COUNTY OF LOS ANGELES
SYBIL BRAND COMMISSION FOR INSTITUTIONAL INSPECTIONS
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June 9, 2026

TO: Supervisor Hilda L. Solis, Chair
Supervisor Holly J. Mitchell
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Supervisor Kathryn Barger

FROM: Haley Broder
Chair of the Sybil Brand Commission for Institutional Inspections

SUBJECT: 2025 ANNUAL REPORT AND RECOMMENDATIONS BY THE SYBIL BRAND COMMISSION FOR INSTITUTIONAL INSPECTIONS ON THE LOS ANGELES COUNTY LOCK-UPS HUMANITARIAN CRISIS

2025 Sybil Brand Commission for Institutional Inspection Members:

Chairperson Haley Broder, Immediate Past Chairperson Raymond Regalado, Vice Chairperson Wynter Daggs, Commissioner Puja Bhatia, Commissioner Norma Cumpian, Commissioner Katherine Hennigan Ohanesian, Commissioner Eric J. Miller, Commissioner Joahanna Terrones, and Commissioner Mary Veral.

I. Overview

The Sybil Brand Commission for Institutional Inspections (SBC) is tasked with conducting unannounced, unescorted inspections across Los Angeles County jail and lock-up facilities. Consisting of 10 member seats, with two available appointments per Supervisorial district, commissioners can conduct no more than two jail inspections monthly. In addition to these monthly inspections, the Commission may assist with inspections at the request of the Los Angeles County Sheriff Civilian Oversight Commission (COC) or the Office of Inspector General (OIG). For 66 years, the SBC has been dedicated to improving the living conditions for those incarcerated in Los Angeles County jails by examining the administration, cleanliness, discipline, and conditions in

the Los Angeles County jails, pursuant to the SBC's governing ordinance.[1] SBC does not have any full-time staff. Haley Broder and Wynter Daggs served as the Chair and Vice-Chair of the SBC, respectively, in 2025.

In 2025, the Sybil Brand Commission (SBC) continued its critical oversight role by conducting **46 unannounced inspections** across Los Angeles County's jail system. Through these inspections, the Commission documented persistent and systemic issues, including **inadequate medical and mental health care access, unsafe living conditions, staffing shortages, delays in grievance resolution, and ongoing threats to the safety and dignity of incarcerated people, particularly women, LGBTQ+ individuals, and those with serious medical or mental health needs**. SBC's 2025 findings underscore the urgent need for sustained accountability, structural reform, and immediate corrective action to ensure constitutional standards of care and human dignity are upheld throughout the County's jail and lock-up facilities.

While the SBC observed targeted operational improvements in limited areas, overall findings indicate that **structural deficiencies remain deeply embedded in the jail system**, requiring sustained leadership attention, transparent accountability, and decisive corrective action. The Commission's 2025 recommendations emphasize a **culture of care and strengthened compliance monitoring** as essential pillars for advancing constitutional conditions and public trust.

We invite the Board of Supervisors and the public to follow our monthly reports and meetings, engage with our work, and support the follow-up on our recommendations.

The following sections describe in greater detail the issues observed by the SBC, followed by SBC's recommendations to the Los Angeles County Sheriff's Department (LASD) and Board of Supervisors.

II. Deaths in Custody

In 2025, there were 46 in-custody deaths in Los Angeles County jail facilities, a historic and **alarmingly high rate averaging nearly one death per week**. This is the second most deadly year in recent history.[2] SBC reviewed and discussed these deaths throughout the year in public meetings with the LASD and identified recurring systemic concerns relating to medical care, mental health treatment, supervision, and institutional coordination. Commissioners consistently emphasized that deaths in custody must be

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[1] Los Angeles County. (n.d.). *Sybil Brand Commission for Institutional Inspections* (Los Angeles County Code §§ 2.82.010–2.82.070). Municode. Retrieved February 25, 2026, from https://library.municode.com/ca/los_angeles_county/codes/code_of_ordinances?nodeId=TIT2AD_DIV3DEOTADBO_CH2.82SYBRCOININ

[2] "In the last 20 years, only 2021—the deadliest year on record—had more deaths-to-date than this year so far. Since the start of 2023, a staggering 122 people have died in LA jails." McCann, S., & Dholakia, N. (2025, December 11). *122 dead in LA jails since start of 2023*. Vera Institute of Justice.

understood not only as individual events but as indicators of broader systemic deficiencies requiring sustained oversight and corrective action.

A significant number of deaths involved individuals experiencing acute medical emergencies or complications from chronic health conditions. Commissioners expressed concern that individuals in medical distress may not have received timely evaluation, monitoring, or intervention prior to their deaths[3]. In several discussions, Commissioners noted the importance of ensuring that incarcerated individuals exhibiting signs of serious illness receive prompt and appropriate medical attention, including access to clinical assessment, treatment, and, where necessary, transport to outside medical facilities.

Another concern is that no death can be "natural" in a facility that is moldy, bug-infested, and environmentally unsound. Clear observation of unsanitary conditions shows unsafe settings. Such conditions can worsen medical situations. In carceral systems, individuals cannot control their own environments and are particularly vulnerable. Confinement itself is an unnatural environment[4]. Chronic stress, overcrowding[5], poor nutrition, violence, and isolation accelerate disease, and lack of autonomy worsens outcomes, therefore, even disease-related deaths are shaped by incarceration conditions. This is a public health issue.

