

**LOS ANGELES COUNTY
SYBIL BRAND COMMISSION FOR INSTITUTIONAL INSPECTIONS**

**REPORT & RECOMMENDATIONS
ON THE
LOS ANGELES COUNTY JAILS
HUMANITARIAN CRISIS**

JULY 2023

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

The Sybil Brand Commission for Institutional Inspections (“SBC”) 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, with an emphasis on the conditions of confinement, and the effects of those conditions on the people who are being incarcerated in the jails.

A humanitarian crisis has existed inside the Los Angeles County jail facilities for many years. 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 administered. There is an urgent need for the County to address the root causes of persistent, inhumane conditions in its jails.

Los Angeles County maintains a prison-sized jail system, with numerous facilities spread out across its geographical expanse. The average monthly population of just one of these facilities, Men’s Central Jail, exceeds the total jail population of the state’s second largest County – it is the largest carceral facility in the state that, critically, is not administered by a department solely dedicated to running a correctional facility. Instead, the Los

Angeles County Sheriff’s Department (“LASD”) maintains a Custody Division responsible for administering the jails, while the County’s Department of Health Services, through its division of Correctional Health Services, provides medical, psychiatric, and mental health services for people incarcerated in the jails. These entities have the primary duty to manage and inspect the jails for safe and humane conditions.

Outside oversight of the jail is provided by a patchwork of entities including the Office of the Inspector General, the Board-appointed Civilian Oversight Commission, and the Sybil Brand Commission for Institutional Inspections. The Department of Public Health conducts annual evaluations of each facility’s environmental, medical/mental, and nutritional health practices, and they are also responsible for responding to public health-related complaints. The Board of State and Community Corrections is responsible for certifying facilities for suitability. Additionally, entities such as a federal monitor and the American Civil Liberties Union of Southern California, which evaluate jail conditions pursuant to various consent decrees. The SBC 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.

What makes the SBC a unique layer of oversight is its composition of community members who engage in inspections of the facilities to inform the County of conditions of confinement and its carceral practices. The County authorizes each Commissioner to conduct a maximum of two inspections of the jail facilities per month.

¹ L.A. County, Cal., Code of Ordinances, tit. 2, § 2.82.090 (2022 & Supp. 2023).

Commissioners generally provide no advance notice of an inspection, but must report their presence in the facilities and LASD expects inspectors to check-in and check-out with the watch commander, who is in charge of day-to-day operations. Commissioners are also usually permitted to conduct inspections without accompaniment by an LASD escort, unless they are entering a larger room or space or 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 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 levels are also aware of the Commission's inspections reports. Commissioners also make efforts to engage with community about jail conditions and provide community insight into the conditions of the County lockups.

Despite the strategies this Commission has pursued in conjunction with other monitoring groups, the SBC continues to be alarmed and frustrated with the regularity with which it finds unsafe, inhumane, and unsanitary conditions in the

jails. The recurrence of issues after this Commission brings them to the attention of responsible parties at the Sheriff's Department is evidence of problems not being adequately addressed. This Commission has found evidence of failures by LASD custody personnel to maintain adequate policies, to adhere to those policies, or to supervise and enforce those policies. This Commission's findings generally do not lead to substantive explanations, acknowledgements of error or disclosures of corrective action plans.

Instead, facility administrators often downplay responsibility for problems identified by this Commission or attribute issues to staffing shortages. However, the Commission has not received anywhere near the level of information from LASD or other County agencies to determine if this has any factual basis. A recent audit of LASD's operations by the County Auditor-Controller has provided unprecedented insight into the mismanagement of jail operations. According to the report, LASD asserted it exceeds budgetary allowances for overtime to address legally required jail reforms pursuant to consent decrees or the demands of past jail commissions, such as the Citizens' Commission on Jail Violence. Yet the Auditor's report found LASD personnel more often than not fail to document the nature and purpose of overtime requests with any sort of description of work.² LASD Custody Division is responsible for 37% of all Departmental overtime allocations.³ Yet at the same time, the unit responsible for facility upkeep routinely underspends its allocated budget by 20% or more.⁴ At the same time, the unit responsible for maintaining jail facilities is instructed to "restrict 'discretionary' spending to provide cost savings to cover" the overtime and "efforts are made within these units to reduce expenditure when feasible."⁵ Thus, while LASD asserts overtime is intended to make jail conditions

² County of Los Angeles Department of Auditor-Controller, *Sheriff's Department – Report on Operational Reviews*, June 2023, p. 9, fn.2, https://file.lacounty.gov/SDSInter/auditor/audit_reports/1144657_2023-06-30SheriffsDepartment-ReportonOperationalReviewsBoardAgendaItem10October12019.pdf.

³ Id. at 17.

⁴ Id. at 19.

⁵ Id. at 25.

safer and more humane to comply with constitutional requirements, this Commission has observed groups of LASD personnel watching movies on County computer systems within view of men with serious mental illnesses languishing in solitary confinement for 22-23 hours a day, and the facilities around them dilapidate without receiving the funding allocations intended for upkeep.

