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(Exempt from filing fees pursuant to Government Code section 6103)

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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF LOS ANGELES

THE PEOPLE OF THE STATE OF CALIFORNIA ex rel. ROB BONTA, ATTORNEY GENERAL OF THE STATE OF CALIFORNIA, Plaintiff, **v.** **COUNTY OF LOS ANGELES; LOS ANGELES COUNTY SHERIFF'S DEPARTMENT; ROBERT G. LUNA, in his official capacity as Los Angeles County Sheriff; LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES, CORRECTIONAL HEALTH SERVICES; DR. TIMOTHY BELAVICH, PH.D., in his official capacity as Director of Correctional Health Services, and DOES 1 to 50, inclusive,** Defendants.	Case No. **COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF**

The People of the State of California (the People or Plaintiff), by and through Rob Bonta, the Attorney General of the State of California, allege the following on information and belief:

INTRODUCTION

1. The People bring this action against Defendants County of Los Angeles (County), the Los Angeles County Sheriff's Department (LASD), County Correctional Health Services (CHS), and Sheriff Robert G. Luna and CHS Director Dr. Timothy Belavich, in their official capacities, for continuing deprivations of the rights of incarcerated persons under state and federal law.

2. Defendants are responsible for the safety and well-being of individuals incarcerated in the Los Angeles County jails (jails or LASD jails), individuals who have been subjected for many years to inhumane conditions. The jails are overcrowded and under-resourced. Incarcerated persons are forced to live in filthy cells with broken and overflowing toilets, infestations of rats and roaches, and no clean water for drinking or bathing. They are provided spoiled, moldy, and nutritionally inadequate meals; little to no access to hygiene items, such as soap, toilet paper, and menstrual products; and almost no time outside their cells. Many individuals suffer physical or mental deterioration in these punitive conditions but are unable to access necessary medical or mental health care, contributing to the shocking rate of deaths inside the jails, many of which are caused by preventable circumstances, such as overdoses, suicides, or violence among incarcerated persons. From 2016 to 2025, approximately 37.5 percent of all deaths in the LASD jails were caused by preventable circumstances. Problematic conditions are particularly acute at Men's Central Jail, a facility that has been plagued with uninhabitable conditions and constitutional violations for years. The County has publicly conceded that Men's Central Jail needs to be replaced and voted to close it in 2020, yet it remains in operation without the necessary issues being addressed.

3. Defendants' healthcare system in the LASD jails is grossly inadequate and has led to significant harm, including unnecessary pain and suffering, preventable injury, and numerous deaths. The healthcare failures in the jails are so profound that the Sybil Brand Commission described Defendants' failure to provide medical care as a "humanitarian crisis." Defendants have

denied thousands of incarcerated people basic medical care, including denying access to prescribed medications, and failing to respond to medical emergencies and serious medical needs. Incarcerated persons regularly wait weeks or even months before they receive medicine or basic care, if they receive it at all. Defendants have also failed to provide minimally adequate mental health care and have denied persons with serious mental health conditions necessary treatment and medication. Chronic and severe understaffing is a significant problem in the jails. In 2023, there were 4,000 patients on a waitlist to be seen for medical care due in part to limited availability of medical staff, and only seven psychologists were available to serve approximately 4,500 patients, a ratio of approximately one psychologist for every 642 patients. On the custody side, deputies were required to work 48 to 64 hours of overtime each month in 2024, due to hundreds of vacancies, putting a strain on operations.

4. Defendants' failure to provide a safe, secure, and habitable environment and failure to provide even minimally adequate medical, dental, and mental health care has resulted in and continues to result in high rates of in-custody deaths every year. More than 345 individuals have died inside the jails since 2016, with approximately sixty percent occurring in the last four years. As of the filing of this Complaint, there have been 36 deaths in the Los Angeles County jails in 2025 alone, or approximately one death per week. This puts the County on track to have more in-custody deaths in 2025 than at any time in the past twenty years.

5. Defendants have been aware of the unconstitutional conditions in LASD jails for decades. The LASD jails have been under court monitoring since at least 1979 for failing to meet the minimum standards of confinement. Public agencies including the Board of State and Community Corrections (Board of State and Community Corrections), Los Angeles County Office of the Inspector General (Office of the Inspector General), Los Angeles County Sheriff Civilian Oversight Commission (Civilian Oversight Commission), and Sybil Brand Commission for Institutional Inspections (Sybil Brand Commission) have issued public reports throughout that time, identifying unlawful conditions inside the jails ranging from overpopulation to the numerous incidents of excessive force, lax discipline, and the presence of deputy gangs. Defendants are aware of the violations identified by monitors and public agencies, as well as

additional deficiencies identified through their own internal review process and other litigation on behalf of persons whose rights have been violated. Sheriff Luna has conceded that "there are some unacceptable conditions" in LASD jails. Similarly, the CHS Director has admitted that "it's impossible to provide adequate treatment" in the LASD jails and that the healthcare system is "broken." In their own review of in-custody deaths, LASD officials have acknowledged critical deficiencies, such as the routine failure to conduct the safety checks required by law. Nevertheless, Defendants have failed, over a period of many years, to remedy violations and to meet the minimum standards of confinement, ultimately harming individuals within their custody, in clear violation of state and federal law.

6. Instead of addressing root causes or devoting resources to resolving acknowledged violations, Defendants have engaged in a longstanding pattern of resisting oversight and accountability. Defendants have expended millions of dollars in defending and settling litigation about abuses in the jails over the years, without making necessary changes to their operations and policies. Defendants have also repeatedly stymied the work of County entities mandated to provide independent transparency, oversight, accountability, and monitoring of LASD. Additionally, over the course of many years and multiple consent decrees, Defendants have failed to implement agreed-upon reforms designed to address some of the same constitutional violations that continue to persist in the LASD jails.

7. In 2021, pursuant to the Attorney General's constitutional and statutory authority to supervise law enforcement officers and ensure that state and federal laws are uniformly and adequately enforced, the Attorney General's Office initiated an investigation of LASD and the LASD jails. Despite the various reform measures previously attempted, the investigation, which included jail inspections, witness statements, and review of internal LASD records, as well as publicly available information, revealed significant ongoing constitutional violations in the LASD jails, including a significant increase in in-custody deaths, despite decreases in the jail population size; uninhabitable and overcrowded jail facilities with inadequate plumbing, sanitation, and temperature control, which have contributed to multiple deaths; high rates of assault; and failure to provide adequate healthcare to people inside the jails.

8. The investigation further revealed systemic problems in the administration and management of the LASD jails. These include, but are not limited to, ineffective and deficient medical and mental healthcare delivery systems that result in the physical and mental degradation of patients, as well as inadequate, outdated, and deficient policies and systems, particularly related to healthcare. Defendants lack adequate data systems to track medical or mental health history information recorded during prior incarcerations, or physical, mental, or intellectual disabilities and related accommodations. Nor are there effective mechanisms to share information between custody and health staff or between detention facilities at local patrol stations and jail reception centers. Defendants also fail to maintain adequate grievance procedures, withholding grievance forms and disregarding grievances that have been submitted. The investigation also revealed systemic issues relating to the training and management of custody and healthcare staff. Defendants fail to meaningfully train and supervise custody and healthcare staff to prevent violations and fail to discipline misconduct by staff. Defendants do not maintain necessary levels of recruitment, hiring, and retention, allowing hundreds of positions for custody and healthcare staff to remain vacant.

9. During the course of the Attorney General's investigation, and up to the filing of this Complaint, the Attorney General has attempted to collaborate with Defendants on addressing the identified violations and finding durable solutions, to no avail. Accordingly, on behalf of the people of the State of California, the Attorney General brings this action to curtail Defendants' longstanding and ongoing pattern and practice of rights violations, seeking injunctive and declaratory relief that would require Defendants to implement overarching remedial measures in the LASD jails including, but not limited to: (1) provide minimally adequate medical, dental, and mental health care to incarcerated persons; (2) protect incarcerated persons from an unreasonable risk of harm; (3) provide habitable, humane, and safe conditions of confinement; (4) respect the dignity and health of incarcerated persons; (5) maintain proper grievance procedures; (6) provide reasonable accommodations and equal access to programs, services, and activities for incarcerated persons with disabilities; and (6) provide access to multi-lingual, interpretation, and translation services for incarcerated persons with limited English proficiency.

JURISDICTION AND VENUE

10. This Court has jurisdiction over this matter pursuant to Article VI, Section 10 of the California Constitution and Code of Civil Procedure section 393.

11. Venue is proper in this County because Defendants are located in Los Angeles County and the events giving rise to this Complaint occurred in Los Angeles County.

PARTIES

12. Plaintiff is the People of the State of California. This civil enforcement action is prosecuted on behalf of the People, by and through Rob Bonta, Attorney General 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.) This action is brought under the Attorney General's broad enforcement powers and pursuant to various provisions of state law including Civil Code section 52.3, which provides that the Attorney General "may bring a civil action in the name of the people . . . to eliminate" a "pattern and practice of conduct by law enforcement officers that deprives any person of rights, privileges, or immunities secured or protected by the Constitution or laws of the United States or the Constitution or laws of the State of California."

13. Defendant County is a county and political subdivision of the State of California, duly organized under the laws of the State of California. Defendant County funds and operates Defendant LASD, an agency of the County and the County's primary law enforcement agency. The County also funds and operates the Los Angeles County Department of Health Services, which includes Defendant CHS, the nation's largest county-run correctional health system.

14. Defendant County funds and, through Defendants LASD and CHS, operates the LASD jails, which houses pretrial detainees and convicted persons in the custody of the County. Defendants County, LASD, and CHS are responsible for the care, custody, security, and rehabilitation of all pretrial detainees and convicted persons housed within LASD jail facilities and for the medical, dental, and mental health care provided to them. The County's jail system includes a series of jails, as well as local detention facilities in patrol stations.

15. Defendant Robert G. Luna is the Sheriff of Los Angeles County and the chief

executive officer of the Los Angeles County Sheriff's Department (Luna or Sheriff). In his capacity as Sheriff, he is responsible for the management and control of all LASD jails and for the health and welfare of all persons in the custody of Defendant County. As such, Defendant Luna is ultimately responsible for the safekeeping of all incarcerated persons in LASD jails. These responsibilities include the operation and administration of all LASD jails, making and enforcing policies, procedures, customs, supervision, and training related to the confinement of incarcerated persons in the jails, station jails, and other County detention facilities. Defendant Luna is sued in his official capacity only.

16. Defendant Dr. Timothy Belavich, Ph.D. is the Director of CHS (CHS Director or Dr. Belavich). In his capacity as CHS Director, he is responsible for management and control of the healthcare services, including medical, dental and mental health services, provided to persons in the custody of Defendant County and housed in the LASD jails. As such, Defendant Dr. Belavich is ultimately responsible for the health and welfare of all incarcerated persons in LASD jails. These responsibilities include the operation and administration of CHS, overseeing the provision of healthcare services, including medical, dental, and mental health care within the LASD jails, and for making and enforcing policies, procedures, customs, supervision, and training related to healthcare services. Defendant Dr. Belavich is sued in his official capacity only.

17. Plaintiff is not aware of the true names and capacities of Defendants sued herein as DOES 1 through 50, inclusive, and therefore sues those Defendants by fictious names. Each fictitiously named Defendant is responsible in some manner for the violations of law alleged in this Complaint. Plaintiff will amend this Complaint to add the true names of the fictitiously named Defendants once they are discovered.

18. Defendants County, LASD, Sheriff, CHS, CHS Director, and DOES 1 to 50 are referred to collectively as "Defendants" throughout, unless specifically stated otherwise.

19. Where this Complaint alleges acts or omissions by one or more Defendants, such allegations shall include the acts and omissions of the officers, deputies, agents, employees, contractors, vendors, affiliates and/or representatives of those Defendants while acting within the

course and scope of their employment or agency with the Defendants.

FACTUAL ALLEGATIONS

I. LASD JAIL FACILITIES AND DEMOGRAPHICS

A. Jail Facilities

20. Defendants operate the largest jail system in the United States, with an average daily population that consistently exceeds the rated population capacity of the jail system as a whole and the facilities used to house the majority of the incarcerated population. It consists of eight jails throughout Los Angeles County and twenty-four detention areas at patrol stations (Station Jails), which are collectively referred to in this Complaint as the LASD jails. The majority of persons confined in the LASD jails are pretrial detainees. The LASD jails also house some persons who have been convicted, yet remain in County custody awaiting the adjudication of other charges, on a temporary basis awaiting transfers, or until they complete their sentences.

21. Men's Central Jail (Men's Central), which houses individuals in general population, administrative segregation, protective custody, and individuals with mild to moderate medical and mental health needs, is located at 441 Bauchet Street, Los Angeles, California 90012. Men's Central was built in 1963 and expanded in 1976. Due to the dilapidated physical condition of the facility and the numerous instances of violence and death within its walls, the Los Angeles County Board of Supervisors voted to shutter Men's Central on at least two separate occasions, most recently in 2020. Men's Central has a rated population capacity of 3,512, with a 2024 average daily population of 3,948 males. As of June 2025, the quarterly average daily population was 3,985.

22. Twin Towers Correctional Facility (Twin Towers) is located at 450 Bauchet Street, Los Angeles, California 90012, adjacent to Men's Central. The facility was opened in 1997. It consists of two high-rise towers and includes the Correctional Treatment Center (CTC). The CTC is a small in-house hospital facility or medical ward that houses individuals with moderate and severe medical and mental health needs, including individuals requiring an inpatient level of care. The facility may occasionally hold female individuals, although Twin Towers generally houses male individuals. Twin Towers has a rated population capacity of 2,432,

with a 2024 average daily population of 2,476. As of June 2025, the quarterly average daily population was 2,595.

23. The Inmate Reception Center (Reception Center), located adjacent to Twin Towers with the same address, is a temporary holding space used for intake, classification, processing, transferring, and release of male individuals in the County's custody. Since the Reception Center is designated as a temporary holding facility, it does not have a rated population capacity.

24. Century Regional Detention Facility (Century Regional), the only female facility in the LASD jails, houses individuals in general population, as well as those with medical and mental health needs ranging from mild to severe. It is located at 11705 South Alameda Street, Lynwood, California 90262. Century Regional includes its own reception center for female individuals being booked into the jails and houses individuals with mental health needs requiring an outpatient level of care. Century Regional has a rated population capacity of 1,708, with a 2024 average daily population of 1,310. As of June 2025, the quarterly average daily population was 1,437.

25. North County Correctional Facility (North County), which houses higher-security male individuals in general population, protective custody, and disciplinary housing, is located at 29340 The Old Road, Castaic, California 91384. The facility's rated capacity is 2,214, with a 2024 average daily population of 2,808. As of June 2025, the quarterly average daily population was 3,063.

26. Pitchess Detention Center-North (PDC-North), which houses individuals with mild to moderate mental health needs, is located at 29320 The Old Road, Castaic, California 91384. The facility's rated capacity is 830, with a 2024 average daily population of 1,197 males. The facility includes housing for individuals with moderate mental health needs and offers Education Based Incarceration (EBI) programs. As of June 2025, the quarterly average daily population was 1,279.

27. Pitchess Detention Center-South (PDC-South), which houses lower-security individuals in general population, is located at 29330 The Old Road in Castaic, California 91384. The facility's rated capacity is 782, with a quarterly average daily population of 507 males as of

June 2025.

28. Pitchess Detention Center-East (PDC-East) is a low-security camp for inmate firefighters, located at 29310 The Old Road, Castaic, California 91384. The facility's rated capacity is 926, with a quarterly average daily population of 10 males as of June 2025.

29. LASD also operates 24 Station Jails, where individuals are temporarily housed before being booked into one of the eight LASD Jails. There is no rated capacity for the Station Jails because they are temporary holding spaces.

