Los Angeles County
Sybil Brand Commission for Institutional Inspections

Draft Report & Recommendations on the Los Angeles County Jails Crises

2023

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To the Honorable Los Angeles County Board of Supervisors and Los Angeles County Sheriff Robert Luna:

The Sybil Brand Commission for Institutional Inspections is authorized by Chapter 2.82 of the Los Angeles County Code to inspect adult jail facilities in the County and to "ascertain its condition as to effective and economical administration, the cleanliness, discipline and comfort of its inmates, and in any other respects."[1] The purpose of this report is to provide the County with a summary of significant findings from this Commission's inspections in 2022-2023.

A humanitarian crisis is unfolding inside the walls of the Los Angeles County jail facilities. The Sybil Brand Commission for Institutional Inspections finds a frustrating persistence of crisis conditions rooted not only in overcrowding but also the manner in which the jail is being administered.

As you know, Los Angeles County maintains a prison-sized jail system, with numerous facilities spread out across the County. Based on its rated capacity, Men's Central Jail would be the largest prison in the state not administered by a department solely dedicated to running a correctional facility. Instead, the Los Angeles County Sheriff's Department is responsible for administering the jail while the Department of Health Services, through its division of Correctional Health Services, provides medical and mental health services for people incarcerated in the jails.

Currently, a patchwork of oversight of the jails is provided by a professionalized Office of the Inspector General and the Board-appointed Civilian Oversight Commission and Sybil Brand Commission for Institutional Inspections, while the Department of Public Health conducts annual inspections of the facilities. The Board of State and Community Corrections is responsible for certifying facilities for suitability. Additionally, there are other entities, such as a federal monitor and the American Civil Liberties Union of Southern California, which report on jail conditions pursuant to various consent decrees. The Sybil Brand Commission is not designated to evaluate or monitor the terms of any legal settlement or consent decree, even though its observations may overlap with the subject matter covered by such binding agreements.

What makes the Sybil Brand Commission a unique layer of oversight is its composition of community members who engage in inspections of the facilities to inform the community of the County's conditions of confinement and its carceral practices. The County authorizes each Commissioner to conduct two inspections of the jail facilities per month. Commissioners generally provide no advance notice of an inspection, but must report their presence to the guard operating the main sallyport, and LASD expects inspectors to "check-in" and "check-out" with the watch commander, who is usually a person with a LASD rank of lieutenant. Commissioners are also usually permitted to conduct inspections without accompaniment by an LASD escort, unless they are entering a room or space with incarcerated persons, such as a larger dormitory. Inspections often involve interviews with people who are incarcerated in the jails, followed by a discussion of the issues presented with law enforcement personnel assigned to the facility.

Inspection reports are published to the Commission's website, sbc.lacounty.gov. The Commission discusses inspection findings at its publicly accessible meetings. In an effort to meet the challenge of overseeing conditions that are often atrocious, this Commission has formed an ad hoc group that meets regularly with representatives of the Civilian Oversight Commission and the Office of the Inspector General to discuss major findings and observed patterns, and has participated in meetings held by the Civilian Oversight Commission to review

[1] https://library.municode.com/ca/los_angeles_county/codes/code_of_ordinances?nodeId=TIT2AD_DIV3DEOTADBO_CH2.82SYBRCOININ_2.82.090INATBEEX

conditions of confinement. When appropriate, this Commission also notifies representatives of other relevant County Departments, such as the Department of Public Health and the Department of Mental Health. Legal authorities at the state and federal level are also aware of the Commission's inspections reports. Commissioners also engage with media to answer questions about jail conditions and encourage community insight into the outcomes of the Commission's efforts.

Despite multifaceted strategies this Commission has developed to educate the County and the community about jail conditions, we continue to be alarmed and frustrated with the regularity with which we find unsafe and unsanitary conditions in the jails. Systemic issues this Commission brings to the attention of responsible parties are not being adequately investigated or addressed. This Commission's findings almost never lead to a response from responsible parties with an acknowledgement of error and a corrective action plan. This Commission has also found evidence of failures by LASD custody personnel to maintain adequate policies, to adhere to those policies, or to supervise and enforce those policies. While staffing shortages may be partly to blame, County agencies have not provided this Commission with sufficient information to determine whether the root cause of crisis conditions in the jails is attributable to a lack of staffing or to a failure to adapt policies and practices to mitigate the harms caused by chronic overcrowding. These failures raise questions about whether the administrative orientation of jail leadership is misaligned with the County's priorities to eradicate odious carceral practices due to internalized hostility to change within the Sheriff's Department.

This report summarizes recent inspection findings illustrative of the challenges to bringing a troubled era for the jails to a conclusion. Part I of this report consists of findings and observations of various components of the jail. Part II consists of a series of recommendations.

Drafter's Note

Efforts have been made to use plain language to achieve clarity when describing the practices of an institutional setting that consists of overlapping and occasionally competing lexicons, and in which terms of art are contextual. The drafters of this report have sought to use "people-first" language foremost by avoiding terms such as "inmate" as much as possible. Departures from this principle have been made occasionally, such as when necessary to be consistent with language in a policy or a statute. The drafters have also sought to be objective when describing the impression or effect of bearing witness to people enduring unconscionable conditions of confinement. Efforts to respect the humanity and to protect the identity and confidentiality of sources have been made. – A.P.S.

Findings & Observations

Twin Towers Correctional Facility

Twin Towers Correctional Facility is the core of the County's jail-based mental health institution for people who have been diagnosed by a health care provider, or otherwise placed into a category, with having a more serious mental illness. The constitutional rights of people who should be receiving such care is the subject matter of a settlement agreement entered into with the United States Department of Justice in 2015.[2] A court-appointed monitor is primarily responsible for determining whether the County is in compliance with the terms of the settlement and files reports with the relevant court periodically throughout the year. As of May 2023, the County has still not achieved complete and substantial compliance with the settlement.

While the Sybil Brand Commission is not designated by the court to evaluate the DOJ agreement, or any other consent decree currently in order at the jail facilities, it conducts inspections in the facilities and makes its own independent observations of conditions therein. These observations may at times overlap with the subject matter of the DOJ agreement.

In 2022-2023, Commissioners conducted numerous inspections of cells housing people with serious mental illness and found conditions there to be abominable. Commissioners observed people languishing in cells covered in human waste and infested with insects for days. These were "H.O.H." cells -- high observation housing -- which are frequently inspected by custody staff multiple times an hour. The cells are designated to be inspected at the beginning of each shift, which must be documented in the daily activity log.