LA County Jail In-Custody Deaths in 2025

Case #	Date	Facility	Race	Gender	Age	Manner of Death / Cause
2025-001	Jan. 10	CSTB (Transport)	Hispanic	M	22	Accident — Heroin Toxicity
2025-002	Jan. 14	MCJ	Hispanic	M	23	Accident — Methamphetamine & Fentanyl
2025-003	Jan. 15	MCJ	Black	M	37	Accident — Fentanyl & Methamphetamine

[3] 3/6/2025, 4/3/2025, June 5, 2025, 8/7/2025, 09/04/2025, 10/02/2025, 11/06/2025 meeting minutes

[4] Vera Institute of Justice. (n.d.). *Mass incarceration is a public health crisis*. https://www.vera.org/news/mass-incarceration-is-a-public-health-crisis

[5] In a presentation shared with the SBC, the Community Safety Implementation Team (CSIT) reported jail population increases, including a 178% increase in people being held under the provision of Prop 36. Los Angeles County Community Safety Implementation Team. (2025, June 28). *Sybil Brand Commission presentation* [PDF]. https://file.lacounty.gov/SDSInter/bos/supdocs/204981.pdf

Case #	Date	Facility	Race	Gender	Age	Manner of Death / Cause
2025-004	Jan. 19	LAGMC (ED)	Black	M	26	Natural — Dilated Cardiomyopathy
2025-005	Jan. 21	LAGMC (ICU)	Hispanic	M	46	Accident — Methamphetamine Toxicity
2025-006	Jan. 27	CRDF	White	F	50	Accident — Effects of Methamphetamine
2025-007	Feb. 02	MCJ	Black	M	40	Suicide — Sharp Force Injuries
2025-008	Feb. 13	Hospital (Med Surg)	Hispanic	M	61	Natural — Atherosclerotic & Hypertensive Cardiovascular Disease
2025-009	Feb. 19	LAGMC	Black	F	49	Natural — Complications of Metastatic Carcinoma
2025-010	March 09	LAGMC (PCU)	Hispanic	M	37	Natural — Atherosclerotic Cardiovascular Disease
2025-011	March 18	LAGMC (ICU)	Black	M	69	Pending Autopsy
2025-012	March 21	LAGMC (Open Ward)	Hispanic	M	56	Natural — Metastatic Biliary Adenocarcinoma
2025-013	March 30	MCJ	Black	M	59	Pending Autopsy
2025-014	March 30	LAGMC (ICU)	Black	M	31	Pending Autopsy

Case #	Date	Facility	Race	Gender	Age	Manner of Death / Cause
2025-015	March 30	LAGMC (ICU)	Black	M	60	Natural — Lung Cancer
2025-016	April 03	LAGMC (MICU)	Hispanic	M	33	Suicide — Hanging
2025-017	April 19	LAGMC (ED)	Black	M	73	Natural — Atherosclerotic & Hypertensive Cardiovascular Disease
2025-024	July 04	Hospital ICU	Hispanic	F	41	Pending Autopsy
2025-025	July 11	TTCF	Hispanic	M	44	Pending Autopsy
2025-026	July 12	TTCF	Hispanic	M	37	Pending Autopsy
2025-027	July 20	LAGMC (ICU)	Hispanic	M	35	Homicide — Gunshot Wounds

Nine (9) of the deaths in 2025 were of individuals aged under 40 years old. Most deaths occurred in pre-sentenced or partially sentenced status — meaning many were still awaiting trial or sentencing. Black and Hispanic incarcerated individuals are overrepresented among in-custody deaths relative to general population figures, which highlights overarching structural inequalities within the criminal legal system.

Commissioners also raised broader concerns about whether medical staffing levels, response protocols, and coordination between custody and medical personnel were sufficient to identify and respond effectively to deteriorating health conditions. The Commission **recommends the following:**

- That the LASD compile death reports to track and study patterns leading to the alarmingly high number of deaths and Corrective Action Plans (CAPs), which are

used to evaluate gaps in medical care, result in a significant change of policy for both LASD and Correctional Health Services (CHS).

While the SBC has not been able to view the LASD's CAPs due to issues of confidentiality, SBC urges LASD to share what changes they will make. Sharing CAPs as an after-action review following deaths does not violate confidentiality but makes the jails safer for others. As a public body, the SBC believes that these changes should be made available to the public.

Mental health–related vulnerabilities were also identified as a contributing factor in deaths in 2025. Concerns regarding the adequacy of mental health monitoring, suicide prevention measures, and housing placement for individuals with known psychiatric conditions were identified. These concerns included whether appropriate supervision levels were consistently maintained and whether individuals experiencing mental health crises were receiving timely and appropriate intervention. Commissioners emphasized the importance of ensuring that individuals with mental illness are properly identified, monitored, and provided access to appropriate treatment and protective measures.

