vests” with nothing underneath. These vests are effectively padded ponchos made of rough material. Many of the men take off the vests in their cells, either because the vests are uncomfortable or because of their mental illness, or both. That means that a significant number of the men in Twin Towers spend 23+ hours in their cells, often naked. The cells are often dirty and covered with graffiti, with multiple-meals-worth of cardboard trays and juice boxes stored, sometimes neatly, sometimes ripped up and spread around the cells.

Commissioners have regularly documented men whose cells are smeared with feces and cells in which urine is leaking out from under the door. Commissioners have also observed Sheriff Department officials turning water off in cells where men are flooding their toilets with the consequence that there is no access to drinking water.

As with Men's Central Jail, Twin Towers Correctional Facility is plagued by mold, rust, and black worms in the showers, as well as rats and other vermin in the facility.

The men in Twin Towers Correctional Facility also lack adequate hygienic resources, such as FISH kits and toothbrushes, as well as cleaning supplies for the cells, making it impossible for them to maintain hygienic living spaces.

Finally, elevator malfunctions restrict mobility and create accessibility issues, resulting in the Sheriff Department deciding that it is incapable of providing in-person visitation opportunities to men housed in Twin Towers. The visitor's side is only accessible via elevator, and with the elevator out of service, no in-person visits are possible.

Century Regional Detention Facility

The August 29, 2024 inspection of Century Regional Detention Center (CRDF), the women's facility in Lynwood, documented persistent facility and elevator issues that impact basic operations and safety. Commissioners noted, "elevators continue to be broken on both sides of the facility. This leads to several operational issues, including inmate workers having to carry heavy trays of food up flights of stairs, delays in court access and medical services." The report highlighted that "the elevators were also broken at the previous inspection" and questioned "why this continues to be a problem" given that "the building is not old." This indicates that even identified infrastructure issues remain unresolved over multiple inspection cycles.

The CRDF inspection also revealed serious electrical safety hazards, including a "light fixture in 2100 [that] is broken and appears to have exposed wire inside the shower (observed by Commissioners). The women were concerned about safety issues from the open wires near the water." This represents an immediate safety hazard that could potentially cause serious injury or death.

At CRDF, Commissioners documented that "water is brown in 2100B (coming out of the sinks). Another sink in 2100B did not work at all." Module 2600 had "toilets leaking in a couple of cells" and "cell 19 – sink does not drain, and there is mold in the cell."

HVAC systems function inconsistently, resulting in temperature extremes. At CRDF, "the temperatures in 2600 cells 7-18 did not have air. Commissioners went in one of the cells and it was stifling hot." At NCCF, inmates reported that the "dorm will get hot due to AC not being turned on or will keep AC on and it becomes too cold." The "temperature was very cold," with "individuals requesting additional blankets and thermals."

Pitchess

The Pitchess facility includes four jails, North County Correctional Facility (NCCF), North, South, and East (which houses only a few men preparing for firefighter training). At NCCF, some of the sinks, urinals, and toilets were not in working order or would overflow, clogged drains, some of the phones were not working, and there were some complaints of mold. Once again, multiple inspections by Commissioners revealed a

critical lack of basic hygiene supplies, especially soap and toilet paper, as well as insufficient cleaning solution to clean common areas and floors.

In addition, the telephones were often broken, making it hard for the men to call their attorneys or their families. Some of the telephones were completely dysfunctional, but all of them took 5-10 minutes to establish a connection. Staff confirmed these connection times were not credited to the 20 minutes of telephone time allotted to each incarcerated person.

Unit 940A Direct Admit

Unit 940A housed people who were being disciplined according to the "Direct Admit" policy. We asked the Watch Commander to provide the Sybil Brand Commission with a copy of the Direct Admit policy. The Commissioners did, however, observe the practice in the Unit, as well as speak to the people incarcerated there and the Deputies on duty. As practiced, the Commissioners have significant worries about the policy.

California Code of Regulations ("CCR") Title 15 § 1081. Plan for Inmate Discipline requires that "[e]ach facility administrator shall develop written policies and procedures for inmate discipline." Title 15 states that:

1. "A copy of the report, and/or a separate written notice of the violation(s), shall be provided to the inmate.
2. Unless declined by the inmate, a hearing shall be provided no sooner than 24 hours after the report has been submitted to the disciplinary officer and the inmate has been informed of the charges in writing.…
3. The inmate shall be permitted to appear on his/her own behalf at the time of hearing and present witnesses and documentary evidence. …
4. A charge(s)shall be acted on no later than 72 hours after an inmate has been informed of the charge(s) in writing.…
6. The inmate shall be advised in a written statement by the fact-finders about the evidence relied on and the reasons for the disciplinary action. A copy of the record shall be kept pursuant to Penal Code Section 4019.5."

Title 15 also contains a provision allowing staff to "segregate[e] any inmate from the general population or program for reasons of personal, mental, or physical health, or under any circumstance in which the safety of the inmates, staff, program, or community is endangered, pending disciplinary action…." However, none of these reasons were applicable to any of the people held in Unit 940A under the Direct Admit policy, as explained to the Commission Staff by the deputies on duty and the Watch Commander at the end of our inspection.

To carry out its policy under Title 15, LASD adopted Los Angeles Sheriff Department Custody Division Manual ("CDM"), Volume 5. These policies require a period of "pre-discipline" which, under CDM 5-09/000.00 is "not to exceed 72 hours, during which an inmate who is being charged with a disciplinary violation is waiting for their Disciplinary Review Board (DRB) hearing. During this time, the inmate's existing privileges shall not

be revoked." CDM 5-09/060.00, which governs the disciplinary review process, reiterates this aspect of pre-discipline, and states that during the prior to a hearing before the Disciplinary Review Board, the incarcerated person "is in the pre-discipline period and their existing privileges shall not be revoked." CDM 5-09/060.00 acknowledges that the purpose of pre-discipline is a constitutionally significant one: "inmates involved in any disciplinary action…have the right to an administrative process (discipline hearing) that adheres to the constitutional principles of due process and equal protection." According to these principles, prior to discipline "[t]he inmate shall be informed of the charge(s) in writing through the Notice of Disciplinary Violation… [which they] shall acknowledge …by writing."

