Assigned for all purposes to: Stanley Mosk Courthouse, Judicial Officer: Maureen Duffy-Lewis

XAVIER BECERRA
Attorney General of California
MICHAEL L. NEWMAN
Senior Assistant Attorney General
SARAH E. BELTON
Supervising Deputy Attorney General
LAURA FAER (SBN 233846)
VIRGINIA CORRIGAN (SBN 292035)
DOMONIQUE C. ALCARAZ (SBN 322761)
LEE I. SHERMAN (SBN 272271)
Deputy Attorneys General
1515 Clay Street, 20th Floor
P.O. Box 70550
Oakland, CA 94612-0550
Telephone: (510) 879-3304
E-mail: Laura.Faer@doj.ca.gov
Attorneys for THE PEOPLE OF THE STATE OF CALIFORNIA

Exempt from filing fees pursuant to Government Code section 6103.

SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

THE PEOPLE OF THE STATE OF CALIFORNIA, EX. REL. XAVIER BECERRA, ATTORNEY GENERAL OF THE STATE OF CALIFORNIA,

Plaintiff,

v.

LOS ANGELES COUNTY; AND LOS ANGELES COUNTY OFFICE OF EDUCATION,

Defendants.

Case No. 21STCV01309

COMPLAINT FOR INJUNCTIVE AND OTHER EQUITABLE RELIEF

The People of the State of California, by and through Xavier Becerra, Attorney General of the State of California (Plaintiff), allege as follows:

JURISDICTION AND VENUE

1. This Court has jurisdiction over the allegations, which arise under the Constitution and the laws of the State of California, and the subject matter of the Plaintiff's complaint filed in this action and the parties to this action; venue is proper in this County; and this Court has jurisdiction to enter these Judgments.

PARTIES

2. Plaintiff Xavier Becerra is the Attorney General of the State of California. The Attorney General is the chief law officer of the state and has the duty to see that the State's laws are uniformly and adequately enforced for the protection of public rights and interests. (Cal. Const., art. V, § 13.)

3. Defendant County of Los Angeles (County or Los Angeles County) is a county of the State of California governed by the Los Angeles County Board of Supervisors. Defendant Los Angeles County Probation Department (Probation) is a public County-operated probation services agency organized and existing under the laws of the State of California in the County of Los Angeles; Los Angeles County Department of Mental Health (DMH) is a public County-operated mental health department organized and existing under the laws of the state of California in the County of Los Angeles; and Los Angeles County Department of Health Services (DHS) is a public County-operated health services department organized and existing under the laws of the State of California in the County of Los Angeles (Probation, DMH, and DHS are collectively referred to as "County" throughout).

4. The Los Angeles County Board of Supervisors is responsible for providing and maintaining, at the expense of the County, a juvenile hall, which is a suitable house or place for the detention of wards and dependent children of the juvenile court and of young people alleged to come within the jurisdiction of the juvenile court and which shall be a safe and supportive homelike environment and not be deemed to be, nor treated as, a penal institution. The Los Angeles County Board of Supervisors is empowered to provide for the establishment of a public

elementary school and of a public secondary school in connection with and for the education of youth in its juvenile halls. The Los Angeles County Board of Supervisors is responsible for providing a suitable superintendent to have charge of the juvenile halls, and for such other employees as may be needed for its efficient management, and shall provide for payment, out of the general fund of the County, of suitable salaries for such superintendent and other employees. The Chief Probation Officer is responsible for the management and control of the County's juvenile halls and for appointing and removing the superintendent and other employees of the juvenile halls.

5. Defendant Los Angeles County Office of Education (LACOE), governed by the Los Angeles County Board of Education, is a public regional educational agency organized and existing under the laws of the State of California operating in Los Angeles County. The Los Angeles County Board of Education is responsible for providing for the administration and operation of juvenile court schools in the County.

FACTUAL BACKGROUND

6. In October 2018, the California Attorney General's Office began an investigation to determine whether the County complied with state and federal laws with respect to conditions of confinement for youth in their care at Barry J. Nidorf Juvenile Hall (BJN) and Central Juvenile Hall (CJH) (together, Juvenile Halls).[1] The Attorney General's Office conducted an investigation into use of force policies and incidents, room/solitary confinement policies and practices, provision of rehabilitative programming, recreation, religious services, education, medical and mental health care, access to and adequacy of grievance procedures, and staff training by the County. The Attorney General's Office conducted multiple site visits to the Juvenile Halls; interviewed more than 80 witnesses; and reviewed thousands of pages of documents, including but not limited to: (a) use of force policies, procedures, and incidents; (b) room confinement, school attendance, and enrollment data; (c) youth grievances; (d) programming, recreation, and religious services data; (e) staff training; (f) Internal Affairs investigations; and (g) conditions of

[1] During the investigation, the County closed down Los Padrinos Juvenile Hall (LPJH), the third juvenile hall that the County operated.

confinement-related reports. As part of its review, the Attorney General's Office retained three experts in various aspects of juvenile justice facility operations, who reviewed thousands of pages of documents, interviewed multiple witnesses, and conducted site visits to the Juvenile Halls. These experts' findings are incorporated as part of the Attorney General's Office findings.

7. The Attorney General's Office found that the County has endangered youth safety and provided insufficient protection from harm, including by: (a) relying on excessive and inappropriate physical and chemical use of force; (b) failing to sustain sufficient staffing at the Juvenile Halls; (c) failing to train staff on de-escalation methods; (d) failing to ensure accurate reporting of use of force incidents; and (e) failing to implement functional data collection systems for effective oversight and accountability, resulting in youth being more susceptible to harm from staff and other youth.

8. The Attorney General's Office further found that the County has failed to provide a home-like environment for youth by subjecting them to conditions of confinement that must be reserved for adult penal institutions and depriving youth of their basic needs, outside exercise, programming, religious services, and adequate and timely medical and mental health care.

9. The Attorney General's Office also found that the County has used room confinement improperly for punishment in violation of California law, including with respect to youth with disabilities.

10. And, the Attorney General's Office found that the County has failed to provide youth an effective method for redress of complaints, including providing sufficient protection against retaliation for complaint filing, and has failed to create an adequate system to track and respond to youth's complaints.

11. The Attorney General's Office also investigated the provision of education, special education, and transition services in the Juvenile Halls. The Attorney General's Office found that LACOE and the County failed to: (a) provide youth with legally required educational minutes; (b) timely enroll youth in school; and (c) work collaboratively to support a youth's transition from juvenile hall.

12. The Parties have worked cooperatively to agree to a remedial plan that covers 12 areas of non-compliance and addresses findings and concerns identified during the investigation.

13. The remedial plan includes among other things:

a. a four-year term;

b. appointment of a monitor to oversee overall compliance and of two subject matter experts, one for education and education-related programming and one for behavioral health;

c. access to records and inspections by the Attorney General's Office, the monitor, and experts;

d. revisions to policies and procedures to reflect legal and regulatory requirements regarding use of force and conditions of confinement;

e. review of use of force incidents by the County's Office of Inspector General (OIG), as well as a recently created unit dedicated to systematic review of use of force incidents;

f. implementation of oversight and accountability mechanisms to ensure decontamination practices comply with law and regulation, to monitor and review weekly use of Oleoresin Capsicum (OC) spray, as it is eliminated in the County, and to ensure corrective measures are taken, as necessary;

g. provision of facility-wide audio-visual camera coverage in each juvenile hall, and an accountability system to ensure cameras are operational, in use, and recordings are regularly reviewed by OIG and the Department;

h. consistent and coordinated implementation of a positive, trauma-informed, incentive-based behavior management system;

i. development of a system and oversight accountability to monitor and ensure youth's access to programming, recreation, religious services, visitation, and calls;

j. revisions to policy and accountability systems to ensure that youth have access to basic necessities, such as hygiene items, bedding, and access to the toilet and privacy protections required by the Prison Rape Elimination Act (PREA);

k. provision of mental health, medical care, and treatment plans to provide timely medical and mental health care, multi-disciplinary team case management for complex cases, and treatment planning to address significant health needs;

l. implementation of a data tracking and accountability system to ensure youth are promptly enrolled in school and provided the requisite school minutes and, if education time is denied, provide compensatory services to youth;

m. provision of a compliant room confinement policy and implementation of a tracking and monitoring system with outside review to ensure practices are consistent with law, regulation, and policy;

n. revisions to the grievance policy, development of a system to track grievances filed and resolved, and assignment of a Department administrator to provide supportive and protective measures to youth who have filed grievances;

o. training on all policy and practice changes and on de-escalation strategies, trauma-informed practices, and youth development;

p. implementation of strategies to address climate and staff attendance;

q. provisions to address meaningful and effective translation and interpretation services and develop career exploration and job readiness programs for youth; and

r. compensatory education services for youth denied education services from January 1, 2018 until the date of entry of the Stipulated Judgments in this matter.

14. The County and LACOE have begun to take positive steps to revise policies and procedures to address the findings and compliance issues regarding conditions of confinement in the Juvenile Halls.

A. The County's Deficient Practices Expose Youth to Unreasonable Risk of Harm.

15. The County is required to maintain a safe, supportive, homelike environment in its Juvenile Halls. Instead, however, youth detained in the County's Juvenile Halls have faced significant risks to their physical safety—both from excessive force employed by facility staff and from the County's failure to protect youth from violence by other youth. These risks are due, in

part, to the County's failure to ensure sufficient staff in the Juvenile Halls and provide meaningful oversight and accountability for staff.

i. The County's deficient practices subject some youth to excessive, retaliatory, and punitive use of force.

16. At both of the County's Juvenile Halls, some staff employ unlawful, excessive physical, and chemical force against detained youth.

17. The County has had long-standing problems with the use of excessive force in its Juvenile Halls. In 2004, following an investigation of the County, the United States Department of Justice (US DOJ) entered into an agreement with the County to resolve systemic concerns that US DOJ identified in the County's three Juvenile Halls. US DOJ found violations of federal law based on systemic abuse by staff, excessive and inappropriate use of force, deficiencies in medical and mental health care, and insufficient protection from harm in the County's Juvenile Halls. US DOJ monitored the County's Juvenile Halls until it determined the County was in full compliance in 2014.