Informed by the Auditor-Controller's report, this Commission cannot escape the conclusion that if the County's humanitarian crisis in the jails feels like the 1993 movie *Groundhog Day*, doomed to repeat *ad nauseum*, then it is in large part due to the Sheriff's Department's own practices. When maintenance of humane and safe conditions in the jail facilities is viewed as discretionary, then turning a blind eye to the basic needs of incarcerated adults will always be incentivized. Furthermore, an operational dynamic that situates jail conditions in opposition to the Department's thirst for unbudgeted overtime allocations will likely reinforce problematic deputy subcultures and sustain jails that are fundamentally misaligned with the County's stated priorities. Until the Sheriff's Department is able to recognize the structural causes for persistent concerns with jail conditions, it is unclear what this oversight body can do within its constraints to have anything but a marginal impact on the causes for why the Los Angeles County jails continue to be fertile environments for violence, abuse, and neglect.

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 jail practices and the drafters of this report have sought to use "people-first" language. 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 confidentiality of sources have been made.

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 2015.⁶ 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 SBC 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

⁶ See Press Release, U.S. D.O.J. Off. of Pub. Affs., *Justice Department Reaches Agreement with Los Angeles County to Implement Sweeping Reforms on Mental Health Care and Use of Force Throughout the County Jail*

System (Aug. 5, 2015), <https://www.justice.gov/opa/pr/justice-department-reaches-agreement-los-angeles-county-implement-sweeping-reforms-mental>.

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.⁷ 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.⁸

Follow-up communication with the Sheriff’s Department and Correctional Health Services revealed confusion as to who is ultimately responsible 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, 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. Allowing adults with serious mental illness to remain in highly unsanitary conditions for indeterminate periods of time is not only degrading, it also has the potential to discourage personnel from making appropriate and timely interventions during recurring welfare checks of individuals who are particularly vulnerable to the stresses and harms of incarceration.

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

⁷ Custody Servs. Div., L.A. Cnty. Sheriff’s Dep’t, *General Population Men’s Central Jail Unit Order: No. 3-07-11* (Rev. Feb. 3, 2023),

<https://file.lacounty.gov/SDSInter/bos/supdocs/180661.pdf>.

⁸ Sybil Brand Comm’n for Inst. Inspections, *Twin Towers Correctional Facility Inspection Report*, at 4 (Mar. 24, 2023),

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

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.”*⁹ It was observed that food was not served during that engagement.

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 facility 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 finds poor and degrading conditions in areas under high or medium observation, the presumption is the existence of those conditions is known to custody personal and therefore attributable to a lack of oversight or supervision.

The mental health housing units on the 5000 floor form part of the complex that has earned the Los Angeles County jail system the distinction of being the referred to as “the world’s largest mental health facility.” The settings and staff interactions are not trauma-informed in accordance with best practices.¹⁰ People are housed in overcrowded warehouse-like spaces on triple-bunks that are often shrouded in sheets or towels for a modicum of privacy. State law requires dormitories to house no more than 64 people, but Commissioners routinely find dorms holding up to 87 people. Correctional Health Services has stated its view that dormitories should have no more than 80 people, which exceeds the limit imposed by state law.¹¹ Air circulation and access to hot water are intermittent. 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

⁹ Id.

¹⁰ See, e.g., Substance Abuse and Mental Health Servs. Admin., *The Sequential Intercept Model (SIM)* (last updated Sept. 27, 2022), <https://www.samhsa.gov/criminal-juvenile-justice/sim-overview>.

¹¹ Sybil Brand Comm’n for Inst. Inspections Meeting Minutes, at 3 (Mar. 15, 2023, 10:00 AM), https://file.lacounty.gov/SDSInter/bos/Commission-publications/minutes/1141195_031523_SBCMinutes.pdf.

of force involving people with mental illness incarcerated in the concentrated dormitory housing in Men's Central Jail.

Concerns about these substandard issues have been raised with County officials and departments including LASD, Correctional Health Services, the Office of the Inspector General, and the Department of Mental Health's Patients' Rights Office.¹³

- 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.¹⁴
- 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 individuals said they were not being provided with cleaning supplies to clean the facilities and Commissioners noted the squalor. Incarcerated people 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.¹⁵

- In July 2022, Commissioners visited 5000 with leadership from Correctional Health Services. Commissioners found one dormitory without a single functional, sanitary drinking fountain – incarcerated adults had adapted a disposable plastic straw as a "D.I.Y." repair to a single drinking water spout to be shared by an entire cohort of people. SBC also found a broken air conditioning unit leading temperatures to be uncomfortably warm. Commissioners found there had been 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.¹⁶
- In August 2022, Commissioners visited 5000 and found the Sheriff's Department had reversed its policy to provide life-saving Narcan inside dormitories. A year earlier, the Sheriff's Department and Correctional Health Services had received significant positive publicity for making Narcan available in dormitories to prevent death

¹³ The DMH Patients' Rights Office purports to provide a "voice" for "mental health consumers" in the jails, but has not been physically present on a regular and ongoing basis in the jails for several years. <https://dmh.lacounty.gov/our-services/patients-rights/>.