Especially important for the "Direct Admit" policy in North County Correctional Facility, CDM 5-09/060.00 stipulates that "[i]nmates have the right to a discipline hearing no sooner than 24 hours, and no later than 72 hours, after having been notified in writing that they are subject to discipline[, and that t]he 24-hour limitation following written notification will allow the inmate time to prepare a defense for the discipline hearing." There is a provision by which to expedite the disciplinary hearing process: however, under CDM 5- 09/060.00, that process requires the incarcerated person to "not contest [ ] the disciplinary violations with which they have been charged and sign [ ] the corresponding waiver field in the Notice of Disciplinary Violation." The Sheriff Deputies supervising the unit did not have any record of waiver of the disciplinary hearing process available to them.

As explained to the Commissioners by the Sheriff Deputies on duty, the Direct Admit policy to discipline is problematic. 940A is a disciplinary unit and so governed by the Due Process Clause of the Constitution, Title 15 and the procedures specified in CDM 5-09/060.00, as discussed above. However, the people placed in disciplinary housing subject to the Direct Admit policy lack paperwork and information about the most significant part of their incarceration. The deputies in charge of Unit 940A specifically told us that the purpose of the Direct Admit policy was to streamline procedures and that they did not have any paperwork on hand.

The Sheriff Deputies on duty explained that the Direct Admit policy as they practice it does not require, they provide the incarcerated person with (1) written notice of the violation; (2) a hearing within 24 hours of being removed to the disciplinary unit; or (3) the incarcerated person being granted a due-process right to appear in their own behalf. As noted, above, these steps are required variously by the United States Constitution, Title 15, and the LASD Custody Division Manual. The Sheriff Deputies explained that, as they practice the Direct Admit policy, so long as they act on the charge within 72 hours by releasing the person held in the disciplinary unit, then the Sheriff Deputies need complete only a minimal written notice and record of the violation requiring discipline and admission in the unit.

In fact, the Sheriff Deputies supervising the unit stated they were awaiting records of the disciplinary process to reach them. The only information regarding the status of the people incarcerated Direct Admit disciplinary unit 940A was the standard form describing the person's status posted on the cell, and that form did not display the usual information contained in these records. As a consequence, many of the people in Unit 940A did not understand why they were there, and the paperwork available (on their cell

door) did not, in most cases, provide any explanation. The Commissioners observed at least 5 people with admission dates of 5/7 (two days before our inspection) or no dates at all. None of the forms in Unit 940A recorded information about their release date or disciplinary status, and many lacked a record of their reason for being held in disciplinary segregation.

None of the people in discipline had received their mandatory discipline review board hearings prior to placement in the disciplinary unit. After discussion with the disciplinary Custody assistant (who was very helpful) and a deputy in the 900 floor we discovered that several of these people would be released the next day (5/10) for rehousing because there wasn't enough evidence, or the paperwork was insufficient to give them discipline.

Other problems raised during our inspection of the Direct Admit unit revealed that while the Deputies hold individuals in Direct Admit for up to 72 hours with no hearing, the people incarcerated there lose their property, lose their space in classes, and their dorm housing.

3. Mental Health and Other Medical Issues

Mental Health

Twin Towers Correctional Center houses men with significant mental illness, designated

- P3: "Unstable due to significant mental illness; persistent danger of hurting self in less acute care setting; or recurrent violence due to emotional instability," or
- P4: "Severe debilitating symptoms; Meets LPS 5150 criteria for danger to self, others, or grave disability."

These people qualify for "High Observation Housing".

According to a September 3, 2015, Joint Settlement Agreement Regarding the County Jails; and Stipulated Order of Resolution entered into by the Department of Justice and the County before Judge Dean Pregerson, a federal judge, "'High Observation Housing' or 'HOH' refers to designated areas for prisoners with mental illness who require an intensive level of observation and care and/or safety precautions." which means that they are separated into one- or two-person cells, often clothed in suicide vests, rather than ordinary jail fatigues, provided limited programming, often while chained to a table or chair. Consistent with the Settlement Agreement, the Sheriff Deputies engage in safety checks of people with the designation of P3 or P4 every 15 minutes.

Other Jails within the County jail system, including Men's Central Jail and Pitchess North, house a population of people categorized as

- P2: "[r]ecurrent episodes of mood instability; Psychotic symptoms maintained by medication and frequent reliance on crisis stabilization services."

This population qualifies as “Moderate Observation Housing,” (MOH) and requires safety checks every 30 minutes.

Century Regional Detention Facility houses women who qualify for High Observation Housing and Moderate Observation Housing in separate parts of the jail from their general population housing.

High Observation Housing

On December 19, 2022, Judge Pregerson entered an order granting Plaintiff United States’ Notice of Motion and Motion for Court Order Setting Deadlines for Substantial Compliance with the 2015 Settlement Agreement. That order included provisions for the “Expansion of Stepdown Program.” The order noted that the County “Jails have been operating “Stepdown” HOH units that serve individuals who previously received inpatient care in the Jails and others in the HOH population.…These units, unlike standard HOH areas, allow individuals to spend most of the day outside their cells without restraints.…They also provide improved programming, and a better care environment overall than standard HOH units.…They are also better at preventing decompensation.”