B. Jail Population and Capacity

30. During the last five years, from January 2020 through March 2025, the facilities used by the County to house the majority of persons in County custody have consistently exceeded their capacity, as rated by the Board of State and Community Corrections. Specifically:

- Men's Central held an average daily population of 4,049 individuals, despite a rated capacity of 3,509, with no monthly averages below 3,573 and a high of 4,632;
- Twin Towers held an average daily population of 2,728 individuals, despite a rated capacity of 2,432, with only eight monthly averages dipping below the rated capacity in the 2,337-2,432 range and a high of 3,231;
- North County held an average daily population of 3,202 individuals, despite a rated capacity of 2,214, with no monthly averages below 2,604 and a high of 4,008; and
- PDC-North held an average daily population of 1,222 individuals, despite a rated capacity of 830, with no monthly averages below 930 and a high of 1,430.

During Plaintiff's investigation, only Century Regional, housing female incarcerated persons, and the two lower security and smaller facilities, PDC-South and PDC-East, regularly held fewer individuals than their rated capacity. Specifically, from 2020 through March 2025, Century Regional held an average daily population of 1,378 individuals, below the rated capacity of 1,708; PDC-South held an average daily population of 806 individuals, above the rated capacity of 708, but fluctuating significantly between a high of 1,405 and a low of 260; and PDC-East held an average daily population of 25 individuals, below the rated capacity of 849.

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C. Population Demographics

31. During the last five years, the annual average population of incarcerated persons identified as having some mental health need ranged from 40 percent to 44 percent of the total population within LASD's Jails. Most recently, as of August 26, 2025, the daily mental health population includes 5,349 male individuals and 1,011 female individuals for a total of 48 percent of the entire incarcerated population. The percentage for the female incarcerated population alone is 67 percent, meaning two thirds of all women incarcerated in the LA jails require access to mental health services.

32. The annual average of incarcerated persons requiring a higher level of medical care beyond medication distribution in the housing units ranged from 469 to 532 during Plaintiff's investigation.

33. The annual average of incarcerated persons requiring Americans with Disabilities Act (ADA) Housing ranged from 376 to 476 during the last five years. As of June 2025, the number of incarcerated persons with mobility limitations and/or physical disabilities rose to 561.

II. FEDERAL COURT CONSENT DECREES, OVERSIGHT ENTITIES, AND MONITORING OF LASD JAILS

34. The LASD jails have a longstanding history of deplorable conditions and constitutional violations. Multiple oversight and monitoring agencies have issued public reports documenting the constitutional violations and, in many cases, have made recommendations to address the problems that Defendants have failed to implement effectively or long term. Defendants and the LASD jails have also been subject to a series injunctions and consent decrees mandating reforms that have, thus far, failed to stem the rights violations occurring in the jails.

35. As far back as 1975, the American Civil Liberties Union (ACLU) Foundation of Southern California filed a federal class-action lawsuit, *Rutherford v. Luna* (C.D. Cal. No. 2:75-CV-04111), on behalf of incarcerated persons to address unlawful conditions in the LASD jails. As a result of this matter, the County has been subject to oversight for more than 40 years, since 1979. Currently, *Rutherford* involves the issue of overcrowding and the related conditions of confinement in the Reception Center, which is governed by a June 2023 Stipulated Order. The

Order is not subject to monitoring by an external party and only applies to the Reception Center.

36. In 1996, United States Department of Justice (U.S. DOJ) also found that unconstitutional conditions existed in LASD jails, including deliberate indifference to serious mental health needs of incarcerated persons, and made several remedial recommendations. In 2002 and in 2015, the U.S. DOJ and County entered into a Memorandum of Agreement and settlement agreement (U.S. DOJ Settlement) respectively, in *United States v. County of Los Angeles* (C.D. Cal., No. 2:15-CV-05903), requiring the County to provide adequate mental health services to incarcerated persons. The County was required to implement several reforms including, but not limited to, providing crisis intervention for those at risk of suicide, training custodial staff on the care of incarcerated persons with mental health disabilities, and implementing appropriate suicide observation. In April 2023, after nearly 10 years of monitoring, a federal district court judge found the County's lack of compliance with the provisions of the U.S. DOJ Settlement necessitating the imposition of more specific remedial action and additional implementation measures.

37. Two other class actions address aspects of the LASD jails. *Johnson v. County of Los Angeles* (C.D. Cal. No. 2:08-CV-03515) is a federal class-action filed in 2008 by the ACLU, Disability Rights Legal Center, and Disability Rights California, involving discrimination against incarcerated persons with mobility disabilities in the jails. The lawsuit was settled on October 30, 2014. The settlement applies to all LASD Jails used to permanently house individuals with mobility disabilities, including Men's Central, Twin Towers, and Century Regional. The Office of the Inspector General serves as the monitor for this matter, and more than a decade later, 11 provisions remain subject to monitoring, with the possibility of regression on other terms that had been resolved due, in part, to Defendants' practice of housing a significant number of persons with mobility impairments in non-ADA housing without necessary accommodations.

38. *Rosas v. County of Los Angeles* (C.D. Cal. No. 2:12-CV-00428) is a federal class action filed in 2012 by the ACLU of Southern California regarding the use of force inside LASD jails. The parties reached an agreement requiring LASD to adopt a plan to reform departmental policies and practices on use of force. Defendants remain out of compliance with significant

provisions of the *Rosas* settlement, including relating to accountability for deputies with use of force violations and supervisors who fail to identify and/or appropriately address those violations.

39. In addition to court-appointed monitors and settlement agreements, the County has been subject to monitoring by oversight agencies for many years. In 1992, the Kolts Commission, formed at the behest of the Los Angeles County Board of Supervisors, issued a scathing report documenting widespread abuse of authority by LASD deputies and lax discipline, which resulted in the appointment of Special Counsel to the Board of Supervisors for ongoing oversight of the LASD. Over the course of more than twenty years, Special Counsel issued more than 30 semi-annual reports, which included numerous recommendations for reforms in the jails. In the final report, in 2014, Special Counsel observed that, despite some positive changes over the years, "brutality seemed to have festered in the jails" and LASD would be "in far better shape" if "Special Counsel's recommendations over the last 20 years in the countless areas that it has studied been swiftly addressed."

40. Currently, three oversight agencies monitor the LASD jails. The Sybil Brand Commission, which was founded in 1959 to address overcrowding and conditions of confinement in the LASD jails, conducts inspections of LASD jails and adult courthouse lockups, as authorized by Chapter 2.82 of the Los Angeles County Code. Each of the ten Commissioners may conduct up to two facility inspections per month, and inspection reports are made available to the public. Additionally, Commissioners may assist with inspections at the request of the Office of the Inspector General or Civilian Oversight Commission.

41. The Office of the Inspector General provides independent and comprehensive oversight, monitoring of, and reporting about LASD and serves as the investigation arm of the Civilian Oversight Commission. The Office of the Inspector General has documented numerous problems in LASD jails, not limited to overcrowding, unavailability of menstrual products, excessive commissary prices, in-custody deaths, overdoses, and issues with the handling of grievances filed by incarcerated persons. The Office of the Inspector General has also documented multiple areas of concerns involving in-custody deaths, including the quality and timeliness of Code of Regulations, Title 15 safety checks, lack of policies and procedures to

respond to multiple people in distress, failure to search persons in custody prior to being transported to and from Court, pill call procedures, and supervision of trustees.

42. The Civilian Oversight Commission also oversees the jails as part of its mission to improve public transparency and accountability with respect to LASD, by: (1) providing robust opportunities for community engagement; (2) ongoing analysis and oversight of LASD's policies, practices, procedures; and (3) advice to the Board of Supervisors, LASD, and the public. Among its duties, the Civilian Oversight Commission has authority to use staff of the Office of the Inspector General or its own members or staff to undertake investigations, inquiries, audits, and monitoring, as well as issue subpoenas.

43. These legal actions, settlements, and monitoring reports from oversight agencies made Defendants aware and gave them clear notice of the continuing violations in the LASD jails and the necessity of reforms. Nevertheless, Defendants have, over many years, failed to remedy the various conditions, policies, patterns and practices causing substantial risks to the health and safety of persons in County custody.

III. LASD JAILS HAVE BEEN PLAGUED FOR DECADES BY SEVERE, PERSISTENT, AND RAMPANT HARMS, WHICH HAVE CREATED CONDITIONS OF CONFINEMENT THAT FAIL TO MEET THE MOST BASIC LEGAL STANDARDS

44. Defendants have repeatedly failed to provide safe and secure housing; adequate medical, dental, and mental health care; and other basic necessities of life. Defendants are deliberately indifferent to the basic needs of persons confined in LASD jails and the substantial risks to the health and safety of those persons stemming from Defendants' persistent failure to meet their basic needs. Defendants' failures have been obvious, notorious and well-documented over many years. The numerous consent decrees, monitoring reports, investigations, oversight and public reports about deplorable conditions and treatment by entities including, but not limited to, the United States Department of Justice, the Office of Inspector General, the ACLU, and the Sybil Brand Commission, since approximately 1975, repeatedly placed Defendants, including the Sheriff and CHS Director, on notice of the ongoing deficiencies and rights violations. Despite their knowledge, Defendants have failed to take necessary and effective corrective action.

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A. LASD Jail Facilities Are Uninhabitable and Unsafe

45. Defendants fail to maintain habitable and sanitary conditions in LASD jails, creating a substantial risk of harm or death to incarcerated persons in County custody.

46. As a result of LASD's and CHS's deficient policies and practices regarding maintaining habitable and safe conditions in the LASD jails and Defendants' creation and/or tolerance of obvious habitability and safety deficiencies, incarcerated persons are subject to an ongoing and substantial risk of serious harm or death. Defendants have over many years failed to ensure that the LASD jails meet and maintain the most basic legal standards with respect to habitable and sanitary conditions. Defendants are aware that the jails are dilapidated, deteriorating in infrastructure and continue to allow severe and prolonged uninhabitable and unsanitary conditions such as feces, vermin, mold, inadequate ventilation and air flow, and fire hazards to proliferate and overwhelm the jails.

47. The uninhabitable and unsafe conditions of the jails include, but are not limited to, broken or malfunctioning plumbing, insufficient ventilation, and vermin and insect infestations. These conditions create safety hazards to incarcerated persons and staff and inhibit the provision of healthcare. The longstanding issues regarding uninhabitable and unsafe conditions is the result of absent and inadequate policies and other remediation by Defendants.

B. Extreme Temperatures Lead to Debilitating and Degrading Conditions and Make the Jails Ripe for the Spread of Disease

48. Defendants fail to alleviate extreme heat and cold temperatures in the jails and fail to provide appropriate warm clothing to incarcerated persons during these extreme events.

49. County oversight agencies, healthcare staff, and persons incarcerated in LASD jails have all reported both extremely cold and extremely hot temperatures in LASD jail facilities, ongoing issues with air conditioning systems, lack of ventilation, and a lack of appropriate clothing for incarcerated persons. During late 2022 and early 2023, two incarcerated persons died from hypothermia inside their cells.

50. In *Rutherford v. Luna*, Case No. 2:75-cv-04000-DDP (C.D. Cal.), declarations filed in February 2023 from 23 incarcerated persons inside various LASD jails said they were

freezing without blankets and covering themselves with plastic bags to stay warm. The County's Office of Inspector General monitors "observed people in custody utilizing plastic garbage bags as blankets and sleeping in plastic garbage bins to shelter from the cold." Sybil Brand Commission inspectors reported on August 29, 2024, that certain areas of Century Regional did not have air or were stiflingly hot. Similar problems of oppressive heat have been experienced at Men's Central and North County.

51. Defendants' failure to ensure adequate temperature regulation and ventilation in the jails endangers the health and safety of persons confined in the LASD jails by making them more vulnerable to illness and death.

C. The Severe and Prolonged Absence of Sanitation Measures Exposes Incarcerated Persons to Feces, Vermin and Trash that Endangers their Health and Safety

52. Defendants lack adequate sanitation policies and practices to ensure habitable and sanitary conditions in LASD jails and to avoid compromising the health and safety of incarcerated persons. Defendants also fail to take adequate measures to eradicate vermin from the jails.

53. Persons with serious mental health disabilities who are confined in LASD jails are housed for prolonged periods of time in cells that are unsanitary and that pose a risk of serious harm to their health, for example, because of feces smeared on the walls.

54. In October 2023, the Sybil Brand Commission reported that, at Men's Central, inspectors observed rat traps and rat feces in the showers and some cells, trash throughout the floors and in empty cells, and food or some kind of bodily fluid on the walls. In June 2024, the Sybil Brand Commission reported that multiple dorms at Men's Central were overcrowded with broken toilets, some containing feces that could not be flushed; a urinal that caused "effluence to emerge through the mid-floor drain" when flushed; and ceilings that had been painted over to cover mold.

55. On October 10, 2024, the Sybil Brand Commission reported that unsanitary conditions persist at the Reception Center. The Commissioners spoke with incarcerated persons at the Reception Center, all of whom reported that they had not received a hygiene package since

their arrival, some for weeks. They also complained of inadequate provisions of toilet paper. The Commissioners noted that they found it difficult to breathe, with one of the Commissioners suffering breathing difficulties even after exiting the unit. Each of the individuals the Commissioners spoke with also reported suffering from insect bites, and the Commissioners observed cockroaches in the cells. The individuals also complained of rats. For an inspection of Twin Towers on March 6, 2025, the Sybil Brand Commission inspectors reported multiple non-functioning toilets, mattresses without required plastic covers, visible mold on walls, and what appeared to be blood on walls and a mattress. These are the kinds of problems the Commissioners have reported to the Watch Commanders and the Commission on every visit. By those direct reports and the Sybil Brand Commission's public reports, Defendants are on notice of these unsanitary conditions.

56. As recently as July 2025, the Sybil Brand Commission reported continued unsanitary conditions at Twin Towers. One Commissioner noted a trail of blood on the floor at Twin Towers, which they were advised had been there for weeks. The Commissioners also noted multiple instances of raw sewage on the floor at Men's Central. In one instance, the Commissioners were denied access to a cell in which incarcerated persons were housed on the grounds that it was unsafe. In another instance, at the Reception Center, the Commissioners had to ask for an inmate to be moved out of a cell where there was sewage on the floor.

D. Inadequate Access to Basic Supplies, Clean Clothing and Linens, and Personal Hygiene Products

57. Compounding the sanitation and habitability issues in LASD jails, Defendants inhumanely deprive incarcerated persons of the ability to maintain basic personal hygiene and cleanliness. LASD jails staff regularly fail to provide incarcerated persons with personal hygiene products, menstrual products, showers, hair care services, laundry services, and adequate and clean clothing and bedding. Some incarcerated persons do not have any mattresses, while others have mattresses with mold or mattresses that are degrading in quality.

58. Code of Regulations, title 15, section 1265, requires Defendants to provide personal care items, including toothbrushes, toothpaste, dental floss, soap, combs, and shaving

implements, often referred to as an "indigent kit" or "fish kit," to each person to be held over 24 hours who is unable to pay for these personal items because of either indigence or the absence of a canteen. Defendants routinely fail to comply with this regulation by not providing personal hygiene products at the time of initial housing or for months. The Office of the Inspector General and the Sybil Brand Commission have routinely reported on a lack of basic supplies, such as soap and toilet paper.

59. Instead of providing the necessary materials to maintain personal hygiene, LASD charges indigent incarcerated persons for hygiene kits from the funds given to incarcerated people by their friends and family for commissary. However, personal hygiene items are frequently out of stock and unavailable to order; when available, they are sold to people in custody at significant markups.

60. Persons confined in LASD jails are routinely denied sufficient access to showers. Often, incarcerated persons are not given access to showers for multiple days, weeks, or more, despite requirements in state law and LASD's policy manual that incarcerated persons be able to shower at least every other day. According to reports, deputies also turn off showers as a form of retaliation.

61. Persons confined in LASD jails do not receive sufficient clean clothing, and laundry services for clothing. Persons confined in LASD jails also often lack access to sheets and towels and laundry services for bedding and linens.

