AGENDA ITEM: 3b

April 21, 2022

DISCUSSION ITEM TITLE:

In-Custody Deaths in Los Angeles County Sheriff's Department Facilities

EXECUTIVE SUMMARY:

The Los Angeles County Sheriff Civilian Oversight Commission (Commission) receives notifications from the Los Angeles County Office of Inspector General (OIG) of deaths which occur within the Los Angeles County Sheriff's Department (LASD) correctional facilities. Commission staff has noted an increasing number of in-custody deaths and as such Commission staff recommends the following: that LASD immediately post in-custody deaths on their website; that LASD collaborate with OIG to include the Department of Public Health's Office of Violence Prevention's Family Assistance Program services into the in-custody deaths process; that LASD provide an annual report concerning in-custody deaths to the Commission; and, that the OIG continue to provide timely and in-depth notifications of LASD custody deaths.

BACKGROUND:

LASD has been responsible for the care, custody and security of people in Los Angeles County dating back to its first wooden structure jail with no cells in the 1850s when the County's population was close to 2,500.[1] Since then, facility conditions and the custody services provided in the LASD jail system have changed. With the number of people in jail increasing, the number of people who die in the LASD jails has also increased.

The Los Angeles County District Attorney's Office conducts in-custody death reviews, but only when a law enforcement officer uses force.[2] The OIG, created in 2014, responds to death scenes, death reviews and are able to view the bodies of people who die in LASD jails. The OIG indicated that from 2016 to 2021, LASD in-custody deaths more than doubled, with 55 in-custody deaths in 2021.[3] The OIG also noted recent issues related to access to the scenes of in-custody deaths, which reflects

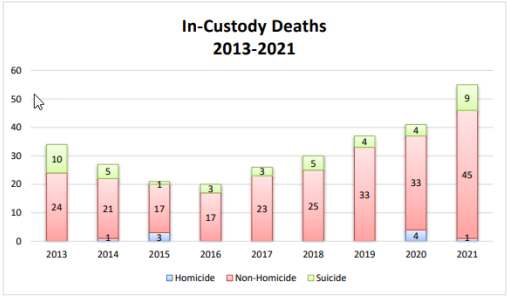

Table 1: Source OIG Report, footnote 3.

[1] LASD. (2019). LASD Museum Timeline 1850-1859. Retrieved from https://lasd.org/pdf-lasd-museum/timeline/1850%20-%201859.pdf
[2] L.A. County District Attorney website. Retrieved 4.6.2022 from https://da.lacounty.gov/reports/icd/2021
[3] L.A. County OIG. Reform and Oversight Efforts: LASD, October-December 2021. Retrieved from https://bit.ly/3uhXCu4

the larger issue of lack of transparency and accountability related to deaths that occur under LASD's custody and care.

The Sybil Brand Commission conducts jail facilities inspections and recently discussed in-custody deaths data from the Medical Examiner-Coroner, which listed 46 in-custody deaths between March 2020 and February 2022.[4] The list provides the location as well as the cause of death for each individual, including suicide, homicide, accident or natural causes. The list reflects that 12 out of the 46 deaths were accidental and involved drugs that made their way into the jail system. Eleven out of the 46 deaths on the list were suicides, with the most common method being hanging. The Commission is also highly concerned that a disproportionate amount of the deaths involves minorities with 21 out of the 46 deaths involving Hispanic people and 14 of the 46 deaths involving Black people. With drug overdoses and suicides making up nearly half of the causes of death, it's clear that the care of incarcerated people must be a top priority for the LASD and affiliated agencies who care for inmates within LASD facilities.

LASD provides the number of people who die per month in each LASD facility in their Custody Services Division Public Data Sharing reports,[5] however it does not include sufficient data to make an analysis possible, nor does it publish raw data in a format that can be examined methodically. LASD also fails to publicly release information on in-custody deaths, as they do with deputy involved shootings.[6] The Family Assistance Program should continue to be involved in timely, trauma-informed notifications of family members of people who die in-custody.[7]

Overcrowding and other in-humane conditions of confinement

The California Board of State and Community Corrections (BSCC) is the independent statutory agency which recommends capacity limits for county jails and has given the LASD jail system a total rated capacity of 12,404 individuals. As of April 4, 2022, the LASD jail system maintains a daily average population of close to 13,000 people,[8] and it has maintained a population over the BSCC-rated capacity over the last 20 years.[9]

The BSCC is also responsible for enforcing the California Code of Regulations Title 15-Mimimum Standards for Local Detention Facilities, which requires that LASD conduct Inmate