According to unit orders, when a cell is found to have unsanitary conditions that pose a "significant health risk," the conditions are to be reported "immediately" to Correctional Health Services and the assigned floor sergeant, and efforts must be made to remove the person from the unsanitary conditions and for it to be cleaned.[3] In this case, that did not happen and this Commission has not received adequate assurance that this is not the norm. Commissioners reported these conditions to LASD and then returned to inspect the same pod several weeks later. At that time, conditions were once again found to be unacceptable. One person, who was communicative and cogent and yet unclothed, proved the existence of an infestation in his cell by reaching under his bed frame and presenting for observation a fist-full of what appeared to be juvenile cockroaches.[4]

Follow-up communication with the Sheriff's Department and Correctional Health Services revealed confusion as to who is ultimately responsibility for maintaining sanitary conditions and pest control at Twin Towers. With LASD and CHS sharing numerous areas of overlap in Twin Towers, personnel should be clear on who is ultimately responsible for something as basic as maintaining sanitary conditions. Yet a review of the Custody Division Manual and the facility's unit orders were vague and ambiguous as to the important matter of who shall be responsible for determining whether highly unsanitary conditions pose a significant health risk to a person such that he or she needs to be removed from the setting. LASD and CHS officials said the confusion was due to a period of time in which a contract with a third-party janitorial service provider was extended to provide such services in the facility. However, the policies and unit orders had not been updated to reflect the scope of the third-party's responsibilities or how such a third-party would be situated within an overall chain of command. LASD also asserted unsanitary conditions were due to the lack of an ample supply of unpaid incarcerated labor,

[2] https://www.justice.gov/opa/pr/justice-department-reaches-agreement-los-angeles-county-implement-sweeping-reforms-mental

[3] https://file.lacounty.gov/SDSInter/bos/supdocs/180661.pdf

[4] https://file.lacounty.gov/SDSInter/bos/Commissionpublications/report/1141138_032423_TTCF_InspectionReport_Sherman.pdf

which they said they have a "huge vested interest" in maintaining.

LASD sanitation policies do not properly account for the apparent complexity of administering a mental health treatment facility. For example, policies state it is the responsibility of each inmate to maintain a clean housing area; however, the policies do not distinguish between a person who is being uncooperative with housecleaning rules from a person who, as a result of a known and documented serious mental illness, may lack the capacity to cooperate or maintain sanitary conditions for their housing area.

Erasures of mental disability in policy play out in view of Commissioners during inspections. For example, many people incarcerated at Twin Towers tell Commissioners they are not being allowed to take a shower, even though regulations require an offer for shower to be made every other day. Deputies administering these pods engage in a practice of labeling inmates as "hostile" on the medical-custodial chart adhered to their cell doors, and have told Commissioners they will subsequently decline to offer the inmate an opportunity to shower. In one case, an individual who said he had been labeled as "hostile" by a deputy while a Commissioner was nearby, told that Commissioner he earned the label because he had expressed anger at custody staff who he said threw food at him through the door slot. Multiple people in Twin Towers have made similar complaints about deputies throwing food at them.

During the same inspection of the same pod, the Commissioner observed custody staff making disrespectful comments to another individual during food service: *"Why do I have to understand what you are going through? Do you want to eat? Do you speak English? Whatever language you understand, lay on your bunk. You're not doing what I told you."*[5] Food was not served.

Deputies who rotate assignments in facilities used for housing people with serious mental illness assert their engagements with people can be dangerous, including at food service or at opportunities for shower. At the same time, Commissioners have observed deputies utilizing disciplinary practices that incorporate obliviousness or indifference to the mental disabilities of people who are incarcerated at Twin Towers for the purpose of treatment. This gives Commissioners the impression of a dynamic set in place by facilities administrators and would at least partly explain why people at Twin Towers are often found not engaging with staff and wallowing in abject filth.

Men's Central Jail

Conditions in Men's Central Jail are widely acknowledged to be very poor and have been so for many years. Substandard conditions are routinely found throughout the facility, but are particularly common in numerous overcrowded dormitories on a single floor, 5000, used to house hundreds of people who have received a diagnosis of mental illness. These dorms are known as "M.O.H." -- medium observation housing -- and the Sheriff's Department is mandated to conduct frequent inspections of the welfare of people multiple times each hour. Thus, when this Commission find poor and degrading conditions in areas under high or medium observation, the existence of those conditions is attributable to a lack of oversight and supervision by custody personnel who have an affirmative duty to maintain a humane facility.

The mental health housing units on 5000 form part of the complex that has colloquially earned the Los Angeles County jail system the distinction of being the "world's largest mental health facility," as it contains scores of individuals who have been categorized and grouped by a so-called "P-level" that should bear

[5] https://file.lacounty.gov/SDSInter/bos/commissionpublications/report/1141138_032423_TTCF_InspectionReport_Sherman.pdf

some relationship to a clinical and custodial impression of a person's mental health. Yet these areas fall outside of the comparatively small medical and mental health care areas that serve as care facilities. Thus, the treatment and care provided in the facilities at Men's Central Jail is often substandard, inconsistent, and chaotic, and the settings and staff interactions are not trauma-informed in accordance with best practices.[6] Concerns about these issues have been raised with County officials and departments including the Sheriff, Correctional Health Services, the Office of the Inspector General, and the Department of Mental Health's Patients' Rights Office.[7]

- In February 2022, Commissioners found individuals in 5000 with limited access to supportive mental health services. The Sheriff's Department's mental health teams, JMET, look for indicia of suicidality, but inmates have no space to meet with counselors in a confidential setting. There is limited recreation time or other recovery activities for individuals with a mental health diagnosis.[8]
- In March 2022, Commissioners revisited 5000 with representatives of the **Office of the Inspector General**. Commissioners visited with people incarcerated in a dormitory that was then overcrowded and under a quarantine order to control the spread of COVID-19. Incarcerated persons said they were not being provided with cleaning supplies to clean the facilities and Commissioners noted the squalor. Incarcerated persons described disrespectful conduct from deputies, as well as feelings of neglect, harassment, intimidation by staff, and an expectation to face retaliation for raising concerns. Staff indicated fights occurred frequently on 5000 and expressed a wish to relocate the mental health population.[9]
- In July 2022, Commissioners visited 5000 with leadership from **Correctional Health Services**. Commissioners found one dormitory without a single functional, sanitary drinking fountain -- incarcerated persons adapted a disposable plastic straw as a D.I.Y. repair to a single spout, shared by an entire cohort of people -- as well as broken air conditioning leading temperatures to be uncomfortably warm. Commissioners found no open maintenance order to repair the water fountains. Deputies alleged it was the inmate's responsibility to report the issue, but grievance forms were not accessible to inmates unless on request, and inmates stated a fear of retaliation for filing grievances. Furthermore, individuals receiving mental health care had no space to meet with mental health care workers to share such concerns in confidence, out of view of law enforcement.[10]
- In August 2022, Commissioners visited 5000 and found the Sheriff's Department had reversed its policy to provide life-saving Narcan in dormitories. A year earlier, the Sheriff's Department had received some publicity for making Narcan available in dormitories to prevent death due to opioid overdose. Inmates also alleged their belief that deputies were slow to

[6] See, e.g., the Sequential Intercept Model. https://www.samhsa.gov/criminal-juvenile-justice/sim-overview

[7] The DMH Patients' Rights Office purports to provide a "voice" for "mental health consumers" in the jails, but has not been physically present in the jails for several years. https://dmh.lacounty.gov/our-services/patients-rights/#:~:text=Please%20contact%20the%20Patients'%20Rights,questions%20or%20need%20more%20information

[8] https://file.lacounty.gov/SDSInter/bos/Commissionpublications/report/1138007_022722MCJInspectionReport_Sherman_Veral.pdf

[9] https://file.lacounty.gov/SDSInter/bos/Commissionpublications/report/1137985_030922MCJInspectionReport_Sherman-FINAL.pdf