62. LASD has engaged in a pattern or practice of failing to provide sufficient mattresses. At the Reception Center, incarcerated persons often sleep on the floor for longer than 24 hours without blankets or pillows, in cold temperatures. For example, at North County and Twin Towers in 2022, the Sybil Brand Commission observed and received complaints of incarcerated persons not having mattresses. In December 2022, a Sybil Brand Commission member reported that at Men's Central, which houses incarcerated persons with mental health disabilities in a compressed living space with triple-bunk beds spaced shoulder-width apart, there was a three-day waiting period to receive mattresses.

63. Defendants also regularly fail to provide menstrual products, including sanitary

napkins, panty liners, and tampons, to persons in custody who need them in the LASD jails. Incarcerated persons have reported that they do not have ready access to menstrual products and have also stated that deputies ration menstrual products, unilaterally deciding whether or not to distribute additional supplies. Despite the enactment of the Reproductive Dignity for Incarcerated People Act in 2024, and Defendants' awareness of their failures in this area, these violations have gone uncorrected.

64. Defendants also deprive incarcerated persons with mental health disabilities of hygiene supplies. In March 2023, the Sybil Brand Commission reported that deputies label incarcerated persons who are presumed to have mental health disabilities as "hostile" and then deprive those incarcerated persons of the means to maintain personal hygiene as a form of punishment or discipline for behavior that may be symptomatic of mental health disabilities, all without consulting mental health clinicians.

65. Further compounding these issues, LASD does not address grievances regarding the lack of personal hygiene products, clothing, or mattresses.

E. Moldy, Inedible, and Inappropriate Food Results in Preventable Illnesses

66. Defendants have repeatedly subjected incarcerated persons to a substantial risk of serious harm or death by supplying inedible, low nutrition meals to incarcerated persons. LASD routinely fails to meet minimum standards regarding food preparation, nutrition, medical diets, and diets for pregnant persons.

67. The food provided in LASD jails has been, variously, expired, moldy, filled with maggots or worms, or otherwise inedible. Even when edible, meals provided by Defendants lack adequate nutritional value, with most meals consisting primarily of highly processed carbohydrates and minimal protein, with very little variation from meal to meal. Numerous individuals in the jails have reported receiving only peanut butter and jelly sandwiches with carrots, chips, and milk for the majority of their meals.

68. Defendants also fail to provide appropriate meals to persons on medical diets and pregnant and lactating people. Even when persons with diabetes, HIV, kidney failure, and other chronic conditions are medically pre-approved for special diets, Defendants fail to provide or

delay the provision of appropriate special diets for those conditions. The Sybil Brand Commission reported that in addition to instances of dietary restrictions being ignored, persons in LASD jails are required to wait until they arrive at "permanent" housing before receiving a medically approved diet.

F. Incarcerated Persons Are Deprived of Safe Drinking Water

69. Defendants have subjected incarcerated persons to a substantial risk of serious harm or death by failing to supply safe drinking water.

70. Drinking fountains, providing potable water, are regularly non-functioning, such that persons confined in LASD jails are forced to drink dirty water straight from the faucet next to their toilets, or other water unsafe for human consumption.

71. Many incarcerated persons are also left without any drinking water, as the faucets in their cells are broken or turned off by LASD staff. For example, in July 2022, Sybil Brand Commissioners and leadership from CHS visited Men's Central and found one dormitory without a single functional, sanitary drinking fountain. They also discovered that there was no open maintenance order to repair the water fountains.

72. Incarcerated persons have also reported that the drinking water smells like chlorine, and that there are worms in the sink faucets and showers.

G. Pregnant Incarcerated Persons Are Denied Necessities and Humane Treatment, Putting Their Pregnancies at Risk

73. Defendants have subjected pregnant persons in County custody to a substantial risk of serious harm or death by failing to provide sufficient filtered water, adequately nutritious and filling prenatal diets, and timely and appropriate reproductive health care. For example, in January 2022, the Sybil Brand Commission reported that pregnant persons confined in LASD jails were being shackled to one another while being transported, that they lacked access to sufficient clean water, that the food they received was not consistent with a prenatal diet, that they were given inadequate exercise time, and that education related to pregnancy and birthing was insufficient.

74. Code of Regulations, title 15, section 1248 requires local detention facilities to

provide pregnant and lactating people with a balanced, nutritious diet approved by a doctor. Yet, pregnant persons in County custody are provided insufficient water and prenatal diets.

75. Defendants also fail to provide pregnancy tests upon request or have delayed providing such tests for over a month. They have failed to provide adequate and timely medical care relating to pregnancies and have failed to ensure post-release services for pregnant persons who are released from LASD jails.

76. Defendants' treatment of pregnant persons results in serious harm. For example, one pregnant woman at Century Regional complained that she was experiencing pain and requested to see a doctor. LASD personnel and CHS medical staff were made aware of her request, but delayed responding. She was eventually taken to a hospital where her baby died. In another incident, the Los Angeles Times reported on jail surveillance clips that had been made public in June 2023, including a clip of a woman sitting in a wheelchair that had been left in a jail hallway. Upon giving birth, her newborn baby fell onto the floor of the jail hallway. The woman appeared unable to reach down to pick up the child or move her arms because her arms appeared to be affixed to the arms of the wheelchair. Another pregnant woman at Century Regional complained that she was left bleeding for 14 days despite her requests for medical assistance. She also claimed that medical staff pressured her to sign authorization paperwork to terminate her pregnancy.

H. Defendants Limit Access to Out-Of-Cell Time, Education Programs, and Other Services Leading to Excessive Isolation and Mental Deterioration

77. Defendants have engaged in a pattern or practice of failing to give incarcerated persons at least 10 hours of out-of-cell time over a seven-day period, as required by Code of Regulations, title 15, section 1065.

78. Even in areas where LASD's policies require more out-of-cell time, such as at Century Regional and in High Observation Housing units, Defendants fail to follow their own policies. For example, incarcerated persons in Moderate Observation Housing at Century Regional are only allowed out of their cells for one hour or one-and-one half hours depending on the deputy on duty in the module, despite LASD's policy requiring two hours of out-of-cell time

per day for individuals at Century Regional. Incarcerated persons in the Forensic Inpatient Unit, housing those with the most severe mental health needs, receive no out-of-cell time.

79. Defendants have also engaged in a pattern or practice of failing to give incarcerated persons access to educational programs and library services, as required by Code of Regulations, title 15, sections 1061 and 1064, leading to unacceptable levels of isolation and mental deterioration. Incarcerated persons face numerous barriers to accessing educational programming, including security classifications, delays in enrollment, and long waitlists, course accessibility and availability, and deputies withholding access to classes as a form of punishment. Incarcerated persons at Twin Towers and PDC-North have no access to library services. Deputies at Century Regional have been known to limit programming as a form of harassment or retaliation against incarcerated persons. Further, Defendants house incarcerated persons in the dayrooms of the housing modules, making the space unavailable for incarcerated persons to use during out-of-cell time or programming.

I. Defendants Conduct Inadequate and Untimely Safety Checks, Failing to Ensure the Safety of Incarcerated Persons

80. Defendants routinely fail to conduct adequate and timely safety checks of incarcerated persons, as required by Code of Regulations, title 15, section 1027.5. Defendants also fail to adequately respond to incarcerated persons in distress during safety checks. These deficiencies subject incarcerated persons to a substantial risk of harm and death.

81. Code of Regulations, title 15 and LASD policy require safety checks to be conducted at least hourly through direct visual observation of all incarcerated persons, to determine the safety and well-being of incarcerated persons. Safety checks are to be conducted more frequently for incarcerated persons in safety cells and sobering cells, for incarcerated persons in restraints, and for incarcerated persons in medical or mental health housing. For incarcerated persons in sobering cells and medical or mental health housing, intermittent direct visual observation shall be conducted no less than every 30 minutes. However, LASD jail personnel routinely fail to conduct safety checks on time, or at all. For example, in 2023, the Board of State and Community Corrections found that a significant number of Safety Check Logs

exceeded the 60-minute lapse between safety checks. LASD jail personnel also regularly miss mandatory safety checks. Moreover, LASD does not have a uniform policy regarding safety checks for all Station Jails, leaving each Station Jail to implement their own version of what constitutes a timely and adequate safety check, absent any accountability from LASD leadership.

82. Defendants' failure to conduct safety checks at the required intervals has led to tragic, preventable deaths. In one case, LASD deputies failed to conduct adequate safety checks for four hours, for an individual who had previously attempted suicide. Deputies missed five safety checks and were late on the remaining three checks during the four-hour period, allowing the decedent to commit suicide. According to reports, the deputies who were responsible for the safety checks were watching videos on county computers during the missed safety checks.

83. LASD jail personnel also fail to conduct safety checks at random or varied intervals, as required by Title 15 and LASD policy. LASD personnel use countdown clocks with set intervals, allowing incarcerated persons to predict the time of the next safety check, resulting in violence and preventable deaths. In one example, an incarcerated person was killed by another incarcerated person in an attack that lasted approximately 15 minutes, the full length of time between the applicable safety checks in that instance.

84. Even when LASD personnel conduct safety checks within the requisite timeframe, they are often not of sufficient quality to assess each individual for signs of life. LASD jail staff conducting safety checks routinely walk past cells without stopping or looking inside, focusing only on the scanner used to document safety checks. Defendants also fail to investigate indications of distress or possible emergencies. For example, in several jail deaths from 2022 to 2023, video surveillance footage showed that the deputy stopped longer than usual in front of the decedent's cell, but the deputy did not open the door to investigate further, and the incarcerated persons were later found unresponsive during subsequent checks.

85. LASD jails personnel also regularly fail to timely respond to violence between incarcerated persons or other emergency situations when conducting safety checks, resulting in injuries, if not serious harm or death.

86. For years, Defendants have demonstrated a pattern of untimely, missed, and

inadequate safety checks, subjecting persons in County custody to serious harm and death, including, but not limited to at least eleven deaths from 2018 to 2024 involving untimely, missed, and/or inadequate safety checks. For example, two suicides occurred three days apart in December 2022, in a nearly identical manner in the showers at the CTC, due to inadequate safety checks. Despite being well aware of the circumstances of the first death, nothing was done to prevent the second death.

87. For years, LASD jails personnel have over relied on predictable and perfunctory safety checks and have regularly failed to maintain the level of safety and security necessary to protect incarcerated persons from violence. For example: (1) In May 2022, an incarcerated person was stabbed inside their cell without any jail personnel noticing until he was found during the following safety check; (2) In January 2022, an incarcerated person was killed by their cellmate at Men's Central; however, his body was not discovered until deputies conducted the next round of safety checks; (3) Similarly, in August 2020, an incarcerated person was killed by their cellmate at Men's Central, but their body was not discovered by deputies until the following safety check; and (4) In August 2018, an incarcerated person was attacked after being placed in a cell with a rival gang member, resulting in a fight that deputies watched from the deputy station for over three minutes.

88. Despite notice of these violations, Defendants have failed to provide adequate training, policies, and direction to jail personnel on how to prevent, appropriately respond to, and document violence between incarcerated persons or other emergency situations when conducting safety checks. LASD has admitted that they do not have enough staffing to perform timely and adequate safety checks. Due to inadequate training, policies, and practices, LASD personnel: (1) do not timely respond to violent incidents at the jails; (2) allow security lapses that endanger incarcerated people; (3) fail to appropriately intervene when assaults and security breaches occur; and (4) fail to appropriately monitor the well-being of incarcerated people.

89. By failing to perform required safety checks and otherwise engaging in a pattern and practice of deliberate indifference to the substantial risk of serious harm to persons confined in LASD jails, Defendants have failed to maintain the safety and security of persons in their

custody, to whom they owe a constitutional duty to protect from both self-harm and violence.

J. Defendants Fail to Prevent Dangerous Contraband in LASD Jails Resulting in Overdoses and Deaths

90. Persons confined in LASD jails face an unreasonable risk of death or serious harm from drug contraband and other dangerous contraband in LASD jails, which Defendants fail to detect and prevent despite a long history of harms resulting from contraband.

91. According to data presented to the Los Angeles County Board of Supervisors in December 2023, from 2018 to 2022, there was an average of 37.8 deaths in the LASD jails each year, and approximately 20 percent of those deaths were due to an overdose.

92. Despite this, Defendants have inadequate policies and practices to detect and prevent contraband from entering LASD jails. LASD fails to conduct comprehensive and consistent searches of custody staff and civilians who work inside the jails and fails to adequately train staff how to detect and prevent contraband from entering the jails.

93. Defendants also routinely fail to investigate the source of drugs that contribute to overdose deaths in the jails or take corrective actions to prevent the future inflow of drugs into the jails. During in-custody death reviews for suspected or known overdoses, Defendants do not discuss how the contraband entered the jails, describe any investigation regarding the source of contraband, or propose any corrective actions to prevent contraband from entering the jails in the future.

94. Defendants' failure to detect and prevent the inflow of contraband in LASD jails results in serious harm and death on an ongoing basis.

IV. OVERCROWDING IN LASD JAILS CREATES AN UNREASONABLE RISK OF SERIOUS HARM AND DEATH

95. Defendants have failed and continue to fail to take effective measures to address overcrowding in the LASD jails, which contributes to the inhumane conditions in the jails and endangers the health and safety of persons in County custody.

96. For many years, LASD jails have exceeded their rated capacity as set forth by the Board of State and Community Corrections. Most recently, the Office of the Inspector General

reported on February 26, 2025, that the number of people incarcerated at Men's Central, PDC-North and North County well exceeded the capacity rated by the Board of State and Community Corrections. In a previous 2022 report, the Office of the Inspector General acknowledged the obvious, that "overcrowding in the Los Angeles County Jails continues to jeopardize the ability of the Sheriff's Department to provide humane conditions of confinement as required by the Eighth and Fourteenth Amendments to the U.S. Constitution."

97. In September 2021, a report commissioned by the County Board of Supervisors based on a comprehensive analysis of the jail system and population reduction initiatives observed:

> [T]here is considerable evidence that the current level of crowding is producing a wide array of negative effects for staff and incarcerated persons alike. The LASD and its medical and mental health partners are not meeting minimum levels of mental health care …. Further the official inmate-on-inmate assault rate is high. … 17-18% of the current jail population is assaulted within a year of confinement. This rate is five times the rate for the [California Department of Corrections and Rehabilitation]. … Collectively these data strongly suggest that the current jail system is unsafe for staff and incarcerated persons alike, and the population needs to be rapidly reduced to meet 90 percent of the [BSCC] bed capacity levels...

98. On a daily basis, Defendants have to move incarcerated persons around the LASD jails to make room for housing, create overflows where none existed before, and stretch existing housing units beyond capacity in order to accommodate the high population numbers. This has resulted in violence and assaults among incarcerated persons, including numerous homicides in the LASD jails.

99. Additionally, overcrowding in the LASD jails exacerbates deprivations stemming from Defendants' already limited resources. For example, nearly 40 percent of LASD's court transportation buses, which are used to take incarcerated persons to court, medical appointments, and state prison, were out of service as of April 23, 2022. It has been reported that, on some days, only six of LASD's eighty-two court transportation buses are running. The lack of functioning buses has resulted in numerous incarcerated persons missing critical court dates and meetings with their attorneys, causing them to stay in jail longer. As of March 21, 2024, the lack of functional court transportation buses caused up to one-third of people incarcerated in the LASD jails to miss court appearances.

100. The overcrowding in the LASD jails disproportionately affects incarcerated persons with mental health and other disabilities.

101. To make room for mental health housing, Defendants have relocated Moderate Observation Housing from Twin Towers to general population dorms in Men's Central, which is above maximum capacity and has an increased risk of violence and assaults.