18. Two years later, multiple County-initiated reviews found that the deficiencies that originally prompted US DOJ to investigate the County had re-emerged in the County's Juvenile Halls. In April 2016, the Los Angeles County Office of the Independent Monitor reported many incidents of alleged misuse of force and officers' dishonesty in attempting to justify their conduct.[2] Later that year, the Los Angeles County Auditor-Controller (AC) reported to the Board of Supervisors its findings of numerous deficiencies in the reporting of incidents, including the failure to adequately track critical incidents and notify key personnel.[3]

[2] Office of the Independent Monitor, Annual Report: Los Angeles County Probation Department (Apr. 2016) pp. 19-22 <https://tinyurl.com/y97rpcbtt> [as of Dec. 15, 2020]; see also Los Angeles County Board of Supervisors, Motion by Supervisors Sheila Kuehl and Mark Ridley-Thomas, Youth Justice Reimagined: A New Model for Youth Justice in Los Angeles County (Nov. 24, 2020) p. 3 [discussing the "overwhelmingly negative" findings of multiple reports and Board-commission study pointing to a need for reform] <https://tinyurl.com/y95pxpf9> [as of Dec. 15, 2020].

[3] County of Los Angeles, Department of Auditor-Controller, Probation Department – Strengthening Critical Incident Protocols to Protect Probation Youth and Promote Accountability (Nov. 18, 2016) <https://tinyurl.com/yc4jvqq2> [as of Dec. 15, 2020] (hereinafter November 2016 Auditor-Controller Report).

19. In several incidents, excessive use of force in the Juvenile Halls has led to criminal prosecution of staff involved. For example, on April 24, 2016, video revealed four probation officers in BJN beating a non-combative 17-year-old youth for two minutes while a supervisor watched. The boy had bruising, black eyes, swelling, abrasions, and a sprained ankle as a result. The youth had filed a grievance against staff before the incident occurred. After investigating the incident, on March 15, 2017, the Los Angeles County District Attorney filed charges for assault under color of authority against three Department employees and the supervisor who ordered the beating.

20. Youth continued to be subjected to excessive and/or unlawful physical force in the County's Juvenile Halls. Probation documents reflected an increase in use of force by 27.4 percent for all Juvenile Halls between January to October 2017, and the same period in 2018, despite a 26.7 percent decrease in the average population.

21. Witnesses have reported excessive and inappropriate use of force incidents, including being slammed to the floor when they were not resisting or engaging in any physical aggression.

22. Pepper spray, or OC spray, is a type of chemical agent that contains capsaicinoids extracted from the resin of hot peppers. It causes an intense burning sensation on the skin and causes tearing and swelling of the eyes. OC spray also has significant respiratory effects, causing the mucous membranes to swell and temporarily restricting breathing. The use of OC spray is contraindicated for youth with respiratory or cardiovascular issues, and for youth who are taking psychotropic medication. In part because of its serious physical effects, the use of OC spray in juvenile facilities is not permitted in approximately 35 states nationally.[4]

23. Probation policy places restrictions on the use of physical and chemical force, and indicates that the use of OC spray is the highest level of crisis intervention permitted. Nevertheless, at both Juvenile Halls, youth have frequently experienced unlawful use of OC spray. In March 2018, Probation reported to the Los Angeles County Probation Commission that between 2015 and 2017, Probation significantly increased the use of OC spray in the Juvenile

[4] Council of Juvenile Correctional Administrators, Issue Brief: Pepper Spray in Juvenile Facilities (May 2011) p. 1 <https://tinyurl.com/yc95yqkf> [as of Dec. 15, 2020].

Halls.[5] The use of OC spray increased by 338 percent at CJH, by 214 percent at LPJH, and by 192 percent at BJN.[6] Probation further reported that in 2017, OC spray accounted for approximately one third of all uses of force; that 85 percent of the time, OC spray was used as a de-escalation tactic; and that 12 percent of uses across all facilities was in response to "nonphysical" violent behavior.[7]

24. In a February 4, 2019 report (February 4 2019 OIG Report), the OIG found that some Probation staff used OC spray as a tool to gain compliance from youth.[8] The OIG's review of 21 incident reports revealed a consistent use of OC spray as an initial or intermediary force option in lieu of de-escalation strategies, and included several incidents where staff used OC spray in the absence of an actual or potential threat of harm by the youth.[9]

25. One witness familiar with conditions in the Juvenile Halls stated that some supervisors were telling unit staff to "spray first and ask questions later."

26. The OIG also reported youth statements that staff regularly failed to issue an OC warning immediately before spraying.[10] Some staff gave general warnings at the beginning of their shifts rather than immediately before spraying.[11] The OIG found that some staff threatened the use of OC spray as an initial effort to gain compliance—even before giving verbal commands—and that this practice appeared to "unnecessarily escalate[] confrontations" in some instances.[12]

27. In the course of the Attorney General's Office's investigation, youth expressed that staff employ OC spray in response to minor misbehavior, and often without advance warning. Youth reported that some staff continued to use OC spray without warning until at least January

---

[5] County of Los Angeles, Probation Commission, Minutes of Regular Meeting of March 22, 2018 (Mar. 22, 2018) pp. 2-4 <https://tinyurl.com/y9fczcly> [as of Dec. 15, 2020] (hereinafter March 22, 2018 Probation Commission Minutes).

[6] *Id.* at p. 2.

[7] *Id.* at pp. 2-3.

[8] County of Los Angeles, Office of Inspector General, Report Back on Ensuring Safety and Humane Treatment in the County's Juvenile Justice Facilities (Feb. 4, 2019) p. 6, <https://tinyurl.com/y876ox29> [as of Dec. 15, 2020] (hereinafter February 4, 2019 OIG Report).

[9] *Id.* at pp. 6-7.

[10] *Id.* at p. 7.

[11] *Id.* at pp. 7-8.

[12] *Id.* at p. 7.

2020. Some staff acknowledged that some of their colleagues relied on OC spray and other forms of physical force to manage behavior, while other staff expressed a belief that they could not address conflict or misbehavior without using pepper spray.

28. Probation's Internal Affairs Office (IA), after reviewing video evidence, has substantiated multiple instances of "misuse of force" or "abusive institutional practices" involving the use of OC spray in situations where there appeared to be no actual or potential threat of harm by the youth. For example, staff have used OC spray on youth after a fight has ended, for getting water without permission, or in response to youth engaging in self-harming behaviors. Youth also reported witnessing staff use OC spray after a fight had ended and youth were walking away. Moreover, Probation staff report that they provide an OC spray warning, and routinely use pepper spray, for youth who are "out of bounds," i.e. outside of Probation's proscribed area. In practice, this means that any youth who does not comply immediately with a Probation staff member's order, for example, to go back to their cell, remain in line, or stay in a particular area (i.e., a classroom) may be immediately restrained through the use of OC spray.

29. Despite the fact that Probation policy requires that staff make every effort to avoid deploying OC spray on youth who have a developmental disability or are prescribed psychotropic medication, on a number of occasions, Probation staff have sprayed youth with developmental disabilities or mental health conditions. One Probation staff member acknowledged using OC spray warnings as a tool to "de-escalate" situations with youth experiencing mental health issues. Youth with development disabilities have reported multiple instances of being OC sprayed, including under circumstances where they were not engaging in any aggressive behavior. Yet another youth with a mental health condition who was engaged in self-harming behavior was OC sprayed in the groin and buttocks.

30. The Attorney General's Office learned of one youth being sprayed five times in one day, and that an officer continued to spray the youth after they told the officer that they had asthma. The Attorney General's office learned of another youth with asthma who reportedly was denied their inhaler for 45 minutes after being sprayed.

31. In its September 2019 report, the OIG stated that it had spoken with several youth with limited English proficiency who stated that in some instances, force had been used because of an inability to communicate with staff, including a Spanish-speaking youth who relayed that he was OC sprayed because he failed to follow orders given in English that he did not understand.[13] The OIG found that "Probation does not have sufficient language access policies that guide its staff in providing services for [Limited English Proficient] youth or their families."[14]

32. Bystander youth are also subjected to OC spray. In its February 4, 2019 OIG Report, the OIG related accounts by youth of being sprayed by OC while staff were chasing or engaging another youth and of staff deploying OC spray accidentally.[15]

33. In addition, documents reviewed show that Probation staff failed to timely and properly decontaminate youth after OC spraying them. Several versions of Probation policies reviewed by the Attorney General's Office require that, after the use of OC spray, staff secure youth and immediately move the youth to a safe area for decontamination with cold water on the face. Every version of these Probation policies in the last seven years prohibit delay of decontamination for punishment or due to a lack of attention.

34. Despite this, in the February 4, 2019 OIG Report, the OIG found that staff failed to timely decontaminate youth and violated policy that explicitly prohibits certain harmful decontamination practices.[16] Examples of violations included confining youth to a room without running water, leaving youth unattended, turning water off in a room occupied by a youth who was subject to OC spray, or using showers to decontaminate youth even where staff could not control the temperature of the water to ensure that it runs cold.[17] For many of these violations, OIG attributed staff non-compliance to a lack of training.[18] However, in at least three incidents, staff actively impeded the youth's ability to decontaminate by turning off access to water in their

[13] County of Los Angeles, Office of Inspector General, Report Back on Ensuring Safety and Humane Treatment in the County's Juvenile Justice Facilities (Sept. 20, 2019) pp. 3-6 <https://tinyurl.com/yb4fk5s5> [as of Dec. 15, 2020] (hereinafter September 2019 OIG Report).
[14] *Id.* at p. 4.
[15] February 4, 2019 OIG Report, *supra*, at p. 8.
[16] *Id.* at pp. 8-9.
[17] *Id.*
[18] *Id.* at p. 22.

rooms or leaving the youth locked in their room overnight without providing an opportunity to decontaminate.

35. Probation policy requires that youth be decontaminated with only cold water and identifies that warm or hot water exacerbates the effect of OC spray. Probation has used OC spray in its Juvenile Halls since the 1990s, and until at least May 2019, had no mechanism to turn the shower water in units to cold. Without cold water showers, youth decontaminated with warm water or in a staff sink.