Both Twin Towers Correctional Facility (men) and Century Regional Detention Facility (women) have Stepdown Programs. Part of the point of using Stepdown units rested on the finding that such units “should reduce the acuity of mental illness across the system, and thus help to reduce the demand on the Jails’ overtaxed inpatient and HOH units, the two most impacted types of mental health housing.” The Order then required Los Angeles County to “expand the number of operational Stepdown units according to the following schedule, which should be feasible based on their implementation plans:…

- 20 Stepdown pods by March 2024;
- 28 Stepdown pods by March 2025.”

On June 27, 2023, the Los Angeles Board of Supervisors passed a motion, sponsored by Supervisor Hilda Solis, Supporting the Expansion of FIP Stepdown and HOH Dorm Units the Los Angeles County Jails, which contained the following “requests”:

- “1. Request that the Sheriff and direct the Department of Health Services (DHS) – Correctional Health Services (CHS) continue to expand rapidly the number of FIP Stepdown and HOH Dorm pods at TTCF and CRDF to a total of 20 pods by March 30, 2024…
- 2. Request that the Sheriff and Direct the Department of Health Services (DHS) – Correctional Health Services (CHS) continue to recruit volunteer Mental Health Assistants, including through recruitment and training initiatives, such as the Merit Masters program, at least two times per year, more if needed.”

On February 21, 2024, the Office of Inspector General, published its first 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).

On the same date, February 21, 2024 Judge Pregerson entered another order, Granting Stipulation to Modify Court Order Setting Deadlines for Substantial Compliance. As part of that order, Judge Pregerson noted that "The County has begun expanding Stepdown units and currently operates 17 such units in the Jails," as well as expanding "its use of High Observation Housing dorms ("HOH Dorms") since the December 2022 order was entered. The County maintains that HOH Dorms are functionally equivalent to Stepdown units. According to the County, both unit types possess the same essential elements, including enhanced, unrestrained out-of-cell time; a therapeutic physical space with games, soft furniture, decorative art or plants, and other pro-social environmental features; consistent and specially trained custody and Correctional Health Services ("CHS") staff; and tailored treatment plans and programming. The County also maintains that HOH Dorms are easier to expand and can safely house more people than Stepdown units. On this basis, the County has asked the United States to agree to modify the December 2022 Order to allow the operational HOH Dorms to be credited toward the Stepdown unit requirement." On the basis of these representations, "The United States agrees that HOH Dorms may be credited toward the Stepdown requirement," and permitted a revised target of "18 such Stepdown units in operation by June 2025."

It was against this background of litigation and transformation in the jails that the Commission visited both the Twin Towers Forensic Inpatient (FIP) Stepdown Unit, as well as one of the Twin Towers HOH dorms, and the Century Regional Detention Facility Forensic Inpatient (FIP) Stepdown Unit. The Commission also invited Mental Health Assistants from each Forensic Inpatient (FIP) Stepdown Unit to attend a meeting of the Commission by teleconference. A core goal of our visits and invitation to speak at our meeting was to understand how the Forensic Inpatient (FIP) Stepdown Unit worked, including a preliminary understanding of the coordination between the Sheriff's Department, Correctional Health Services, and the Mental Health Assistants who currently operate the Forensic Inpatient (FIP) Stepdown Units, as well as to observe and understand the operation of the HOH Dorms.

At the Twin Towers Forensic Inpatient (FIP) Stepdown Unit, Commissioners spoke primarily with Craigen Armstrong, who had worked for 7 years as Mental Health Assistant, had graduated as a Merit Master from the Education Based Incarceration program at Men's Central Jail, and is a co-author with Adrian Berumen of the book, The Solution: Mental Health Assistants. Mr. Armstrong described the process of selecting and training mental health assistants, as well as caring for people with significant mental health issues in the Forensic Inpatient (FIP) Stepdown Unit.

Mr. Armstrong stressed that one of the core difficulties of working with this population of significantly mentally ill people is that these are people who no-one wants: no program within the jail, and often not even their families outside the jail.

The Twin Towers Forensic Inpatient (FIP) Stepdown Unit is still a High Observation Unit with regular safety checks, but it has a distinctive and therapeutic appearance. It is immaculately clean, with floors painted by the Mental Health Assistants: as an ocean complete with fish, sunken ship, and treasure chest; as a space diorama with a small Millennium Falcon; and as a "Picasso" canvas—although it is more like a nascent

Pollock with splashes of paint decorating the floor. All of this gives the unit a much more cheerful and relaxed appearance than the rest of the jail.

The Century Regional Detention Facility Forensic Inpatient (FIP) Stepdown Unit is bright and clean, but lacks the murals and books of the Twin Towers Forensic In-Patient (FIP) Stepdown Unit.

In each location, the people incarcerated in the Forensic Inpatient (FIP) Stepdown Unit kept their cells very clean. There was none of the graffiti that covers the walls of cells elsewhere in the High Observation Housing units of Twin Towers of Century Regional Detention Facility. The people in the cells were alert and calm and wore a version of the usual jail fatigues, rather than the usual blue suicide vest (a padded and somewhat uncomfortable poncho) which is often discarded, leaving many of the people on High Observation Housing elsewhere in Twin Towers languishing naked in their cells.

In Twin Towers, the unit has comfortable chairs and plants, and each pod is surrounded by books that the people incarcerated there can easily access. There are tables and dry-erase boards. In all but one of the five pods, the people incarcerated there are not handcuffed or chased when they engage in programming. The Mental Health Assistants work to ensure that people spend no more than a month programming in handcuffs before being moved to a pod where the people are not in restraints. In Century Regional Detention Facility, there were tables and dry erase boards, but none of the other amenities available in Twin Towers.