[10] https://file.lacounty.gov/SDSInter/bos/Commissionpublications/report/1137996_072722MCJInspectionReport_Sherman.pdf

respond to calls for medical emergencies.[11]

- In December 2022, Commissioners observed a use of force incident involving a person with mental illness incarcerated at Men's Central Jail as he was being transferred from a dormitory on 5000 to another facility for a higher level of mental health care. During the incident, Sheriff's deputies obstructed Commissioners from observing. After the **Civilian Oversight Commission** invited members of this Commission to meet with Assistant Sheriff Sergio Aloma to discuss the matter, it was learned the Sheriff's Department was aware of the particular challenges associated with the manner in which people are incarcerated on 5000 and that a use of force was confirmed by the Sheriff's Department to be under investigation for being inappropriate.[12]
- In December 2022, Commissioners found incarcerated individuals in dormitories on 5000 wearing dirty clothing and other unsanitary and unhygienic conditions. Commissioners found inmates in overcrowded dorms, analogized the setting to people being packed like "sardines" in triple bunks, some without being given a foam pad mattress. Inmates described not being served hot meals, as required by law. Commissioners observed conditions to be "abysmal" and "unsafe," with no visibility into many of the bunks. Commissioners also visited with inmates who had been placed on a disciplinary row, and were being treated as such, not because they had violated any jail policy, but because they had been labeled "walk-outs" for refusing to be housed in the overcrowded dorms due to concerns for their personal safety.[13]
- In March 2023, Commissioners visited 5000 (and well Twin Towers) with representatives of the **Department of Mental Health Patients' Rights Office**. The Department of Mental Health is not the direct provider of mental health services to incarcerated people, but the Patients' Rights Office purports to "provide support and a voice for male and female mental health consumers that are in the county jail by investigating and responding to inmates' mental health complaints and concerns" and to "educate Jail Mental Health and Los Angeles County Sheriff staff on patients' rights issues."[14] This Commission found this office of DMH had not been inside the jail since at least the beginning of the COVID pandemic and, in general, only participates in conservatorship hearings as patient advocates remotely via videophone, and therefore its advocates are unfamiliar with the conditions mental health patients may be subjected to, including while they languish on the wait list for escalated in-patient care. Incarcerated persons who receive mental health treatment in the jail have no meaningful way to exercise their right to contact Patients' Rights Advocates to raise issues about the conditions or concerns with the provision of mental health care.[15]

[11] https://file.lacounty.gov/SDSInter/bos/Commissionpublications/report/1137998_0822_MCJInspectionReport_FrutosandSherman.pdf

[12] https://file.lacounty.gov/SDSInter/bos/Commissionpublications/report/1138002_121322_MCJInspectionReport_Regalado_Sherman.pdf

[13] https://file.lacounty.gov/SDSInter/bos/Commissionpublications/report/1138004_122622_MCJInspectionReport_Miller_Sherman_Veral.pdf

[14] https://dmh.lacounty.gov/our-services/patients-rights/#:~:text=Please%20contact%20the%20Patients'%20Rights,questions%20or%20need%20more%20information.

[15] https://file.lacounty.gov/SDSInter/bos/Commissionpublications/report/1141136_031623_MCJ_InspectionReport_Veral.pdf

Century Regional Detention Facility

At Century Regional Detention Facility, where women in the County are incarcerated, this Commission finds evidence of isolation, seclusion, poor sanitary conditions, slow-to-negligent medical care, poor nutrition, dehumanizing strip searches among the litany of substandard conditions. Testimony from a person incarcerated at CRDF in 2020, and later graduated from the Office of Diversion and Re-entry's Housing program, was shared at a town hall in skid row with delegates from the United Nations' International Independent Expert Mechanism to Advance Racial Justice and Equality in the context of Law Enforcement (EMLER), who visited Los Angeles to hear testimony from Black residents regarding the impacts of incarceration and policing on their lives:

> *"The process of being in the women's jail is dehumanizing. Pre-housing is filthy and nasty. There was no screening process, so I was in the same space as people having mental health breakdowns. Once housed, we are placed on 23- and 24-hour lockdowns on alternating days. You have to shower, make phone calls, collect mail--if they give it to you--in that short period which ends up being about 30 mins every other day.*
>
> *You always have to be quiet so they can hear their radios. We didn't have reading materials. We were just stuck there in our own heads. Being in my head wasn't a good space to be in, and because of these isolating conditions and because I was facing 25 to life, I had an anxiety attack. Despite thinking I was having a heart attack; they were very slow to give me medical attention. Eventually I was seen and placed on a 5150 hold."*

These conditions, and conditions like it, have been endured by community members for decades and we as Commissioners can confirm still exist. In 2015, Dignity and Power Now, an advocacy organization, published a report documenting the prevalent patterns of medical neglect and abuse experienced by Black women in the jails. The report documents how practices and conditions in the County's jail for women fail to comply with domestic, regional, and international human rights law.

Interviews gathered in the 2015 report draw a direct line between the experience of Black women in custody almost 10 years ago and today. Many of the concerning and harmful trends documented continue to be confirmed by recent inspections by members of the Sybil Brand Commission in 2023. One interviewee from the 2015 report, Nina, recounts the story of isolating and dehumanizing conditions that included 23-to 24-hour lockdown, inability to see a mental health professional despite numerous requests, and dehumanizing treatment by deputies that pushed her to attempt suicide. Nina said in the report: "I wanted to see a doctor and couldn't. That's why I jumped." Nina's experience is alarmingly similar to recent testimony from people held in CRDF.

Below is a list documented conditions from our reports as well observed impact on the women who reported to the Sybil Brand Commission:

- On February 3, 2023, Commissioners inspected the 2500 and 2700 modules and documented numerous issues that required corrective action including rampant complaints of insects in the cell water faucets, insufficient access to t-shirts, thermals, and underwear. Women across more than one module complained about a chemical smell reminiscent of bleach present in the shower and drinking water. Commissioners confirmed the smell by direct observation. Multiple women across more than one module reported

skin rashes that they have developed. One woman reported having waited weeks for medical staff to address the rashes but at the time of the inspection she had not been seen.

- Across more than one inspection this year, people in CRDF have complained of not being not being given enough tampons or sanitary napkins. People held in CRDF have shared that deputies ration these items and make an arbitrary determination as to whether a request reflects an actual need. Pregnant women have reported concerns of inadequate medical care and treatment. One complained that she experienced bleeding after an OBGYN exam. After requesting a different doctor, she said she has been denied OBGYN appointments since. A pregnant woman complained that she was experiencing pain and requested to see a doctor. Staff was made aware of the request but delayed responding to her request as did medical. She was eventually taken to a hospital where she lost her baby.
- During a follow-up inspection on February 3, several women complained about mistreatment by deputies. There have been consistent reports from women that deputies are disrespectful, threatening, and abuse their authority. Several women shared that the deputies call them the "b word" and the "N word." Women report that deputies decide on a whim whether people at CRDF receive access to programming. When attempts were made to take the issues to the facility Captain, deputies were reported to have said, "I don't care what the captain says."
- One week after the February 3rd inspection, the Sybil Brand Commission was contacted by the lawyer of a woman who made complaints to us during the inspection. The lawyer was very concerned about the mental and emotional state of her client who reported that since speaking to the Commission had experienced retaliation. Her client shared that deputies were not letting people out of their rooms regularly, continued to use foul racially demeaning language, were throwing their food on the floor, and had limited their access to showers. Her client reported that deputies were upset that the women "went over their heads." Her lawyer visited her client at CRDF, who was at the time being held in isolation. She was directed by Sheriff staff to a waiting room where after 25 minutes, her client did not show. The lawyer returned to the staff responsible for managing visits and was told that she could not see her client because her client was on discipline. Another deputy intervened to make clear that a visit from her lawyer superseded a client being on discipline.
- After finally being allowed to see her client, the lawyer reported that her client was very emotionally upset and cried for the first 5 minutes of their visit. Her client reported that she felt like "she was being pushed to her edge" and that a deputy who was subject to previous complaints said to her "why don't you go cut yourself. Isn't that what is in your file."