102. To accommodate the large population of persons with serious mental health disabilities, LASD resorts to housing people with the highest mental health acuity levels, and many of whom have other co-occurring disabilities, in cramped, locked cells together for sometimes 23 hours a day, seven days a week, without any meaningful opportunity for rehabilitative programming, education, or out-of-cell recreation.

103. In July 2023, the Sybil Brand Commission reported that the settings and staff interactions in the mental health dorms at Men's Central are not trauma-informed in accordance with best practices. According to the report, "[p]eople are housed in overcrowded warehouse-like spaces on triple-bunks that are often shrouded in sheets or towels for a modicum of privacy." The Commissioners routinely found dorms holding up to 87 people, even though state law requires that dormitories house no more than 64 people.

104. The lack of available mental health housing in the LASD jails has contributed to the overall overcrowding in the jails and Reception Center and prevents incarcerated persons with mental health disabilities from transferring out of the Reception Center in a timely manner. The main clinic waiting area at Reception Center is often overcrowded with incarcerated persons waiting to be assessed by CHS medical and mental health staff and to be transferred to permanent housing. Additionally, there are often 10 to 15 persons in each of the overflow cells, and many of these persons are in those cells for more than a day without air conditioning. In order to sleep, incarcerated persons have to lay down on the benches and floors with little to no room left between them.

105. CHS Director Dr. Belavich, has repeatedly said in public forums, including the September 2022 Sybil Brand Commission meeting, that "[t]he acuity and the sheer number [of people with a mental illness] have made it such that it's impossible to provide adequate treatment

in this facility or in the jail system." Similarly, when discussing the mental health protocols, access to mental health, and delay in mental health services during a meeting with the Sybil Brand Commission in September 2022, the CHS Director described "a broken system." In one instance in 2023, two medical emergencies occurred within minutes of each other at Men's Central. CHS blamed low staffing and resources for their inability to adequately respond to both emergencies and had to prioritize one person, resulting in the other person's death. Defendants have been overwhelmed by the ballooning population, leading to significant delays in, and blatant denial of, necessary care to those with serious medical and mental health needs.

106. Overcrowding and unsanitary conditions in the Reception Center create delays in medical and mental health care, which result in the deterioration of the physical and mental health of incarcerated persons. Overcrowding in the Reception Center also delays permanent housing assignments, which further exposes persons to inadequate conditions of confinement and programming. Incarcerated persons are being kept for hours or days in overcrowded conditions with no access to showers or basic hygiene products. For example, on one date in December 2022, there were over 100 incarcerated persons waiting in the Reception Center for a medical evaluation and over 70 incarcerated persons waiting for a mental health evaluation. An additional 49 individuals were waiting in an overflow module to be assessed. Overcrowding in the Reception Center cells where persons are packed in shoulder-to-shoulder for extended periods of time exposes them to intolerable conditions of confinement, safety risks, and untreated health needs.

107. On June 28, 2022, the Board of Supervisors stated:

> The number of people being processed in the [Reception Center] is increasing to concerning levels that are resulting in people being held at the [Reception Center], a temporary holding area, well over the mandated 20 hours. This is particularly affecting people with mental health needs who are, depending on their severity, waist chained to a bench, wearing nothing but a suicide vest.

By way of example, on June 7, 2022, a 72-year-old incarcerated person collapsed while waiting for intake at the Reception Center. This individual had been at the Reception Center for two days without being evaluated for housing by a medical provider.

108. Contributing further to overcrowding in LASD jails, Defendants have a pattern

and practice of holding incarcerated persons in custody beyond their release dates, including those who are entitled to release pursuant to a court order, those for whom charges have not been filed, and those whose charges have been dismissed by the district attorney. Persons deemed incompetent to stand trial often wait for months to be transferred to a state hospital. In a March 2024 report, Disability Rights California found that people with mental health disabilities who are in mental health conservatorships are being held in the jails even after their criminal charges are dropped. According to the JFA Institute, length of stay is the major contributor to the County's jail population and is significantly longer than in other jurisdictions.

109. Despite longstanding knowledge of overcrowding in LASD jails and the resulting harms and unreasonable risk of harm to the health and safety of persons in County custody, Defendants have not undertaken actions to reduce the population in the jails to 90 percent of the capacity rated by the Board of State and Community Corrections. According to LASD data, 48 percent of the jail population has mental health issues. A 2020 study found that at least 61 percent of the mental health population in the jails, adding up to almost 3,900 persons, can be diverted out of the jail. Despite this, the County continually fails to provide sufficient funding and resources to the Office of Diversion and Reentry to generate the community infrastructure that can divert people safely from the jails and create the reentry network necessary to prevent recidivism and provide continuity of medical and mental health treatment.

V. FAILURE TO PROVIDE CONSTITUTIONALLY ADEQUATE MEDICAL CARE TO INCARCERATED PERSONS

110. Persons confined in LASD jails are entirely dependent on Defendants for their healthcare and treatment of all medical, dental, and mental health conditions. Defendants LASD and CHS are jointly responsible for ensuring access to medical, mental health, and dental care, as acknowledged in their policies. This joint responsibility requires both Defendants LASD and CHS to comply with the statutory guidelines and regulations enacted for the protection of incarcerated persons. However, the custodial healthcare system in the LASD jails is grossly inadequate and subjects all incarcerated persons to a substantial risk of serious harm, including unnecessary pain and suffering, preventable injury, and death.

A. Failure To Adequately Identify and Treat Incarcerated Persons at Intake and Initial Screening Results in Physical and Mental Deterioration or Death

111. Defendants have a pattern and practice of failing to adequately identify and treat the medical, dental, and mental health needs of newly arrived incarcerated persons at the Station Jails and during the initial screening and intake process at the reception centers.

112. LASD controls 24 different Station Jails across the County where thousands of detainees with serious medical, dental, and mental health needs each year are held post-arrest while awaiting transfer to the jail reception centers. All persons booked into LASD jails enter through one of the two reception centers: the men enter through the Reception Center at Twin Towers, and the women are processed at Century Regional. The Reception Center at Twin Towers processes approximately 120,000 people a year.

113. Defendants do not hire and assign medical or mental health professionals to provide care or conduct screenings at Stations Jails. Other than cardiopulmonary resuscitation training, LASD personnel at Station Jails receive no medical or mental health training. Such personnel are unqualified and ill-equipped to identify and monitor detainees with medical or mental health conditions requiring treatment or surveillance. Without medical or mental health training, LASD personnel at Station Jails rely on "visual examinations" to attempt to identify conditions requiring immediate treatment. This perfunctory scan by individuals with no medical training can be the difference between life-saving treatment and death.

114. Once an incarcerated person arrives at the LASD jails, Defendants often fail to properly and accurately assess health acuity levels at intake, in violation of Code of Regulations, Title 15, section 1207 requirements for medical receiving screenings. This leads to lapses in ensuring that incarcerated persons receive consistent and necessary healthcare services following intake. For example, an independent monitor appointed by U.S. DOJ to oversee jail conditions expressed "concern" in Fall 2021 that his team "has continued to find patients with urgent or emergent conditions that were likely present at the time of the intake screening that should have been detected during a standard intake process but were not detected."

115. Defendants' pattern or practice of failing to identify and treat medical and mental

health conditions at intake exposes persons in County custody to a serious risk of harm or death, including deaths from alcohol intoxication and drug overdose soon after arrest.

B. The Lack of Centralized Access to Medical and Mental Health Records in the LASD Jails Results in Serious Harm or Death

116. Defendants routinely fail to consider medical or mental health history recorded during prior incarcerations, such that serious but treatable medical and mental health conditions known to Defendants and previously documented by LASD and/or CHS go undetected and unaddressed during decision-making about classification, housing, and other important decisions made at intake. In January 2021, an incarcerated person died by suicide at Men's Central, after having been previously incarcerated approximately seven times from 2019 to 2020. During each of the prior incarcerations, he was housed at Twin Towers due to his extensive history with mental illness and multiple prior suicide attempts, according to his family. Decedent's family filed a lawsuit against the County, which settled for $2,500,000.

117. Defendants also fail to ensure that medical and mental health information is transferred from the Station Jails to the jail reception centers. Incarcerated persons are expected to self-report medical and mental health conditions during the screening at Station Jails, then repeat the same process once they arrive at the reception centers, resulting in haphazard and inconsistent reporting.

118. CHS also lacks access to critical LASD custody information relevant to the delivery of medical and mental health care, including the Reception Center waitlist and all electronic databases maintained by custody staff. For example, if a detainee presents behavioral health issues at a Station Jail, LASD personnel complete a Behavioral Observation and Mental Health Referral Form, which is transferred along with the detainee to the appropriate jail reception center and stored in the electronic database. However, CHS does not have access to the same electronic database, meaning medical and mental health staff may be making assessments without relevant information that is already in LASD's possession. Similarly, because CHS lacks access to the Reception Center waitlist, medical and mental health staff do not know how long a newly arrived individual has been waiting for a medical and/or mental health evaluation.

C. Lack of Access to Prescribed Medication at the Reception Center Results in Serious Harm or Death

119. Incarcerated persons waiting in the Reception Center have no access to medications they were prescribed prior to arrival at the LASD jails or to medically prescribed diets, which prevents CHS from managing and administrating medically necessary pharmaceuticals. This has led to untimely and preventable near-deaths and injuries. In one tragic instance, jail staff at Men's Central failed to provide an incarcerated person his scheduled medication causing him to suffer a major stroke. In another instance, a man with Alzheimer's and dementia diagnoses was arrested by LASD deputies in June 2022 and died within several days of being taken into custody. LASD received immediate notification from family of the necessity of his daily medication to ensure that he would "know where he was or what was happening," yet the man was neither given his medication nor taken to the hospital. He was housed in general population at Men's Central and then transferred to Twin Towers, where he was found unresponsive in his cell three days after his arrest.

120. CHS lacks adequate policies and practices to prevent gaps in medication for persons entering the jails with community-prescribed medications. When a prescription or supply of medication has lapsed, incarcerated persons have waited for months for an appointment with a CHS medical provider or clinician to renew the prescription. Defendants have also failed to create an organized and consistent system for distributing medications, resulting in CHS staff giving out medications that are mislabeled, have no label, are inaccurately measured, or are the wrong medication. Most of the jail facilities have a machine that pre-packages prescribed medications. However, at North County and Pitchess Detention Center, medications are poured by hand by CHS nursing staff, because the facility does not have a machine to pre-package medications. The practice of pouring medications by hand exposes incarcerated persons to increased risk of receiving the wrong medication and experiencing serious harm.

D. Defendants Fail to Identify, Treat, and Monitor Recently Incarcerated Persons Under the Influence of Alcohol and Drugs, at Risk of Withdrawal, and at Risk of Suicide, Resulting in Serious Harm and Death

121. Defendants have a pattern and practice of failing to provide adequate medical care

and monitoring to recently arrested persons who are under the influence of alcohol or drugs, who are at risk of experiencing drug or alcohol withdrawal while in custody, or who may attempt suicide, which has directly led to serious harm as well as preventable deaths.

122. As a result of deficient policies and training, Defendants place detainees who are presumed to be under the influence of alcohol or drugs into sobering cells in Station Jails without performing a medical assessment. In some instances, LASD personnel also fail to recognize when a detainee is under the influence of alcohol or drugs.

123. LASD personnel fail to perform adequate Code of Regulations, Title 15 safety checks or maintain direct constant observation of detainees in Station Jails who are under the influence or detoxing from alcohol or drugs. The layout of some Station Jails prevents direct observation of detainees in sobering cells, and the sobering cells generally do not have video surveillance.

124. Defendants also fail to provide adequate detoxification or withdrawal treatment for recently incarcerated persons and fail to provide adequate treatment and monitoring to persons with substance use disorders (SUDs). The accepted standard of care for treating SUDs is an approach known as Medication Assisted Treatment (MAT). Defendants limit access to the MAT program. Although MAT is known to prevent opioid related overdose and deaths and reduce recidivism, CHS has an exceedingly long waitlist and has failed to offer continued maintenance of medication. Persons in custody who have overdosed report not having access to MAT or receiving their initial dose of the medication but then being placed on a waitlist for access to follow-up medication, with a delay possibly causing a relapse and avoidable withdrawal symptoms.

125. Furthermore, Defendants have utterly failed at protecting incarcerated persons and custody personnel from exposure to narcotic substances in the jails. On October 29, 2024, there was a mass incident of suspected drug overdose in Dorm 5600 of Men's Central where seven incarcerated people were hospitalized, including one in critical condition. Seven custody deputies were themselves taken to the hospital upon experiencing symptoms related to the suspected overdose incident. This followed an earlier mass overdose incident at the Men's Central Jail on

October 8, 2024, where an incarcerated person died and seven others were hospitalized. Just months before that in 2024, at least seven incarcerated people overdosed at Century Regional, requiring all of them to receive emergency medical treatment at a nearby hospital.

126. Defendants know that drug overdose incidents endanger the health and safety of incarcerated persons and LASD personnel, yet have made no meaningful efforts to improve tracking for narcotics recovery in the LASD jails or to address the unconscionable mass overdose incidents that are occurring inside the LASD jails.

127. Defendants also fail to provide adequate suicide precautions at Station Jails for recently arrested detainees who are deemed to be a suicide risk and who are awaiting transport to a jail reception center. Since there are no mental health professionals at Station Jails, detainees who express suicidal ideation are supposed to be transported to a jail reception center. However, transportation to a jail reception center can potentially take hours or even days depending on the availability of LASD personnel. Meanwhile, LASD personnel place detainees who express suicidal ideation in a cell at the Station Jails, without direct constant observation by LASD personnel or video surveillance inside the cell.

128. In one notable death, an arrestee who was booked and placed in a holding cell at Industry Station Jail in November 2018, was given no medical evaluation or attention from the time of his arrest through the time of his death. Arresting officers did not advise station personnel of concerns expressed by the decedent's family that the arrestee required medical attention and should be sent to a hospital. Early the following morning, decedent hung himself in jail, less than nine hours after being arrested. Decedent's family filed a lawsuit against LASD that settled for $1,900,000.

E. Defendants Fail to Timely and Adequately Respond to Requests for Healthcare, Including for Emergent and Urgent Conditions, Jeopardizing the Health of Incarcerated Persons and Subjecting them to Unnecessary Pain and Suffering

129. Defendants have a pattern and practice of failing to respond to emergent and urgent healthcare needs of persons in LASD jails, and of failing to provide timely and adequate treatment for non-emergent healthcare needs that would prevent unnecessary pain and suffering

or the development of more serious problems and medical, dental, or mental health emergencies. Defendants' failure to provide timely treatment—or any treatment—after receiving notice of incarcerated persons' medical, dental, or mental health needs creates a substantial risk of serious harm and death.

130. To obtain healthcare, persons confined in LASD jails are required to submit a Health Service Request form (HSR), describing their need for medical, dental, or mental health services. Incarcerated persons face numerous barriers to submitting HSR forms, including the unavailability of HSR forms in the housing units in the jails; LASD personnel refusing to provide HSR forms to incarcerated persons or discouraging incarcerated persons from submitting HSR forms; LASD personnel inquiring into incarcerated persons' confidential healthcare needs; and LASD personnel reading the completed, confidential HSR forms and refusing to submit the forms to CHS healthcare staff. LASD fails to adequately train jail personnel how to appropriately respond to incarcerated persons' requests for medical care.

131. Even when LASD personnel forward completed HSR forms to CHS, CHS fails to process the forms and provide treatment in a timely and adequate manner as required by CHS's policy. For example, at North County, HSR forms are not scanned immediately and sit in a filing cabinet, including forms marked "Urgent." In May 2023, CHS had a backlog of 4,000 medical appointments that had not yet been scheduled and a backlog of 700 to 800 dentistry requests.

132. Defendants' failure to timely process and respond to HSR forms is compounded by their failure to create an effective tracking system and scheduling system for medical appointments and for incarcerated persons' medical records. CHS has no established timeframes dictating deadlines by which an incarcerated person requesting care must receive an appointment with a medical professional. As a result, CHS nursing staff triage HSR forms based on their own independent judgment and decide which requests should be designated as urgent and scheduled for an examination. Even then, incarcerated persons whose requests have been deemed urgent do not receive medical appointments in a timely manner.