[4] In-custody deaths from 03-13-2020 to 02-07-2022 with PI.xlsx. L.A. County Sybil Brand Commission for Institutional Inspections, 3.2.2022 Meeting Agenda. Retrieved the from http://file.lacounty.gov/SDSInter/bos/supdocs/166803.pdf
[5] LASD Custody Services Division Public Data Sharing 2021 Quarter Three Report. Retrieved from https://bit.ly/3KpuciY
[6] OIG's Report Calls on LA's Supervisors to Continue Assistance Program for Families Whose Loved Ones Die in Custody. Witness L.A. 2.26.2022, by Taylor Walker. Retrieved from: https://bit.ly/3NXD3eb
[7] OIG Semi-Annual Report on Implementation of the Family Assistance Program. 2.22.2022. Retrieved from https://bit.ly/37naSEG
[8] LASD. (2022). Correctional Services Daily Briefing. Retrieved from https://lasd.org/transparency/custodyreports/#2022_Daily
[9] State of California. (2022). Jail Profile Survey. Retrieved from https://bscc.ca.gov/s_fsojailprofilesurvey/

Safety Checks to ensure individuals' safety and welfare.[10] According to Title 15,[11] safety checks must be conducted and documented through direct visual observation of all incarcerated people with no more than a 60-minute lapse between safety checks. The LASD Custody Division Manual Policy on Inmate Safety Checks[12] provides varying times for conducting checks with some being once per hour to once every 15 minutes, depending on the housing area. An LASD audit of safety checks at Men's Central Jail from April 1-30, 2020 noted that 29 of 95 safety checks were beyond the 30 minutes timeframe stated in LASD policy, which leaves only 69% within policy.[13] A similar LASD audit at North County Correctional Facility[14] from November 1-30, 2020, reported that 3 out of 93 safety checks were beyond 60 minutes. Both reports reflect a glimpse of time for which anything could have transpired in the jail system, including an in-custody death. The conditions of overcrowding, including lack of monitoring incarcerated people, should be evaluated to see if this could reduce the number of in-custody deaths.

Physical and mental health of incarcerated people, and inadequate care

In addition to exceeding capacity, the LASD jail system confines people with various needs, ranging from people with physical and mental health needs to those who require varying levels of supervision for their own safety and the security of the facility. In December 2021, LASD reported that 43% of the 13,300 incarcerated people had mental health concerns, and that 32% of incarcerated people require specialized housing, such as moderate or high observation housing.[15]

In 2018, healthcare within the LASD jail system was overhauled with the intention to raise the quality of healthcare behind bars and better equip incarcerated people to manage their health after release.[16] As several years have passed, there needs to be a review of current healthcare in the jails to ensure that the level of care not only meets guidelines, but that it provides the greatest level of healthcare feasible.

Drugs/contraband in LASD facilities

Over the years, the LASD jail system has seen an increase in drugs smuggled into the jail,[17] which creates additional problems for LASD and for those in their custody and care. The

[10] LASD. (2020). Title 15 Compliance-Inmate Safety Checks Audit Custody Services Division-General Population-Men's Central Jail. Retrieved from https://lasd.org/wp-content/uploads/2021/02/Transparency_Audit_Reports_2020-5-A_Intranet_Internet.pdf
[11] Cornell Law School. (2021). California Code of Regulations Title 15 § 1027.5 – Safety Checks. Retrieved from https://bit.ly/3xcDFGz
[12] LASD. (2022). Custody Division Manual Policy 4-11/030.00-Inmate Safety Checks. Retrieved from https://bit.ly/37nYtAe
[13] LASD. (2020). Title 15 Compliance-Inmate Safety Checks Audit Custody Services Division-General Population-Men's Central Jail. Retrieved from https://lasd.org/wp-content/uploads/2021/02/Transparency_Audit_Reports_2020-5-A_Intranet_Internet.pdf
[14] LASD. (2021). Title 15 Compliance-Inmate Safety Checks Audit Custody Services Division-North County Correctional Facility. Retrieved from https://lasd.org/wp-content/uploads/2021/08/Transparency_Audit_Title_15_Compliance_Inmate_Safety_Checks_Audit_2021-3-A_081721.pdf
[15] LASD. (2021). Custody Division Population Quarterly Report October-December 2021. Retrieved from https://bit.ly/3NXf3aQ
[16] Health Care Revamp at the L.A. County Jails. California Healthline. By Anna Gorman. 3.1.2018. Retrieved from https://bit.ly/3DToAuQ
[17] LA Times. (2014). Los Angeles County jails among those seeing surge in drug smuggling. Retrieved from https://bit.ly/3v1nNUS