Commissioners further identified cases in which individuals experienced prolonged deterioration in their physical or mental health prior to death, raising concerns about ongoing monitoring and responsiveness. During inspections and case reviews, Commissioners reported observations that incarcerated individuals with serious medical symptoms, including severe and persistent illness, were not always receiving timely follow-up care or intervention. These cases highlighted the need for improved continuity of care, enhanced communication between custody and medical staff, and more effective systems to identify and respond to worsening medical conditions. Looking back to 2024, when Commissioners discovered a noose in a cell and could not find jailers available to provide support for a prolonged period of time, the SBC remains concerned about the swift and proper handling of mental health needs and emergencies.

Substance use and overdose-related risks were also identified as an ongoing concern contributing to in-custody deaths. Commissioners discussed the role of narcotics entering jail facilities and the potential relationship between contraband drugs and preventable fatalities. The Sheriff's Department reported efforts to implement preventative measures, including installation of body scanners, enhanced monitoring, and specialized housing and treatment programs designed to support individuals who have overdosed and reduce the introduction of contraband into facilities. However, these scanners were only for those incarcerated, not for staff, custody, Correctional Health Services (CHS), or volunteers.

Commissioners emphasized the importance of addressing both prevention and treatment, including early identification of substance use disorders and improved access to medical and behavioral health services. The Commission **recommends the following:**

- The immediate installation of body scanners at all facilities to scan items being brought into facilities by all individuals, including staff members.

Commissioners also raised concerns regarding supervision, observation, and institutional practices that may affect the timely identification of individuals in distress. The Commission emphasized the importance of mandated Title 15 safety checks[6], attentive and adequate staffing, and proper documentation to ensure that incarcerated individuals are regularly monitored and that signs of medical or psychological distress are promptly addressed[7]. Concerns were expressed that failures in observation or communication could contribute to delayed intervention and increased risk of preventable deaths.

Transparency and timeliness in reporting deaths were also identified as areas of concern. Commissioners noted that determinations of cause and manner of death often remained pending for extended periods, limiting the Commission's ability to fully evaluate contributing factors and identify corrective measures. Commissioners emphasized the importance of timely access to information, including medical findings, investigative reports, and systemic reviews, in order to fulfill their oversight responsibilities and identify patterns that may require policy or operational changes.

Throughout 2025, the Sybil Brand Commission continued to emphasize that deaths in custody frequently reflect underlying systemic issues, including access to medical care, adequacy of mental health services, supervision practices, staffing levels and efficacy, and institutional coordination. Commissioners underscored the County's responsibility to ensure the health and safety of incarcerated individuals and stressed the importance of continued reforms, improved medical and mental health care delivery, enhanced supervision protocols, and greater transparency. The historic high number of deaths in 2025 culminated in California Attorney General Rob Bonta's lawsuit against the Los Angeles Sheriff's Department, highlighting the continued pattern and practice of appalling conditions in county jails that result in a loss of life.[8] The lawsuit cited the Sybil Brand Commission 27 times, as the Commission regularly and consistently documents inhumane conditions observed during their monthly inspections.

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[6] Board of State and Community Corrections. (2017). *Adult Titles 15 – Effect April 1, 2017* (PDF). California Board of State and Community Corrections. http://bscc.ca.gov/wp-content/uploads/Adult-Titles-15-Effect-4-1-17.pdf, TTCF 3/31/25 Inspection Report, NCCF 4/23/25 Inspection Report, MCJ 5/13/25 Inspection Report, CRDF 6/29/25 Inspection Report, TTCF 7/11/25 Inspection Report, IRC 7/23/25 Inspection Report, CRDF 10/7/25 Inspection Report, TTCF 10/26/25 Inspection Report, CRDF 11/25/25 Inspection Report.

[7] 7/10/2025 meeting minutes, item 2 LASD Report Back on Title 15 Checks.

[8] Bonta, R. (2025, September 8). *Attorney General Bonta sues Los Angeles County Sheriff's Department over inhumane conditions at county jails* [Press release]. Office of the Attorney General, California Department of Justice. https://oag.ca.gov/news/press-releases/attorney-general-bonta-sues-los-angeles-county-sheriff%E2%80%99s-department-over

III. Facility Status & Sanitation

Physical infrastructure continues to present a major barrier to humane conditions across all Los Angeles County jail facilities. Inspections have repeatedly documented aging and deteriorating buildings that result in unsanitary housing environments, persistent plumbing failures, inadequate ventilation and temperature regulation, and broken safety fixtures with restricted accessibility. These systemic deficiencies have been consistently cited in SBC reports throughout 2025 and demonstrate ongoing environmental health and safety risks for incarcerated individuals.