In Twin Towers, Commissioners spoke with about eight Mental Health Assistants from different modules. The Mental Health Assistants included about three who were undergoing training. Commissioners also spoke with three Mental Health Assistants in Century Regional Detention Facility. The Mental Health Assistants ensure that the people incarcerated in the Forensic Inpatient (FIP) Stepdown Unit take their medication. That is a time-consuming process that requires persuasion and monitoring, including explaining to the incarcerated person the nature of their illness and the effect of their medication. In addition, some incarcerated people do not swallow their medication, but hide it in their cheeks or spit it out. Mental Health Assistants are skilled in spotting when incarcerated people do not take their medication. They have a special interest not shared by nurses or Deputies in ensuring that the people in Forensic Inpatient (FIP) Stepdown Unit take medication: if the patients do not, then they may become unresponsive and sometimes aggressive or violent.

Deputy and nursing staff do not want to do pill call. Medication is distributed by Licensed Vocational Nurse (LVN), nurses trained in basic, specific nursing skills, and so not Registered Nurses (RN) with more advanced training and patient care planning skills. If an incarcerated person refuses their medication, rather than persuading the person to take their medication, Deputies and nursing staff usually just keep on going. Both Deputies and nursing staff have shared that persuading incarcerated people to take their pills takes too long. Given these difficulties, there was significant turnover in the nursing staff assigned to Forensic Inpatient (FIP) Stepdown Unit.

Historically, Mental Health Assistants have had difficulties working with Sheriff Deputies who take a more punitive approach. For example, the Mental Health Assistants developed an incentive program involving placing daily stars on a sheet outside each

cell for every incarcerated person who performed basic hygiene functions. It was difficult to get people with severe mental illness to take care of themselves and their living conditions. The program would then provide the successful incarcerated people with some small food treats, such as cookies, at the weekend. LASD Deputies initially impeded program by removing star-sheets from outside the cells. It took the Mental Health Assistants a significant amount of work to persuade the Deputies not to pull down these sheets when they did their inspection rounds.

Mental Health Assistants reported similar difficulties in Century Regional Detention Facility. Commissioners spoke with three Mental Health Assistants in 1300 FIP-Stepdown, who explained that they were struggling to get some sheriffs and some members of Correctional Health Services to "buy into" the program. In particular, some of the deputies did not accept the treatment orientation of the Mental Health Assistants and took a more punitive approach. The Deputies had ended the practice of Mental Health Assistants visiting women in high observation housing to explain the FIP-Stepdown program and encourage those women to join it. This also explained why the FIP-Stepdown had a significant portion of spare places.

Mr. Armstrong explained that another challenge is faced by LASD having deputies train in the Forensic Inpatient (FIP) Stepdown Unit. The Mental Health Assistants know patients and are able to deal with them without using restraints. On the one hand, starting Sheriff Deputies' training in the Unit enables them to observe how well people with significant mental problems can succeed in the jail. However, because the training officer must ensure that the Deputies know the procedures that apply to other parts of the jail, trainees use restraints to move people incarcerated people around the Unit. We observed at least one person being moved in this way. Some training officers treat upset patients as a training opportunity and put incarcerated people on discipline who may not qualify to teach the training officer how to write up infractions.

The Forensic Inpatient (FIP) Stepdown Unit is undergoing a period of significant turnover. The Unit Director used to be a dedicated psychiatric technician, Sarah Tong. However, she died in December 2023. Sergeant Flores, who used to oversee the program, has been promoted and is no longer with the Unit. One of the founders of the Mental Health Assistant program, Adrian Berumen, has returned to a State correctional facility. Even though the Board of Supervisors' motion and Judge Pregerson's order has led to visits from interns and psychiatric students but with no long-term staffing of Forensic Inpatient (FIP) Stepdown Unit with psychiatric technician to replace Dr. Tong.

The proposed expansion has had significant effects on the Twin Towers Unit. Mental Health Assistants require 6 months of training to complete the program developed by Mr. Berumen and Mr. Armstrong, in conjunction with the former Director of the Felony Inpatient (FIP) Stepdown unit, Sarah Tong, who was a psychiatric technician. The Mental Health Assistants do not receive outside training.

After six months of training in the Twin Towers Unit, successful trainees would receive the designation "Certified Mental Health Assistant." Certification simply signified that an incarcerated person had completed the Mental Health Assistant course and received the certification. However, Correctional Health Services objected to the designation of "certified" and required the Mental Health Assistants to stop calling themselves certified.

Now, they are called Inmate Mental Health Assistants (although some of the Deputies refer to them as “merit masters,” which is the name of the Education-Based Incarceration program that they have completed before engaging in the rest of the Mental Health Assistant training program).

Until recently, a psychiatric technician, Sarah Tong was the director of the Twin Towers Forensic Inpatient (FIP) Stepdown Unit. However, Ms. Tong complained of lack of support from Correctional Health Services. According to Mr. Armstrong, Ms. Tong received more support from the sergeants overseeing the Forensic Inpatient (FIP) Stepdown Unit (Sergeant Flores) than Correctional Health Services. It appears that in the time since she died in December, Correctional Health Services has not appointed a new psychiatric technician to the Unit.

The previous process for selecting Twin Towers Mental Health Assistants was that Ms. Tong, the Forensic Inpatient (FIP) Stepdown Unit Sergeant, and the Mental Health Assistants would participate in selecting who becomes a Mental Health Assistant and how they are trained. The smooth running of the Forensic Inpatient (FIP) Stepdown Unit depends upon having Mental Health Assistants who understand from their own experience how incarcerated people relate to each other, what are their interests and incentives, and how they operate within the power-dynamics and politics of the jails. Mr. Armstrong suggested that people who do not understand or are not suited to dealing the difficulties presented by chronically ill inmates disrupt the Unit.