¹⁴ Sybil Brand Comm'n for Inst. Inspections, *Men's Central Jail Inspection Report*, at 3 (Feb. 27, 2022, 12:30PM),

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

¹⁵ Sybil Brand Comm'n for Inst. Inspections, *Men's Central Jail Inspection Report*, at 3-5 (Mar. 9, 2022, 6:30-8:30 AM),

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

¹⁶ Sybil Brand Comm'n for Inst. Inspections, *Men's Central Jail Inspection Report*, at 2 (July 27, 2022, 8:00-10:00 AM),

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

due to opioid overdose. Information from LASD suggested the number of deaths due to opioid overdose had dropped significantly since the Narcan policy began. Inmates also alleged deputies were slow to respond to calls for medical emergencies.¹⁷

- In December 2022, Commissioners observed a use of force incident involving a person with mental illness as he was being transferred from a dormitory on 5000 to another facility for a higher level of care. During the incident, Sheriff's deputies obstructed Commissioners from observing the use of restraints. 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 not only aware of this incident and that an inappropriate use of force was under investigation, but also expressed awareness of the particular challenges associated with the manner in which people with mental illness are incarcerated on 5000.¹⁸
- In December 2022, Commissioners found incarcerated individuals in dormitories on 5000 wearing dirty clothing as well as 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 a daily hot meal, as required by state law. Commissioners observed conditions to be "abysmal" and "unsafe," with no visibility into many of the bunks due to use of towels and sheets to remediate the effects of overcrowding. 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.¹⁹

- In March 2023, Commissioners visited 5000 (and 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 adults in the jails, 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."²⁰ 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 hearings as

¹⁷ Sybil Brand Comm'n for Inst. Inspections, *Men's Central Jail Inspection Report*, at 3 (Aug. 22, 2022, 8:00-10:00 AM),

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

¹⁸ Sybil Brand Comm'n for Inst. Inspections, *Men's Central Jail Inspection Report*, at 3-4 (Dec. 13, 2022, 1:00 PM),

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

¹⁹ Sybil Brand Comm'n for Inst. Inspections, *Men's Central Jail Inspection Report*, at 3 (Dec. 26, 2022, 2:00 PM),

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

²⁰ *Patient's Rights*, L.A. Cnty. Dep't of Mental Health (last updated Feb. 15, 2023), [https://dmh.lacounty.gov/our-services/patients-](https://dmh.lacounty.gov/our-services/patients-rights/#:~:text=Please%20contact%20the%20Patients'%20Rights,questions%20or%20need%20more%20information)

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

patient advocates remotely via videophone. Without being physically present, its advocates are unfamiliar with the wider context and conditions mental health patients may be subjected to, including while they languish on the wait list for escalated inpatient 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.²¹

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."

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—

These conditions, and conditions like it, have been endured by community members for decades and this Commission's inspection findings confirm they 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 SBC 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.

²¹ Sybil Brand Comm'n for Inst. Inspections, *Men's Central Jail Inspection Report*, at 5 (Mar. 16, 2023, 10:00 AM -12:00 PM),

<https://file.lacounty.gov/SDSInter/bos/Commis>

Report & Recommendations on the Los Angeles County Jails Humanitarian Crisis

Below is a list of documented conditions from SBC reports as well as the observed impact on the women who reported to the SBC:

- 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 SBC was contacted by the lawyer of a woman who made complaints to the SBC 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 – were under intense scrutiny by the federal courts for the past few years. Litigation brought by the ACLU under a nearly 50-year-old consent decree – by some accounts, the oldest ongoing consent decree in the nation – focused attention on conditions that included 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.²² Findings by the SBC were cited in the ACLU’s filings. The litigation led to preparation for arguments over whether the court should hold the County in contempt for failure to comply with its orders and was resolved by a stipulated settlement that yielded numerous commitments by the County, including a promise to add nearly 2,000 community beds as alternatives to jailing people with mental illnesses, most within the next two years.²³

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 the attacks of September 11, 2001 and the

1999 mass shooting at Columbine, and vowed the Sheriff’s Department would change course.²⁵ It was a fraught and bracing analogy in support of what would prove to be a false promise. The Office of the Inspector General warned the problems at IRC could not be fixed without a reduction in the overall jail population.

While overcrowding is an issue, even when the facilities are not visibly overcrowded or busy, affronts to basic values of decency can be observed. 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 jail complex. However, issues permeate the entire system and affect conditions in all the jails.

²² *ACLU Seeks Court Order Against L.A. County Over Horrific Conditions at Jail Facility*, ACLU (Sept. 8, 2022), <https://www.aclu.org/press-releases/aclu-seeks-court-order-against-la-county-over-horrific-conditions-jail-facility>.