OIG report noted that some individuals refuse a body scan or strip search, hampering LASD's ability to detect and deter contraband.[18] There have also been cases of LASD staff trying to bring drugs into the jails.[19,20] The LASD Policy on Searches[21] is a tool for use at its discretion, to maintain the safety and security of incarcerated people, but there are limited details as to the use of this tool to control the intake of contraband into LASD jails. With the number of in-custody deaths due to drug overdose, the issue of contraband in LASD facilities needs to be explored.

In-Custody death reporting:

In 2000, the Death in Custody Reporting Act (DCRA) was enacted requiring the U.S. Attorney General to collect data on the death of any person under arrest, enroute to be incarcerated or is incarcerated in a municipal or county jail.[22] The U.S. Department of Justice Bureau of Justice Statistics created the Mortality in Correctional Institutions, which began collecting data on in-custody deaths such as the decedents name, date of birth, gender, race, ethnicity, date, time and location of death and manner of death. In April 2021, the Bureau of Justice Statistics reported between 2000 and 2018 the number of deaths in local jails due to drug or alcohol intoxication had more than quadrupled.[23] It further noted that in 2018, about 25% of the in-custody deaths were Black people and 13% were Hispanic people.[24] The DCRA requirements were created to identify in-custody deaths and develop solutions to avoid them, including preventable deaths such as suicides.[25] LASD is required to report in-custody deaths to State Administering Agencies that compiles and aggregates the data before submission to the Bureau of Justice Administration. LASD should not incur any undue burden or additional staffing needs to place DCRA mandated data on the LASD public website along with information related to developing policies and program changes that may be made to reduce in-custody deaths.

RECOMMENDATION/CONCLUSION:

After reviewing and analyzing LASD and OIG documents to create this report and for the reasons listed throughout this report, staff recommends the Commission should:

[18] OIG. (2018). Reform and Oversight Efforts: Los Angeles County Sheriff's Department January 2018. Retrieved from https://bit.ly/3vm4LsD
[19] Los Angeles Daily News. Former LA County sheriff's deputy sentenced to 4 years in prison. 9.3.2010. Retrieved from https://bit.ly/3jidzKo
[20] Sheriff's Assistant Accused of Trying to Bring Drugs to Jail. U.S. News. 11.9.2021. Retrieved from https://bit.ly/3xcOTv1
[21] LASD. (2022). CDM Policy 5-08/010.00-Searches. Retrieved from http://pars.lasd.org/Viewer/Manuals/12684/Content/13305?showHistorical=True
[22] U.S. Department of Justice Office of Justice Programs. (2021). Death in Custody Reporting Act Factsheet. Retrieved from https://bja.ojp.gov/sites/g/files/xyckuh186/files/media/document/DCRA-Factsheet.pdf
[23] U.S. DOJ BJS. (2021). Mortality in Local Jails, 2000-2018-Statistical Tables. Retrieved from https://bjs.ojp.gov/content/pub/pdf/mlj0018st.pdf
[24] Ibid.
[25] U.S. Department of Justice Office of Justice Programs. (2021). Death in Custody Reporting Act Factsheet. Retrieved from https://bit.ly/3DPzVw2

1. Request that LASD post in-custody deaths information on their public website, comparable to the deputy-involved shootings postings (consistent w/DCRA data at a minimum),[26] and submit a written update to the Commission within 30 days on the status of implementation;
2. Request that the LASD develop and submit an annual report to the Commission on in-custody deaths that includes an overview of policies developed or changed, programmatic changes or new programs developed and related employee discipline (non-confidential information) with the first report due to the Commission effective January 2023.
3. Request that LASD and OIG work with the Commission to identify a more efficient manner to communicate to the Commission when in-custody deaths occur and to receive periodic updates and report back to the Commission within 30 days;
4. Request that LASD, OIG and the Department of Public Health's Office of Violence Prevention integrate the Family Assistance Program services into the in-custody deaths process and provide a written update to the Commission within 45 days; and
5. Staff will continue to monitor this matter on an ongoing basis.

GUEST SPEAKERS:

- Subject matter expert, LASD
- Cathleen Beltz, Assist. Inspector General, OIG

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COC:tj

[26] LASD. (2022). Deputy Involved Shootings. Retrieved from Deputy Involved Shootings - Current (lasd.org)