36. On April 5, 2019, the County District Attorney filed criminal charges against six probation staff for unreasonable use of OC spray at LPJH between April 2018 and July 2018. The video and written evidence showed that staff members failed to decontaminate the youth and did not provide truthful and accurate documentation regarding decontamination efforts.

37. In February 2019, the County Board of Supervisors voted to phase out the use of OC spray in the Juvenile Halls. In June 2019, the County's Probation Department drafted a plan to phase out OC spray, with an estimated cost to Probation of nearly $39 million.[19] The Board has not provided full funding for the plan and many of the changes have not moved forward.[20]

ii. The County engages in actions and practices that endanger youth safety.

38. The Attorney General's Office has found that youth-on-youth harm is an additional concern at the Juvenile Halls. For example, at CJH, youth stated that staff set a youth up for assault by moving him to a unit with known "enemies" and failing to stop the assault after it began. In another reported instance, staff rewarded a youth for assaulting another youth who was a "trouble maker" on the unit.

[19] County of Los Angeles, Probation Department, Embracing the Future: Elimination of Chemical Agents in the Probation Department's Juvenile Facilities and Development of Youth-Centered Therapeutic Milieus and Staff Support Systems (June 21, 2019) <https://tinyurl.com/yam5h4r3> [as of Dec. 15, 2020].

[20] E.g., County of Los Angeles, Department of Auditor-Controller, Probation Department – Juvenile Institutions Cost Savings Review (June 9, 2020, Board Agenda Item 10) (Dec. 3, 2020) < https://tinyurl.com/yd94p8ef> [as of Dec. 15, 2020].

39. Youth also reported that on at least one unit within BJN, youth pressured other youth to fight each other when staff was not looking. As discussed in further detail below, insufficient staffing has resulted in inadequate oversight, permitting these behaviors to go unchecked.

iii. The County inaccurately reports and inadequately collects and reviews use of force incidents.

40. Documentation examined by multiple governmental agencies—dating back to 2016—has shown numerous staff providing incomplete or inaccurate information about youth being aggressive to justify staff members' uses of force. The OIG, in the February 4, 2019 OIG Report, stated that "[a] majority of the staff-generated reports associated with the troubling incidents reviewed were not comprehensive and appeared to omit necessary information. Reports rarely described the events that led to the use-of-force, making it difficult for subsequent reviewers to assess the need for the force used. Additionally, several reports did not appear to accurately describe the youth behavior that necessitated the use of OC spray, stating generally that the subject youth move aggressively in attempts to assault staff, though video shows a passive posture and no movement."[21]

41. Moreover, the OIG described a training slide used by Probation that encouraged staff to avoid certain terms in writing incident reports in order to avoid suspicion.[22] The OIG noted that the slide could be interpreted as encouraging staff to avoid accurately describing potentially improper tactics.[23]

42. The Attorney General's Office reviewed six IA files that found staff were dishonest in their reporting or investigative interviews. For example, in an incident on January 12, 2018 at CJH, a Senior Detention Services Officer (SDSO) used physical force against a youth after the youth used a slur and swore in response to a piece of his food being thrown in the trash. The SDSO grabbed the youth by the neck of his sweatshirt, slammed him on the table, pulled him to the floor, and then walked the youth to his room with the youth's arm pulled behind his back. The IA determined that during his IA interview, the SDSO falsely stated that the youth had

[21] February 2019 OIG Report, *supra*, at p. 17.
[22] *Id.* at pp. 15-16.
[23] *Id.*

threatened him and punched him and that he had not bent the youth's arm behind his back. The IA further determined that both the SDSO and a Detention Services Officer (DSO) minimized the types of physical force employed in their initial reports about the incident.

43. IA documents show that the County does not maintain proper and timely oversight of all use of force incidents. In a March 8, 2019 report, the OIG noted a delayed review of 300 to 400 use-of-force reports at one juvenile hall in 2017.[24] In 14 of the 31 use of force incidents the Attorney General's Office reviewed, the IA review took more than four months to complete. Seven of those took longer than six months to review, and three took 11 months to review.

44. The documents reviewed by the Attorney General's Office showed a DSO at CJH who was consistently using profanity, threatening youth, and pulling youth's ears, hair, and noses to gain compliance for an unknown length of time. The DSO also left youth identified as requiring one-on-one supervision unsupervised on five separate occasions. IA's investigation only focused on the DSO's actions during a six-week period, in which it found eight incidents of "abusive practices" corroborated by video evidence. The investigation took over eight months to complete.

45. Despite the well-documented issues regarding use of force and accountability in the Juvenile Halls, the County has failed to develop an effective system to track and analyze use of force on an ongoing basis and to implement necessary corrective actions.

46. In a November 2016 report, the Los Angeles County Auditor Controller reviewed critical incidents in the Juvenile Halls from fiscal years 2013 to 2016 and found that Probation does not comprehensively track critical incidents, including analyzing and investigating the incidents to "identify systemic patterns that require further review and corrective action."[25]

47. In its March 2018 presentation to the Los Angeles County Probation Commission, Probation stated that the Department did not have a system to track data on use of force.[26]

[24] Los Angeles County, Office of Inspector General, Report Back on the OIG Investigation and Improving Safety in the Juvenile Facilities (Mar. 8, 2019) p. 4 <https://tinyurl.com/y7yxnzsb> [as of Dec. 15, 2020] (hereinafter March 2019 OIG Report).

[25] November 2016 Auditor-Controller Report, *supra*, at p. 2.

[26] March 22, 2018 Probation Commission Minutes, *supra*, at p. 3.

48. In the March 2019 OIG Report, the OIG noted numerous concerns with the reliability and availability of Probation use of force data, including failure to collect relevant data points, lack of sufficient guidance to staff on how to document uses of force, and an information system that is not designed for statistical data analysis.[27] In response, then-Chief Probation Officer Terri McDonald stated that Probation was aware of challenges with its data collection and of the need to improve data collection.

49. In its February 28, 2019 report, the OIG stated that it had "little to no confidence in the reliability of the Department's data on youth-on-staff assaults" and that Probation leadership had informed the OIG that "line-level staff were routinely inaccurately reporting youth-on-staff assaults."[28] The lack of such a data system contributed to the County's failure to identify and correct escalating use of OC spray and to ameliorate other unsafe conditions in the Juvenile Halls.

50. At both Juvenile Halls, certain areas of the facility are not covered by video cameras. In addition, cameras installed at the Juvenile Halls lack the capacity to record audio. Staff expressed frustration at the lack of cameras, the placement and range of cameras, and at the inability to access, review, and monitor camera footage. The OIG has reported that most use of force incidents are not captured on video.[29] The failure to install an adequate video surveillance system endangers youth and staff, as cameras can be a deterrent to inappropriate behavior and video footage can provide evidence documenting incidents involving problematic conduct.

iv. The County provides insufficient staffing and staff training resulting in unsafe conditions in its Juvenile Halls.

51. In 2018, at the request of the County Board of Supervisors, Research Development Associates, Inc. issued a public report regarding governance and operations in the Juvenile Hall after conducting multiple interviews and an onsite visits. The report concluded that the Juvenile Halls faced "inconsistent staffing levels due to a high number of staff under investigation, staff

[27] See generally March 2019 OIG Report, *supra*.

[28] County of Los Angeles, Office of Inspector General, Los Angeles Times Article Regarding Youth-on-Staff Assaults at Probation Juvenile Facilities (Feb. 28, 2019) p. 1 < https://tinyurl.com/y994nq89> [as of Dec. 15, 2020].

[29] March 2019 OIG Report, *supra*, at p. 3.

that are injured, or staff that call out sick" and noted that "newer staff in the halls feel underprepared to face day-to-day challenges."[30]

52. On April 29, 2019, the President of the County of Los Angeles Probation Commission submitted a letter to Probation, expressing his concern that BJN "is significantly understaffed every day. Employees are stated to be quitting. Employees are calling in sick or on disability in significant numbers. Consequently, staff who do show up are being held over regularly and without recourse or the ability to prepare for extended shift work. Staff on duty are also experiencing burn-out and exhaustion; they are overworked and stretched too thin within their units, causing delayed or no responses to emergency calls for help."[31]

53. Between January and August 2019, eight to thirty DSOs called out sick each day at BJN. Similarly high numbers of staff called out at CJH between March and September 2019.

54. As a result of these call-outs, the Attorney General's Office found that the County has not been operating with sufficient staff to: (a) carry out the overall facility operations and programming; (b) provide for safety and security of youth and staff; and (c) meet established standards and regulations. The Attorney General's Office's investigation found that the County has also asked staff to work lengthy back-to-back shifts, including back-to-back 20-hour shifts, to the detriment of staff health and morale, which ultimately has affected the safety and well-being of the youth they supervise. Based on numerous youth and staff statements and as confirmed by Probation documents, youth have not received consistent recreation, programming, outdoor exercise, religious services, behavior management program, and education due to insufficient staffing. When youth are forced to remain in a locked cell room or on the unit due to insufficient staffing, safety risks increase.

[30] Los Angeles County Executive's Office, LA Probation Governance Study, Prepared by Research Development Associates, Inc. (Feb. 13, 2018), LA Probation Department Assessment included as part of the LA Probation Governance Study (Aug. 18, 2017) p. 81 <https://tinyurl.com/ycezskws> [as of Dec. 15, 2020] (hereinafter August 2017 Governance Study).

[31] Joe Gardner, President, Los Angeles County Probation Commission, letter to Chief Probation Officer Terri L. McDonald, Apr. 25, 2019 <https://tinyurl.com/ycssqgy9 > [as of Dec. 15, 2020].

55. Staff have stated that staffing shortages impede their ability to respond to critical incidents. For example, staff noted that when they called for support in critical incidents, response times were long. Staff assert that inadequate staffing makes it more difficult to engage in effective relationship building and other efforts that prevent incidents from occurring and to engage in de-escalation when incidents occur.

56. Witnesses have reported that many staff at BJN are relatively new and insufficiently trained to communicate with, create relationships with, and de-escalate youth, so that minor incidents quickly become major and, sometimes violent, incidents.