133. Defendants also fail to respond to incarcerated persons' medical needs that are reported or apparent during daily "sick calls." According to policy, LASD and CHS are jointly

responsible for ensuring "[a]ccess to daily nurse clinic services for incarcerated persons to receive appropriate services for non-emergency or injury." Yet, Defendants' process for conducting sick calls is overburdened and fails to account for the increasing population of people with healthcare needs, including persons with serious medical, dental, and mental conditions, and insufficient staff to perform the necessary duties to treat that population. According to data reported to the Board of State and Community Corrections, the average number of incarcerated persons seen at sick call declined by more than half during the five-year period between 2017 and2022, although the average daily population declined only 14 percent during that time.

134. Inspections by Plaintiff and the Sybil Brand Commission indicate that calls for immediate medical attention are ignored, requests for medical attention are not fulfilled, and individuals feel they must submit numerous HSR forms to receive medical care or otherwise burden the judicial system by seeking a motion to compel medical care. In June 2023, the Sybil Brand Commission expressed concern that incarcerated persons cannot get the attention of custody staff and, in particular, concern about what would happen if an incarcerated person had a medical emergency.

135. Several of the LASD jails do not have an Urgent Care facility, causing delays in treatment of urgent conditions for persons confined in these facilities. There is no Urgent Care facility at the North County / PDC campus, which houses one-third of the jail population. There is also no Urgent Care facility at Century Regional, which is the only custodial facility that houses incarcerated women. A patient requiring urgent care at the North County / PDC campus or at Century Regional must be transported by ambulance to a local hospital or to the Urgent Care facility at Twin Towers, causing delays for urgent conditions that may become worse or cause unnecessary pain while left untreated.

136. Defendants fail to provide timely access to healthcare professionals and treatment even when such access is ordered by courts. For example, an incarcerated person at Men's Central complained that he had three court orders related to care for dental problems that were causing him pain and difficulty eating, but had still been waiting 10 months for dental care. Another incarcerated person at Men's Central also had to get a court order for dental work, but

even with the court order, he was only given a pain pill for a week and put back on the waitlist. In February 2023, a county public defender submitted a declaration indicating that on multiple occasions after courts ordered the LASD jails to provide mental health evaluations and medication for her clients, Defendants nevertheless failed to provide the ordered evaluations and treatment.

137. Delays in treatment and failure to provide treatment in response to HSR forms causes incarcerated persons to experience unnecessary pain and suffering and creates unreasonable risks to their health and safety. Incarcerated persons wait weeks or even months before they are scheduled for an examination with a healthcare professional or before they receive treatment or medicine. Some incarcerated persons never receive a response to their HSR forms.

F. Delays and Failure to Treat Serious Medical Needs at the LASD Jails Have Contributed to Numerous In-Custody Deaths

138. Defendants have a pattern and practice of delaying and denying incarcerated persons access to appropriate, competent, and necessary medical care for serious medical needs and failing to transfer seriously ill patients for inpatient hospitalization. Defendants' deliberate indifference to the serious medical needs, health and welfare of incarcerated people has led to numerous untimely and preventable in-custody deaths and unnecessary pain and suffering.

139. Defendants' failure to timely and adequately treat serious medical conditions is a particular problem for incarcerated persons with heart conditions. Premature cardiovascular disease is the leading cause of in-custody deaths in the jails, which includes deaths from arteriosclerotic cardiovascular disease, cardiomyopathy, pulmonary embolism, cardiac arrest, congestive heart failure, and heart disease. Approximately five percent of the decedents with cardiovascular disease are African Americans. Ninety percent of all premature cardiovascular disease deaths are persons under 65 years old, with the average age of 51 years. African Americans make up nine percent of the County population, and 49 percent of all in-custody cardiovascular disease deaths.

140. One tragic case of an incarcerated person dying from heart disease occurred at Twin Towers in January 2023. Decedent was sent to the Urgent Care Clinic for "weak

appearance" and "lack of mobility" after a Registered Nurse observed him lying naked on a blanket on the floor. Over an hour and a half later, he was still sitting in his cell due to a reallocation of staffing needs to take three patients from Urgent Care to the hospital. Due to an utter lack of care and seemingly forgotten by LASD and CHS personnel, he became unresponsive, and no one stopped to check him for signs of life or to render emergency aid. Defendants did not begin cardiopulmonary resuscitation until 18 minutes after the decedent was found unresponsive, and CHS delayed calling 911.

141. Defendants also systematically fail to detect and provide appropriate treatment to persons with Hepatitis C, a viral, blood-borne liver disease, that is very common in carceral settings. Despite the widespread knowledge that the disease is prevalent in jail populations and can cause cirrhosis, liver cancer, heart disease, kidney disease, arthritis and diabetes, Defendants do not screen for Hepatitis C at intake. According to a physician who treated Hepatitis C patients in LASD jails, the number of patients who are being treated are in the dozens in a system where Hepatitis C cases in the jails probably number in the thousands. That physician stated in April 2024 that "the system continues to fall woefully short of the sort of concerted effort that could dramatically reduce the toll of the infection within and beyond the jails." In the last five years, there have been seventeen deaths in LASD jails where decedents tested positive for Hepatitis C.

G. Defendants' Failure to Implement Effective Protocols and Systems for Follow-Up Medical Treatment and Chronic Care Causes Delays and Treatment Failures

142. Defendants fail to meaningfully maintain and implement a chronic care management program, which would help track the population with chronic illnesses that need medication management or ongoing monitoring, e.g., diabetes, heart disease, hypertension, and stroke.

143. The National Commission for Correctional Health Care advises that patients with chronic disease, other significant health conditions that require ongoing treatment, and disabilities receive ongoing multidisciplinary care aligned with evidence-based standards. National standards dictate that providers must follow chronic disease protocols and special needs treatment plans as clinically indicated by monitoring the patient's condition and determining the frequency of

follow-up for medical evaluation and treatment. However, Defendants have no chronic management care system, lack a system to track incarcerated persons who need follow-up medical treatment, and knowingly fail to create such systems. This creates a substantial risk of harm, injury, or death and has led to the preventable deaths of incarcerated persons with chronic conditions, such as diabetes and heart disease.

144. The absence of necessary systems for providing regular and follow-up medical care is exacerbated by information deficits. CHS's Chief Medical Officer has no access to data regarding wait times for medical providers or dentists, and therefore, cannot act to remedy excessively long wait times to see a physician. Similarly, CHS does not have access to Automated Justice Information System, which provides current information on the custody status of persons confined in LASD jails, including transfers and court dates, and so that information cannot be taken into account for appointment scheduling.

145. Additionally, Defendants have a pattern and practice of accepting appointment refusals from incarcerated persons who may not have the mental capacity to consent to or refuse treatment, which prevents critical medical interventions from taking place.

146. Defendants also improperly treat an assumed failure to respond as refusal. For example, an incarcerated person was placed in detox housing when she arrived at Century Regional in September 2022 for alcohol and heroin withdrawal. She allegedly refused detox assessments twice before she died from effects of heroin, methamphetamine, and chronic alcohol use two days after her arrest. However, during LASD's death review, it was revealed that she may not have actually refused the earlier assessments and could have been unresponsive at those times. A custody assistant summoned her for a detox assessment using an intercom in the cell, and someone in the cell responded, although the custody assistant was not sure if the person responding was the decedent or her cellmate. When a nurse subsequently went to the cell to confirm the refusal, the decedent was unresponsive and later pronounced dead. Similarly, in October 2022, an incarcerated person at Men's Central was asleep during pill call, no efforts were made to locate him, and he was not given his medications. Although he did not make a direct refusal to CHS healthcare staff, his failure to show up for pill call was effectively treated as a

refusal. He was seen later that day for a meal but was later found unresponsive and died.

147. Defendants also accept refusals for medical and mental healthcare from patients who state their refusals to LASD personnel, which violates CHS policy that a refusal may only be made to healthcare staff.

148. LASD also fails to document refusals. For example, an incarcerated person was placed in segregation at Men's Central after he allegedly refused a chest screen for tuberculosis. He was then subsequently removed from the detox program after he refused an alcohol withdrawal evaluation. He was a no-show for a chest screen six times, but only one of those no-shows was properly documented as a refusal. He was ultimately found unresponsive in his cell and died. The deputy who discovered him believed he was in withdrawal and pretending to be unresponsive so he did not have to wake up for pill call because he had been refusing everything.

149. Compounding these issues, Defendants do not track adverse consequences resulting from refusal of treatment.

VI. FAILURE TO PROVIDE CONSTITUTIONALLY ADEQUATE MENTAL HEALTH CARE

150. Defendants have a pattern and practice of failing to provide timely and adequate mental health care to incarcerated persons in the LASD jails. Defendants also fail to provide the least restrictive environment for incarcerated persons with mental health disabilities and, by failing to provide timely and adequate mental health services, subject these incarcerated persons to unnecessarily restrictive, non-therapeutic, and unsafe housing units. These failures create a substantial risk of further decompensation and harm.

A. Defendants Place Incarcerated Persons with Serious Mental Health Disabilities in Inappropriate and Highly Restrictive Reception Center Housing That Endangers their Health and Welfare

151. Defendants subject incarcerated persons with mental health disabilities to highly restrictive housing in intake overflow units and fail to ensure timely assessments and any therapeutic interventions for these individuals. If an incarcerated person is deemed in need of a bed in High Observation Housing, which houses individuals with serious mental health disabilities needing an intensive level of observation and care, but one is not available in one of the High Observation Housing intake units, the person is placed in a Reception Center overflow

unit that houses individuals waiting to be assessed by Mental Health or Psychiatry. Incarcerated persons in Reception Center overflow are restricted to their cells most of the day, only receiving outside time for showers and phone calls, although many have reported not receiving these privileges daily. Defendants also subject incarcerated persons with serious mental health disabilities to restrictive and isolating conditions in the intake units at Century Regional.

152. Defendants fail to ensure regular and timely assessments of incarcerated person in Reception Center overflow who have already been deemed to require high-level psychiatric care, in part by failing to assign responsibility for such assessments between different teams of clinicians.

153. The days and weeks following intake to jail are considered a high-risk period as many newly arrived incarcerated persons are experiencing clinical symptoms, intoxicated, or experiencing withdrawal. Defendants' pattern and practice of housing individuals for any period shortly after intake in a high restrictive transitional environment devoid of any therapeutic intervention or clear clinical guidelines is clinically inappropriate, risks exacerbating and prolonging symptoms, and increases the chances of adverse events.

B. High Observation Housing for Incarcerated Persons with Serious Mental Health Disabilities Subjects them to Inhumane, Non-Therapeutic Conditions and Concomitant Harms

154. Defendants house incarcerated persons with serious mental health disabilities in High Observation Housing Lockdown pods ("HOH Lockdown pods"), which subjects them to unnecessarily restrictive, non-therapeutic, and inhumane conditions. As of July 2024, Defendants housed more than 600 incarcerated people in HOH Lockdown pods. The HOH Lockdown pods fail to provide said incarcerated persons with the required out-of-cell time, fail to provide adequate treatment for the serious mental health needs of the persons housed in them, and fail to provide habitable conditions of confinement. These conditions cause grave and known risks to the health and safety of incarcerated persons with serious mental health disabilities, including the risk of decompensation and death.

155. According to CHS Policy, High Observation Housing is "for clients that require an intensive level of observation and care and/or safety precautions but do not require

hospitalization."

156. Incarcerated persons in HOH Lockdown pods spend up to 22 hours in their cells most days, in violation of Code of Regulations, title 15, section 1065 and LASD's policies, in what is essentially solitary confinement. When taken out of their cells, these individuals are restrained and chained to the tables in the common area with no ability to move around the area freely.

157. Defendants have failed to comply with CHS policy that incarcerated persons in High Observation Housing are to receive 10 hours per week of therapeutic activities. Very few incarcerated persons in HOH Lockdown pods receive some therapeutically appropriate group therapy; often they are not allowed out of their cells and only a fraction of patients are taken out of their cells to meet with CHS clinicians.

158. Incarcerated persons in HOH Lockdown pods do not receive intensive psychiatric treatment services and are housed in filthy, inhumane environments, in violation of CHS Policy and National Commission on Correctional Health Care standards, which establish that acute care residential units should have continuous mental health coverage and a safe and therapeutic environment conducive to symptom stabilization and maintenance of good personal hygiene.

159. Jail inspections have uncovered HOH Lockdown pods with feces smeared on the walls, trash piled up in cells, and toilets that are clogged and overflowing. CHS clinicians have reported the persons are rarely taken out for showers, and only come out of their cells for showers once every 10 days.

160. CHS clinicians are supposed to see HOH Lockdown patients weekly but have reported that given their workload they can only visit patients biweekly at most. Most of the interactions with clinical staff occur at the cell side rather than outside of the cells, which does not allow for privacy or in-depth clinical, therapeutic interventions.

161. Further, Defendants fail to provide safe housing for incarcerated persons with serious mental health disabilities, since they double-bunk individuals in High Observation Housing without consulting medical or mental health personnel. Double bunking in High Observation Housing has resulted in homicides, serious incidents of violence, and other incidents

with the potential for violence. For example, two individuals killed their cellmates in High Observation Housing in less than six months between September 2022 and May 2023. One of the individuals who was killed was strangled to death by his cellmate. The cellmate had expressed homicidal intent 10 days before the incident but was cleared to be housed with a cellmate. Another person in High Observation Housing was severely injured by separate cellmates on two different occasions.

C. Moderate Observation Housing for Incarcerated Persons with Serious Mental Health Disabilities Is Non-Therapeutic and Fails to Provide Timely and Adequate Mental Health Treatment

162. In Moderate Observation Housing used for individuals with serious mental health disabilities, Defendants have engaged in a pattern or practice of subjecting incarcerated individuals to non-therapeutic housing with inadequate mental health care, despite the known risks that this poses to the health and safety of incarcerated persons with serious mental health conditions, including the risk of decompensation.

163. The American Psychiatric Association and National Commission on Correctional Health Care standards establish that residential units or residential level of care be provided for individuals with serious mental illness and for individuals who are experiencing situational stresses who do not require acute care but may not function adequately in general population and need enhanced services. Defendants fail to comply with these standards and fail to ensure that all Moderate Observation Housing units at the jails are therapeutic.

164. CHS Policy states that treatment should be provided in "mental health dormitory areas for clients with a broad range of diagnoses and functioning, whose mental health needs can be cared for in a less intense and more open setting than the high observation areas but preclude their tolerating general population housing." The policy further states that in these units, "clients are to be offered group activities, including weekly community meetings, and are to be seen monthly by a clinician and as needed by a psychiatrist." Although not specific to Moderate Observation Housing, this policy also states that on-site services include, at a minimum, "integrated treatment for co-occurring mental health and substance abuse disorders, including but not limited to motivational interviewing, education and behavioral therapies, shall be provided on

a regular basis depending on clients' individualized needs and treatment plans." However, the Moderate Observation Housing units in Men's Central and PDC-North cannot be considered a therapeutic environment. The manager of the Men's Mental Health Program admitted that the physical configuration of Men's Central is not appropriate for Moderate Observation Housing. Moreover, many individuals in the Moderate Observation Housing units at Men's Central and PDC-North have reported not seeing clinicians for months at a time.

165. Due to ongoing CHS and LASD staffing shortages, clinicians cannot provide monthly treatment visits for individuals in Moderate Observation Housing. Although clinicians are required to see mental health clients every 30 days, the actual frequency is nowhere near that. The lack of sufficient clinicians for the Moderate Observation Housing population at Men's Central does not allow for monthly clinical encounters or therapeutic group activities. There is also a lack of adequate mental health clinical staff for the Moderate Observation Housing population at PDC-North.