²³ *ACLU Reaches Landmark Settlement in L.A. County Jails Case*, ACLU (July 15, 2023), <https://www.aclu.org/press-releases/aclu-reaches-landmark-settlement-in-l-a-county-jails-case>.

²⁵ Remarks at the Meeting of the Sybil Brand Comm’n for Inst. Inspections (Sept. 23, 2021), at 53:00 (transcript available at <https://lacountyboardofsupervisors.webex.com/recording/service/sites/lacountyboardofsupervisors/recording/20e6dad86feb51039be590050568fa1a2/playback>)

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.²⁷ 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 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 SBC 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.

Courthouse Lockups

The scope of SBC’s inspections includes courthouse lockup areas where incarcerated adults are escorted for legal proceedings. LASD has

asserted it is not responsible for maintenance and upkeep of lockup facilities within the courthouses, which often show signs of disrepair. However, LASD is responsible for ensuring incarcerated adults receive transportation to and from the courts and adequate medical care while they are on site, and thus bear responsibility for the treatment and care of incarcerated adults when in LASD custody outside the jails. Commission inspections have found individuals with medical issues or other special needs are not provided appropriate meals while at these facilities. Individuals who require certain medications throughout the day may not have the ability to obtain additional necessary doses while at court. Additionally, LASD has reported a substantial number of individuals are not transported to courts on a daily basis, but has not provided this Commission with a documented accounting or data for the reasons.

System-wide Issues

Deficiencies in the Medical and Mental Health Care Delivery System

This Commission has sought 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.”²⁹ Yet the scope of this oversight is constrained by limitations jail administrators impose on this Commission’s ability to access relevant information pertaining to the care delivery system.

Jail administrators have a constitutional duty to ensure people receive adequate health care when they are incarcerated in the jails, and the

²⁷ Sybil Brand Comm’n for Inst. Inspections, *North County Correctional Facility Inspection Report*, at 1-2 (May 13, 2022),

<https://file.lacounty.gov/SDSInter/bos/Commis>

[sionpublications/report/1137994_051322NCCFI_inspectionReport_Miller_Veral.pdf](https://www.sionpublications.com/report/1137994_051322NCCFI_inspectionReport_Miller_Veral.pdf).

²⁹ L.A. County, Cal., Code of Ordinances, tit. 2, § 2.82.090 (2022 & Supp. 2023).

provision of health care in the jails is not simply a function of clinical decision-making.³⁰ According to jail policy, custody personnel from LASD along with medical and mental health personnel from Correctional Health Services – a division overseen by the Department of Health Services – have a duty “to work together to ensure all inmates receive appropriate health care services within a reasonable time period.”³¹

This Commission’s efforts to inspect the jail facilities has yielded evidence that the jail healthcare delivery system provides substandard care to incarcerated adults. This evidence includes statements of acknowledgement by Correctional Health Services leadership, allegations of substandard care by incarcerated adults, and data provided by the County to the Board of State and Community Corrections.

Incarcerated Adults Frequently Allege Delays To Receiving Appropriate Medical Care

This Commission regularly hears from adults incarcerated in the jails who either make direct requests for health care, allege excessive or indeterminate wait times, or feel their requests to see a clinician are been ignored or disregarded. During an inspection of several overcrowded dormitories used primarily for people receiving mental health treatment in Men’s Central Jail in December 2022, Commissioners found more than 25 requests for medical attention, many of which were requests for

medication. Those requests were relayed by Commissioners to CHS leadership. Several complaints came from individuals who presented obvious symptoms of medical distress. One man was visibly sweating while another appeared to be emaciated and said he had been rapidly losing weight.³² Several months later, in that same dorm module, a pre-trial 33-year-old man died in his bunk from a cause and manner that has yet to be disclosed by LASD or the Medical Examiner.³³

The regularity of observations like these, in the context of admissions of substandard care by medical leadership, are exemplary of a care delivery system that would benefit from dedicated oversight. Resources are needed to evaluate where the shortcomings are to ensure people are receiving the standard of care, and jail administration is meeting its own standard that incarcerated adults “receive appropriate health care services within a reasonable time period.”³⁴ A recent estimate from Correctional Health Services said individuals with medium-low level mental health diagnoses categorized as P2 wait an average of 47 days for a follow-up visit with a psychiatrist. A waiting period that exceeds the average period of time an individual spends in the jail 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.³⁵

³⁰ *Estelle v. Gamble*, 429 U.S. 97 (1976).

³¹ L.A. Cnty. Sheriff’s Dep’t, Custody Division Manual 5-01/050.00, *Access to Health Care*,

<https://pars.lasd.org/Viewer/Manuals/14249/Content/13179#.>

³² Sybil Brand Comm’n for Inst. Inspections, *Men’s Central Jail Inspection Report*, at 6 (Dec. 26, 2022, 2:00 PM), https://file.lacounty.gov/SDSInter/bos/Commissionpublications/report/1138004_122622_MCJInspectionReport_Miller_Sherman_Veral.pdf.