Inmate Reception Center

Conditions at the Inmate Reception Center -- the gateway into the County's jail complex -- are currently under intense scrutiny by the federal courts. At the time of writing, litigation was pending as the judge presiding over a nearly 50-year-old consent decree -- by some accounts, the oldest ongoing consent decree in the nation -- prepared to hear arguments over whether to hold the County in contempt for failure to comply with court orders. This litigation was initiated by the American Civil

Liberties of Southern California, which pursuant to their oversight duties, found the following: people with serious mental illness being chained to chairs for days at a time, sleeping while sitting up; people sleeping head to foot on a concrete floor; people defecating in trash cans and urinating into orange juice cartons; general squalor and unhygienic conditions; and the failure to provide people with adequate healthcare in terms of providing medication for mental illness, chronic health conditions, or detoxing from drugs or alcohol.[16] Findings by the Sybil Brand Commission were cited in the ACLU's brief.

During a Civilian Oversight Commission meeting in November 2022, ACLU attorney Melissa Camacho stated the issues with the IRC had been noted by the Civilian Oversight Commission in 2019 and 2021 and had only escalated. During a September 2021 meeting of the Civilian Oversight Commission, former Assistant Sheriff Brendan Corbett called the crisis at IRC an "unfreezing event," comparing it to American tragedies including 9/11 or Columbine, and vowed the Sheriff's Department would change course -- a discordant analogy in support of what would prove to be a false promise.[17]

The Office of the Inspector General has repeatedly warned the problems at IRC cannot be fixed without a reduction in the overall jail population. Yet even when the facilities are not visibly overcrowded or busy, affronts to basic values of decency can be found. During an inspection in May 2023, Commissioners found four men in freshly-issued jail clothing locked and shivering in a cold, damp, and unventilated shower room, pleading to be let out to move to the next stage of the intake process. They said they had been left in that environment unsupervised for more than an hour. When a Custody Assistant was asked why they were there, she replied that someone would get them shortly.

As the County strives to bring conditions at IRC into compliance with constitutional requirements, degradation remains the norm for people who have been admitted and are being processed through the facility. If the infrastructure itself was not purposefully designed to produce traumatizing experiences for people from their very first moments inside, little is done to prevent such outcomes, despite a steady beat of intentions to change the manner in which the facility is run.

Pitchess Detention Facilities & North County Correctional Facilities

In general, this Commission has found conditions in the North County/Pitchess facilities tend to be less problematic than those at the downtown jails. However, issues permeate the entire system and affect conditions in all the jails. In January 2023, Commissioners found generally good relations at PDC-North between deputies, treatment staff, and people detained in the facility – conditions that were demonstrative of LASD's capacity to maintain a facility in such a manner if it chose to do so.

However, Commissioners still heard complaints about delays in access to mental health medications and other administrative problems. A May 2022 inspection of NCCF identified systemic problems with access to mail/communication, ongoing plumbing problems, and delays in court line processing times.[18] For example, Commissioners spoke to individuals who had spent over 18 hours in transport to and from their court hearings. LASD acknowledged these problems during this inspection. In March 2023, Commissioners found two mentally ill inmates designated for high observation mental health housing in the 900

[16] https://www.aclu.org/press-releases/aclu-seeks-court-order-against-la-county-over-horrific-conditions-jail-facility

[17] https://lacountyboardofsupervisors.webex.com/recordingservice/sites/lacountyboardofsupervisors/recording/20edad86feb51039be590050568fa1a2/playback at 53:00

[18] https://file.lacounty.gov/SDSInter/bos/Commissionpublications/report/1137994_051322NCCFInspectionReport_Miller_Veral.pdf

module, which further highlights the interconnectedness of issues in the jail system.

Despite there not being access to mental health services on the weekends, these inmates remained locked in cells for days awaiting treatment. Commissioners were told that LASD can sometimes have 8-9 trips per day (2 deputies per car) taking people back and forth for mental health assessments. It was reported to us that sometimes NCCF staff call TTCF to confirm bed space, drive all the way there and then it is given away by the time they arrive. Rather than drive back the deputies will sometimes "sit" with the person for several hours/multiple shifts in a cell in IRC.

Falling Through Cracks:

Deficiencies in the Medical and Mental Health Care Delivery System

Jail administrators have a constitutional duty to ensure people receive adequate health care when they are incarcerated in the jails.[19] This Commission seeks to provide some oversight of the jail's management of the health care delivery system consistent with its legal authority to "ascertain [each adult jail facility's] condition as to effective and economical administration, the cleanliness, discipline and comfort of its inmates, and in any other respects."[20] Yet the scope of this oversight is limited by resources the County chooses to dedicate to this Commission and by the fact that jail administrators do not provide this Commission with access to relevant information, including medical records.

Nevertheless, the provision of health care in the jails is not solely a function of clinical decision-making. According to jail policy, custody personnel along with medical and mental health personnel have a duty "*to work together* to ensure all inmates receive appropriate health care services within a reasonable time period."[21] This Commission routinely finds evidence that give cause for doubts about whether the collaborative dynamic that exists currently is producing effective results that ensure safe and humane jail conditions consistent with the constitutional rights of incarcerated people.