Unsanitary conditions remain widespread and chronic. Commissioners have observed extensive mold covering ceilings, walls, and vents, contributing to respiratory complaints among incarcerated people across all facilities visited. Across Men's Central Jail (MCJ), in particular, trash and discarded food accumulate throughout housing units, with cockroach infestations visible on floors and crawling on individuals' bodies. In some housing areas, the lack of basic hygiene supplies has forced individuals to improvise by using book pages as toilet paper. Rat and bug infestations are common in cells and common areas, with rat feces found in showers and housing units. Toilets are frequently broken or overflowing, and in some instances, raw sewage has been observed by Commissioners. Feces have been found smeared on walls of inhabited cells, posing direct health hazards to all individuals in the unit. Some cells lack functioning water fixtures, leaving individuals without reliable access to sanitation or drinkable water. Food has been reported as spoiled, moldy, or nutritionally inadequate, often served without sufficient access to hot water or potable drinking water. Trash and bodily fluids on floors and walls make housing areas difficult to clean and obstruct visual safety checks, which pose a safety risk for incarcerated individuals. Access to showers is inconsistent, with some individuals reporting prolonged periods without bathing, further compounding hygiene and health concerns. These conditions have been repeatedly documented, underscoring systemic sanitation failures and inadequate maintenance practices.

Plumbing and water failures remain persistent across facilities. Commissioners have identified broken or non-functioning toilets that cannot be flushed and contain human waste. Overflowing fixtures and sewage discharge through floor drains have been reported as a result of plumbing malfunctions. Some cells have no running cold water, forcing individuals to share or improvise water access. Drinking fountains have been found non-functional, requiring individuals to rely on sink water near or attached to the tops of shared toilets. Housing units have experienced intermittent or fully shut-off water service. Showers have been observed to be non-operational or running continuously, creating unsanitary conditions and contributing to humidity and mold growth. Reports of dirty or contaminated water, including brown or foul-smelling water used for drinking and bathing, have also been documented.

Broken safety fixtures and restricted accessibility continue to be recurring problems. Across all lockups, commissions have observed toilets that cannot flush and retain

human waste, as well as malfunctioning urinals that cause sewage to back up through floor drains. Overcrowded dorms combined with broken fixtures have made safe sanitation difficult to maintain. Aging and dilapidated infrastructure has resulted in non-operational lights, toilets, and water fixtures, impacting individuals' ability to safely access basic utilities. Because toilets and showers are frequently broken or clogged, incarcerated individuals must depend on deputies for limited access, effectively restricting independent and safe use of essential hygiene fixtures.

These conditions reflect a long-standing pattern documented by the SBC and are reinforced by county, state and federal oversight bodies, including the Sheriff Civilian Oversight Commission (COC), Office of Inspector General (OIG), American Civil Liberties Union (ACLU), California Board of State and Community Corrections (BSCC), and Department of Justice (DOJ). Persistent failures in physical maintenance, sanitation systems, and water infrastructure continue to compromise the health, safety, and dignity of incarcerated individuals. Oversight inspections consistently identify unsanitary housing conditions, plumbing and water system failures, unsafe or contaminated drinking water, broken sanitation fixtures, and restricted access to basic hygiene. These environmental conditions compound physical health risks, exacerbate mental distress, and hinder effective service delivery.

Without the closure of Men's Central Jail (MCJ) and substantial dedication to infrastructure repair and sustained maintenance across all facilities, these systemic deficiencies will continue to undermine humane treatment standards across all Los Angeles County jail facilities. Accordingly, the Commission **recommends** the following;

- That Los Angeles County prioritizes immediate focus on plumbing systems, water quality, sanitation, ventilation, and functional safety fixtures.
- That a facility-wide environmental health audit be conducted to identify urgent hazards, followed by a transparent remediation plan with timelines and accountability measures.
- That the County establish routine preventative maintenance protocols, increase custodial and facilities staff, and ensure independent verification of water safety and sanitation standards. Until permanent repairs are completed, temporary mitigation measures must be implemented to guarantee continuous access to potable water, functional toilets, showers, and basic hygiene supplies.
- That the County implement sustained oversight and public reporting as essential to prevent recurring deterioration and to safeguard the health and dignity of incarcerated individuals.

Water Conditions at Century Regional Detention Facility (CRDF)

At all 9 SBC inspections of CRDF occurring in 2025, reports describe particularly concerning water conditions. Rust-colored, brown water has been observed flowing directly from housing unit faucets. Foul-smelling water has been reported, suggesting

contamination or inadequate treatment. Worms or larvae have been observed emerging from pipes, indicating biological contamination of the water infrastructure. Commissioners have documented brown water collected in containers during inspections coming directly from CRDF pipes. Reports further indicate that CRDF staff avoid drinking facility water, while incarcerated individuals must rely on it, or purchase limited bottled water available through commissary and not accessible to everyone in the jail. These findings reflect systemic water safety failures, elevated for corrective action by the SBC for over one year. SBC contacted the County's Department of Public Health (DPH) for inspections, where they found sewer moths in multiple drains. However, DPH tested the water at CRDF in August 2025 and found no corrective action was needed, which stands in complete contradiction to the brown water observed by Commissioners on multiple visits and consistently reported by incarcerated persons.

IV. Health & Mental Health

The Sybil Brand Commission documented systemic delays in medical and psychiatric assessments, medication delivery, specialty referrals, and discharge planning, particularly affecting individuals with:

- Serious mental illness
- Chronic medical conditions
- Mobility limitations
- Pregnancy and post-partum

Mental health crisis response capacity remained insufficient, increasing risks of self-harm, psychiatric decompensation, and prolonged isolation and preventable suicide related deaths.