³³ See Case No. 2023-009, April 9, 2023. The Los Angeles County Sheriff’s Department publishes a list of in-custody deaths on its website pursuant to A.B. 2761, 2021-2022, Reg. Sess. (Cal. 2022) (enacted into law and chaptered as Cal. Pen Code § 10008). *LASD Inmate In-Custody Deaths*, L.A. Cnty. Sheriff’s Dep’t, (last updated June

17, 2023), <https://lasd.org/transparency/icd/>. While the Sheriff’s Department has been posting the sentencing status of individuals who died in the jail facilities, as of this writing, it is declining to disclose 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’s disclosure can be interpreted to insinuate the guilt of each person who dies in its custody.

³⁴ Custody Division Manual 5-01/050.00, *supra* note 23.

³⁵ Sybil Brand Comm’n for Inst. Inspections Meeting Minutes, at 3 (Feb. 15, 2023, 10:00 AM), https://file.lacounty.gov/SDSInter/bos/Commissionpublications/minutes/1138899_021523_SBCMinutesBM.pdf.

***Correctional Health Services Leadership
Acknowledges Care Is Substandard***

Correctional health care officials have admitted the care delivery system they manage is 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 SBC, 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.”³⁶ He said clinical staff were “overwhelmed” by caseloads and when jail administrators sought 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.”³⁷ (As of this report’s publication, the County entered into a stipulated agreement that would, in part, acknowledge those deficiencies by expanding the number of non-carceral beds for the diversion of people with serious mental health conditions between 2023-2025.³⁸)

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 that 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.³⁹

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 says it 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.⁴⁰

***“Sick Call” Data Reinforces The Need For
Independent Oversight of the Correctional Health
Care Delivery System***

The County reports publicly-accessible data related to the administration of the jails to the Board of State and Community Corrections on a monthly basis as part of its statewide Jail Profile Survey. The purpose of the data is to “provide counties a means of tracking changes in their populations and assessing and projecting program and facility needs.” The survey includes the number of inmates

³⁶ Sybil Brand Comm’n for Inst. Inspections Meeting Minutes (Sept. 21, 2022, 10:00 AM),

https://file.lacounty.gov/SDSInter/bos/Commissionpublications/minutes/1131799_092122_SBCMinutes.pdf (supporting documentation available upon request).

³⁷ Id.

³⁸ Order Granting Joint Stipulation (Doc. 399), *Rutherford v. Luna*, 2:75-cv-04111, (C.D. Cal.) available at

<https://storage.courtlistener.com/recap/gov.uscourts.cacd.44699/gov.uscourts.cacd.44699.402.0.pdf>.

³⁹ See Nicholas E. Mitchell, Monitor’s Report No. 14 at 61, *United States v. Cnty. of Los Angeles*, No. 2:15-cv-05903-DDP-JEM, (C.D. Cal. filed Sept. 30, 2022) (Doc. 221).

⁴⁰ Sybil Brand Comm’n for Inst. Inspections Meeting Minutes, at 3 (Mar. 15, 2023, 10:00 AM),

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

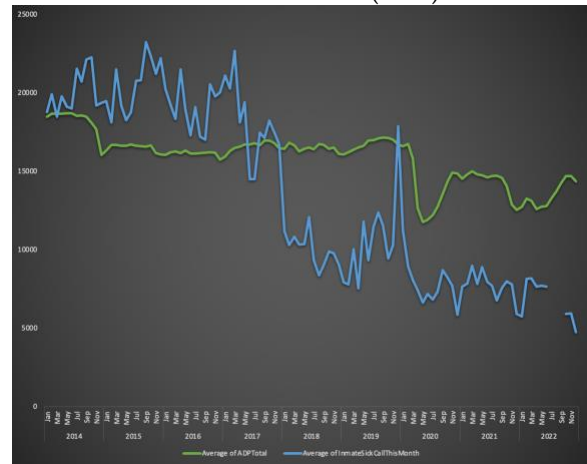
assigned to medical beds, physician encounters, dental encounters, and sick calls.⁴⁷ Within the County facilities, a “sick call” is defined as the process used to “identify, examine, and/or care for inmate illnesses, injuries and/or make referrals for specialized healthcare treatment.”⁴⁸ According to this data, the average number of inmates seen at sick call declined by more than half 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, based on statements from administrators and this Commission’s troubling observations during inspections, increased efficiencies do not fully explain the reduction in the number of sick calls. This Commission is concerned that the “sick call” data is evidence of incarcerated adults facing systemic barriers to accessing medical care. An incarcerated person should 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.”⁴⁹ But Commission inspectors regularly find request forms are not readily accessible to incarcerated adults in housing areas without obtaining permission from custody personnel. Inspectors also hear from inmates who say they do not have access to medical request forms or grievance 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 monitoring the quality of care and whether all entities responsible for services within the jail systems are fulfilling their duty to “work together” to ensure requests for care are being responded to within a reasonable time.