Jail health care officials have admitted they are currently incapable of providing constitutionally adequate mental health treatment for people incarcerated in the jails and are failing to comply with statewide policies designed to ensure adequate treatment and housing of people within the jails. In a September 2022 meeting of the Sybil Brand Commission, Dr. Timothy Belavich of Correctional Health Services predicted the jail would likely continue to be under Department of Justice oversight for its mental health program because "there are simply too many mentally ill individuals in the jail."[22] He said clinical staff are "overwhelmed" by caseloads and when jail administrators seek to discharge individuals with higher level mental health needs to urgent care on a 5150 upon release, Dr. Belavich said they are told non-carceral facilities "won't take them… Everybody gets to be at capacity except the jail." He said people with "lower-level needs" get "overlooked" and due to "an imperfect system… fall through the cracks."[23]

This Commission regularly hears from people incarcerated in the jails who either make direct requests for health care, complain about long wait times, or feel their requests for care have been ignored or disregarded. A December 2022 inspection of several overcrowded dormitories used primarily for people receiving mental health treatment in Men's Central Jail found more than 25 requests for medical

[19] Estelle v. Gamble, 429 U.S. 97 (1976)

[20] https://library.municode.com/ca/los_angeles_county/codes/code_of_ordinances?nodeId=TIT2AD_DIV3DEOTADBO_CH2.82SYBRCOININ

[21] Custody Division Manual Section 5-01/050.00 - Access to Health Care

[22] https://file.lacounty.gov/SDSInter/bos/Commissionpublications/minutes/1131799_092122_SBCMinutes.pdf#search=%22belavich%22

[23] https://file.lacounty.gov/SDSInter/bos/Commissionpublications/minutes/1131799_092122_SBCMinutes.pdf#search=%22belavich%22

attention, including requests for psychiatric medication, including one complaint from an incarcerated patient who had been told by a doctor at intake that he would be getting medications but had not received them. Another complaint came from a man who was visibly sweating. Another person requested care as he appeared to be emaciated and said he was losing weight.[24] That inspection occurred several months before, in the same dormitory, a pre-trial (or pre-sentenced) 33-year-old man died in his bunk on May 13, 2023 from a cause and manner that has yet to be disclosed by LASD or the Medical Examiner.[25]

Such observations or complaints are not irregular. In fact, it is the regularity of these observations that makes them exemplary of a mental and medical health care system that does not ensure people receive responses to requests for health care within a reasonable time, consistent with a duty, as described in policy, to ensure people "receive appropriate health care services within a reasonable time period."[26] A recent estimate from Correctional Health Services said inmates with medium-low level mental health diagnoses categorized as P2 wait an average of 47 days for a follow-up visit with a psychiatric physician. An average waiting period to see a doctor that exceeds the average period of incarceration is confirmatory that some individuals may never see a clinician for a follow-up consultation after their swift initial intake unless the medical need is recognized as urgent.[27]

Leaders from Correctional Health Services have attributed substandard care to a shortage of health care workers in the jails. However, the Federal Monitor's report, filed in September 2022, noted staffing ratios utilized by CHS "do not sufficiently address the qualitative improvements" to mental health care required by the County's settlement agreement with the Department of Justice.[28]

This Commission has sought information about delays to care, including treatment frequency standards and how it evaluates the performance of clinicians and jail administrators to ensure adequate care. Dr. Belavich has said the system of care delivery utilizes frequency standards relative to different health conditions, but it does not track delays to providing responses to requests for care. Correctional Health Services conducts "look back" audits to comply with legal demands of consent decrees, but does not utilize productivity metrics for clinical staff or set an expectation for a number of patient encounters each day, making it impossible for this Commission to determine systemic causes for any reduction in the number of clinical encounters or anticipate the prospective impact of additional staffing on the quality of care.[29]

Data collected by the Board of State and Community Corrections (BSCC) as part of its monthly Jail Profile Survey reinforces the need for enhanced oversight. The purpose of the BSCC data is to "provide counties a means of tracking changes in their populations and assessing and projecting program and facility needs."[30] One metric the County reports to the BSCC is the number of "sick calls" each month. According to this data, the average number of inmates seen at

[24] https://file.lacounty.gov/SDSInter/bos/Commissionpublications/report/1138004_122622_MCJInspectionReport_Miller_Sherman_Veral.pdf

[25] The Los Angeles County Sheriff's Department publishes a list of in-custody deaths on its website at https://lasd.org/transparency/icd/ pursuant to AB 2761, which was enacted into law and chaptered as Penal Code §10008. While the Sheriff's Department has been posting the sentencing status of individuals who died in the jail facilities, it is so far not disclosing the custodial status of the decedent in accordance with the statutory requirement to include "whether the person was awaiting arraignment, awaiting trial, or incarcerated." By disclosing only a person's sentencing status, the Sheriff's Department fails to disclose the number of decedents who died pre-trial.

[26] Custody Division Manual Section 5-01/050.00 - Access to Health Care

[27] https://file.lacounty.gov/SDSInter/bos/Commissionpublications/minutes/1138899_021523_SBCMinutesBM.pdf#search=%22belavich%22

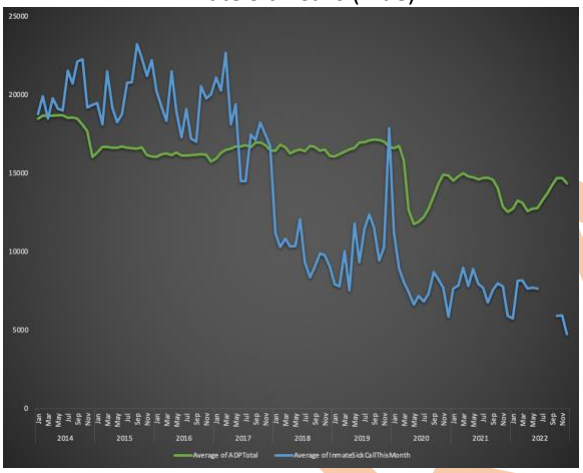
[28] See Monitor's Fourteenth Report, filed September 30, 2022 at Page 61

[29] https://file.lacounty.gov/SDSInter/bos/commissionpublications/minutes/1141195_031523_SBCMinutes.pdf#search=%22*%22

[30] https://www.bscc.ca.gov/s_fsojailprofilesurvey/

sick call each month declined 56% during the five-year period between 2017-2022, a period of time in which the average daily population declined only 14%. (Figure 1). CHS has attributed the greatly reduced number of inmate sick calls to changes in managed health care processes. However, efficiencies in the medical care delivery system do not rule out other potential causes for the reduction in the number of sick calls based on this Commission's encounters and observations during inspections.

Figure 1: Inmate Sick Calls (2014-2022) - Average Daily Population (Green), Average Monthly Inmate Sick Calls (Blue)



Data source: Board of State and Community Corrections Jail Profile Survey

An incarcerated person must be able to request a sick call by completing a Health Services Request Form, which should be "accessible to inmates in their housing locations at all times."[31] Commission inspectors regularly hear from inmates who say they do not have access to medical request forms in their housing locations, are not having their requests for medical attention fulfilled, who feel they must submit numerous medical request forms to be seen, or who claim deputies simply ignore their requests for a medical request form. Enhanced oversight of the management of health care processes, particularly an evaluation of the causes for this substantial drop in the reported number of sick calls, is critical to evaluating the quality of care and whether all entities responsible for services within the jail systems are fulfilling their duty to "work together" to ensure people's requests for care are being responded to within a reasonable time.

There are other examples of facts exemplary of an ineffective collaborative dynamic between the entities responsible for ensuring a safe or humane jail. As described above, the Sheriff's Department and Correctional Health Services reported to this Commission contradictory beliefs about who was responsible for maintaining sanitary conditions in high observation housing areas in Twin Towers, which were found to be extremely unsanitary and posed a significant health risk to people who are incarcerated and employees.