SBC inspections conducted in 2025 continued to document systemic delays and gaps in medical and mental health care across all Los Angeles County jail facilities. The Commission found that these delays are not isolated incidents but reflect persistent structural failures that disproportionately impact medically and psychiatrically vulnerable populations.

Individuals frequently experienced delays in receiving initial medical and psychiatric assessments following booking, resulting in missed or late identification of serious mental illness, pregnancy, and chronic medical conditions. In many cases, follow-up evaluations after positive screenings were inconsistent or significantly delayed. Medication continuity was also compromised, with prescribed psychiatric and medical medications often delayed, interrupted, or not promptly restarted after housing transfers or court appearances. These lapses increased the risk of destabilization for individuals who had previously been stabilized in the community.

Even when medication is available and provided, the jail staff often fail to ensure that people with serious mental illness take the medication provided. In general, deputy and nursing staff have shared with SBC that they dislike “pill call.” Medication is distributed by Licensed Vocational Nurses (LVNs), who are nurses trained in basic, specific nursing skills, and 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 continue their rounds. Both deputies and nursing staff have shared with the SBC that persuading incarcerated people to take their pills takes too long. Given these difficulties, there was significant turnover in the nursing staff assigned to the Forensic Inpatient (FIP) Stepdown Unit.

By comparison, currently incarcerated Mental Health Assistants (MHAs) ensure that the people assigned to the FIP Stepdown Units at Twin Towers Correctional Facility (TTCF) and CRDF take their medication. The FIP Stepdown Unit is a High Observation Housing (HOH) unit staffed by incarcerated individuals who are sentenced to long-term incarceration within TTCF and CRDF. These men and women receive specialized training from and are supervised by a dedicated psychiatric technician. The unit has a much more cheerful and relaxed appearance than the rest of the jail, with art and color. The people housed in the FIP Stepdown Unit keep their cells very clean. There is none of the graffiti that covers the walls of cells elsewhere in the HOH units of TTCF or CRDF. Despite significant mental illness, the people in the cells are alert and calm. Individuals wear a version of the usual jail fatigues, rather than the usual blue “suicide vests” (i.e., a padded and somewhat uncomfortable poncho) common to other HOH units. Elsewhere in TTCF and CRDF, these “suicide vests” are often discarded, leaving many of the people on HOH languishing naked in their cells. Many times, those individuals ask Sybil Brand Commissioners when they can get their clothing back.

Mental Health Assistants recognize that ensuring people in their care take their medication is a time-consuming process that requires patience 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, as is typical in many mental health facilities. MHAs 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 the FIP Stepdown Unit take medication. That is, if the patients do not take their medication in earnest, then they may become unresponsive and sometimes aggressive or violent, making it harder for the MHAs to succeed at their job and support those in the unit.

With the exception of the FIP Stepdown Units in TTCF and CRDF, access to specialty care remains limited across facilities. Inspections identified prolonged delays in referrals for higher levels of medical and psychiatric treatment, including obstetric services for pregnant individuals, mobility-related care, dental care, follow-up care, and advanced

mental health services. Reports also noted delays in transfers and reclassification to higher-level psychiatric housing and treatment modules, further restricting timely access to appropriate care. Off-site and on-site medical appointments were frequently delayed or missed due to transportation and staffing barriers, and coordination failures between custody, healthcare staff and court schedules, all of which SBC shared with CHS and urged improved coordination.

Nearly every visit of the SBC to a jail or lock-up facility ended with a list of individuals needing medical care who had been missed by the system. The SBC shared those needs directly with CHS for follow-up. At a follow-up CRDF inspection, one individual told a Sybil Brand Commissioner that their support of her request had ensured she was tended to and saved her life, after her medical request forms had previously gone unanswered for months.

Discharge and reentry planning also remained inadequate for individuals with complex medical and psychiatric needs. The Commission observed insufficient preparation for continuity of care upon release, including gaps in medication bridging, lack of confirmed follow-up appointments, and minimal coordination with community-based providers. These deficiencies increase the likelihood of relapses, hospitalization, and re-incarceration for vulnerable individuals.

The impact of these delays was most pronounced among individuals with serious mental illness, chronic medical conditions, mobility limitations, and those who were pregnant or post-partum. For individuals with serious mental illness, delays in psychiatric evaluation and treatment often resulted in worsening symptoms, increased reliance on restrictive housing, heightened risk of self-harm, and, in some cases, preventable suicides and deaths. Chronic medical conditions were frequently under-monitored, leading to preventable medical complications. Individuals with mobility impairments faced barriers to accessing timely care due to housing placements and transportation challenges. Pregnant and post-partum individuals experienced delays in prenatal and follow-up care, raising concerns about maternal and infant health outcomes.

Mental health crisis response capacity remained insufficient across facilities. Inspections documented delayed responses to suicidal ideation, acute psychiatric distress, and emotional destabilization. In the absence of adequate clinical intervention, individuals were often placed in restrictive housing or isolation, which further exacerbated psychiatric symptoms and increased the risk of self-harm, decompensation, and suicide[9].