57. Despite the significant impacts on youth and staff safety and on facility operations, the Attorney General's Office's investigation found that the County has not implemented a systematic plan to respond to staff shortages or to hold staff accountable for complying with leave policies. Although Probation has requested funds for additional staff positions, Probation had not developed a plan for addressing staffing shortages or holding staff accountable for complying with leave policies in the interim.

58. Staff reported that they had not received training on de-escalation or that the training they received was inadequate. Staff reported similar concerns regarding the adequacy of training on building relationships with youth and trauma-informed care. Lack of training on these subjects means staff, especially newer staff, have been unprepared to communicate with youth and build relationships with youth, and thus less able to properly de-escalate youth to the detriment of youth safety.

59. The Attorney General's Office found that Probation has not developed a system or plan for recruiting and hiring staff with a focus on youth development, expertise in working with youth with mental illness, and with common life experience and language that enhance the ability to relate to and supervise youth. Moreover, the Attorney General's Office found that Probation places new hires with the least experience, training, and education in its Juvenile Halls first, and as a step in the process to promotion to juvenile camp and adult field services positions, resulting in some staff who may not be interested in or equipped to work with a youth population.

60. In his April 26, 2019 report to the Board of Supervisors, the County's DMH Director stated that because "[p]robation staff in the juvenile halls tend to be the most recently hired in the Department, and in general, have less experience in dealing with youth with mental illness than more seasoned staff . . . [t]hey typically are not as skilled in crisis response and utilizing de-escalation techniques, dialectical behavior therapy (DBT) techniques, or other techniques to defuse situations that could otherwise escalate."[32] These hiring and recruiting practices impede Probation's ability to provide a safe, supportive homelike environment for youth in the Juvenile Halls.

v. The County misuses mechanical restraints.

61. Mechanical restraints may only be used during transportation "upon a determination made by the probation department, in consultation with the transportation agency, that the mechanical restraints are necessary to prevent physical harm to the juvenile or another person or due to a substantial risk of flight." (Welf. & Inst. Code, § 210.6.) Youth stated, and youth's attorneys confirmed, that they are always restrained during transportation. Witnesses confirmed Probation does not make individualized determinations; instead, witnesses informed the Attorney General's Office that the decision whether to use restraints is entirely dependent on the youth's charges.

B. The County Fails to Provide a Homelike Environment.

62. The County's Juvenile Halls are required to be "safe and supportive homelike environment[s]" that are not treated as "penal institution[s]." (Welf. & Inst. Code, § 851.) Despite this, the environment in the County's Juvenile Halls is unsafe, unsupportive, and unsuitable for youth.

63. A County Board of Supervisors-requested governance study of Probation in 2017 found that the Juvenile Halls "are run down."[33] Specifically, it noted that CJH "is in need of

[32] County of Los Angeles, Department of Mental Health, Report and Response on the Office of Inspector General Investigation and Improving Mental Health Treatment and Safety in the Juvenile Facilities (Item 7, Agenda of February 19, 2019) (Apr. 26, 2019) p. 7 <https://tinyurl.com/y9k6mwvx> [as of Dec. 15, 2020] (hereinafter April 2019 DMH Report).

[33] August 2017 Governance Study, *supra*, at pp. 5, 8, 51.

extensive repair and renovation. Its layout and conditions do not support a rehabilitative approach or align with best practices."[34] The study recommended that the County "completely overhaul" CJH by "[s]hutting down sections unfit for housing young people or temporarily clos[ing] CJH" altogether; "[t]emporarily transfer[ring] youth to another facility . . . while CJH is completely renovated;" and "[r]enovating the facility to create a human and therapeutic environment."[35] Moreover, it found that BJN and LPJH "lack physical structure that would facilitate youth rehabilitation or reflect trauma-informed design" and all facilities were in need of "repairs, renovations, and remodeling."[36]

64. In an April 26, 2019 report to the County Board of Supervisors, the County's DMH Director stated: "Current facilities provide environments that are often counter-therapeutic and negate efforts to stabilize and enhance the youth's functional abilities. As a result, the facilities likely contribute to the youth irritability and overall behavioral issues. The juvenile hall setting in particular is not conducive to providing effective treatment for mental health issues. Progress made in treatment is quickly eroded as the youth may be repeatedly triggered and re-traumatized by the environment. Because of a lack of privacy and a therapeutic treatment space, youth are not able to fully participate in treatment."[37]

65. In its May 24, 2019 interim report on the phasing out and elimination of OC spray in juvenile facilities, Probation confirmed that "[t]he conditions in which the youth reside and staff work are not rehabilitative in nature and may exacerbate or actually induce trauma. For example, the units are linear in design, have hardened furniture and lack art and non-institutional feel in living units and in the common areas."[38] Probation observed that the living units had a "cold and institutional feel" and that there was a need for living units to be "updated and refurbished."[39] According to the report, "[c]reating a physical plant that allows for small group living units in the

[34] *Id.* at pp. 5, 80.
[35] *Id.* at p. 56.
[36] *Id.* at p. 80.
[37] April 2019 DMH Report, *supra*, at p. 5.
[38] Los Angeles County, Probation Department, Phasing Out and Eliminating the Use of Oleoresin Capsicum Spray in Juvenile Facilities – Interim Report (Item No. 11, Agenda of February 19, 2019) (May 24, 2019) p. 10 <https://tinyurl.com/y7tpwhhp> [as of Dec. 15, 2020].
[39] *Id.*

juvenile halls requires significant changes to the existing structure. Similarly, establishing a more therapeutic environment will require a significant paradigm shift and additional resources."[40]

66. During the Attorney General's Office's site visits, it found the Juvenile Halls lack adequate lighting, proper ventilation, and temperature controls. At BJN, the Attorney General's Office observed food on the floors, thick layers of dirt on the ceiling vents, graffiti on windows, and cockroaches in youth's rooms. Youth also reported observing cockroaches and spiders on living units. At both BJN and CJH, most youth's bedrooms were bare. There were no mirrors, no space for personal items such as toiletries or clothing except under the bed, and no desks or chairs to study. The only exceptions to this were the handful of specialized housing units like BJN's Girls Hope Center and CJH's Girls and Boys Care and Enhanced Supervision units.

67. The Attorney General's Office investigation raised concerns that the County did not have an effective evacuation plan and training regarding the same in case of emergencies. In October 2019, a wildfire threatened BJN. Reports indicate that during the evacuation from BJN, youth were inadequately supervised and youth from different security levels were mixed in the vehicles, allowing some youth to assault others without interruption and resulting in injuries to several youth. Reports also indicated that two youth had their clothing stripped off by other youth during the evacuation. Staff involved in the evacuation reported that they had not been sufficiently trained in evacuation procedures. Additional concerns about the County's evacuation policies, procedures, and training were raised in July 2019, when a delay in evacuation at a County juvenile camp led to youth and staff being forced to shelter in place during a wildfire.

68. The Attorney General's Office and its experts also observed that youth do not have adequate privacy when using the showers or toilets as required by PREA. (28 C.F.R. § 115.315(d).) PREA privacy curtains, which are meant to cover a youth's body when they shower or use the toilet, were not installed in all units. In the units where they were installed, a number of curtains were installed incorrectly or had been removed. Moreover, while Probation has posted cross-gender announcement signs on the entry doors to each housing unit, many staff fail to announce their gender when entering a housing unit, risking youth privacy.

[40] *Id.* at p. 13.

69. The Attorney General's Office and its experts found, overall, that the size, configuration of the Juvenile Halls unit space, bleak environment, and lack of stimulation adversely impacts the ability to properly supervise, maintain safe space, and promote meaningful engagement between youth and staff, to the detriment of the delivery of effective programming, group work, and trauma informed behavioral health services.

C. The County Fails to Provide Adequate Mental Health and Timely Medical Care.

70. Many youth in the Juvenile Halls have significant mental health needs. The Director of DMH has reported that in 2018, 96 percent of youth detained at BJN, 93 percent of youth at CJH, and 85 percent of youth at LPJH had open mental health cases, and that in early 2019, 35 percent of youth in County juvenile justice facilities were treated with psychotropic medication.[41] Probation leadership has confirmed that more than 90 percent of the youth in its Juvenile Halls have an open mental health case.

71. The Attorney General's Office found that the Juvenile Halls have insufficient mental health staff to meet the needs of youth. The Director of DMH has stated that "current DMH staffing is inadequate to address the current high mental health needs of youth in juvenile halls … DMH staffing would need to increase significantly from its current number of clinicians and psychiatrists assigned to provide mental health services in the juvenile halls."[42] DMH staff described that BJN has significantly less DMH staff than CJH. During its site visits to BJN, the Attorney General's Office witnessed that while most of the 24 units had an office for a mental health clinician, only two DMH staff were present on the units. At CJH, there were more DMH staff on the units, including in the HOPE Center, specialized, and general population units. However, the Attorney General's Office's investigation found that majority of DMH staff do not work with the entire unit, but rather only with individual youth on their caseload.

72. DMH staff reported being afraid to be on the units. During its three site visits, the Attorney General's Office observed that DMH staff were not reporting to work regularly and that DMH staff who were present were not using their offices or providing regular services on the

[41] April 2019 DMH Report, *supra*, at p. 3.
[42] *Id.* at p. 5.

units to all youth. Probation staff reported to the Attorney General's Office, and the OIG relayed in its September 20, 2019 report, statements by youth and Probation staff that DMH staff "generally do not approach youth experiencing a mental health or behavioral crisis until the youth has calmed down, or unless the youth has expressed explicit suicidal ideations."[43] Probation staff reported that DMH staff often do not respond when a youth is having a mental health crisis, when DMH help is most needed. The result is that youth may need to be confined for safety or later placed on a more restrictive supervision level, instead of receiving necessary mental health support during the mental health crisis. DMH staff reported that inadequate and cumbersome reporting and service request systems between Probation and DMH impeded their ability to provide timely services and crisis intervention.