After the Board of Supervisors Motion and District-Court ordered expansion, Correctional Health Services and LASD are taking more of a role in controlling the selection of incarcerated people to serve as Mental Health Assistants. Correctional Health Services does not participate in the training program for Mental Health Assistants, but simply provides the Merit Master's program in Men’s Central Jail.

Mr. Armstrong suggested that LASD and Correctional Health Services do not understand the training process for Mental Health Assistants and do not understand the unique challenges faced by individuals who are incarcerated in a jail setting in serving as Mental Health Assistants. Not every person who graduates from the Merit Master program in Men’s Central Jail is capable of dealing with the challenges presented by treating the people in the Forensic Inpatient (FIP) Stepdown Unit. Now there is only limited participation in Mental Health Assistants.

Mental Health Assistants in Century Regional Detention Facility had similar complaints. They 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.

Under the new expansion agreement, LASD and Correctional Health Services require only graduation from the merit master program to qualify as a Mental Health Associate for the Forensic Inpatient (FIP) Stepdown Unit, as well as providing peer support training. However, Mr. Armstrong criticized LASD’s over reliance on peer support, because that training does not address the nature of the various illnesses that the Mental Health Associates treat, and so does not provide all the required skills to become a Mental Health Professional. As Mr. Armstrong explained, that puts people at

risk because Merit Master training on its own does not prepare people to be in a pod with low-functioning people with mental health problems.

Another effect of the new policy is limiting the pool of people who could qualify as Mental Health Assistants. One of LASD's policy goals is to try to find people who can receive good time credits for working in pods. However, given the jail population, there are relatively few people who qualify for prison credits. Other incentives already available include increased contact visits and to order certain goods from Amazon. However, Armstrong suggested that one of the real benefits is to work on oneself and to work away from the "politics" of the dorms and cells (including racial politics).

Forensic Inpatient (FIP) Stepdown Unit leaders wanted to create a Mental Health Assistant class in Men's Central Jail taught by the Mental Health Assistants themselves. Mr. Armstrong met with Dr. Hellman, the Educational Development Administrator at the Sheriff's Department, about a year ago. However, Mr. Armstrong suggested that they were unable to get permission to teach a Merit Master course.

The Mental Health Associates also partnered with Education-Based Incarceration (EBI) to help set up the Century Regional Detention Facility Forensic Inpatient (FIP) Stepdown Unit at the women's jail. Mr. Armstrong and the Mental Health Assistants at Twin Towers were teleconferencing with the women Mental Health Assistants to help with their training. However, when Lieutenant Hicks, who was involved in setting up the Century Regional Detention Facility program moved from Century Regional Detention Facility to Twin Towers, coordination with the Twin Towers Mental Health Assistants stopped. When Century Regional Detention Facility Mental Health Assistants asked for the same hot meals ration (two per day) as the Mental Health Assistants in Twin Towers, LASD leveled down and dropped the Twin Towers hot meal ration to one per day, rather than level up the women Mental Health Assistant's ration to two per day.

Part of the LASD resistance to allowing Mental Health Assistants to provide Education Based Incarceration training appears to stem from some a punitive orientation because of the Mental Health Assistants' criminal records. This posture appears to be shared at both Twin Towers Correctional Facility and Century Regional Detention Facility.

To comply with the Court-ordered expansion of mental health units, LASD proposed to introduce an alternative, phased model to replace current Forensic Inpatient (FIP) Stepdown Unit structure. In the phased model, each module would consist of are five dorms, A, B, C, D, and E dorms, each capable of housing 16 people in 8 two-person cells. The plan is to have a process of graduation from pod-to-pod in which an incarcerated person with severe mental illness moves from E-dorm, where they are placed in a single cell, clothed in a suicide gown and allowed limited chained and handcuffed programming, to D-dorm, where they remain in a single cell, but now the clothed in prison fatigues and allowed limited chained and handcuffed programming, to C-dorm, where the incarcerated person is able to share a cell and receives more programming, but still chained and handcuffed, to B dorm, which is the Forensic Inpatient (FIP) Stepdown Unit, in which the incarcerated person is no longer chained and handcuffed on programming and receives attention from a Mental Health Assistant, and finally to A-Dorm where the incarcerated person no longer is afforded the assistance of a Mental Health Assistant.

There has been no formal meeting between the Mental Health Assistants and the Watch Commander or captains to discuss expansion of the program. If there are meetings, these are facilitated by the Office of Inspector General. The most contact that the Mental Health Assistants have with LASD and Correctional Health Services is at the ceremony for graduating inmates when they exit the Forensic Inpatient (FIP) Stepdown Unit. Otherwise, Correctional Health Services rarely show up in the Forensic Inpatient (FIP) Stepdown Unit.

The Commissioners who visited these "High Observation Housing dorms ("HOH Dorms")…[that t]he County maintains…are functionally equivalent to Stepdown units" found that the HOH Dorms were significantly less treatment-oriented that the Forensic Inpatient (FIP) Stepdown Units. For example, certain men incarcerated in the HOH Dorm were allowed out of their cells during the week, and could receive three hours unrestrained "programming" (the generic term for the different types of program offered to the people incarcerated in the jail system) in the morning and three hours in the afternoon, during which time they would receive counseling with the mental health staff. However, only those people who were cooperative would receive this out-of-cell time. During Commissioners visits to the HOH dorms, less than a quarter of the men housed there were deemed cooperative enough to receive out-of-cell programming. Worse, on weekends none of the people incarcerated in the HOH Dorms were allowed out of their cells because there were no psychiatric staff to conduct programming.

The men with whom the Commissioners spoke in the HOH Dorm were significantly less comfortable than the people in the Forensic Inpatient (FIP) Stepdown Unit. The cells were covered in graffiti and were generally less clean.