D. Defendants Fail To Identify and Provide Appropriate Treatment for Incarcerated Persons with Serious Mental Disabilities Who Experience Mental Health Emergencies or Require an Inpatient Level of Care

166. Defendants have a pattern or practice of failing to accurately identify incarcerated persons who would qualify for a Welfare and Institutions Code section 5150 psychiatric admission to a psychiatric emergency room or an inpatient unit. This has resulted in persons who have grave mental health disabilities being placed in housing in LASD jails that is not compatible with their clinical needs and has led to a deterioration of their mental health conditions and significant risks to their health and safety.

167. CHS's policies and standards fail to draw clear and appropriate distinctions between persons assigned to High Observation Housing, designated as P3, and persons admitted for a hospital-level of care, designated as P4. The criteria for P3, according to policy and practice, matches the criteria that would be used in the community to recommend transport to a psychiatric emergency room or inpatient unit, as confirmed by several CHS clinicians who reported that when they assess incarcerated persons for discharge, many of those deemed P3 would be referred for a Welfare and Institutions Code section 5150, rather than released into the community. There

are many incarcerated persons in LASD jails who are classified as P3, but in need of acute psychiatric hospitalization, yet they are not classified as P4. CHS has a pattern and practice of failing to refer these individuals for inpatient treatment, despite their need for higher levels of mental health treatment, and instead keeping them in High Observation Housing.

168. Defendants improperly restrict inpatient mental health treatment based on an unreasonably strict rule for medication refusal (at least three refusals over a seven-day period) that is unrelated to the level of care needed by the patient. Persons who are classified as P3 who, by all other clinical criteria should be classified as P4 and referred for inpatient treatment, are excluded from the P4 designation due to only having, e.g., two medication refusals per week. This means that many incarcerated persons who are psychotic, including, e.g., those for whom the medication they take is ineffective, are not referred by CHS for inpatient treatment until their symptoms and risk level become severely acute.

169. There are more P4 patients than there are available in-patient psychiatric beds in the jails. This discourages CHS clinicians from classifying incarcerated persons as P4, rather than P3, even where they require a hospital level of care, because the unavailability of housing in the Forensic Inpatient Unit only allows for the most extreme cases of psychiatric need.

170. The National Commission on Correctional Health Care in 2015 established that incarcerated persons with mental illness should have access to necessary inpatient psychiatric hospitalization. Individuals misclassified as P3, and thus not eligible for the Forensic Inpatient Unit, constitute an under-representation of the actual number of individuals incarcerated in the jails who require inpatient level of care and, instead, spend most time locked in cells without receiving proper mental health services.

E. Defendants Systemically Fail To Provide Timely Access to Mental Health Care and Treatment

171. Defendants fail to timely respond to incarcerated persons requesting mental health care and are deliberately indifferent to the risk of harm that results from this systemic failure. To request mental health care, incarcerated persons may submit a Health Service Request form, describing their need for mental health services. Incarcerated persons face numerous barriers and

delays to submitting Health Service Request forms as previously described in relation to incarcerated persons with medical needs.

172. Defendants fail to adequately train personnel and to provide adequate resources to timely address and respond to incarcerated person's requests for mental health care, such that incarcerated persons needing mental health treatment must wait long periods, even months before seeing a mental health clinician or receiving their prescribed medication. Incarcerated persons are not informed of the resolution to their Health Service Request forms.

173. Defendants also fail to evaluate incarcerated persons who present as "gravely disabled," as defined in Welfare and Institutions Code section 5350, due to a mental health disability, at intake or within 24 hours, which is a violation of Code of Regulations, title 15. Incarcerated persons who present as gravely disabled are sent to High Observation Housing intake, where they do not see a clinician until 72 hours after admission.

F. Defendants Use Non-Therapeutic and Overly Restrictive Measures that Increase Risk for Suicidal Individuals Instead of Appropriate Mental Health Interventions and Treatment

174. Defendants routinely subject incarcerated persons at risk of suicide to overly harsh, restrictive, and isolated housing conditions that can exacerbate symptoms of their mental health disabilities and increase the risk of harm.

175. In a study released by the U.S. Bureau of Justice Statistics for jail mortality rates for the years 2009 to 2018, Los Angeles County had an average suicide rate of 25.8 percent. In 2018, the suicide rate was 30.3 percent as compared to the 6 percent rate in 2015. Data from the LA County Medical Examiner-Coroner indicates that 2021 marked the highest number of deaths by suicide inside Twin Towers and Men's Central in eight years. In 2021, the suicide rate at Twin Towers and Men's Central was about one per every 1,000 people, more than 10 times the suicide rate for Los Angeles County in 2020.

176. The National Commission on Correctional Health Care and the American Psychiatric Association, as well as general best practice standards on the management of suicidal individuals, state that isolation should be avoided for persons at risk of suicide. The removal of personal belongings, including clothing, the use of physical restraints, and the removal of routine

privileges should be avoided or used as a last resort if an individual is actively engaging in self-harming behavior. According to the National Commission on Correctional Health Care, ongoing effective suicide risk assessment for individuals under Suicide Precaution should be conducted in a private and confidential setting, and not through the cell door. Defendants fail to meet these standards in the LASD jails.

177. Individuals at risk of suicide are placed on suicide precautions in Supplemental Assessment Team housing units, with limited and unclear standards for out-of-cell time and length of stay. Individuals are locked in their cells for at least 22 hours and many for 24 hours per day. Although these units are supposed to be temporary, the reality is that many individuals remain in Supplemental Assessment Team housing units for days and weeks.

178. Defendants overuse suicide gowns for incarcerated persons under suicide precautions in the LASD jails. Suicide gowns are often uncomfortable and ill-fitting and provide little warmth. The inability to place individuals at risk of suicide under appropriate levels of supervision likely contributes to the overuse of suicide gowns. The gowns and other restrictions used by Defendants for suicide precautions create non-therapeutic and detrimental environments for incarnated persons who are already experiencing acute mental health crises. Additionally, persons at risk of suicide may hide their suicidal ideation to avoid the extreme discomforts and restrictions of suicide precautions, leaving their risk of self-harm totally untreated.

179. Defendants also fail to provide therapeutic or rehabilitative interventions to persons deemed at risk of suicide. Clinical encounters are provided through cells doors, making it difficult to conduct a thorough assessment of suicide risk or the mental status of an individual if they are not cooperative due to their mental status or concerns about the lack of privacy in these encounters. These practices deprive individuals with acute mental health needs of appropriate evaluation and treatment, despite their obvious and acknowledged risk of self-harm.

180. The overly restrictive, anti-therapeutic, and seemingly punitive conditions in the jails for individuals at risk of suicide are counterproductive as they can exacerbate suicidal behaviors and discourage individuals from any further disclosure of suicidal thoughts. Placing individuals who are suicidal under these extremely restrictive conditions, devoid of any

therapeutic interventions, and not properly regulated by clinical policies is unsafe and dangerous and increases the risk of adverse events.

G. Lack of Adequate Policies Addressing Involuntary Administration of Psychotropic Medications Puts Incarcerated Individuals at Risk of Traumatizing and Inappropriate Mental Health Treatment

181. Defendants administer involuntary psychotropic medication without proper safeguards and without adequately monitoring individuals for possible negative reactions following the administration. For some individuals confined in LASD jails, the involuntary administration of medication is not occurring in an appropriate space provided by mental health, in deliberate indifference to the safety and welfare of incarcerated persons with serious mental health disabilities.

182. Defendants' policies and practices regarding the involuntary administration of psychotropic medications fail to provide clear guidance to LASD and CHS staff on appropriate standards for how involuntary psychotropic medication is to be administered. CHS's written policies and personnel have provided conflicting information, with some sources indicating that incarcerated persons are taken to the Forensic Inpatient Unit for involuntary administration; others stating that the administration occurs by removing the individual from their cell on a gurney; and others stating that the administration takes place in the cell. CHS policies also fail to indicate how long the individual is to be monitored following the involuntary administration of medication. As a result, persons confined in LASD jails who are involuntarily medicated are subjected to arbitrary, inconsistent, and inappropriate practices that fail to meet appropriate medical and mental health treatment standards. For example, at Century Regional, LASD personnel have assisted with the involuntary administration of medication by going into a cell late at night or early morning while an individual is sleeping and before they are fully awake to avoid resistance and holding down the individual's arms with a control hold, while a CHS nurse injects the individual with the medication.

VII. DEFENDANTS' HEALTHCARE DELIVERY SYSTEM IS A HUMANITARIAN CRISIS PERPETUATED BY MASSIVE UNDERSTAFFING AND FAILURE TO EXAMINE AND REMEDY ADVERSE OUTCOMES

183. Defendants have consistently failed to provide timely access to adequate

healthcare, intervention, treatment, follow-up, and attention to injured, ill or unwell incarcerated persons, which results in serious injury or loss of life, needless suffering, worsening of existing medical conditions, and life-threatening consequences. The failures of healthcare in the jails are so profound that the Sybil Brand Commission, in a July 2023 report, denounced the healthcare delivery system in the LASD jails, calling it a "humanitarian crisis." For years, the healthcare provided by Defendants in the LASD jails has fallen short of minimum constitutional requirements and failed to meet prisoners' basic health needs. Critically ill prisoners have begged LASD and CHS for treatment, only to be ignored or disregarded. Defendants' own employees, scores of incarcerated persons, concerned family members, and advocates have repeatedly sounded the alarm about the risk of serious injury and death to incarcerated persons in the jails, yet the problems and rights violations persist.

A. Defendants' Deficient Staffing for Medical, Dental, and Mental Health Care Guarantees Delays in Treatment and Failure to Provide Adequate Treatment, with Substantial Risk of Serious Harm to Persons Confined in the LASD Jails

184. Defendants lack adequate staffing to address the healthcare needs of incarcerated persons housed within the jails, and have failed to remedy these inadequacies for years, despite being aware of critical levels of understaffing, all to the detriment of those incarcerated patients.

185. Defendants are aware that they have failed to hire, train, supervise, and retain adequate medical, dental, and mental health staff, whether by hiring additional staff, retaining existing staff, or contracting with third-party providers or academic institutions to make up for the shortfall in staffing numbers. CHS continues to be understaffed and consequently, unable to provide timely and proper medical care for incarcerated persons in the jails. CHS administrators and officials are aware that the deficiencies in staffing of necessary healthcare professionals directly results in gross delays and deficiencies in the services that are provided to persons confined in the LASD jails, endangering their health and putting them at risk of serious harm and death.

186. In October 2023, the jails had only 12 full-time employed psychiatrists, despite having 43 approved positions. According to the CHS Director, CHS needed at least double the number of psychiatrists, four nurse practitioners, four social workers, and between 15 to 17

psychiatric technicians to adequately address the mental health needs of the incarcerated patients in their care. CHS would need at least four psychiatrists and at least three additional nurse practitioners just to adequately meet the needs of the patients in the Forensic Inpatient unit alone.

187. In October 2023, there were only seven psychologists on CHS staff, serving approximately 4,500 patients, a ratio of approximately one psychologist for every 642 patients. The CHS Men's Program had 16 psychiatric social worker positions and one psychologist position vacant. In the Women's Mental Health Program, vacancies for mental health staff were estimated to be around 40 to 50 percent. These enormous vacancies drastically reduce the level and quality of rehabilitative programming and therapeutic services that incarcerated people with mental health disabilities receive in the jails, leading to greater isolation and heightened risk of psychological deterioration.

188. CHS fails to maintain sufficient numbers of clinicians in the Reception Center to conduct intake evaluations of incarcerated persons within the 24-hour timeframe required by the *Rutherford* consent decree or timely evaluate persons who are referred for other reasons, such as release evaluations, evaluations of patients referred for disruptive behaviors, and assessments for potential contraindications for disciplinary segregation.

189. In 2015, the County Board of Supervisors voted to create CHS to administer mental health care in LASD jails under the Department of Healthcare Services; previously, the Department of Mental Health was responsible for such care. This decision, a significant structural change, pulled multiple mental health provider positions, including psychiatrists, from the jails, and replaced them with mental health social workers, who are not medical doctors and do not have the power to prescribe medication.

190. Importantly, the realignment also eliminated the Chief Psychiatrist position at CHS, as the position did not exist within the Department of Healthcare Services. This means the Chief Medical Health Psychiatrist now reports to the Chief Medical Officer, a medical doctor, and not to someone in mental health care. CHS's organizational structure leads to a breakdown in communication between mental health staff who prescribe psychotropic medications and clinicians who conduct screenings, assessments, and counseling, and does not allow staff to share

goals for the patients they treat.

191. Defendants also fail to maintain sufficient numbers of medical and dental care professionals to provide minimally adequate care to the more than 13,000 incarcerated persons in the jails. As of May 2023, there were 4,000 patients on a waitlist to be seen for a medical issue. In December 2023, CHS listed 543 vacancies across all series and classifications.

192. In 2023, the CHS Medical Director estimated that there were 12 to 15 physicians employed by CHS for the entire jail population, with 25 vacancies. At that time and according to the CHS Medical Director, CHS needed at least an additional three physicians, ten nurses, and three to five physician assistants to adequately address the medical needs of incarcerated patients in their care.

193. CHS only employs eight dentists to run seven different dentistry clinics. In May 2023, there was a waitlist of 700 patients for dentistry appointments to be scheduled. That means there is a wait time of 75 days for a patient to be seen; in private practice, the average wait time might be seven days.

194. Nursing staff serve as the backbone of the medical care delivery system in the jails. As of December 2023, there were 274 vacancies for nursing staff, with one in three positions vacant. Without sufficient nursing staff, the jails lack critical staff to timely triage and respond to incarcerated people's requests for medical care, to adequately screen, monitor, and provide follow-up care to incarcerated people who have serious and chronic illnesses, or to treat incarcerated people when medical emergencies occur. Nurses report that they are overextended in a jail system that is horrendously overcrowded, often being responsible for up to 175 patients at a time with little or no assistance.

195. The Forensic Inpatient Unit is the inpatient mental health unit for male incarcerated people with the most serious mental health needs; unlike other patients in other units, patients in the Forensic Inpatient Unit are seen twice a week. CHS has been cited for inadequate staffing levels in the Forensic Inpatient Unit, and CHS's reassignment of nurses to the unit directly led to overloading of the other units to a dangerous level.

196. On two separate occasions, CHS administrators proposed to the County Board of

Supervisors that the LASD jails should move from an "episodic care" model to a "primary care" model of healthcare. The primary care model is considered best practices in the provision of healthcare and had been discussed as a goal for several years within CHS and the Department of Health Services. A move to a primary care model would mean hiring additional nursing staff, nursing assistants, and possibly physicians. With the existing staff at CHS, it would be "impossible to get closer to that model."

197. Defendants fail to train, supervise, and instruct nurses, physician assistants, physicians, and other agents to ensure they do not violate the rights of incarcerated persons. For example, CHS employees have reported that CHS administrators train them to "assume that patients are lying" when patients state that they have a serious medical issue and need to go to the emergency room.

198. Defendants fail to discipline staff who commit acts of abuse, act in a manner adverse to a patient's best interests, or otherwise provide care in a way that puts the health and safety of incarcerated persons at risk. CHS fails to establish procedures to correct known and observed deficiencies in treatment, including where it violates the rights of incarcerated persons and to prevent future occurrences. CHS also fails to provide continuing and periodic training for medical staff on understanding, recognizing, reporting and responding to issues of incarcerated persons' health care and treatment.

199. Worsening the situation, CHS management retaliates against staff who advocate for better patient care and raise concerns about substandard patient care. CHS reprimands, threatens, intimidates, demotes and fires employees and personnel who courageously reported acts of wrongdoing by other employees and personnel. CHS employees have explained that management "acts like a mafia," awarding promotions not based on merit, but on nepotism and personal relationships. This has been a problem for many years at CHS. In some instances, CHS covered up acts of misconduct and abuse by CHS employees and personnel and sanctioned a code of silence by and among employees, personnel, and management.