73. In the September 20, 2019 OIG Report, the OIG noted that DMH staff were unfamiliar with DMH's policies on engaging with youth with limited English proficiency or with the availability of telephonic interpretation services, which often resulted in non-engagement or use of other youth or Probation staff to translate during sessions.[44] Use of Probation staff hinders mental health counseling. For example, the OIG shared that one youth said it was difficult to discuss emotional needs during the session for fear of Probation staff misunderstanding or using the information learned in the session against the youth.[45]

74. The DMH Director of Mental Health stated that the "[f]ailure of the current system to fully meet the needs of the changing nature of the detained youth population may have, in part, contributed to the increased use of force … in the juvenile halls over the past three to four years. Simultaneously, the increased use of force and residual elements of a punitive culture may be compounding the mental health conditions of youth."[46]

75. Staff shortages and poor communication have impeded timely access to medical services. During its site visits, the Attorney General's Office identified several youth who received delayed care for identified medical needs.

[43] September 2019 OIG Report, *supra*, at p. 16.
[44] *Id.* at p. 22.
[45] *Id.* at p. 5.
[46] April 2019 DMH Report, *supra*, at p. 6.

D. The County Fails to Provide Physical Exercise, Recreation, Programming, and Religious Services.

76. The Attorney General's investigation found that the County has regularly failed to provide youth in its Juvenile Halls access to legally required programming, exercise, recreation, and religious services. As a result, youth detained in the Juvenile Halls lack meaningful opportunities to engage in rehabilitative programming.

77. A review of Probation documents showed that youth at both Juvenile Halls were not consistently receiving the required minimum one hour of outdoor recreation. At BJN, 20 unit logs indicated that no youth in those units received outdoor recreation between April 1 and June 7, 2019. In this same period, only three unit logs indicated that 100 percent of youth in those units received outdoor recreation. All youth at BJN were denied outdoor activity from May 16 to 19, 2019. At CJH, 69 Sunday unit logs indicated that youth did not receive any outdoor recreation in either the morning or the afternoon for nearly six months from January 6, 2019 through June 9, 2019. Additionally, youth stated that for some stretches, they did not receive outdoor recreation for anywhere from two to four weeks at a time, and when they did, they would receive 30 to 45 minutes of recreation rather than the full required hour. During its site visits, the Attorney General's Office observed only three to four units at either hall engaged in outdoor recreation. Youth reported that as of December 2019 and January 2020, youth at CJH continued not to receive required outdoor recreation, instead receiving outdoor recreation only occasionally and for about 30 minutes per session.

78. Witnesses consistently reported an ongoing failure to provide required outdoor recreation, programming, and exercise due to insufficient staffing.

79. A review of Probation's documentation on the provision of outdoor recreation and exercise revealed illegible notations, incomplete notations, and missing logs. During a site visit, the Attorney General's Office reviewed documentation that was incomplete and inconsistent, and staff were unable to locate several days of logs. Staff and youth reported that, due to staffing shortages, outdoor recreation and exercise had been denied for an entire week.

80. In addition, youth at both Juvenile Halls were denied access to religious services. Witnesses informed the Attorney General's Office that religious services were cancelled for several weeks in a row for all youth in April and May 2019 at BJN. Probation documents indicate that religious services at BJN were cancelled for one or more units or for the entire facility on several Sundays between January 1 and June 7, 2019, and for 18 out of 22 weeks reviewed, at least one entire unit was reported as not attending religious services. At CJH, several Sunday religious services were also cancelled for multiple units for over six months between January 6 and June 16, 2019, as indicated by Probation documents. In December 2019 and January 2020, youth reported that they were not able to participate in religious services every weekend at CJH; instead, only a limited number of youth could attend and youth were required to alternate weekends.

81. A review of Probation's documentation on the provision of religious services revealed missing documents, inconsistent documentation, and incorrect notations for bible study and religious services.

82. In its 2017 report to the County Board of Supervisors, Research Development Associates, Inc., found that staff and youth agreed that there were few opportunities to receive rehabilitative or other programming in the Juvenile Halls.

83. Multiple witnesses stated that programming for youth had been canceled on multiple dates. During site visits by the Attorney General's Office, multiple witnesses reported that programming had been discontinued or cancelled due to inadequate staffing. Although daily schedules were posted during the Attorney General's Office's June and August visits, the Department was not adhering to these schedules.

84. Behavior Management Programs (BMPs) serve to incentivize a safe and secure environment and to improve youth behavior by emphasizing pro-social interactions, reinforcing the importance of education and positive behavior, and upholding fairness and equity. Probation's BMP is, by policy, supposed to be an "activity-rich and highly structured programming model that emphasizes positive reinforcement for appropriate behaviors while seeking to minimize the use of negative consequences." Through the BMP, as stated in policy,

youth are supposed to learn pro-social behaviors essential to rehabilitation and earn daily points that they can in turn use to get rewards at the Al Jones store every Saturday. Staff are required to track points on a merit ladder and post these in the units for youth to see.

85. However, both staff and youth at BJN stated that the BMP was not implemented with fidelity for almost one year. Youth described being unfamiliar with the BMP and how to earn points; instead, youth only knew they would get snacks on Saturdays if they did not get a write-up. Youth did not receive incentives to change behaviors and Probation staff did not provide information and training about the BMP program, or consistent feedback as required, to equip youth with the knowledge and skills necessary to manage their own behavior.

86. A review of Probation documents showed that on at least seven occasions between January 1 and June 7, 2019, specific units at CJH did not participate in the Al Jones store rewards program because there was insufficient staff to transport the youth. Documentation of the Al Jones store for BJN was missing for March 16 through June 7, 2019, and the logs provided were contradictory. However, the documentation from BJN indicates that youth were not taken to the Al Jones store for at least two months between January 1, 2019 and March 9, 2019; instead, snacks were delivered to the units and distributed indiscriminately. Several staff also reported that no youth were receiving rewards for a period of time, which contributed to behavior issues in the facility because youth did not have an incentive for positive behaviors. Moreover, during the Attorney General's Office's first two site visits to BJN, the Al Jones store was boarded up.

E. The County Unlawfully Denies Access to Bathrooms, Appropriate Bedding, and Other Basic Needs.

87. The Attorney General's Office's investigation found that youth detained in the Juvenile Halls often do not have their most basic needs met.

88. Youth reported that Probation staff deny them access to the bathrooms at CJH.

89. Youth in one or more general population units at CJH described being forced to relieve themselves in their cells when staff fail to open their cell doors at night. Youth stated that some staff are slow to respond to youth's need for the bathroom or water at night in order to penalize youth. Youth have resorted to saving milk cartons to use in the middle of the night. If

they do not have milk cartons, youth will bunch up a towel or item of clothing to urinate on. This practice is particularly traumatizing to teenage girls during their menstrual cycle. Youth have been punished for resorting to relieving themselves in their cells.

90. The Attorney General's Office's investigation found that Probation staff at both Juvenile Halls sometimes deny youth extra bedding during cold nights as a form of punishment, retaliation, and control. Youth stated that some staff have favorite youth to whom they will provide extra bedding while refusing to provide extra bedding to others, and that if a youth requests an extra blanket, there is no guarantee they can get another blanket. Youth reported that they were often cold at night.

91. The blankets, sheets, and mattresses that the Attorney General's Office observed at the Juvenile Halls were insufficient and institutional.

92. The Attorney General's Office and its experts observed that youth at the Juvenile Halls often have ill-fitting clothing that is not climatically suitable at night. The Attorney General's Office's investigation found that youth were not permitted to keep their pants on at night. Thus, to keep warm, youth often wore their sweatshirts as pants. While some youth at CJH were provided long johns, they were not available to all youth. Youth were generally required to wear the same clothes for school, exercise, and sleep.

93. Witnesses reported that female youth in the Juvenile Halls had been provided disposable underwear that itches and is not durable in contravention of regulation and County policy. When the Attorney General's Office inquired about this practice, staff were not able to explain why disposable underwear was being used.

94. The Attorney General's Office and its experts observed that the 3-in-1 shampoo, conditioner, and cleanser provided was of poor quality. Youth stated that lotions, cleansing, and hair products provided are not culturally specific, and that although some staff provided better quality, appropriate products, these were not equitably distributed.

95. The Attorney General's Office investigation found that Probation staff at both Juvenile Halls deny some youth phone calls as a form of punishment, retaliation, and control. Youth may not be denied contact with parents for the purpose of discipline, but the Attorney

General's Office found that staff at CJH denied youth phone calls with parents as a form of discipline. By Probation policy, youth must receive one free call a week. The length of the free call can vary by shift, by unit, and by hall. Youth at both Juvenile Halls reported that call length could range from five to 20 minutes, and that whether a youth gets a second free call is also variable by staff. And, per Probation's BMP training materials in effect during the investigation, if a youth does not earn 17 points a day, the youth will not receive more than one phone call per week.

96. The Attorney General's Office's investigation found that youth were generally required to call collect for any other call beyond the one free call a week required by Probation policy. Due to the expense of collect calls, some youth are unable to make more than one call a week, and thus have had less communication with their families. During the course of the Attorney General's Office's investigation, youth reported that collect calls were not available in at least one unit at CJH because a phone was not available.

97. Youth reported being denied telephone calls with their lawyers. These youth described staff telling them that if they use their one call a week to call their family, they do not have the right to make another call to their attorney.

98. Additionally, youth have been denied visits with their attorney at CJH. Witnesses reported that attorneys are sometimes not allowed to make unannounced visits and, in some instances, attorneys have waited two to three hours to see clients.

99. At both Juvenile Halls, the Attorney General's Office's investigation found that family visitation is scarce, and Probation has not taken a proactive role in improving family engagement. Probation has not provided adequate orientation for families to help them understand visitation hours and requirements. Additionally, Probation has not offered transportation services. Up and until recent changes made in response to the COVID-19 pandemic, video conferencing technology was not available for family conferences. Youth reported that staff at CJH sometimes threatened to cancel family visits for a youth if they misbehave.

100. Youth reported, and the Attorney General's Office and its experts observed, that the food provided was unappetizing and cold. Most youth complained about the food and often did not eat it. The Attorney General's Office's experts found there were no substitute meals or snacks between meals provided. Witnesses reported that youth went to bed hungry.

101. Youth stated that Probation staff at CJH sometimes deny youth additional food servings as a form of punishment, retaliation, and control.

102. Youth at both Juvenile Halls reported being denied water or punished for drinking water. Approaching a drinking fountain for water without permission was the precipitating basis for at least one use of force incident the Attorney General's Office reviewed. Youth expressed they often go to bed thirsty and that staff are slow to respond to requests for water during the night.