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

There is a clear need for more resources to be brought to ensure 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 systems, Dr. Belavich responded that accreditation did not have a “huge interplay” with quality of care, but conceded, “places that are good get accredited.”⁵² Given the County’s “Care First”

⁴⁷ See *Jail Profile Survey*, Cal. Bd. of State and Comty. Corrs., https://www.bscc.ca.gov/s_fsojailprofilesurvey/.

⁴⁸ See, e.g., Custody Servs. Div., L.A. Cnty. Sheriff’s Dep’t, *Century Reg’l Det. Facility Sick Call, Pill Call, Self-Medication and Health Care Passes Unit Orders: 05-08-060* (Rev. Sept. 29, 2022), <https://pars.lasd.org/Viewer/Manuals/GeneratePDF/19669?reportIndex=0>.

⁴⁹ *Id.*
⁵² Remarks at the Meeting of the Sybil Brand Comm’n for Inst. Inspections (Mar. 15, 2023, 10:00 AM), at 21:00-30:00 (transcript available at

https://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=10681).

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.⁵³

Jail Staff Culture

The SBC collectively remains concerned about the culture among some deputies working in custody. In 2012, the Citizens' Commission on Jail Violence ("CCJV"), a blue-ribbon commission formed by the Board of Supervisors, found evidence of deputy violence in the jails, often perpetrated by deputy gangs, including the "3000 Boys."⁵⁴ The CCJV noted a culture of "tacit approval" of violent deputy gangs within the Sheriff's Department. The CCJV criticized LASD for ignoring the problem and allowing deputy gang members to use excessive force to the point of breaking bones of inmates in the County jails.⁵⁵ Additionally, the CCJV found that LASD "rarely finds or meaningfully punishes dishonesty and failure to report force incidents, and it takes months (or even years) to address deputy misbehavior," and "for years, management has known about and condoned deputy [gangs] and their destructive subcultures... contribut[ing] to force problems in the jails as well as numerous off-duty force incidents involving deputies."⁵⁶

More than ten years after the CCJV report, an investigation by the *Los Angeles Times* found evidence of LASD personnel saving video recordings of violence and neglect in the jails.⁵⁷ One video included images of "a woman giving birth in the middle of a hallway, where her newborn falls out onto the jail floor in a puddle of blood."⁵⁸ Another video showed a fight among people incarcerated at Men's Central Jail, and a 14-minute delay before deputies respond.⁵⁹ According to the *Times*, these videos portrayed an environment "so inured to violence that [incarcerated individuals] continue on with their daily routine, working out and reading even as bloody brawls and beatings unfold feet away."⁶⁰ In another report, the ACLU of Southern California shared recent evidence of LASD deputies "slamming a handcuffed inmate's head into a concrete wall at the Men's Central Jail with no apparent provocation."⁶¹

This Commission continues to be concerned that a self-aware culture of impunity exists 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 Commission's ability to observe an incident where a mental health patient was being transferred out of Men's Central Jail, which resulted in a use of force.

⁵³ Section 1115 Waiver Watch: How California Will Expand Medicaid Pre-Release Services for Incarcerated Populations, KFF, (Feb. 07, 2023),

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

⁵⁴ See Report of the Citizens' Comm'n on Jail Violence cited *supra* note 37, p.102, available at <https://ccjv.lacounty.gov/wp-content/uploads/2012/09/CCJV-Report.pdf>.

⁵⁵ Id. at 72.

⁵⁶ Id. at 95.

⁵⁷ Keri Blakinger, "Fights, beatings and a birth: Videos smuggled out of L.A. jails reveal violence, neglect," *Los Angeles Times*, June 24, 2023, <https://www.latimes.com/california/story/2023-06-24/fights-beatings-and-a-birth-videos-smuggled-out-of-la-jails-reveal-violence-neglect>.

⁵⁸ Id.

⁵⁹ Id.

⁶⁰ Id.

⁶¹ Keri Blakinger, "Video shows deputy slamming handcuffed inmate into concrete wall at Men's Central Jail," *Los Angeles Times*, June 3, 2023, <https://www.latimes.com/california/story/2023-06-03/video-shows-deputy-slam-handcuffed-inmate-into-concrete-wall-at-mens-central-jail>.

Report & Recommendations on the Los Angeles County Jails Humanitarian Crisis

- 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 health disability.
- Mandatory safety checks in high observation housing consist of deputies walking by and scanning the bar codes 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."
- A group of at least 7 LASD personnel of various ranks were found watching movies on County computer systems while, in the next room, people with serious mental illness languished in solitary confinement for up to 23 hours per day and complained about not being permitted to take a shower. LASD personnel engaged in repartee with Commissioners about the movie before realizing they were doing anything wrong.

When SBC reports concerns to LASD personnel, such as a watch commander, other senior

officers, or the designated LASD liaison, leaders are often attentive, take notes, and commit to investigating what is brought to their attention. On occasion, action is taken to address problems that are raised. However, with regard to deputy culture, this Commission lacks confidence that the strategies presented to address these problems will in fact uproot or interrupt 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 this Commission has relayed fears and reports of retaliation to staff, LASD has responded in a manner that disregards or minimizes those fears.