Contributing factors identified by the Commission include chronic staffing shortages in medical and mental health services, inadequate coordination between custody, court

[9] National Alliance on Mental Illness. (2024, June 20). *How solitary confinement contributes to the mental health crisis*. https://www.nami.org/blog/how-solitary-confinement-contributes-to-the-mental-health-crisis/

scheduling, healthcare operations, and insufficient clinical infrastructure. The Commission also observed a culture among staff and deputies marked by deflection of responsibility and inconsistent empathy toward incarcerated individuals. Frequent housing transfers further disrupt continuity of care and compromise treatment planning. Additionally, overcrowding—exacerbated by the impacts of Proposition 36—has intensified pressure on already limited clinical resources.[10]

Lastly, through inspections of courthouse holding facilities, another concern regarding medication and continuity of care arose. Despite LASD reports that individuals should receive their medication prior to arriving at the court, or with medications with them, we have observed that this can cause issues when they have worn off, and/or does not happen in practice. Many individuals sent to court state they do not have their medications sent with them and must wait until they return to their assigned housing for their medications to be given to them. We are frequently told by a person waiting for their court appearance coming from North County Correctional Facility (NCCF) that they took their medication at 2:00 A.M. when they were awoken to get ready for transport to court. This is unacceptable – people need to be taking their medication at the prescribed times (morning, with breakfast, or multiple times per day). We also spoke with an individual who was at the Inmate Reception Center (IRC) court line following his full-day court appearance, housed at MCJ. He was experiencing a medical emergency following a full day without his medication, and he only received medication when the Commissioners spoke with him and alerted LASD about the emergency, so they could call for medical attention. It is imperative that, despite the required logistics of attending court dates, individuals are given their medications within the prescribed timeframe.

These persistent failures compromise the health, safety, and dignity of incarcerated individuals and significantly increase the risk of constitutional violations related to deliberate indifference to serious medical needs, thereby exposing Los Angeles County to substantial legal liability and potential litigation. The Commission found that current conditions undermine stabilization efforts, exacerbate long-term health needs, and place vulnerable populations at heightened risk of preventable harm. Without structural reform and sustained investment in medical and mental health care delivery systems, these systemic delays and gaps will continue to jeopardize both individual outcomes and public safety.

To address ongoing delays and gaps in medical and mental health care documented in 2025 inspections, the Sybil Brand Commission **recommends the following;**

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[10] In a presentation shared with the SBC, the Community Safety Implementation Team (CSIT) reported jail population increases, including a 178% increase in people being held under the provision of Prop 36. Los Angeles County Community Safety Implementation Team. (2025, June 28). *Sybil Brand Commission presentation* [PDF]. https://file.lacounty.gov/SDSInter/bos/supdocs/204981.pdf

- System-wide reforms to ensure timely, consistent, and appropriate treatment, particularly for individuals with serious mental illness, chronic medical conditions, mobility limitations, and pregnancy-related needs.
- That the County strengthen intake screening and enforces clear timeframes for follow-up medical and psychiatric assessments.
- Prioritize Medication continuity through improved verification systems and adequate pharmacy staffing to prevent interruptions in care.
- Access to specialty services should be expanded through increased clinical staffing, improved scheduling, and the use of telehealth where appropriate.
- That Mental health crisis response capacity be enhanced by increasing on-site crisis clinicians, reducing reliance on isolation, and implementing therapeutic stabilization alternatives.
- That discharge planning should ensure continuity of care through timely medication supply and confirmed community referrals.
- Improved coordination, data tracking, and independent oversight are needed to monitor compliance and drive corrective action.
- A sustained investment in healthcare staffing and infrastructure is essential to prevent ongoing harm and ensure constitutional standards of care, along with an expansion of the MHA program.

V. Food & Nutrition

Over the course of inspection reporting throughout the year, there were numerous complaints of hunger, indicating insufficient food quantity and quality. It has continuously been reported that meals arrive inedible. For example, people incarcerated in Los Angeles County jails report to us that they receive moldy bread, raw chicken, green/blue eggs, and expired milk[11]. Sybil Brand Commissioners have directly observed these food conditions at multiple facilities across multiple inspection reports. In addition to the quality of the food, individuals reported they receive “enough food for a child, not a grown person.”

Due to the poor quality and standardized–and often insufficient–portions, many incarcerated individuals rely heavily on commissary food opposed to the jail-provided meals. This necessitated reliance on commissary to avoid hunger, does not support nutrition and further places pressures on the loved ones and families of those incarcerated to provide significant funds[12]. Individuals without access to such support

[11] Multiple incarcerated individuals at Century Regional Detention Facility (CRDF) reported “spoiled/uncooked food, rancid milk, rotten eggs, moldy bread” during the August 19, 2025, inspection https://file.lacounty.gov/SDSInter/bos/commissionpublications/report/1192656_081925_CRDFInspectionReport_Broder_Terrones.pdf. See report on website for further details.

[12] “Examples of the overpriced food and drink items include: 3-ounce, Beef Ramen pack for $1.60; 12 ounces of Water for $1.43; 8-ounce package of Flour Tortillas for $6.05; 4.23-ounce pouch of FC Chunk Light Tuna for $8.58; 12.5- ounces of Keebler Club Crackers for $10.95; 8-ounce bag of Cheetos Flamin’ Hot for $6.46. The same for

are in an even more vulnerable position when it comes to reliance on the unreliable food source.