F. The County and LACOE Fail to Provide Legally Required Education Services.

103. The Attorney General's Office's investigation found that the County routinely fails to transport youth in the Juvenile Halls for legally required educational services and that the County and LACOE have engaged in other practices, such as failing to timely enroll youth in school, that deny youth legally required educational services.

104. At both Juvenile Halls, various youth have not been timely enrolled in school, with some youth not being enrolled in school for days or weeks after their arrival at the halls. Youth who were not timely enrolled in school have been confined to their room for the entire school day for days to one week at a time. Delays in enrollment have been due in part to delays in completing required medical, educational, and mental health screenings and assessments during the intake process.

105. In part due to insufficient staff, the County has failed to physically transport youth at BJN from their units to school at the facility every day, and youth have arrived late to school, if they were taken at all. The Attorney General's Office received similar reports that youth at CJH were not being transported to school consistently or timely due to insufficient staff.

106. According to Probation and LACOE documents reviewed by the Attorney General's Office, from on or about January 2019 to August 2019, multiple units did not receive the required daily 240 minutes of education and/or transportation to school was delayed at BJN.

107. During this time, LACOE and Probation documents reflected irreconcilable differences with respect to school attendance and youth enrollment. These discrepancies are due in part to a lack of a joint LACOE-Probation system for data sharing and accountability regarding enrollment and attendance. LACOE has begun sending a staff member to check Probation's daily population sheet to ensure all youth are attending school.

108. Youth stated and the Attorney General's Office observed that individual students and, sometimes, entire units can be suspended from school and sent back to their units during instructional time. Youth noted that if one youth misbehaves, the entire unit can be held back from school, and that if there is a fight in the unit, school would be cancelled.

109. The Attorney General's Office's investigation found that educational instruction quality is highly variable within and across the Juvenile Halls. An education expert working with the Attorney General's Office found some classrooms at the Juvenile Halls exhibited high quality instruction that reflected the Road to Success Academy curricular framework with student ambassadors who explained the theme for the current unit and examples of student work posted throughout the classroom. However, other classrooms or dayrooms within the Juvenile Halls exhibited no instruction, denying youth an adequate opportunity to learn. Some youth stated that all youth on a unit received the same assignments in class. Youth were not assigned homework.

110. The Attorney General's Office found that there is no career-technical education or vocational training available at the Juvenile Halls. Although some youth are able to access community college coursework, access is limited. Youth who have graduated from high school sometimes do not have access to college coursework and are not provided any education services during the day.

111. Youth reported and the Attorney General's Office witnessed that some youth attend school in the dayrooms on their living unit. Although youth did not need to be transported to another building within the facility to attend school on the unit dayrooms, classes in some units

have started late or were not conducted at all because the space was not clean and ready for use at the start of the school day or LACOE staff did not show up to teach.

112. The education expert also found that teachers in the dayroom do not have the same access to materials and technology essential to providing quality instruction and students have limited access to computers and other technology. On the dayroom, youth expressed—and the Attorney General's Office witnessed—that most youth were not provided educational instruction. Instead, youth worked independently with handouts or laptops.

113. During one of the visits by the Attorney General's Office, it witnessed no class held for the youth in the Girls HOPE Center at BJN and witnesses did not know why the teacher had not shown up. That day, the youth on the unit went without any instruction; Probation staff reported that at least two of those youth were students with disabilities who had Individualized Education Programs (IEPs). While Probation staff attempted to help them with their assignments, they were not certified instructors.

114. Some youth with disabilities have not been provided with the instructional minutes and services required by their IEPs.

115. Youth described not receiving regularly scheduled physical education class.

116. Youth who need higher-level high school courses have reported having to wait long periods of time before they can enroll in on-line courses through Odysseyware or not being able to continue in courses in which they were enrolled prior to their detention.

117. During an Attorney General's Office visit in June 2019, there were a significant number of youth out of class for "sick call."

118. Other youth who "refused" to go to school were kept in room confinement or, on some units, allowed to play video games or watch television on the unit. Because Probation staff believed they do not have the authority to require a youth to go to school, they allowed the youth to stay on the unit.

119. The closure of LPJH created an influx of youth at CJH because it is now the only intake facility. During the Attorney General's Office's August 2019 visit, approximately 40 to 50 youth sat in the intake unit, which only had rooms for 14 youth. Staff stated that youth sat in the

dayroom all day and watched television instead of receiving education or programming, and that they had trouble finding beds for them to sleep in each night. There were two to four staff supervising youth in intake.

120. The crowding and delay in services and required assessments for youth in the CJH intake unit is exacerbated by the lack of a validated risk assessment instrument or a structured decision-making tool to ensure objective screening and assessment prior to admission. Juvenile facilities that fail to have either a structured decision-making tool or a validated risk assessment routinely incarcerate youth who pose little to no risk and who research shows can be better served in the community.

121. The education expert identified a lack of timely education and transition planning, which impedes youth's access to an adequate education and successful transition back into the community.

G. The County Fails to Consistently Comply with State Law and County Policy When Placing Youth in Room Confinement.

122. There is consensus among experts in adolescent mental and physical health that solitary or room confinement—placement in a locked room or cell with minimal contact with people other than facility staff—is deeply harmful to youth. As the American Academy of Child and Adolescent Psychiatry has stated, "[t]he potential psychiatric consequences of prolonged solitary confinement are well recognized and include depression, anxiety, and psychosis. Due to their developmental vulnerability, juvenile offenders are at particular risk of such adverse consequences."[47]

123. On January 1, 2017, Welfare and Institutions Code section 208.3 became effective. Welfare and Institutions Code section 208.3 provides that room confinement shall not be used until other less restrictive options have been attempted and exhausted and shall not be used to the extent that it compromises a youth's mental or physical health. A youth may be held up to four hours in room confinement; after that point, staff must either return the youth to the general

[47] American Academy of Child & Adolescent Psychiatry, Juvenile Justice Reform Committee, Solitary Confinement of Juvenile Offenders (Apr. 2012) <https://tinyurl.com/y7lvbu7d> [as of Dec. 15, 2020].

population or obtain authorization from the facility superintendent, consult with medical health or medical staff and/or develop an individualized plan with goals and objectives to return the youth to the general population, and document the use of room confinement. In addition, room confinement cannot be used for the purposes of punishment, coercion, convenience, or retaliation by staff.

124. Youth in the Juvenile Halls, however, have been subjected to multiple days of room confinement, including after incidents of rule breaking, and not for the intended short term de-escalation use. Moreover, some youth placed in room confinement have been denied access to education and programming.

125. On May 3, 2016, the Los Angeles County Board of Supervisors passed a motion to end the practice of placing youth in restrictive housing. In response, Probation converted its Special Housing Units and Assessment Units, which had been used for room confinement, to Healing Opportunities and Positive Engagement (HOPE) Centers. The HOPE Centers were intended as a short-term intervention that would permit youth to stabilize before being returned to the general population.

126. By 2017, reports surfaced that youth were being held in the HOPE Center at CJH for multiple days, even after they had stabilized, and were being denied access to education or programming. On October 4, 2017, the County of Los Angeles Probation Commission submitted a formal inspection report documenting its findings that the conditions in the HOPE Center at CJH were contrary to the Board of Supervisors' directive banning solitary confinement.[48] During an October 25, 2018 meeting, the Probation Commission discussed its findings with Probation leadership. During that discussion, Chief Deputy Sheila Mitchell stated that it was "unfortunate" that the HOPE Centers were being used as Special Housing Units, as the HOPE Center was created to replace Special Housing Units.[49] As of January 10, 2019, more than three years after the effective date of Welfare and Institutions Code section 208.3, Probation had not finalized or

[48] Los Angeles County, Probation Commission, Annual Report (2017) p. 8 <https://tinyurl.com/y9fdn7c9> [as of Dec. 15, 2020].

[49] Los Angeles County, Probation Commission, Minutes of Regular Meeting of October 25, 2018 (Oct. 25, 2018) p. 3 <https://tinyurl.com/y784eucd>[as of Dec. 15, 2020].

issued a policy for the use of HOPE Centers in the Juvenile Halls. In part, Probation leadership has attributed the inappropriate use of the HOPE Centers to the failure to finalize and issue a policy on the use of the HOPE Center.

127. The Attorney General's Office reviewed monthly records from the HOPE Center at CJH from December 2018 through June 7, 2019. These records noted reasons for confinement including "out-of-bounds," "possession of contraband," and "suspended from school," situations which are unlikely to require de-escalation. For example, on June 3, 2019, records reflect that one youth was place in the HOPE Center for de-escalation for three hours due to "graffiti in gym." Between December 2018 and May 2019, about 30 to 40 youth were placed in the HOPE Center at CJH for "disruptive behavior" per month.

128. During January to May 2019, the County's records show that between four and 11 youth each month were confined in the HOPE Center at CJH for more than 72 hours. In some cases, youth were confined for 100 hours or longer. Records reflect that one youth was confined in the HOPE Center for nearly a month, and another was confined for 58 days.

129. Youth held in the HOPE Center or room confinement have the right to participate in education and programming. However, some youth kept in the HOPE Center for multiple days, and sometimes a week, were unlawfully denied access to leave their cells except to eat or shower. Other youth were only permitted to leave their cells for school, eating, and showering.

130. Legally required documentation regarding a youth's stay in the HOPE Center was not accurate and failed to include critical information such as: (a) when medical or mental health staff were consulted; (b) whether an individual plan was developed for reintegration; (c) the reasons for room confinement that went beyond four hours and any necessary approvals to do so; and (d) whether or when the youth was given a hearing before long-term confinement.

131. The Attorney General's Office reviewed records on the use of de-escalation units at BJN from December 2018 through June 2019. The records reviewed appeared incomplete; in many cases, the reason for the referral, the time of release from de-escalation, the supervisor approval, and whether a mental health assessment was completed were missing from the records.

Indeed, the logs for March through May 2019 do not reflect any youth receiving programming while in room confinement, and reflect only one youth receiving a mental health assessment.