These interactions give this Commission 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 this Commission's troubling experience with a deputy at CRDF who stated she was following the directives of a senior officer, the SBC does not believe this will 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.⁶² Given that staff rotations are a tool that has been available to the Sheriff's at least over the last decade, the SBC believes its impact is temporary and insufficient to remedy the problems routinely observed.

⁶² See Report of the Citizens' Comm'n on Jail Violence cited *supra* note 37.

A Failed Grievance System

Across several facilities, the formal inmate grievance or 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.⁶³ Commissioners made a request to the deputy in the module to make a copy of the form for SBC 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 said SBC members could not leave with the grievance form. When asked why, the deputy said their captain said it was not allowed. SBC Commissioners present requested that the captain come to the module to speak directly -- Commissioners have never had a problem receiving documents given by people in custody. After waiting roughly 10 minutes, the SBC Commissioners began handwriting the content of the complaint. While

doing so, the deputy came over and snatched the document out of Commissioner's possession and took the form back to the desk. When asked on what grounds they were refusing permission to possess 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. 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, the SBC liaison. At an in-person meeting with Captain Montoya, Commander Macias, and Commander Alva, Commissioners discussed this issue and broader concern around Deputy culture at CRDF. As noted above, Captain Montoya informed SBC 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 the SBC 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 SBC's understanding, as communicated by LASD to Commissioners, that disposition forms are internal documents to the department and would not be in the possession of someone held in custody.

⁶³ Cheryl Grills & Ingrid Archie, Sybil Brand Comm'n for Inst. Inspections *Century Regional Detention Facility Inspection Report* (Feb. 3, 2023, 4:20 PM),

For these reasons, this Commission has cause to doubt the completeness of summary reports provided by the Sheriff's Department related to the efficiency and effectiveness of the jail's grievance process. For example, LASD recently reported just 6% of all grievances filed in the first quarter of 2023 related to a capacious category of "processing, delays, overcrowding and conditions of confinement."⁶⁴ The report did not indicate the subject matter of the other 94% of grievances or whether the remainder of grievances were even reviewed. To the extent the Sheriff's department will continue to access the grievance system for the purposes of providing analytical trend reports of data related to the conditions of confinement, this Commission recommends such reports be produced and provided by an independent third-party auditor 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 SBC, with support from the Civilian Oversight Commission, and in collaboration with Loyola Marymount University and the Psychology Applied Research Center @ LMU and Imoyase 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."⁶⁵ 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.

⁶⁴ Custody Servs. Div., L.A. Cnty. Sheriff's Dep't, *Conditions of Confinement 2023*, Quarter One Report, at 3 (2023),

<https://file.lacounty.gov/SDSInter/bos/supdocs/COC2023Quarter1report042523.pdf>.

⁶⁵ Leroy D. Baca, Educ. Based Incarceration Bureau, L.A. Cnty. Sheriff's Dep't., *Preface to Creating a Life Worth Living* (2d ed. Jan. 2013), 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, are plagued by conditions of confinement that are unconstitutional and inhumane.

The Sheriff's Department's failure to maintain a sanitary facility and to conduct regular inspections of its facilities for sanitary conditions reflects an administrative orientation with a limited commitment to upholding basic values. Jail officials acknowledge overcrowded conditions or isolation tends to add stress to people incarcerated with mental health conditions.⁶⁷ The Federal Monitor has noted a link between the poor conditions in the jails and incidents of self-directed violence and harm among incarcerated adults.⁶⁸ The Medical Examiner has attributed in-custody deaths involving acts of self-harm by individuals in unsanitary housing areas to "the stress of being placed in custody" exacerbating one's mental condition. The County should acknowledge the harms of continuing to house incarcerated individuals in overcrowded and unsanitary jail conditions.

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

Deaths resulting from interactions with the US criminal legal system are a national public health emergency. This Commission has reviewed records provided by the Medical Examiner's Office identifying the causes of in-custody deaths since the year 2000. An analysis of these records show

concerning trends and patterns that require further attention, including racial disparities in in-custody mortality rates and trends in underlying causes of "natural" death. Between 2000-2020, the Medical Examiner was far more likely to deem the in-custody deaths of incarcerated African Americans to be "natural," as 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 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.⁷¹ However, the Medical Examiner does not evaluate whether so-called "natural" deaths were unexpected, preventable, or were the result of error, negligence, or some aspect of the manner in which the jails are administered. Due in part to acknowledged deficiencies in the jail's medical care delivery system, the County should establish an independent task force with appropriate specializations to conduct annual mortality reviews of all in-custody deaths, including those deemed "natural" by the Medical Examiner, and make its findings accessible to the public.

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

⁶⁷ Sybil Brand Comm'n for Inst. Inspections Meeting Minutes, at 3 (Feb. 15, 2023, 10:00 AM), https://file.lacounty.gov/SDSInter/bos/Commissionpublications/minutes/1138899_021523_SBCMinutesBM.pdf.