200. Defendants also fail to provide adequate supervision of medical, dental, and mental health staff creating an undue risk of adverse clinical outcomes. Defendants fail to

maintain an adequate and clear organizational structure that allows for appropriate support and adequate supervision of healthcare professionals in the LASD jails and for communications between healthcare staff. This lack of an adequate and clear organizational structure creates an undue risk of negative clinical outcomes and harm to incarcerated persons.

B. Defendants' Deficient Custody Staffing Impedes the Provision of Timely and Adequate Healthcare to Incarcerated Persons

201. LASD custody personnel are responsible for ensuring that incarcerated persons are safely monitored and transported to clinics and medical facilities for treatment. Custody personnel assist CHS healthcare professionals by providing security when necessary, among other duties.

202. As of November 5, 2023, there were 110 vacancies of sworn personnel, and 333 vacancies of non-sworn personnel assigned to custody in LASD jails. As of February 2025, LASD had over 2,300 unfilled sworn positions and 1,900 unfilled professional staff positions, between vacancies and impairments, accounting for almost 25% of LASD's total budgeted staff. Because of insufficient staffing, custody personnel have long been required to work mandatory overtime hours. Over 30 percent of all sworn and professional personnel, which amounts to 1,259 employees per month, completed back-to-back double shifts in custody during the 2023 year, to the detriment of staff health and morale. Mandatory overtime increases staff burnout and exhaustion because staff are overworked and stretched too thin, causing delays or no responses to emergency calls for help.

203. Defendant LASD's Access to Care Bureau acts as a liaison between CHS and LASD generally. The Access to Care Bureau assists clinicians at Twin Towers and Century Regional, but not at the PDC facilities, due to staffing shortages. Staffing is the biggest challenge for the Access to Care Bureau, and the lack of adequate staffing taxes all employees, directly affecting patient care due to delays and failure to transport patients for urgent care or clinic appointments.

204. LASD has failed to recruit and retain staff members for custody positions in the LASD jails. One issue affecting turnover is that custody assignments are not perceived as desirable by recruits, and "no one wants to make custody a career." The perception that custody is

not a desirable assignment also makes it less likely that officers will accept promotions into the LASD jails, as it is perceived to be a "waste of time," "dead time," and "going backwards" in one's career. Defendants have made little effort to incentivize sworn and unsworn personnel to work long-term in custody, thus perpetuating a culture that treats the custody setting as professionally inferior.

205. LASD has not been operating with sufficient staff to: (1) carry out the overall facility operations and programming, (2) provide for safety and security of incarcerated people and staff, and (3) meet established standards and regulations. Neither LASD nor the County has implemented a systematic plan to respond to staff shortages, and the shortages are ongoing.

206. LASD custody personnel receive no formal training on responding to mental health crises, medical emergencies, and other critical incidents in the jails. All training, such as it is, is informal, "on the job" mentorship only. LASD Academy training focuses on training patrol deputies, not custody personnel, and does not reflect the distinct duties and responsibilities related to the custodial setting. LASD custody personnel have not received adequate training and re-training on necessary topics for the custody setting.

C. Defendants Conduct Superficial In-Custody Death Reviews that Fail To Remedy Obvious and Critical Failures in Defendants' Operations that Endanger the Health and Safety of Incarcerated Persons

207. Following the death of a person confined in the LASD jails, Defendants conduct an in-custody death review. Defendants' in-custody death review process does not effectively operate to identify and remedy systemic problems in the LASD jails, involving custody and healthcare staff, that contribute to in-custody deaths and present significant risks to other incarcerated persons in the future. On average, LASD and CHS spend less than 90 minutes total discussing each death. The majority of that time is spent reading a written summary of each decedent's history in custody, including the decedent's medical and mental health history. LASD and CHS routinely fail to discuss the potential or contributing causes and any factors that may have contributed to each death. In several death reviews, the cause of death was only mentioned after the Office of the Inspector General specifically inquired about the circumstances surrounding particular deaths. CHS fails to conduct its own death review or morbidity-and-

mortality review process.

D. Defendants Impose Disciplinary Segregation on Incarcerated Persons with Serious Mental Illness, Persons with Intellectual and Developmental Disabilities, and Pregnant Persons Even When It Is Contraindicated Because It Would Pose an Undue Risk Their Health and Safety

208. Defendants have a practice of placing incarcerated persons, including but not limited to those with serious mental illness, intellectual and developmental disabilities, and pregnancies, in isolated disciplinary segregation, when that disciplinary segregation is contraindicated for their health and safety, and of failing to remove incarcerated persons from disciplinary segregation upon a determination that the incarcerated person has a serious mental illness or intellectual or developmental disability. Defendants also lack sufficient policies and practices to ensure that incarcerated persons who have medical and mental health circumstances that are incompatible disciplinary segregation are not placed there. As a result, Defendants subject incarcerated persons to a substantial risk of serious harm or death.

209. Incarcerated persons in restrictive disciplinary segregation in LASD jails are isolated and lack opportunities for sensory stimulation or social interaction.

210. Defendants place incarcerated persons with serious mental illnesses in disciplinary segregation in conditions that lead to decompensation and substantial harm. The environment in the jails exacerbates existing mental health disabilities and can create mental health disabilities in people who entered lockup without preexisting serious mental health disabilities, especially for individuals housed in solitary confinement. For example, LASD maintains a disciplinary unit at Men's Central for incarcerated persons taking psychotropic medications. The unit is dirty; many cells have broken wall telephones; and it lacks natural light.

211. Defendants lack clear policies and practices for determining whether individuals with serious mental illness should be placed in disciplinary housing. This creates an undue risk of decompensation and harm to these individuals. Additionally, LASD disciplines incarcerated persons for behavior that is related to their mental health disabilities. Incarcerated persons with serious mental health disabilities who are classified with a mental health designation of P3 serve their discipline in High Observation Housing under extremely restrictive and isolating conditions

that place them at risk of further decompensation and harm. Many incarcerated persons classified as P3 not only have serious mental illnesses, but they are experiencing acute symptoms. Some appear suitable for a P4 level and in need of inpatient treatment. While serving discipline, these individuals are not taken out of their cell for programming and privileges, such as visitation and phone calls, are removed. As a result, they only leave their cells for showers, and then only if they are considered stable. An individual with serious mental illness serving discipline in High Observation Housing spends 24 hours isolated in their cells most days during their disciplinary period.

212. Defendants also house incarcerated persons with mental health disabilities in the disciplinary row at PDC-North even if they are not being disciplined. Even though individuals housed in these cells are not serving a disciplinary term, they are essentially in discipline because they do not have access to outdoor yard or programming.

213. Although LASD policy prohibits the housing of a pregnant person in an isolated cell, pregnant persons continue to be housed alone in disciplinary segregation for long periods of time, with no evidence that custody staff has collaborated with medical staff to ensure they are placed in an appropriate housing location that is conducive to their access to necessary prenatal and/or medical care.

VIII. DEFENDANTS FAIL TO APPROPRIATELY HOUSE AND TREAT LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER, AND INTERSEX (LGBTQ+) PERSONS AND VICTIMS OF SEXUAL VIOLENCE

214. Defendants have a pattern or practice of failing to ensure safe and appropriate housing for LGBTQ+ incarcerated persons in the jails, leading to a substantial risk of serious harm or death. LASD deputies also subject LGBTQ+ incarcerated persons to humiliation and retaliation. Incarcerated LGBTQ+ persons at Men's Central have reported that deputies make threats to dehumanize them, and subject them to humiliating and excessive strip searches. Defendants also fail to provide training for LASD and CHS staff on how to address transgender and gender non-conforming incarcerated persons to prevent discrimination, harassment, and dignitary harms.

215. Although LASD has a policy requiring individualized determinations for the

classification and housing of LGBTQ+ and gender non-conforming incarcerated persons, LASD has a regular practice of automatically transferring incarcerated persons with male genitalia to the Reception Center and housing them at a men's facility even if they identify as a woman. This practice violates Prison Rape Elimination Act (PREA) regulations prohibiting the housing of transgender and intersex incarcerated persons based exclusively on external genital anatomy and directly contradicts representations made by LASD about their policy.

216. Defendants fail to ensure that incarcerated persons are safe from sexual abuse and victimization. For example, the Sybil Brand Commission reported that an incarcerated person at Twin Towers filed a PREA complaint and yet LASD continued to house him in a cell overseen by his accused assailant. LASD staff also retaliate against incarcerated persons who make PREA complaints, which is a violation of PREA and LASD policies, and Defendants fail to take reasonable and necessary steps to prevent and eliminate both sexual abuse and victimization of incarcerated persons and retaliation against incarcerated persons who make PREA complaints. As of August 2024, the Office of the Inspector General reported that none of the Station Jails have achieved full compliance with the PREA Standards, that corrective action identified many years earlier had yet to be implemented, and that LASD had focused compliance efforts on Station Jails, despite the vast majority of PREA-related allegations arising in custody jail facilities. The same issues remained in a May 2025 report by the Civilian Oversight Commission.

217. LASD engages in a pattern and practice of excessive, invasive, humiliating, unwarranted, and frequent group strip searches and visual body cavity searches, including as punishment and retaliation. LASD's strip search and visual body cavity search policies continue to be degrading and humiliating. For example, incarcerated persons at Twin Towers who had a mental health acuity level of P2, indicating mental health disabilities, were forced to undergo visual body cavity searches in large groups upon transfer from one intake housing area to a permanent housing area. They were asked to pull their underwear down to their ankles, bend, cough, and spread their buttocks, as LASD deputies shined a flashlight between the cheeks of their buttocks. Deputies conducted this strip search in the area right before entering the housing modules and in front of the elevator. The location was directly in an open area where deputies and

other incarcerated people could view the naked bodies of those being searched. Incarcerated persons reported feeling humiliated and degraded by this invasive and dehumanizing search.

IX. DEFENDANTS HAVE A PATTERN AND PRACTICE OF IMPEDING THE FILING OF GRIEVANCES AND DISREGARDING GRIEVANCE PROCEDURES

218. Defendants County and LASD fail to maintain a proper grievance procedure for incarcerated persons, thereby preventing them from exhausting administrative remedies. LASD fails to make grievance forms readily available to incarcerated persons in violation of LASD policy, and custody personnel refuse to provide the forms when requested. The Sybil Brand Commission also received reports that incarcerated persons are being restricted to "one 'grievance' per form."

219. LASD is violating its own policy on grievance processes by failing to issue a written response to grievances and by failing to respond to grievances at all. For years, the Office of the Inspector General has raised concerns about the quality of Defendants' grievance investigations and responses. Plaintiff spoke with numerous incarcerated persons who had submitted multiple grievances but had received no response. Some incarcerated persons reported as many as 20 and 30 grievances that had been unanswered.

220. In addition to being necessary for incarcerated persons to satisfy legally mandated exhaustion requirements, grievance forms constitute the established procedure for incarcerated persons to report problems, including problems that create a substantial risk of serious harm, to Defendants. Defendants' pattern and practice of failing to make grievance forms available to incarcerated persons and failing to respond to grievances demonstrates deliberate indifference to ongoing rights violations.

X. DEFENDANTS DISCRIMINATE AGAINST AND FAIL TO ACCOMMODATE INCARCERATED PERSONS WITH DISABILITIES IN VIOLATION OF STATE AND FEDERAL LAW

221. LASD jails house significant numbers of individuals with disabilities. By policy and practice, Defendants discriminate against incarcerated persons with disabilities through their failure to provide meaningful access to programs, services and activities; failure to provide reasonable accommodations; and failure to provide effective communication. These actions and

inactions are unlawful. They also significantly increase the risk of substantial harm to incarcerated persons with disabilities.

A. Defendants Lack Policies and Practices Necessary for Identifying and Tracking Incarcerated Persons with Disabilities

222. Defendants do not maintain an effective central tracking system for, or adequate information about, incarcerated persons with disabilities and the accommodations they require, either in custody records or in CHS records. Defendants also lack necessary and comprehensive policies on reasonable accommodations, particularly for non-mobility disabilities. The absence of policy and lack of adequate information gathering and tracking exposes incarcerated persons with disabilities to discrimination, failures to lawfully accommodate, and the risk of substantial injuries.

223. Defendants' jail intake questionnaire is inadequate to document if a person has a disability and their disability needs, including necessary accommodations. Defendants also do not adequately train LASD jails personnel to collect or maintain information about an incarcerated person's disabilities and related accommodations. To the extent that Defendants maintain information about a person's disabilities in any form, LASD and CHS staff do not have timely access to the information to inform them of the person's disabilities and appropriate accommodations.

224. The main method of identification of persons with disabilities is limited to wristband codes: D for deaf; I for blind; U for prosthetics, crutches, walker, and canes; and W for wheelchair. Defendants have a general inmate information system or Automated Jail Information System (AJIS), where wristband disability codes are entered, along with other classification information. However, to access information about persons with disabilities, this system requires a query to be submitted to Custody Support Services, a data team that runs complex programming queries. The query will generate a report that supplies an incarcerated person's cell location, last name, and the matching classification code. This report is only generated on an ad hoc basis. Defendants do not have a system that allows for personnel to run a contemporaneous report that tracks where persons with disabilities are housed at any time.

225. Defendants also do not have a system that tracks persons with disabilities who have been previously housed in the LASD jails. This effectively means that any person with disabilities who re-enters the LASD jails faces a renewed risk of discrimination and failure to accommodate, despite Defendants' previous knowledge of their disabilities and needed accommodations.

226. Absent an adequate tracking system, custody, medical, and mental health staff and contractors have no easily accessible means to determine whether a person has a disability, and what, if any, accommodations that person requires. On an ongoing basis, this deprives persons with disabilities of meaningful access, reasonable accommodations, and effective communication mandated by Government Code section 11135, the ADA, and Section 504 of the Rehabilitation Act of 1973 (Section 504). The failure to provide reasonable accommodations exposes incarcerated persons with disabilities to discrimination, exploitation, and substantial risk of serious harm or death.

B. Defendants Fail to Accommodate Persons with Hearing, Speech, and Vision Disabilities

227. Incarcerated people with hearing, speech, and other communication disabilities have difficulty effectively communicating with jail staff and require accommodations, both to enable effective communication, and to effectuate equal access to programs and services offered by the LASD jails. Defendants regularly fail to provide reasonable accommodations to individuals with hearing, speech, and other communication disabilities and fail to adequately train staff how and when to provide such accommodations, in violation of Government Code section 11135, the ADA, and Section 504.

228. Defendants do not provide sign language interpreters, hearing aids, or other auxiliary aids during the booking and intake process. This failure to accommodate incarcerated persons with hearing and speech disabilities prevents them from communicating effectively with staff about specific concerns, including during the medical and mental health screening process. This increases the risk that medical or mental health disabilities will be undiagnosed or misdiagnosed, potentially causing serious harm.

229. LASD distributes an Assistive Device Leaflet to persons with mobility disabilities, but there are no leaflets or other informational materials for persons with auditory, sensory, and other disabilities. Incarcerated persons at the Reception Center can wait nearly 24 hours for a pair of hearing aids.

230. Defendants fail to provide equal access to telephone services to incarcerated people who are deaf or hard of hearing. Incarcerated people without disabilities generally have access to standard telephones when they are in the common area of their housing unit. By policy and practice, an incarcerated person may make unlimited telephone calls, unless restrictions are necessary to preserve safety and security. In contrast, Defendants fail to provide anything close to the same level of access to incarcerated people who are hard of hearing or have other disabilities impacting communication, who cannot freely use functioning video relay service, or video remote interpreting, or even the now-outmoded Telecommunications Device for the Deaf phones.