132. Referrals to the HOPE Center have been frequent. In the Juvenile Halls, referrals increased from 2,147 in 2017, to 2,257 in 2018. Between January 2019 and May 2019, Probation records reflected 593 referrals to the HOPE Center in CJH alone.

133. Youth with developmental disabilities have been subjected to lengthy periods of room confinement in the HOPE Center. Records indicate a large number of confined youth had developmental disabilities or were experiencing mental health needs.

H. The County's Grievance Process Fails to Provide an Adequate Avenue for Redress of Rights and Protection from Retaliation for Seeking Redress.

134. The Attorney General's Office's investigation found that the County's grievance system fails to provide youth with an adequate means for redress of the aforementioned rights deprivations.

135. The Attorney General's Office found that youth and families are not provided with comprehensive orientation to the juvenile hall program, and in particular, orientation as to the grievance system, upon intake.

136. Youth who have submitted grievances stated that they rarely received a response or, if they did, it was delayed and no changes were made. In its September 20, 2019 report, the OIG noted that multiple youth had alleged sexual misconduct by a particular staff member, but that youth reported that the staff member was permitted to continue interacting with female youth who had complained about the conduct.[50] Several youth indicated that staff advised them not to waste their time filing grievances. Some youth were unaware that they could call the Office of Ombudsman to file a complaint.

137. Youth expressed to the OIG and the Attorney General's Office that they were reluctant to file a grievance for fear of retaliation.[51] Youth reported that there is a stigma perpetrated by staff that only "snitches" use the grievance system. Although Probation provides

[50] September 2019 OIG Report, *supra*, at p. 15.
[51] *Id.*

locked boxes for the submission of grievances, youth expressed to the OIG that these boxes are often located in view of staff stations, creating a perception among youth that staff take note of who submits grievances.[52] These concerns have been reiterated in studies commissioned by the County, including a report issued in 2016 involving interviews by trained professionals with more than 100 youth in Probation camp custody.

138. Some witnesses reported that youth who filed grievances, particularly if they named a particular staff member, had been subjected to retaliation. Other witnesses reported because they had learned of retaliatory actions taken against other youth who complained, they did not feel comfortable filing a grievance.

I. Proposed Resolution by the Parties

139. Since September 2019, the parties have negotiated in good faith on plans to remedy the findings of the Attorney General's Office investigation and have come to an agreement to address the findings of the investigation that includes long-term remedial plans with respect to conditions of confinement and provision of services in the Juvenile Halls. The County and LACOE have already begun to make changes to their respective policies, procedures, and practices and are in the process of implementing several of the terms agreed upon by the parties. In addition to oversight by the Attorney General's Office, the County, and LACOE, the plan will be overseen by an independent lead monitor and two subject matter experts who possess relevant expertise. As a condition of the settlement, the County will also implement a compensatory support plan that includes tutoring and other educational assistance for youth who missed instruction through no fault of their own.

140. Plaintiff now seeks an order requiring the County and LACOE to implement the agreed-upon reforms and respectfully requests that the Court enter Judgment as set forth in the proposed Stipulated Judgments.

[52] *Id.*

CAUSES OF ACTION

FIRST CAUSE OF ACTION

(Unlawful and Unreasonable Risk of Harm in Violation of California Constitution, article I, sections 1, 7, Welfare and Institutions Code sections 851, 210.6, and California Code of Regulations, title 15, sections 1310, 1321, 1352, 1357, 1358, 1390)

141. Plaintiff re-alleges all paragraphs set forth above and incorporates them by reference as though they were fully set forth in this cause of action.

142. The California Constitution, article I, section 1 grants all people certain inalienable rights, including pursuing and obtaining safety, happiness, and privacy.

143. The California Constitution, article I, section 7 prohibits the deprivation of life, liberty, or property without due process of law or the denial of equal protection of the laws. Detainees, like youth held in the Juvenile Halls, are entitled to the protections of the due process and equal protection clauses of article I, section 7 of the California Constitution.

144. California Welfare and Institutions Code section 851 requires juvenile halls to be safe and supportive homelike environments and not deemed to be, nor treated as, penal institutions.

145. California Welfare and Institutions Code section 210.6 requires probation departments to make an individualized determination of whether a youth is a substantial flight risk or mechanical restraints are required to prevent physical harm during transportation.

146. California Code of Regulations, title 15, section 1310 makes all Title 15 minimum standards applicable to county juvenile halls. California Code of Regulations, title 15, section 1321 requires that there be an adequate number of staff to carry out the overall facility operations and programming, provide for the safety and security of youth and staff, and meet established standards and regulations. California Code of Regulations, title 15, section 1352 requires that the youth be classified and housed in a safe and least restrictive setting. California Code of Regulations, title 15, section 1357 prohibits use of force for the purpose of punishment, discipline, retaliation, or treatment.

147. California Code of Regulations, title 15, section 1358 prohibits the use of physical restraints as punishment, discipline, or treatment and permits physical restraints only where a youth presents an immediate danger to themselves or others, a youth is causing destruction of

property, or a youth reveals an intent to self-harm. California Code of Regulations, title 15, section 1390 prohibits the deprivation of bed and bedding; daily shower, access to drinking fountain, toilet and personal hygiene items, and clean clothing; full nutrition; contact with parent or attorney; exercise; medical services and counseling; religious services; clean and sanitary living conditions; the right to send and receive mail; education; and rehabilitative programming as a form of discipline.

148. The County violated California Constitution, article I, sections 1 and 7, Welfare and Institution Code sections 851 and 210.6, California Code of Regulations, title 15, sections 1310, 1321, 1352, 1357, 1358, and 1390 by: (a) over-relying on use of force—both physical and chemical—when youth did not present a threat or were acting in a developmentally appropriate way; (b) failing to protect youth from harm by other youth; and (c) restraining all youth during transportation without an individualized determination. These violations have been exacerbated by insufficient staffing, the failure to accurately report incidents, lack of training and oversight, and the failure to provide adequate mental health care.

SECOND CAUSE OF ACTION

(Failure to Provide a Homelike Environment and Provide Youth With Legally Mandated Services in Violation of California Constitution, article I, section 7, Welfare and Institutions Code sections 202, 851, California Code of Regulations, title 15, sections 1356, 1371, 1372, 1374, 1376, 1377, 1390, 1460-67, 1480, 1483, 1500, 1501, 1510)

149. Plaintiff re-alleges all paragraphs set forth above and incorporates them by reference as though they were fully set forth in this cause of action.

150. The California Constitution, article I, section 7 prohibits the deprivation of life, liberty, or property without due process of law or the denial of equal protection of the laws.

151. California Welfare and Institutions Code section 202 requires that youth under the jurisdiction of the juvenile court receive care, treatment, and guidance consistent with their best interest.

152. California Welfare and Institutions Code section 851 requires juvenile halls to be safe and supportive homelike environments and not deemed to be, nor treated as, penal institutions.

153. California Code of Regulations, title 15, section 1356 requires policies and procedures that ensure youth receive appropriate counseling and casework services.

154. California Code of Regulations, title 15, section 1371 requires policies and procedures for programs, recreation, and exercise that minimize the amount of time a youth spends in their room or bed area. Youth must receive three hours of programs, recreation, and exercise during the week and five hours on the weekends or other non-school days, of which one hour shall be outdoor activity, weather permitting. At least one hour of programming and one hour of recreation shall be provided daily and any suspension of these activities cannot exceed 24 hours. Youth must receive at least one hour of large muscle exercise daily. California Code of Regulations, title 15, section 1372 requires the facility to provide access to religious services or religious counseling at least once a week.

155. California Code of Regulations, title 15, section 1374 requires that youth be allowed to receive visits from parents, guardians, and their children. The facility may approve youth's grandparents, siblings, and other supportive adults for visitation. California Code of Regulations, title 15, section 1376 requires policies and procedures that provide youth access to the telephone. California Code of Regulations, title 15, section 1377 requires that facilities develop procedures to ensure the right of youth to access legal services such as visits, confidential communications, and cost-free telephone access to their attorney.

156. California Code of Regulations, title 15, section 1390 prohibits the deprivation of bed and bedding; daily shower, access to drinking fountain, toilet, personal hygiene items, and clean clothing; full nutrition; contact with parent or attorney; exercise; medical services and counseling; religious services; clean and sanitary living conditions; the right to send and receive mail; education; and rehabilitative programming as a form of discipline.

157. California Code of Regulations, title 15, sections 1460-1467 provide for the amount of food, types of diets, and food services the facility must provide. Youth must be provided three meals in a 24-hour period with at least one of those meals being hot food. Additionally, youth shall be given a snack between two and four hours after the dinner meal is served.

158. California Code of Regulations, title 15, section 1483 requires that a sufficient quantity of clothing, bedding, and linen be available for the needs of the facility population. California Code of Regulations, title 15, section 1480 requires that clothing provided to youth be clean, reasonably fitted, in good repair, and climatically suitable. California Code of Regulations, title 15, section 1500 requires that each youth be provided clean laundered, suitable bedding and linens, including one blanket or more upon request. California Code of Regulations title 15, section 1501 requires that sheets, mattress covers, pillow cases and towels be exchanged for clean replacements at least once a week. Blankets must be cleaned or laundered once a month.

159. California Code of Regulations, title 15, section 1510 requires regularly scheduled housekeeping tasks for the maintenance of an acceptable level of cleanliness, repair and safety throughout the facility.

160. The County violated the California Constitution, article I, section 7, Welfare and Institutions Code sections 851 and 202, and California Code of Regulations, title 15, sections 1356, 1371, 1372, 1374, 1376, 1377, 1390, 1460-1467, 1480, 1483, 1500, 1501, and 1510 by failing to provide youth with clean facilities, proper clothing, climatically suitable bedding, adequate food and nutrition, phone calls, visitation, programming, religious services, and outdoor exercise, and denying youth access to basic rights to use the restroom and drink water.

THIRD CAUSE OF ACTION

(Failure to Provide Medical and Mental Health Care and Unlawful Discrimination of Youth with Disabilities in Violation of California Constitution, article I, sections 7, 17, Government Code section 11135, Welfare and Institution Code section 851, California Code of Regulations, Title 15 sections 1355, 1400, 1407, 1411, 1413, 1417, 1418, 1430, 1432, 1433, 1437)

161. Plaintiff re-alleges all paragraphs set forth above and incorporates them by reference as though they were fully set forth in this cause of action.