Additionally, in communication with the Sheriff's Department, officials have taken an administrative posture that HIPAA, the federal law that protects sensitive personal health information, bars custody personnel from accessing ongoing or historical medical treatment records. In fact, HIPAA explicitly permits disclosures of health information to corrections officials when "necessary" for the health and safety of an individual, other inmates, officers, employees, and "the administration and maintenance of the safety, security, and good order of the correctional institution."[32] An administrative posture that custody officials cannot know an incarcerated person's health status is inconsistent with the need to maintain an institution's "good order." While there may be other salutary reasons to protect the personal health information of a person in jail facing legal jeopardy, HIPAA restrictions are not a justification for obliviousness to a person's mental health needs, particularly when one-

[31] Under state law, a "sick call" is the general requirement that "any incarcerated person requesting medical/mental health attention be given such attention." (Cal. Code Regs. tit. 15 § 1211). In the County facilities, a "sick call" is defined as the process to "identify, examine, and/or care for inmate illnesses, injuries and/or make referrals for specialized healthcare treatment." See CRDF Unit Orders at https://pars.lasd.org/Viewer/Manuals/GeneratePDF/19669?reportIndex=0

[32] 45 CFR § 164.512(k)(5)

third of the jail population is receiving some form of mental health treatment. But as this Commission has observed custody personnel manifest indifference to a person's health status ("Why do I have to understand what you are going through," see above section on Twin Towers), strategic ignorance of a person's health status is an administrative practice in the jail facilities.

To the extent that accessing an individual's health records is a bona fide dilemma for both incarcerated people and custody personnel and creates a conflict between the Sheriff's Department's custody and patrol functions, it underscores the need to greatly reduce the pre-trial population and for the Sheriff's Department to transition towards a "dual track" system, in which deputies are recruited and trained for full careers in Custody assignments, a recommendation first made by the Citizens Commission on Jail Violence over a decade ago.[33]

Furthermore, due to the numerous admissions made by the leadership of Correctional Health Services that the care provided in the jails is substandard, there is a need for enhanced accountability and oversight in the correctional health care system. When this Commission asked leaders from Correctional Health Services about the potential value of an expert model of managed health care oversight, such as accreditation by a national body that sets treatment standards for correctional health care, Dr. Belavich responded that accreditation did not have a "huge interplay" with quality of care, but conceded, "Places that are good get accredited."[34] Given the County's "Care First" interventionist orientation that focuses on identifying the health needs of vulnerable populations, as well as the potential promise of improved care inherent to the State obtaining a milestone waiver to the federal Medicaid exclusion policy, there appears to be strategic opportunities for leaders to address substandard conditions within the jail's system for delivering medical and mental health care.[35]

Jail Staff Culture

As a Commission, we collectively remain very concerned about the culture among some deputies working in custody. During our inspections and in follow up meetings we have made efforts to offer positive feedback, relay positive testimony from those in custody to staff, and to acknowledge the work of deputies during inspections. However, we are concerned that what exists is a self-aware culture of impunity amongst some deputies working in custody. While it cannot be said that all custody personnel subscribe to or participate in this culture, enough custody personnel do such that it defines the experience of being incarcerated for many people we've spoken to. Some examples include:

- Deputies obstructing the observation of an incident where a mental health patient was being transferred out of his cell in the 5200 module of Men's Central Jail, which resulted in a use of force.
- People incarcerated in Twin Towers reporting to Commissioners that a patient with severe needs, whose cell was smeared with feces for days, was told to clean the cell himself. The patient had severe needs and had been on the waiting list for the Forensic In-Patient unit for more acute mental health needs for over a month.
- Deputies in Twin Towers expressing their indifference to a person's apparent mental disability.
- Mandatory safety checks in high observation housing consist of deputies walking by and scanning the bar codes

[33] https://ccjv.lacounty.gov/wp-content/uploads/2012/09/CCJV-Report.pdf

[34] https://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=10681 at approximately 21:00-30:00

[35] https://www.kff.org/policy-watch/section-1115-waiver-watch-how-california-will-expand-medicaid-pre-release-services-for-incarcerated-populations/

of cells rather than confirming signs of life.

- Multiple women in CRDF across the last year have reported being fearful of retaliation and/or having experienced retaliation for complaining about conditions.
- Multiple women complaining that deputies refer to them using the "B word" and the "N word."
- The lawyer of a woman in custody at CRDF was wrongfully told she could not see her client because she was on discipline.
- When reporting the fear of retaliation to the Captain at CRDF, it was disregarded as "a misperception."

When reporting our concerns to watch commanders, our LASD liaison, or other senior officers, they are often attentive, take notes, and commit to taking action. However, with regard to deputy culture, we are not confident that the strategies presented to us to address these problems will in fact uproot or interrupt what we believe to be a harmful culture amongst custody personnel. For example, senior officers at CRDF have committed to enacting discipline where evidence confirms there is a problem. However, as noted above, an investigation into custody personnel (who has been the subject of multiple complaints to the Commission) has not been completed after a year. When we communicate fears and reports of retaliation to staff it is often disregarded or minimized.

These interactions give us little faith in the Sheriff's internal mechanisms of deterrence or accountability. In an April meeting with senior personnel at CRDF, Commander Alva committed to walking the facility himself to observe, talk to staff as well as people in custody about their concerns, and document any issues himself. While a hands-on approach from more senior officers is appreciated, given the volume of complaints, given reports that deputies have openly stated that they "do not care" what seniors officers say, and given our troubling experience with a deputy at CRDF who stated she was following the directives of a senior officer, we do not believe this will not be enough. The Sheriffs have also stated that rotating officers is a tool they use to address cultural issues. In its final 2012 report, the Citizen's Commission on Jail Violence recommended that LASD rotate deputies to break up problematic cultures.[36] Given that staff rotations are a tool that has been available to the Sheriff's at least over the last decade, we believe its impact is temporary and insufficient to remedy the problems we have observed.

A Failed Grievance System

Across several facilities, the complaint process is found to be flawed and ineffective, and many reasons have been provided by the Sheriff's Department for why this is so. At CRDF, Commissioners observed and heard complaints about an intentional disregard for the complaint process by custody personnel. Women reported to Commissioners that deputies have no regard for the complaint process. Deputies will hand complainants a stack of grievance forms, confident that their complaints will be ineffective if the forms are filled out and submitted. Some deputies reportedly take grievances out of the repository, read them, and tear them up. Deputies were reported telling women "Complain all that you want. Nothing will change."

In the February 3, 2023 CRDF inspection, a woman held in the 3800 provided SBC Commissioners with a grievance form that she had submitted and was given a written response to by a sergeant.[37] Commissioners made a request to the deputy in the module to make a

[36] https://ccjv.lacounty.gov/wp-content/uploads/2012/09/CCJV-Report.pdf

[37] https://file.lacounty.gov/SDSInter/bos/Commissionpublications/report/1141129_020323_CRDFInspectionReport_Archie_DrGrills.pdf

copy of the form for our records and so that the complainant could retain the original; it is important that people in custody retain evidence that they have pursued all channels available to them to remedy complaints. The copy was provided, however after completing the inspection of the module the same deputy told our Commissioners that we could not leave with the grievance form. When we asked why, the deputy told us that their captain said it was not allowed. We requested that the captain come to the module to speak with us as we have never had a problem receiving documents given to us by people in custody. After waiting roughly 10 minutes, we began handwriting the content of the complaint, in case we weren't allowed to take it. While doing so, the deputy came over and snatched the document out of our Commissioner's possession and took the form back to the desk. When asked on what grounds they were refusing to let us take the form, the deputy responded in an impatient and disrespectful tone: "You're going back and forth with me about this. You can't take it." The deputy then proceeded to tear the grievance form to remove the portion of the document that contained the Sergeant's written response and kept it. Our Commissioners were then handed the remainder of the torn document.