Moderate Observation Housing

In an effort to ease the strain on Men's Central Jail, LASD converted Pitchess North to Moderate Observation Housing, beginning in September 2023. This means that people with significant mental illness that responds to medication are housed in Men's Central Jail, Inmate Reception Center, Century Regional Detention Center, and Pitchess North.

Pitchess North has the services of a full-time psychiatrist 5 days a week (but not 24 hours per day) and on weekends from 4-6 hours. The jail also uses telepsychiatry to ensure that people incarcerated in North could access psychiatric help.

Deputies did, however, identify a number of structural challenges stemming from converting a jail designed for general population, where the people housed do not have a significant mental impairment, to housing a population of people categorized as P2 or above, which means that they have "[r]ecurrent episodes of mood instability; Psychotic symptoms maintained by medication and frequent reliance on crisis stabilization services." This population qualifies as "Moderate Observation Housing," (MOH) and requires safety checks every 30 minutes.

Each dormitory, though "designed for no more than 64 inmates," Title 24, §1231.2.8 Dormitories, has a capacity of 80 people. During the Commissioners visits, Pitchess North was close to capacity in all the dormitories, including the cells in pods primarily designed to hold individuals with disciplinary problems, but which now also houses

individuals who were designated “High Observation Housing” (HOH) because their mental health had deteriorated, and were awaiting transportation to Twin Towers. These men may wait multiple days while for a space to open up for them in Twin Towers.

LASD Deputies reported that this new population requires more resources than previously provided at Pitchess North, including more frequent safety checks, but also more psychiatric treatment, including in-person visits and remote, telepsychiatry visits. None of the people incarcerated in Pitchess North are eligible to serve as trustees, who are defined as “low risk inmates…given increased responsibility to maintain the overall cleanliness of the jails.” To cope with the absence of North trustees, LASD transports trustees in from Pitchess South.

Pitchess North does not have an on-site medical facility nor housing for people with a mental health status below or above P2. Accordingly, the new population needs more transportation, and often much more lengthy transportation, not simply to court in Los Angeles, but also to hospital elsewhere on the Pitchess campus, as well as to Twin Towers or to Men’s Central Jail should their mental health change our should they cause themselves or others physical injury.

A significant problem was the housing of people whose mental health deteriorated, so that they were categorized P3 (“Unstable due to significant mental illness; persistent danger of hurting self in less acute care setting; or recurrent violence due to emotional instability”) or P4 (“P4: Severe debilitating symptoms; Meets LPS 5150 criteria for danger to self, others, or grave disability”), requiring them to be removed from the dormitories.

During Commissioners’ visits, Sheriff Deputies in the Modules raised major concerns about their ability to cope with the increased demands put on the Sheriff Deputies. Some of these complaints concerned the ways in which catering to mentally ill people required more staff to engage in transportation for medical issues, leaving less staff in the dormitories. Another stress was the requirement that Sheriff Deputies engage in more frequent safety checks, which required 2-3 Deputies to check the dorms every 30 minutes. Other complaints noted that people with mental illness require different skills from Deputies, and that some Deputies did not have extensive prior experience working with this population.

In particular, some of the Sheriff Deputies complained that North was “super-short staffed” produced a staffing chart showing that about half the positions were either “closed” or “unavailable to fill.” The Sheriff Deputies suggested that a significant number of the positions were “unavailable to fill” because Sheriff Deputies found it hard to work with this population and would call in as unavailable. The shortage of Sheriff Deputies was exacerbated by frequent calls to transport patients to a remote medical facility or to other jails downtown, whether because the incarcerated person has changed their mental health status or because they cannot cope with life in a large dormitory rather than a smaller cell. Each time an incarcerated person requires transportation, they must be accompanied by two officers. Sheriff Deputies suggested that whereas when Moderate Observation Housing safety checks were first instituted, policy required a minimum of three officers per round of checks, that number had been dropped to two.

Sheriff Deputies suggested these problems with transportation were exacerbated by the dilapidated nature of the squad cars, which were described as hand-me-downs, often without air conditioning, but for security reasons the Sheriff Deputies could not open the rear windows. In addition, the Sheriff Deputies claimed a fleet of new squad cars had been left unattended for so long they had become rat-infested and unusable.

Sheriff Deputies also noted that there was no provision to have a psychiatric nurse or doctor available 24 hours per day at the facility, and suggested that some of the newer nurses who had not worked at the facility for a long time did not like the conditions and so there was a lot of turnover among the nursing staff. In addition, the nurses were more likely to resolve problems with the people they were treating by asking that they be moved to the medical facility, which then required two deputies to transport the incarcerated person, reducing staffing in the dorms. Nurses were more likely to ask for emergency assistance than deputies, requiring more deputies to accompany the nursing staff, causing deputy shortages elsewhere on the dorms.

The problems identified in Pitchess North are not unique to that facility. Housing people with significant mental illness in dorms of 80 people results in disciplinary issues because mentally ill people are more likely to act out in unpredictable ways. In Men's Central jail, mental health treatment remains severely limited, with insufficient staffing and resources. In the Moderate Observation Housing dorm, the men reported that the emotional support lines available to help them with their mental health issues routinely went unanswered. Commissioners also found that inmates that they reported to the jail as suicidal were sent to Twin Towers Correctional Facility for a very brief period of hours, and then returned to the same conditions/environment in Men's Central Jail with no change in treatment. This suggests that identified mental health crises are receiving only superficial responses rather than meaningful intervention and treatment.

Finally, a member of the medical staff in Men's Central Jail reported that their major health worry for the men in the facility, and especially those with mental health problems, was physical violence.

Other Medical Issues

The medical care system within the facilities demonstrates several critical deficiencies. There are widespread reports of delayed medical attention, with individuals waiting extended periods to receive care for acute conditions.