162. The California Constitution, article I, section 7 prohibits the deprivation of life, liberty, or property without due process of law or the denial of equal protection of the laws.

163. The California Constitution, article I, section 17 prohibits the infliction of cruel and unusual punishment.

164. California Welfare and Institutions Code section 851 requires that juvenile halls not be deemed to be, nor treated as, penal institutions and that juvenile halls be safe and supportive homelike environments.

165. California Government Code section 11135 prohibits discrimination on the basis of physical or mental disability, national origin, ethnic group identification, or medical condition under any program or activity that is funded directly by or receives any financial assistance from the state. The prohibition against discrimination on the basis of ethnic group identification includes a prohibition on discrimination based on language. (Cal. Code Regs., tit. 2, § 11161, subd. (b).)

166. California Code of Regulations, title 15, section 1400 requires that the juvenile hall administrator ensure that health services are provided to all youth. California Code of Regulations, title 15, section 1407 requires policies and procedures for multi-disciplinary sharing of health information and prohibits the facility from using youth to translate confidential medical information for other non-English speaking youth. California Code of Regulations, title 15, section 1411 requires that juvenile halls have policies and procedures that ensure that youth have unimpeded access to health care.

167. California Code of Regulations, title 15, section 1413 requires that individualized treatment plans be developed for all youth who are receiving services for significant medical, behavioral/mental health, or dental health care concerns.

168. California Code of Regulations, title 15, section 1355 requires that an institutional case plan be developed for each youth held at least 30 days or more and created within 40 days of admission that includes objectives, a plan to meet those objectives, periodic evaluation progress, a transition plan which includes, as appropriate, input from family, the youth, and the Regional Center for youth who have a developmental disability. California Code of Regulations, title 15, section 1418 requires that any youth who is suspected or confirmed to have a developmental disability is referred to the local Regional Center for the Developmentally Disabled for purposes of diagnosis and/or treatment within 24 hours of identification.

169. California Code of Regulations, title 15, section 1417 requires policies and procedures pertaining to pregnant and post-partum youth.

170. California Code of Regulations, title 15, section 1437 requires that facilities have policies and procedures to provide behavioral/mental health services. California Code of Regulations, title 15, section 1430 requires that a documented intake health screening procedure shall be conducted immediately upon entry to a facility. California Code of Regulations, title 15, section 1432 requires that a health assessment be conducted within 96 hours of admission. California Code of Regulations, title 15, section 1433 requires that a daily routine exist for youth to request medical and mental health services, and that provision be made for any youth requesting or observed to be in need of health care to be given that attention by a licensed or certified health care professional.

171. The County violated the California Constitution, article I, sections 7 and 17, Welfare and Institution Code section 851, and California Code of Regulations, title 15, sections 1355, 1400, 1411, 1413, 1418, 1430, 1432, 1433, 1437 by failing to provide prompt, unimpeded access to necessary medical and behavioral/mental health care.

172. The County violated Government Code section 11135 by failing to provide adequate medical and behavioral/mental health care for youth with physical disabilities, mental disabilities, medical conditions, and those with language access barriers.

FOURTH CAUSE OF ACTION

(Failure to Provide Education Services in Violation of the California Education Code sections 220, 46141, 48645.3, 48647, 56150, 56341, 46345, California Code of Regulations, title 15, sections 1355, 1370)

173. Plaintiff re-alleges all paragraphs set forth above and incorporates them by reference as though they were fully set forth in this cause of action.

174. Youth in California have a fundamental right to education under the California Constitution. (*Serrano v. Priest* (1977) 18 Cal. 3d 728.)

175. California Education Code section 220 prohibits discrimination on the basis of disability, gender, gender identity, gender expression, nationality, race or ethnicity, religion, sexual orientation, or immigration status in state-funded education programs.

176. California Education Code section 46141 requires the school day to be at least 240 minutes long.

177. California Education Code section 48645.3 requires that juvenile court schools be open on weekdays unless it is a holiday or other County Board of Education approved closing.

178. California Education Code section 48647 requires the county office of education and county probation department to have a joint policy on transition planning that includes collaboration with the local education agencies where youth will attend school upon release. The county office of education and county probation department must develop an individualized transition plan for any youth detained for more than twenty consecutive schools days. The county office of education must provide youth detained twenty consecutive schooldays or fewer an individualized learning plan, if one exists, upon release.

179. California Education Code section 56150 requires special education programs be provided to youth with exceptional needs who are placed in juvenile hall. California Education Code section 56345 requires youth receive the special education, services, and accommodations in their IEPs and California Education Code section 56341 requires that their IEP teams meet to ensure youth are tested for their specific learning disability and provided the services they need.

180. California Code of Regulations, title 15, section 1370 requires the County Board Education to provide quality education for all youth in juvenile court schools. Youth must be immediately enrolled in school and a preliminary education plan must be developed within five school days.

181. The County and LACOE violated California Education Code sections 220, 46141, 48645.3, 48647, 56150, 56341, and 56345 and California Code of Regulations, title 15, sections 1355, 1370 by failing to ensure that: (a) youth attend and are immediately enrolled in school; (b) all students receive 240 minutes of instruction daily; (c) students with disabilities receive the services and instruction in their IEP and Section 504 plans; (d) youth are timely provided with an education and transition plan and required follow-up services; and (e) youth receive an adequate education.

FIFTH CAUSE OF ACTION

(Unlawful Use of Room Confinement in Violation of California Constitution, article I, sections 1, 7, 17, Welfare and Institutions Code sections 208.3, 851, California Code of Regulations, title 15, sections 1354.5, 1370)

182. Plaintiff re-alleges all paragraphs set forth above and incorporates them by reference as though they were fully set forth in this cause of action.

183. The California Constitution, article I, section 1 grants all people certain inalienable rights, including pursing and obtaining safety, happiness, and privacy.

184. The California Constitution, article I, section 7 prohibits the deprivation of life, liberty, or property without due process of law or the denial of equal protection of the laws.

185. The California Constitution, article I, section 17 prohibits the infliction of cruel and unusual punishment.

186. California Welfare and Institutions Code section 851 requires that juvenile halls not be deemed to be, nor be treated as, penal institutions and that juvenile halls be safe and supportive homelike environments.

187. California Welfare and Institutions Code section 208.3 and California Code of Regulations, title 15, section 1354.5 limit the use of solitary or "room" confinement. Room confinement shall not be used before other less restrictive options have been attempted and exhausted unless attempting those options poses a threat to the safety and security of a youth or staff. Room confinement may not be used for purposes of punishment, coercion, convenience, or retaliation by staff or to the extent that it compromises the mental and physical health of a youth. Further, after a youth is held up to four hours in room confinement, staff must either return the youth to the general unit or document the reason for extension, obtain documented authorization by the facility superintendent or designee every four hours thereafter; and develop an individualized plan to reintegrate the youth.

188. California Code of Regulations, title 15, section 1354.5 requires that facility administrators develop and implement written policies and procedures regarding room confinement that are consistent with California Welfare and Institutions Code section 208.3.

189. California Code of Regulations, title 15, section 1370 requires that education be provided to all youth regardless of separation status, including room confinement, except when providing education poses an immediate threat to the safety of self or others.

190. The County violated the California Constitution, article 1 sections 1, 7 and 17, California Welfare and Institutions Code sections 208.3 and 851, and California Code of Regulations, title 15, sections 1354.5 and 1370 by placing youth in segregation as punishment or discipline without due process of law, including a timely hearing, and notice of the reason for the segregation, failing to provide youth in room confinement basic needs such as clean facilities, mental health and medical care, outdoor recreation, religious services, programming, education, phone calls, and visitation, by failing to properly document use of room confinement, by failing to consult with medical or mental health staff and/or develop an individualized plan for youth in room confinement with goals and objectives to reintegrate the youth into the general population, and by failing to timely implement a written policy and procedure addressing the use of room confinement.

SIXTH CAUSE OF ACTION

(Inadequate Access to Grievances and Protection From Retaliation for Seeking Redress in Violation of California Constitution, article I, sections 3, 7 and California Code of Regulations, title 15, section 1361)

191. Plaintiff re-alleges all paragraphs set forth above and incorporates them by reference as though they were fully set forth in this cause of action.

192. The California Constitution, article I, section 3 guarantees to the people the right to instruct their representatives, petition government for redress of grievances, and assemble freely to consult for the common good.

193. The California Constitution, article I, section 7 prohibits the deprivation of life, liberty, or property without due process of law or the denial of equal protection of the laws.

194. California Code of Regulations, title 15, section 1361 requires the facility have policies and procedures for youth to confidentially submit and appeal grievances. There is no time limit for filing grievances. Grievances must be reviewed and responded to within three business days, unless it relates to health and safety issues which must be addressed immediately.

The facility has ten days to resolve the grievance unless circumstances dictate a longer timeframe. The facility must provide multiple internal and external methods to report sexual abuse and sexual harassment.

195. The County violated the California Constitution, article I, sections 3 and 7, and California Code of Regulations, title 15, section 1361 by failing to have an adequate grievance procedure. Youth's reasonable fear of retaliation and lack of response to grievances filed make existing grievance procedures ineffective.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully prays for the court to enter judgment as follows:

196. For the court to issue an order enjoining Defendants from engaging in the unlawful practices challenged in this Complaint, requiring Defendants to implement the injunctive and equitable relief provisions set forth in the proposed Stipulated Judgments, and entering final judgment;

197. For the Court to exercise continuing jurisdiction over this action to ensure that Defendants comply with the judgment as set forth in the proposed Stipulated Judgments; and

198. For such other and further relief as the Court deems just and proper.

Dated: January 13, 2021

Respectfully Submitted,

XAVIER BECERRA
Attorney General of California
MICHAEL L. NEWMAN
Senior Assistant Attorney General
SARAH E. BELTON
Supervising Deputy Attorney General
VIRGINIA CORRIGAN
DOMONIQUE C. ALCARAZ
LEE I. SHERMAN

LAURA FAER
Deputy Attorneys General
Attorneys for the People of the State of California