Systemic Hunger and Nutritional Complaints

Across Sybil Brand Commission inspections, Commissioners documented widespread complaints of hunger, with some incarcerated people reporting not getting enough food to feel satisfied. These findings echo patterns seen in multiple reports earlier in 2023-2025 that noted insufficient food portions leading to hunger, highlighting the persistence of this issue.

There were complaints of moldy burritos, very cold meals, and reports of food poisoning from dinners, indicating problems both with preparation and food quality that would affect overall nutrition. SBC findings reported that facilities often failed to consistently accommodate special diets (e.g., vegetarian, high-protein, religious diets), which contributed to dissatisfaction and hunger complaints among incarcerated people.

There have also been highly concerning reports that special diets were often held from individuals as an act of punishment or retaliation. The TTCF inspection of July 2025 shared that an "[i]ndividual reported that when a disturbance or incident occurs, deputies have an 'excuse' for special diets arriving cold. He noted weeks to months for special diets to be approved by medical [authorities]."

Courts, Stations, and Inmate Reception Center (IRC) Courtline

When someone arrives at a jail facility, they are assessed during a detailed intake process. During this assessment, a medical review is completed, which determines whether any special needs are necessary. This assessment includes a physical and mental health medical review. If a determination is made that the individual needs special diets or medications, medical orders will be written for custody staff to follow.

Commissioners noted significant concern in reports specific to the ability, or lack thereof, of courthouse holding facilities to fulfill special dietary needs while a pre-sentenced incarcerated individual is attending court.

Many of the court holding facilities are supplied with lunch bags consisting of ingredients to make peanut butter and jelly sandwiches, and a juice box. This raises concern for any incarcerated person who might have any food allergies or other special dietary needs, such as diabetes. Commissioner inquiries led to LASD stating that individuals

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hygiene items, such as 3.5-ounce bar of Neutrogena Soap for $5.53; 12-ounce container of Pantene Classic Clean Condition for $10.28; and 10- ounce container of Vaseline Cocoa Butter Lotion for $9.50. Alongside the prices, there is a weekly spending limit of $195, which includes a limit of $40 in vending cards plus an unknown additional handling fees and the 9.5% tax." Los Angeles County Board of Supervisors. (2025). Motion by Supervisors Hilda L. Solis and Lindsey P. Horvath: *People Over Profit: Fairness and Equity in Commissary Prices for the Los Angeles County Jails* (PDF). Los Angeles County. https://file.lacounty.gov/SDSInter/bos/supdocs/193045.pdf

going to court with dietary restrictions should leave their place of incarceration for court with their special diet. In practice, per Commissioner inspections, this is not happening. Commissioners have spoken with many individuals pre-court or returning from court, or at court lockups, who do not have food to eat due to their special diets.

We **recommend** systematization and better assurances that individuals are provided with their special diets prior to heading to court and that the LASD avoid serving foods prone to allergies.

VI. Complaint System / Grievances

The SBC observed significant barriers to meaningful grievance resolution, including:

- Delayed response timelines
- Inconsistent documentation and follow-up
- Limited feedback loops
- Inadequate tracking of systemic patterns
- Lack of forms available
- Lack of regular checking of forms
- Paper system rather than electronic documentation.

This undermines incarcerated individuals' ability to seek redress and limits institutional learning from recurring problems.

Commissioners noted that many people filed grievances that went unanswered, and there was no grievance tracking system — people presented stacks of grievances without responses. In some modules, grievance forms were not available at all, and incarcerated people could not easily obtain them, having to ask staff for one. When SBC requested grievance forms from staff, they did not have them, had to go get them, or had to print them.

In one 2025 MCJ SBC inspection report, multiple men in one dorm complained that they filed grievance forms regarding a lack of night lights, inoperable toilets, inadequate access to lawyers, and long-term confinement in a unit. The men reported that none had received a response to their grievances. This is not an isolated occurrence and, instead, is representative of a pattern consistently noted in Sybil Brand inspection reports.

VII. Sexual Violence and Prison Rape Elimination ACT (PREA) Non-Compliance at CRDF

In inspection reports from multiple SBC visits to CRDF in 2025, Commissioners received and forwarded complaints from incarcerated women describing sexual

misconduct and privacy violations in shower areas, including sexual harassment and sexual assaults by Los Angeles Sheriff's Department deputies.

It must be noted that the sexual violence to disproportionately target Black, Latino/a, and Indigenous incarcerated women. The power balance within the jail is extreme, and those incarcerated are vulnerable. When deputies control every aspect of an incarcerated person's life, including movement, access to food, nutrition, medical care, visitation, grievance forms, programming, and showers, such structural leverage can be sexually exploited as a form of coercion and abuse. Black and Indigenous women and transgender women are overrepresented in reports of sexual abuse in custody.

Women incarcerated at CRDF alleged that deputies watched them shower from elevated vantage points, that **privacy protections were inadequate, and that this cross-gender shower viewing violated PREA**. Complaints of voyeuristic behavior were reported directly to Commissioners during inspection visits. During inspection visits in June, August, September, and October 2025, women at CRDF reported sexual assault by deputies.