Specific examples of denied or delayed care include:

- An inmate with "stitches that need to be removed and was told they would be removed last week"
- An inmate "requesting medical follow-up for leg that was shot (uses cane, needs more medical support)"
- An inmate who "needs glasses, has sent in medical requests for months"
- An inmate whose "finger broke, was not set straight, cannot bend it -- surgery was canceled, he said because he was told there were not enough deputies to escort him"

- "Concerns raised for not being able to receive dental work due to a machine being broken for over 3 months" at NCCF
- Multiple issues of delayed or ignored requests for hormone injections for LGBTQ+ population in MCJ

As explained above, sanitary conditions at Men's Central Jail present significant health problems for the men held there. On a number of different visits, Commissioners have observed significant rashes on several inmates, including on the limbs, buttocks, chest, and back of the men in this jail. Commissioners have also observed rashes which appeared to be MRSA/Staph infections, indicating a potential facility-wide infectious disease outbreak that medical staff did not address properly.

Commissioners have repeatedly reported extensive medical care delays across multiple modules. Commissioners documented inmates waiting weeks, and even months, to receive urgent medical care.

In Twin Towers Correctional Facility, Commissioners have observed men held in the Urgent Care area for hours and not being seen. Deputies left inmates sitting by themselves, which is against policy, until the Commissioners approached the men to question them about their treatment.

In Century Regional Detention Center (CRDF), Commissioners documented particularly alarming neglect of medical emergencies. Commissioners reported that "several people in 2100 reported various medical issues that are ignored because they are in single cells, and they are at the mercy of staff coming inside the module to help them. Staff reportedly ignores medical emergency calls." One inmate "reported they have seizures and has seized in the cell without assistance, despite the other women around yelling out for help." Another "reported that she had a broken finger and had to wait over six hours for care because deputies ignored the call buttons." These serious delays in responding to medical emergencies create dangerous, potentially life-threatening conditions.

At CRDF, Commissioners found that "several women in 2100 appeared and reported (to a Commissioner who is a licensed mental health professional) to have mental health issues that were not being addressed. Instead, these women were labeled with behavioral problems and placed in solitary, only getting out of their cells for one hour per day. They felt this exacerbated their [mental health issues]." The inappropriate placement of mentally ill inmates in solitary confinement rather than providing treatment represents a particularly concerning practice.

Multiple inspection reports document disruptions in medication continuity during court appearances, creating serious risks for medically vulnerable individuals.

4. Required Safety Checks

As noted above, federal courts have mandated that LASD engage in safety checks every 15 minutes for people in High Observation Housing and every 30 minutes for

Moderate Observation Housing. However, these protocols are not being followed consistently, compromising inmate safety.

On numerous occasions across different facilities, Commissioners have found Sheriff Deputies were watching television or videos, rather than monitoring the men under their care. The Commission has regularly raised concerns that safety checks have been performed in a perfunctory and superficial manner. There has been no observable change in this practice in any of the jails over the last two years, since our complaints about this practice started. While the Sheriff Deputies record walking past the cells on their electronic devices, which records these walks on the Uniform Daily Activity Log (UDAL), Commissioners routinely observe the officers walking past dark or "tented" rooms and bunks ("tenting" is the practice of hanging sheets, towels, or laundry over windows or down the side of bunks, making it impossible to observe what is going on inside the room or on the bunk) without looking into the room or bunk to determine whether the person is safe.

In one egregious incident, a man lay dead on his bunk in Men's Central Jail for hours despite Sheriff Deputies conducting mandatory "safety" "checks." In another example in Men's Central Jail, two Commissioners were conducting interviews with the people housed there. One of the incarcerated people was taking a shower; his cell door was wide open, and the contents of his cell were clearly visible. As the Commissioners talked to that person, a Sheriff Deputy performed one of the mandatory 30-minute security checks. That Deputy went along the row, scanning the cells they passed to record their check. After the Deputy had completed their check, the Commissioners continued down the row to the showering person's cell and discovered a self-constructed noose hanging from the ceiling. Though unlikely to support the incarcerated person's weight, the noose was obvious to anyone looking into the cell and its presence was consistent with the suicidal ideation articulated by the incarcerated person while taking his shower. The Commissioners reported the noose to the deputies, eight of whom were sitting in the main office in the unit watching a video on a large screen television. The Sheriff Deputies said they would check on the cell later, but remained seated watching the video on the television.

When the Commissioners returned to the sheriff station in 1750 after completing their inspection of the various rows in the unit, they discovered that the eight seated Sheriff Deputies were in fact watching a sexually explicit video on their wide-screen television. It was only upon the entrance of the second, female Commissioner that the Sheriff Deputies hurriedly removed the video from the screen. In addition, the station was covered with a variety of stickers, including a "Gadsden Flag" (a depiction of a curled snake, usually with a "don't tread on me" logo); and an anti-President Biden sticker. There was also a stack of about eight videos next to the computer monitor.

In the meantime, the Commissioners managed to track down the Sheriff Deputy who had conducted the earlier security check. The Deputy pulled down the noose, but simply threw it on the floor outside his cell. One of the Commissioners, a trained social worker, had a lengthy conversation with the incarcerated person who was still in the shower and confirmed that he had suicidal ideation. When the Commissioners requested additional mental health support and for his suicidal ideation to be taken seriously, the Sheriff Deputy shrugged the request off.

The safety check practices in the jails are a farce. They represent a persistent failure of discipline by the Sheriff Deputies and a persistent failure of supervision by senior officers. Despite reports at each meeting identifying inadequate safety checks, LASD officials refuse to change these dangerous practices and senior LASD officials have even berated Commission staff for failing to adequately supervise these failures and report them to the Watch Commander (when, in fact, Commissioners regularly do so). This refusal to take responsibility for the safety of people with mental health and other issues by engaging in minimal scrutiny of their health conditions is of a par with the other health failings noted elsewhere in this report.