All the content from the February inspection was documented in the Commission's inspection report and communicated to Captain Montoya at CRDF and Commander Macias, our SBC liaison. At an in-person meeting with Captain Montoya, Commander Macias, and Commander Alva, we discussed this issue and broader concern around Deputy culture at CRDF. As noted above, we were informed by Captain Montoya that the investigation into a specific deputy at the facility prompted a year ago had not been completed. The Sheriffs admitted that this was a long timeline for a complaint to be processed.

Regarding the deputy who tore the complaint form, Commander Macias assured us that the deputy had been briefed on the proper protocol as well as how the situation should have been handled. Commander Macias shared that both the deputy, and their supervising officer who gave the deputy directives to withhold the form, were confused, and believed that the grievance was a "disposition form" which is a confidential document. However, it is our understanding, as communicated to us from the Sheriff's department, that disposition forms are internal documents to the department and would not be in the possession of someone held in custody.

For these reasons, this Commission has good cause to doubt the completeness of data released by the Sheriff's Department related to the grievance process which showed that out of 2,180 grievances received in January, February, and March 2023, just 134 grievances - 6 percent of the total - related to the capacious category of "processing, delays, overcrowding and conditions of confinement."[38] The Sheriff's Department did not indicate the subject matter of the other 94% of grievances or whether the remainder of grievances were reviewed. To the extent the Sheriff's department will continue to access the grievance system to provide summary reports of data related to the conditions of confinement, this Commission recommends such reports be produced and provided by an independent third party, such as the Office of the Inspector General.

"Education-Based Incarceration" and Other Programming

In 2022, the Los Angeles County Board of Supervisors tasked the Sybil Brand Commission, with support from the Civilian Oversight Commission, and in collaboration with Loyola Marymount University and the Psychology Applied Research Center @ LMU and Imoyase

[38] https://file.lacounty.gov/SDSInter/bos/supdocs/COC2023Quarter1report042523.pdf

Community Support Services, to survey the jail population of its educational or programming needs. LASD has made educational programs a core component of incarceration in the jail facilities and historically included not only GED programs, but also vocational programs, personal growth, or 12-step programs. LASD has celebrated these programs for their potential to create "reduced rates of recidivism, increased employability, and family reunification."[39] Indeed, those in custody who stand to gain the most from educational programs are people of color, people who are under-educated, people who are impacted by unresolved past trauma, and others.

This Commission has found the scale of LASD's educational programs were greatly diminished during the Covid-19 pandemic. It has been very difficult to obtain data to assess the number of people currently incarcerated who are eligible, enrolled, or actively participating in educational programs. But the results of the survey showed significant gaps between offerings and the needs for programming. Nearly all respondents expressed interest in participating in a program, but 71% of people reported programs were "never" or "rarely" made available to them. More than half reported programs were cancelled without good reason or explanation. The highest enrollment was found at CRDF and the lowest course enrollment was found at Twin Towers and MCJ. Black respondents across the jails reported the lowest access to education-based incarceration programming.

[39] https://file.lacounty.gov/SDSInter/lasd/145553_March2013-EBI_CreatingALifeWorthLiving.pdf

Recommendations

1. **Acknowledge the Los Angeles County jails, as administered by the Los Angeles Sheriff's Department, historically and currently do not uphold basic standards of decency and do not maintain facilities that are informed by "Care First" health interventions.**

Sanitation

The Sheriff's Department's failure to maintain a sanitary facility and to conduct regular inspections of its facilities for "highly sanitary conditions" reflects an administrative orientation with a limited commitment to upholding basic values.[40] Unsanitary conditions are routinely found in numerous facilities administered by the Sheriff's Department and the persistence of unsanitary conditions is evidence of sanitation policies being given no meaningful effect. The Sheriff's Department has repeatedly failed to provide adequate explanations for its inability to comply with statewide and county-wide policies regarding the safe and secure housing of individuals within its jails.

This Commission has examined the policies and found unit orders that are not uniform across facilities and do not always define who is ultimately directly responsible for the regular and continuous maintenance. For example, the unit orders for sanitary conditions at Twin Towers Correctional Facility delegates responsibility to another County Department, Correctional Health Services, to determine whether and when a cell smeared with human waste is a significant health risk for people who are incarcerated. In one case, this Commission found an individual had been in that cell for days, despite the fact of his poor health condition was known by both deputies and clinical staff, and the cells nearby were infested with insects. After that person was transferred to another cell, an inspection six weeks later found many cells in the same pod with persistent insect infestations and many inoperable toilets. Despite the Sheriff's Department's duty to inspect and maintain these facilities, a cleaning was only undertaken after discovery by this Commission. By May 2023, the Sheriff's Department had begun a superficial repainting of the pods, but the root cause of the issue -- problematic unit orders for the facility -- remain in place.

Overcrowding

County officials admit there is a link between overcrowding and the health status of incarcerated persons. State law requires dormitories to house no more than 64 people, but Commissioners routinely find dorms holding in excess of 80 people, often on triple-bunks. Correctional Health Services has stated its view that dormitories should have no more than 80 people, which exceeds the limit imposed by state law.[41] Jail officials have acknowledged overcrowded conditions or isolation tends to add stress to people incarcerated with mental health conditions.[42] Commission inspections find Sheriff's Department custody personnel describing fights are more frequent in areas of the jail which house people with mental health diagnoses, but it currently does not track uses of force involving people with mental illness incarcerated in the concentrated dormitory housing in Men's Central Jail. Commission inspections have observed people being transferred to Twin Towers for having serious mental illness victimized by uses of force the Sheriff's Department officials have admitted were under investigation for being improper.

[40] California Code of Regulations, Title 15 Section 1280: Facility Sanitation, Safety, and Maintenance; Custody Division Manual: 5-11/020.000 - Sanitation

[41] https://file.lacounty.gov/SDSInter/bos/Commissionpublications/minutes/1141195_031523_SBCMinutes.pdf#search=%22belavich%22

[42] https://file.lacounty.gov/SDSInter/bos/Commissionpublications/minutes/1138899_021523_SBCMinutesBM.pdf

2. Form a Task Force to Investigate Patterns of Unexpected and Potentially Preventable In-Custody Deaths.

This Commission has reviewed records from the Medical Examiner's Office of in-custody deaths since the year 2000 and finds concerning trends and patterns that deserve further attention. Records show significant racial disparities in in-custody mortality. For example, between 2000-2020, the Medical Examiner was far more likely to deem in-custody deaths of incarcerated African Americans to be "natural," compared to Hispanic/Latinx and White incarcerated persons. Moreover, the Medical Examiner is more likely not to reach a determination of the mode of death (i.e., suicide, homicide, natural, etc.) when a person dies at Twin Towers Correctional Facility, where African American people are more likely to die relative to their share of the County and jail populations.[43] A mode of death is listed as "undetermined" in 15% of cases of African American in-custody death at Twin Towers between 2007-2020. The Medical Examiner does not evaluate whether such deaths were unexpected, preventable, were the result of medical error, negligence, or misconduct. By contrast, the California state prison system does undertake such a review, due in part to historically acknowledged deficiencies in the prison's medical care delivery system. For these reasons, the County should establish a task force with appropriate specializations to conduct annual mortality reviews of all unexpected in-custody deaths, including those deemed "natural" by the Medical Examiner, or to authorize the Department of Public Health to study all in-custody deaths at the jails, similar to a recent study published on deaths of people experiencing homelessness.