⁶⁸ See Nicholas E. Mitchell, Monitor's Report No. 15 at 4, *United States v. Cnty. of Los Angeles*, No. 2:15-cv-05903-DDP-JEM, (C.D. Cal. filed July. 17, 2023) (Doc. 257).

⁷¹ Chief Medical Exam'r, L.A. Cnty. Dep't of Med. Exam'r. and Coroner, *Pub. Rec. Doc. Produc. re Data on In-Custody Deaths in the L.A. Cnty. Jail System from 2000-2021* (on file) (finding that 37% of the 131 people who died at Twin Towers Correctional Facility between 2000-2021 were Black or African American, counting all cases where the EventPlace, EventAddr, or Death Addr were identifiable as the location of the Twin Towers Correctional Facility).

safety and security of people incarcerated in the jails. The CCJV documented witnesses to so-called “gladiator fights” in the jails, where deputies are at best slow to respond to critical incidents.⁷² When this Commission has brought forward evidence of neglect to the Sheriff’s Department, SBC 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 this oversight body can do within its constraints to have anything but a marginal impact on the causes for why the Los Angeles County jails continue to be fertile environments for violence, 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.

In February 2023, the Board of Supervisors passed a motion seeking a report-back related to the County’s non-compliance with multiple consent decrees and settlements 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 request the County to include as part of that assessment a public inquiry into the human costs of operating a jail beset by

unconstitutional conditions for a prolonged period of time. This request would include a series of hearings 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 SBC 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 its 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 person should be subjected to the indecent, unsanitary, and inhumane conditions that it has 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, representatives of the SBC, the ACLU, and the Office of the Inspector General all stated that it is most important to significantly reduce the jail population if the County is going to meaningfully address these issues. As of the drafting of this report, more than half 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.

The SBC urges the County 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 the SBC as outside observers. Reducing the pretrial population is a necessary remedy and urgent step as lengths of stay in the jail are increasing across the

⁷² *Report of the Citizens’ Comm’n on Jail Violence*, cited *supra*, note 3, at 100.

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 2020.⁷³ 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.⁷⁴ 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. The SBC recommends the County establish an independent pretrial services system that emphasizes a robust care first approach and facilitates a significant reduction of the jail population. The SBC further recommends creating transparent, on-line accounting for the creation of non-carceral beds.

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 commitments made pursuant to a settlement agreement with the ACLU, and the appointment of a Countywide compliance coordinator and a new Office of Constitutional Policing within the Sheriff's Department. The SBC requests the Board to empower it consistent with those changes, including

by examining whether the Commission is adequately resourced to fulfill the expectation of the County Executive Office that it "ensures 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, which has hindered inspections from time to time; a description of the types of Department records which this Commission shall have access; and clearance to document jail conditions with photographs, video recordings, and audio recordings, particularly as the Sheriff's Department has begun permitting media access to the facilities.

Conclusion

Los Angeles County has been aware of mistreatment – and public outrage about mistreatment – in the County jails for decades. This Commission finds jail conditions today are poor and represent ongoing, imminent, and potential risks to public health and safety, and fail to comply with constitutional and international standards. Yet the County continues to commit space in the jails to housing individuals, including scores of people receiving treatment for mental illness, who receive substandard care, neglect, and mistreatment by staff.

⁷³ Fei Wu et al., L.A. Cnty. Pretrial Data Ctr., *Pretrial Landscape: 2020-2022*, <https://storymaps.arcgis.com/stories/3f07018a72f446d2b9914f6225327a9e> (Data provided by the CIO in the May 18th, 2023 quarterly Pretrial Data Workgroup meeting.)

⁷⁴ Carceral Ecologies and BioCritical Studies Lab'ys., UCLA Inst. for Soc'y & Genetics, "Natural Causes?" *58 Autopsies Prove Otherwise*:

Evaluating the Autopsies of 58 Deaths in Los Angeles County Jails 2009-2018 (June 2022),

<https://ucla.app.box.com/s/sv54jmxhmq19kqifpakh4jfu3vnmhbqt/file/974263270262> (finding 75% of people who died in custody between 2009 and 2018 died in pretrial detention).

Substandard and unconstitutional conditions in these jails, whether as forms of punitive discomfort or non-punitive frustrations, lack penological legitimacy. An expanding body of research shows carceral conditions worsen a person's mental and medical health. 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, Latinos, and Indigenous people are disproportionately criminalized and incarcerated in LA County, the operation of an unconstitutional jail disproportionately harms African American, Latinos, and Indigenous people 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."⁷⁵ Clearly, the games have not stopped. Oversight alone, as presently constituted, cannot change that. It is ultimately the responsibility of the Sheriff's Department and the Board of Supervisors to decide whether such longstanding practices will continue.

⁷⁵ Remarks at the Meeting of the Civilian Oversight Commission (Nov. 17, 2022) at 01:05 (https://youtu.be/LI4Jo7eD_rg).