5. Nutrition

There is a very concerning pattern related to food service at the facilities. There have been numerous reports of insufficient food portions, leading to hunger among the incarcerated population. The December 20, 2024 inspection of Men's Central Jail (MCJ) documented individuals in module 4800B receiving lunch consisting of "two slices of bread with no bologna or filling inside whatsoever." Commissioners noted "many reports of hunger across the dorm" in module 5800, indicating a systemic issue with food quantity.

This problem extends throughout the system. The November 14, 2024 inspection of Twin Towers Correctional Facility (TTCF) documented inmates explicitly stating: "If we do not have a commissary, we do not get enough food to eat per day." The September 17, 2024 inspection revealed an inmate who had "recently ended a six-day hunger strike due to not receiving gluten-free meals and high-protein additions."

The October 10, 2024 inspection of the Inmate Reception Center (IRC) revealed serious issues with meal timing. Inmates were documented as "leaving Wayside at 3 AM, getting PB&J at court, then not returning to Wayside until 9-10 PM -- no food in between." This means some individuals may go nearly 24 hours without a meal.

Additionally, the facilities have failed to consistently accommodate special dietary requirements. The October 30, 2024 inspection of Men’s Central Jail (MCJ), inspection documented "four individuals shared that they have not received their special diets despite requests being submitted for a while (i.e., vegetarian, high protein, halal)." One inmate reported that "halal diet not met for many months."

Food service quality issues include frequent delivery of cold meals that should be served hot. Commissioners directly observed, "5300 food was sitting in the hallway the entire time prior to and through our inspection of the dorm." The TTCF inspection noted inmate reports that "food is not fully cooked soy meat, veggies come still frozen."

These conditions have created a problematic dependency on the commissary system. Inmates across multiple facilities reported "high commissary prices compared to state, federal, and other counties," creating hardship for families and forcing inmates to go without necessities.

6. Grievances

The formal grievance system, which should provide a mechanism for addressing concerns, is fundamentally compromised. Grievance forms are frequently unavailable to inmates, making it impossible to document complaints through proper channels formally.

The December 20, 2024 inspection of MCJ confirmed this issue, with Commissioners explicitly noting that "individuals did not have access to grievance forms" in both module 4800B and module 5800. Commissioners had to intervene by "requesting Deputies pass out forms" and "stayed until forms were provided to all requested."

The September 17, 2024 inspection of TTCF documented similar grievance access issues, with explicit "reports that people are not receiving grievance forms when asking for them" in module 252. At NCCF, Commissioners observed that "grievance did not appear readily available and must be requested from the deputy when needed."

When grievances are filed, they often receive no response or face delayed response times. In module 5100, inmates reported "insufficiently prompt response to grievances." In module 5600, "many reported that they have made attempts to contact ACLU, cannot get through or leave a message," suggesting inmates are attempting to seek external advocacy due to failures of the internal grievance system.

The November 14, 2024 inspection of TTCF documented serious allegations of retaliation against those who file grievances. Commissioners recorded a complaint: "Deputies yell and curse at us, call us stupid and dumb. If we file grievances, they retaliate. I've been sent to the naked rooms where they make fun of us." This suggests that the grievance system is difficult to access, and inmates face potential punishment for attempting to use it, creating a chilling effect on reporting legitimate concerns.

These systemic failures undermine accountability and prevent legitimate facility concerns from being identified and resolved.

7. Transportation

Transportation infrastructure issues are affecting court appearances across multiple facilities. The October 2024 inspections documented "a severe bus shortage makes it very difficult to get transport to and from court easily. 912 people had to be moved through to court today, with only 6 buses." The NCCF inspection documented extreme scheduling issues, with "2:30am wakeup call and late night back, some reporting that they don't get back in until as late as 11:30pm," creating "sleep deprivation" that can affect inmates' ability to participate effectively in their legal proceedings.

These findings are based on documented evidence from official inspection reports covering multiple facilities throughout the County correctional system from January through December 2024. They demonstrate that these are systemic issues requiring system-wide solutions, not isolated incidents.

RECOMMENDATIONS

1. An urgent review of conditions in the jails contributing to the surge in jail deaths at the end of 2024, in particular, drug deaths;
2. Review of the policy decision not to increase scrutiny of LASD staff to determine whether they are bringing drugs into the jail;
3. Mandatory and significant mental health training to ensure Sheriff Deputies provide a “care first” response for those suffering mental health crises in the jail system;
4. A complete review of the safety check process, with mandatory retraining of all jail Deputies and documented supervision by senior officers to ensure that deputies engage in proper checks of people incarcerated in the jails;
5. A significant increase in the amount and diversity of education-based incarceration options at Men’s Central Jail and Twin Towers Correctional Facility;
6. The provision of Spanish Language options for education-based incarceration at all the facilities, including Century Regional Detention Facility;
7. The urgent hiring of medical professionals, including especially psychiatric professionals;
8. A review of pill call to make sure that pills are properly distributed to those incarcerated in the Los Angeles Jail System;
9. The immediate closure of Men’s Central Jail.

HB:WD:vsz

c: Executive Officer, Board of Supervisors
Los Angeles County Sheriff
County Counsel
Office of the Inspector General
Sheriff’s Civilian Oversight Commission
Director, Los Angeles County Department of Health Services
Director, Los Angeles County Department of Correctional Health Services
Director, Los Angeles County Department of Mental Health
Director, Los Angeles County Department of Public Health
Director, Los Angeles County Department of Justice Care and Opportunities
Justice Deputies, Board of Supervisors
Social Services Deputies, Board of Supervisors
Education Deputies, Board of Supervisors
Health Deputies, Board of Supervisors