3. Acknowledge the limitations of oversight to constrain deputy culture.

For decades, the County has known about the serious problems arising from the deputy culture of the Sheriff's Department. During the Citizens Commission in Jail Violence, the focus was not only on a deputy culture that enabled excessive use of force but also encouraged violence among incarcerated people, intentionally made people vulnerable to violence, or turned a blind eye to the safety and security of people incarcerated in the jails. For example, the CCJV documented witnesses to so-called "gladiator fights" in the jails, where deputies are at best slow to respond to critical incidents.[44] When this Commission has brought forward evidence of neglect that is egregious to the Sheriff's Department, our findings are often disregarded as anomalies instead of evidence of persistent patterns of violations of duty by custody personnel that have been documented for several decades. When this Commission communicates incarcerated people's experience of retaliation, fear of retaliation, or abusive behavior to leadership in LASD, it has been ignored, minimized, and discredited as a misperception on the part of the incarcerated person. Until the Sheriff's Department is able to recognize the historical context of persistent concerns and lead personnel to internalize and actualize its duties to ensure jail conditions are safe, sanitary, and humane, it is unclear what oversight bodies can do to make the County jails anything but fertile environments for abuse and neglect.

4. Assess the human costs of the County's non-compliance with consent decrees and other legal demands of people incarcerated in the County's jails.

[43] Counting all cases where the EventPlace, EventAddr, or Death Addr were identifiable as the location of the Twin Towers Correctional Facility. Of the 131 people who died at Twin Towers Correctional Facility between 2000-2021, 37% were Black or African American.

[44] https://ccjv.lacounty.gov/wp-content/uploads/2012/09/CCJV-Report.pdf

In February, the Board of Supervisors passed a motion seeking a report-back related to the County's long overdue non-compliance with multiple consent decrees governing unconstitutional jail conditions. Specifically, the motion seeks an "itemization of the costs associated with the Consent Decree(s), including legal costs (outside/in-house counsel), monitoring costs, expert fees, and the like." This Commission would advise the County to include as part of that assessment an inquiry into the human costs of operating an unconstitutional jail by holding a hearing before the Board from directly-impacted communities, including people who are presently and formerly incarcerated in the County jails, as well as key findings from the inspections of the Sybil Brand Commission and other entities responsible for monitoring the jails. The purpose of these hearings would be to ensure the community recognizes the full impact of the County consistently falling short of these legal obligations.

5. Take swift steps to significantly reduce the pre-trial population in line with the "Care First, Jail Last" road map.

It is this Commission's position that no incarcerated person should be subjected to the indecent, unsanitary, and inhumane conditions that we have identified in the jails, nor should they be subjected to a violent and adversarial deputy culture while incarcerated. In a recent convening on jail conditions hosted by the Civilian Oversight Commission, a representative of the Sybil Brand Commission, the ACLU, and the Office of the Inspector General all stated that it is most important to significantly reduce the jail population if we are going to meaningfully address these issues. As of the drafting of this report, 51% of the jail population is pretrial and therefore legally presumptively innocent and undeserving of punishment. On May 19th, Superior Court Judge Riff issued a preliminary injunction on Los Angeles County to stop the punishment of people, "based on their poverty," whom the legal system presumes are innocent. We urge you to consider that the features of this punishment, as declared by Judge Riff, includes subjection to the very conditions, patterns, and culture that have alarmed us as independent observers.

Reducing the pretrial population is a necessary remedy and urgent step as lengths of stay in the jail are increasing across the board. According to the county's own data, the length of stay for Black women, houseless people, and people with mental health conditions facing misdemeanors has doubled since 2020.[45] Additionally, the majority of deaths that occur in the county jail system, occur within the pretrial population. An analysis of autopsy reports conducted by the Carceral Ecologies and BioCritical Studies labs at UCLA found that 75% of people who died in custody between 2009 and 2019 died while in pretrial detention.[46] As of May 23rd, 64% of the people who have died in the county jails in 2023 had not yet been sentenced. The number rises to 74% when the partially sentenced population is included. The preliminary injunction includes a 60-day period for the county to participate in the production of an alternative pretrial model. We recommend the County establish an independent pretrial services system that emphasizes a robust care first approach and facilitates a significant reduction of the jail population.

6. Ensure the Sybil Brand Commission is provided with adequate resources to fulfill the County's expectations that it ensures conditions in the jails reflect "safe, humane, and best practices."

We are aware of administrative changes to address consent decree compliance, including the appointment of a Countywide compliance coordinator and a new Office of Constitutional Policing within the Sheriff's Department. We

[45] Data provided by the CIO in the May18th, 2023 quarterly Pretrial Data Workgroup meeting.

[46]

request the Board to empower the Sybil Brand Commission consistent with those changes, including by examining whether the Commission is adequately resourced to fulfill the expectation of the County Executive Office to "ensure that conditions… reflect safe, humane, and best practices," as described in the County's internal documents.

This may include revising the ordinance to enable Commissioners to conduct more than two inspections per month (the current maximum), and whether other changes could be made so the Commission could be working more effectively with the Office of the Inspector General and the Civilian Oversight Commission. Additionally, the Commission requests a memorandum of understanding with the Sheriff's Department related to access without advance notice or accompaniment; a description of the types of Department records which this Commission shall have access; and clearance to document jail conditions with photographs, particularly as the Sheriff's Department has begun permitting media access to the facilities.

Conclusion

This Commission is aware of historical accounts of mistreatment, and concomitant outrage at mistreatment, in the Los Angeles County jails for a century or more. This Commission finds the conditions present at the Los Angeles jail conditions today represent both imminent and potential risks to public health and safety. An expanding body of research suggests carceral conditions worsen a person's mental and medical health, and yet the County continues to commit space here to housing individuals, including scores of people receiving treatment for mental illness, who receive substandard care, neglect, and mistreatment by staff.

Substandard and unconstitutional conditions in these jails, whether as forms of punitive discomfort or non-punitive frustrations, lack penological legitimacy. The persistence and regularity of unconstitutional conditions in facilities aimed at furthering law enforcement objectives reinforces critiques of the criminal justice system, undermining faith and trust in the integrity of the County's public safety apparatus. Furthermore, because African Americans are disproportionately criminalized and incarcerated in LA County, the operation of an unconstitutional jail disproportionately harms African Americans and makes certain jail practices indistinguishable from racial oppression.

Last November, the Los Angeles County Inspector General Max Huntsman suggested the Sheriff's Department's was using incarcerated individuals as part of a "shell game." Clearly, the games have not stopped. Oversight alone cannot change that. It is ultimately the responsibility of the Sheriff's Department to decide whether such longstanding practices will continue.