Commissioners reported that multiple women shared that deputies sexually assaulted them and forced unwanted acts, including being observed in shower areas and being subjected to degrading conduct by male staff, such as watching women shower and manipulating shower conditions for amusement. Accused deputies named in the reporting process were still employed, with some reassigned to other facilities. Upon the Commissioners reporting issues to the PREA officer at CRDF, both Commissioners felt intimidated and not trusted. The reporting did not seem trauma informed. The ongoing class-action lawsuit against the County arising from these allegations has wide monetary implications for the County, which might have been avoided if LASD had acted on the Commission's earlier findings over the prior many months.

Between January 2022 and September 2025, 592 allegations of abuse and harassment against staff, including claims of sexual misconduct, were filed by people who are incarcerated. In Fall 2025, during a COC meeting, the COC questioned LASD's claim that there had been no "substantiated" staff-on-inmate sexual abuse allegations in recent years, calling that lack of substantiation a "red flag" about the investigative process, which the SBC reiterated.

Under the PREA, 2003, sexual abuse of incarcerated people is recognized as a misuse of institutional power, not consensual sex. While LASD responds that they have a "zero tolerance policy towards sexual violence," this is clearly far from the truth or reality at the Los Angeles County jails.

The SBC is particularly concerned about retaliation following reporting, and the lack of trauma-informed care, mental health treatment, and appropriate follow-up for survivors reporting sexual crimes while incarcerated. Sexual assaults in jails and prisons are

fundamentally abuses of systemic power and exploitation of the most vulnerable, and this must be handled appropriately, seriously, and swiftly.

VIII. Recommendations

We reiterate the recommendations from the Sybil Brand Commission's 2024 Annual Report, and note that in the months since its release, none of the recommendations have yet been implemented to a satisfactory or significant change-worthy level:

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's 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.

We recommend the following in addition to the above 2024 recommendations:

1. Closure of Men's Central Jail (MCJ) with no new locked replacement run by LASD.
    a. The physical conditions within MCJ are inhumane and we must mandate the immediate closure of the jail.
    b. The Sybil Brand Commission met with the Community Safety Implementation Team (CSIT), which assured the Commission that the Public Defender, Alternate Public Defender, courts, ODR, DMH, DPH, and Substance Abuse Prevention Control all agree that MCJ needs to close.

   c. Especially in the case of people with significant mental illness, the SBC strongly recommends an alternative to sheriff-run institutions, as the culture of care necessary for treating such people is beyond the capacity of the Los Angeles Sheriff's Department and contrary to their highly punitive culture which consistently indicates a disdain for the people in their custody, including the longstanding failure to engage in adequate Title 15 safety checks.
2. Ensuring that men and women in the LA County jail system have access to grievance forms and adequate and timely explanation of any grievance denial, as well as instituting an external ombudsperson to review the grievance database to identify systemic problems raised by people in the jail system.
   a. Grievance forms are often unavailable because the form dispensers are empty or are restricted to regular access through control by deputies.
   b. People in the jails complain that they are given insufficient explanation for any denial of their grievance form requests or lack of follow-up.
   c. An independent review of the grievance process to identify systemic issues with timeliness and complaints is necessary, given the number of grievances made by people in the jails. The grievance tracking process must be electronic.
3. Provide special diet accommodation, medication and mobility aids as needed, even on court dates for those medically indicated to receive such provisions.
4. An independent investigation of alleged PREA violations in CRDF, as well as an independent investigation of the treatment of transgender people in MCJ.
   a. The Commission is deeply concerned with reports of PREA violations reported in CRDF and is concerned that an investigation by the LASD alone is insufficient to provide the appearance of justice and impartiality required to assure the public of the safety of the women held in county custody.

IX. Conclusion

The SBC is committed to conducting unannounced, unescorted inspections of the Los Angeles County lock-up and jail facilities. We view it as a privilege to enter these spaces and provide the community with our unfiltered look at what is happening inside to their loved ones, neighbors, and community members. We continue to be horrified by what we see occurring in these facilities, from improper sanitation, the status of food and nutrition, outstanding health needs, and overarching conditions.

The SBC is particularly alarmed by stories of sexual violence shared by incarcerated women, the unsanitary water, the lack of care in dealing with a host of health issues,

and, of course, the extremely high and unacceptable number of deaths that occurred within LASD's custody this past year.

The SBC will continue to inspect these conditions and report its findings. The SBC strongly urges the Sheriff's Department and Board of Supervisors to take seriously the issues raised in this report and adopt the SBC's recommendations to bring about the changes needed to maintain the wellbeing, health, and dignity of the incarcerated people in our care.

HB:vsz

c: Los Angeles County Board of Supervisors
Los Angeles County Sheriff
Executive Officer
California Attorney General's Office
County Counsel
Education Deputies, Board of Supervisors
Justice Deputies, Board of Supervisors
Health Deputies, Board of Supervisors
Social Services Deputies, Board of Supervisors
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
Inspector General, Los Angeles County
Executive Director, Los Angeles County Sheriff's Civilian Oversight Commission