231. Defendants use "Purple" machines for video relay service/video remote interpreting, which provides real-time access to an American Sign Language interpreter, but only have one stationary Purple machine in Twin Towers and four mobile units across Twin Towers, Reception Center, Century Regional, and Men's Central for the entire LASD jail population. Although Purple is widely available through a computer application and is low-cost, there is not a single Purple machine in any of LASD's dozens of Station Jails. Additionally, LASD jail staff are not adequately trained on how to use the Purple machine and overly rely on calls to the LASD's former ADA Coordinator, who is fluent in American Sign Language, to interpret in person.

232. Defendants fail to provide incarcerated persons who are blind or have low-vision with auxiliary aids to permit participation in programs and services at the jails, including but not limited to inmate request forms not being made available in Braille or large print; grievance forms not being made available in Braille or large print; and notices and signs posted throughout the jails that are not available in Braille or large print, in violation of Government Code section 11135; the ADA; 28 Code of Federal Regulations sections 35.152, subdivision (b)(1) and 35.130, subdivision (b)(1)(vii); and Section 504.

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C. Defendants Fail to Accommodate Persons with Intellectual and Developmental Disabilities

233. Defendants do not track persons with intellectual and developmental disabilities. If such disabilities are identified at intake, Defendants do not have a classification code and have no way to track where persons with developmental disabilities or intellectual disabilities are housed within the jail system and what reasonable accommodations these persons may need or have requested. Defendants also fail to adequately train staff how to track whether reasonable accommodations have been provided to individuals with developmental or intellectual disabilities.

234. Defendants' failure to accommodate incarcerated persons with developmental or intellectual disabilities, either by failing to identify the disabilities and reasonable accommodations in the first instance, or by failing to track and consistently provide accommodations, impairs their ability to communicate effectively with staff and exposes them to an increased risk that medical or mental health issues will be undiagnosed or misdiagnosed.

235. Defendants' failure to identify, and the lack of an adequate disability and accommodation tracking system for persons with developmental or intellectual disabilities results in denial of equal access to programs and services, discrimination, failure to lawfully accommodate, and substantial risk of serious harm, in violation of Government Code section 11135, the ADA, and Section 504.

D. Defendants Fail to Accommodate Persons with Physical Disabilities and Persons Who Need Assistive Devices

236. Defendants fail to ensure that incarcerated persons with disabilities are provided with and allowed to retain assistive devices, including, but not limited to, wheelchairs, walkers, crutches, eyeglasses, magnifiers, screen readers, canes, braces, tapping canes, hearing aids, and pocket talkers, in violation of Government Code section 11135, the ADA, and Section 504. Defendants fail to consider the specific needs and abilities of persons with disabilities in assigning assistive devices, to the detriment of their overall health and safety.

237. LASD's policy on incarcerated persons with disabilities also violates the ADA

implementing regulations' requirement that public entities give primary consideration to the preferred auxiliary aids and services used by a person with a disability. (28 C.F.R. § 35.160.) Neither CHS nor LASD define "auxiliary aid" or "assistive device"; CHS only offers a list of such devices. Staff using these policies, especially those who are not well-trained and not familiar with the range of assistive devices a person with disabilities might require, improperly and without cause decline to provide incarcerated people with their requested assistive devices, in violation of Government Code section 11135, the ADA, and Section 504.

238. By policy and practice, CHS improperly applies an "appropriate accommodations" standard to determine whether to provide assistive devices to incarcerated people. Specifically, CHS policy states that "patients with verified mobility impairments will receive appropriate accommodations for their specific mobility impairment." CHS's policy of an "appropriate accommodations" standard is narrower than the ADA's reasonable accommodation requirement that a public entity provide assistive devices or other accommodations as necessary to ensure meaningful access to programs, services, and activities, provided that doing so is reasonable. Because of CHS's improper standard, people with disabilities do not receive needed assistive devices and cannot access the programs and services offered at LASD jails.

239. Defendants fail to ensure that persons with disabilities are housed in units and assigned to beds that are accessible and safe. Each of the LASD jails contains multiple housing units, which differ in their design, and importantly, in their accessibility to people with disabilities. By policy and practice, LASD custody staff make decisions about where to house a particular person without considering the person's disability-related needs. Due to LASD's failure to identify and track people with disabilities, custody staff decide where to house a person without essential information regarding the person's needs, significantly increasing the risk that the person will be assigned to a housing unit that is not accessible, because, for example, it lacks adequate toilets, grab bars in the shower, flat shower entrances, shower benches, or sufficient space for a wheelchair.

240. Defendants' ongoing placement of incarcerated persons who require mobility accommodations in non-ADA housing areas of Men's Central and Twin Towers significantly

increases the risk of injuries. Additionally, incarcerated persons who have prescriptions for mobility assistive devices are not provided their prescribed mobility assistive device.

241. Defendants lack adequate policies, practices, and training for ensuring that people who require lower bunk bed assignments actually receive lower bunk bed assignments and are able to sleep in lower bunks. As a result, people who require lower bunk assignments as accommodations for their disabilities are at times forced to sleep on upper bunks, which subjects them to a risk of harm.

242. By policy and practice, patient access to the physical therapy facility in the LASD jails is "contingent on the patient's security status and the safety of others." Because of CHS's improper standard, people with disabilities who need physical therapy do not receive it and cannot access programs and services at LASD jails.

243. Defendants' written policies permit staff to remove devices based on security concerns without adequate safeguards for ensuring that the removal of assisted devices is justified and for providing alternative accommodations that do not implicate any identified safety concerns.

E. Defendants Fail to Provide Equal Access to Programs, Services, and the Grievance System

244. Defendants have a pattern or practice of being deliberately indifferent to the health and safety of incarcerated persons with disabilities and fail to provide equal access to programs, services and activities, in violation of Government Code section 11135, the ADA, and Section 504. Defendants do not consistently provide notification of monthly town hall meetings at all jails to apprise incarcerated persons of all available programming as required by their policy.

245. Defendants house many people with mobility disabilities at Twin Towers, which consists of seven floors, and persons with mobility disabilities are housed on the highest floor. Some programs at Twin Towers, including recreation, health appointments, social visits, and attorney visits, are on bottom floors separate from the housing units and are accessible only via stairs or the elevator. However, the elevators are routinely broken and malfunctioning. These practices effectively prevent people with mobility disabilities from accessing programs and

services at the jails, including, but not limited to recreation, health appointments, social visits, and professional visits. Likewise, at Century Regional, which houses female inmates including those with mobility disabilities, out-of-service elevators create difficulties for persons with mobility issues when traveling to and from their housing locations.

246. Defendants do not maintain a sufficient number of accessible vehicles for persons with disabilities or provide reasonable accommodations during transportation to ensure individuals with disabilities are transported safely and securely.

247. Defendants do not have an emergency preparedness plan that accommodates individuals with mobility disabilities, intellectual or developmental disabilities, hearing and visual disabilities, or mental health disabilities.

248. Defendants do not have a functional or effective grievance system to be used by incarcerated persons with disabilities, in violation of Government Code section 11135, the ADA, and Section 504. Incarcerated persons with disabilities must use the general Inmate Request form or grievance procedure, which lacks any field for an incarcerated person to note that the grievance concerns disability accommodations.

249. Defendants also fail to ensure that grievance bins have adequate supplies of forms available for submitting a grievance, custody request or Health Service Request form, including for purposes of requesting disability accommodations or submitting ADA-related grievances. When incarcerated persons request such forms, they are often advised that forms are not available or that staff will return with a form, which rarely occurs.

250. Defendants utilize a categorization system within the Custody Inmate Grievance Application (CIGA) to designate grievances. LASD resolves ADA-related custody grievances and CHS resolves ADA-related medical grievances. In reviewing grievances, Defendants are not categorizing ADA-related grievances properly and sometimes designate them as other categories, which directly impacts the ability to identity, track, and address all ADA-related issues within a grievance.

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F. Men's Central is not ADA Compliant

251. Men's Central is so antiquated and dilapidated that it cannot comply with basic requirements of the ADA and Section 504. The structural design of Men's Central renders it impossible to comply with the ADA. LASD's own former ADA Coordinator has insisted that the facility should have been closed before the ADA went into effect.

252. The Medical Outpatient Security Housing (MOSH) in Men's Central does not have a single cell that is ADA compliant. This housing area is set aside for persons with disabilities and increased medical needs but does not have grab bars of the right length, at the right height, or in the right position vis-a-vis the toilet; anti-suicide plating to make sure the person cannot tie a ligature; or beds of appropriate height. All the beds in the medical cells are critically high and impossible for a person in a wheelchair to get in. The same collection of defects is also present for all other cells at Men's Central.

253. Defendants have been on notice of the lack of safe, accessible, and ADA-compliant housing at Men's Central. For example, in 2022, the former ADA Coordinator for the LASD jails wrote a report summarizing his findings that not a single cell in Men's Central was ADA compliant and delivered it to his LASD chain of command. He received no response, and no changes were made as a result of the report.

254. Code of Regulations, Title 24, Parts 1 and 2 state requirements for adult local detention facilities. Men's Central and other LASD jails do not meet Title 24 standards regarding fire safety, temporary holding cells, sobering cells, housing cells, day rooms and activity areas for mobility impaired, and generally areas impacting the health and safety of persons in the jails.

XI. DEFENDANTS FAIL TO PROVIDE MULTILINGUAL ACCESS TO PROGRAMS, ACTIVITIES, AND SERVICES FOR INCARCERATED PERSONS

255. Defendants fail to provide adequate language interpretation and translation services to incarcerated persons, despite knowing what constitutes meaningful language access services in the correctional context. Defendants' failure to provide incarcerated persons who have limited English proficiency with the necessary language access services means that these incarcerated persons are denied the services that are made available to English-speaking

incarcerated persons.

256. Los Angeles County is a racially and ethnically diverse county, with one in three people who identify as being born outside of the United States. According to the United States Census Bureau's American Community Survey from 2022, 37.7 percent of the population of Los Angeles County speak a language other than English at home. Substantial numbers of persons who live and work in Los Angeles County and interact with the LASD jail system are unable, either because they do not speak or write English, or because their primary language is other than English, to effectively communicate with LASD and CHS staff.

257. LASD and CHS manage and/or administer programs and/or activities that receive direct and indirect federal financial assistance from the United States Department of Justice, which means that under Code of Regulations, Title 6, section 610, Defendants are prohibited from discriminating against or otherwise excluding individuals on the basis of race, color, or national origin in any program or activity.

258. Defendants have failed to develop and implement a language access plan in the jails, which disproportionately impacts limited English proficient populations and leads to capricious and discriminatory decisions that unlawfully deny full and equal access to programs, services, and healthcare in the jails based on limited English proficiency and national origin.

259. Defendants' booking and intake process does not include solicitation or documentation of an arrestee's spoken language, language preference, or language needs. None of the booking documents contain categories for this information.

260. Defendants do not translate vital documents into the languages frequently spoken by persons with limited English proficiency who are confined in the LASD jails and languages common among residents of Los Angeles County who have limited English proficiency.

261. Defendants fail to provide adequate language interpretation and translation services as a general matter; to secure qualified interpreters for non-medical purposes, including non-English speaking deputies at intake; and to ensure that language interpreters other than custody deputies are available to facilitate access to healthcare in all facilities and interpret sensitive medical information.

262. Defendants fail to train LASD and CHS personnel to handle circumstances requiring interaction and communication with incarcerated persons who have limited English proficiency.

263. These deficiencies result in the failure to provide meaningful access to programs and services. Additionally, CHS's deficient policies and practices regarding incarcerated persons with medical, dental, and mental health needs who require language assistance leads to said incarcerated persons being subjected to an unreasonable risk of death or serious harm due to being unable to effectively communicate with healthcare professionals in the jails.

264. Monolingual persons and persons with limited English proficiency in LASD jails routinely suffer avoidable harm because of their inability to speak English. This harm is due to Defendants' routine failure to provide necessary language access services, in violation of their statutory mandates to do so.

CAUSES OF ACTION

FIRST CAUSE OF ACTION

Pattern or Practice of Conduct that Deprives Incarcerated Persons of the Rights, Privileges, or Immunities Secured or Protected by the Constitution or Laws of the United States or the Constitution or Laws of the State of California in Violation of Civil Code section 52.3

Plaintiff Against Defendants County, LASD, Sheriff, and Does 1 to 50

265. Plaintiff repeats, realleges, and incorporates herein by reference all the allegations in all the preceding paragraphs of this complaint as though they were fully set forth herein.

266. Civil Code section 52.3, subdivision (a) prohibits governmental authorities, an agent of a governmental authority, and persons acting on behalf of governmental authorities, from engaging in a pattern or practice of conduct by law enforcement officers that deprives any person of rights, privileges, or immunities secured or protected by the Constitution or laws of the United States or the Constitution or laws of the State of California. (Civ. Code, § 52.3, subd. (a).)

267. Through the conduct, acts, omissions, policies, patterns, practices, and customs described in this Complaint, Defendants County, LASD, Sheriff, and Does 1-50 cause persons incarcerated in the LASD jails to be deprived of rights, privileges, or immunities secured and protected by the Eighth and Fourteenth Amendments to the United States Constitution; Article I,

Sections 7 and 17 of the California Constitution; Code of Regulations, Titles 15 and 24; the Americans with Disabilities Act (42 U.S.C. § 12101 et seq.); the Prison Rape Elimination Act (34 U.S.C. § 30301 et seq.); Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794); Dymally-Alatorre Bilingual Services Act (Gov. Code § 7290 et seq.); Government Code section 11135; and federal and state laws guaranteeing due process, equal protection, and equal access to benefits, activities, and programs, as set forth more fully in subsequent causes of action, which are incorporated herein by reference.

268. Defendants' violations are continuing and ongoing. Unless restrained by the Court, Defendants will continue to engage in the conduct, acts, omissions, policies, patterns, practices, and customs that deprive persons confined in the LASD jails of their rights, privileges, or immunities under state and federal law and cause significant and irreparable harm. Accordingly, the Attorney General, on behalf of the People of the State of California, seeks declaratory and injunctive relief to remedy these pervasive violations.

SECOND CAUSE OF ACTION

Punitive Conditions of Confinement and Deliberate Indifference to the Health, Safety, and Welfare of Pretrial Detainees and Other Persons Who Have Not Been Convicted in Violation of Article I, Section 7 of the California Constitution and the Fourteenth Amendment to the United States Constitution

Plaintiff Against All Defendants

269. Plaintiff repeats, realleges, and incorporates herein by reference all the allegations in all the preceding paragraphs of this complaint as though they were fully set forth herein.

270. Article I, Section 7 of the California Constitution and the Fourteenth Amendment to the United States Constitution prohibit the deprivation of life, liberty, or property without due process of law. Pretrial detainees and other persons confined in LASD jails who have not been convicted are entitled to the protections of the due process clauses of the California and United States Constitutions.

271. Under these provisions, pretrial detainees and other persons confined in LASD jails who have not been convicted must be provided with humane conditions of confinement and the basic necessities of life, including but not limited to: adequate food, water, clothing, shelter,

sanitation, personal hygiene, exercise, safety, and healthcare. These constitutional provisions also protect persons who have not been convicted from punishment, including intentional punishment and conditions and practices of pretrial detention that are punitive and not reasonably related to a legitimate governmental objective. Officials violate the rights secured by these constitutional provisions where they act with deliberate indifference to the health, safety, and welfare of pretrial detainees and other person who have not been convicted, subject them to a substantial risk of serious harm, and/or recklessly disregard their serious medical, dental, and mental health needs.

272. Through the conduct, acts, omissions, policies, patterns, practices, and customs alleged in this complaint, Defendants have repeatedly violated the rights, privileges, and immunities of pretrial detainees and other persons in the LASD jails who have not been convicted that are secured or protected by Article I, Section 7 of the California Constitution and the Fourteenth Amendment to the United States Constitution. These violations include, without limitation: the failure to provide potable water, minimally adequate nutrition, exercise, out-of-cell time, adequate and clean bedding, adequate and clean clothing, necessary personal hygiene supplies, and environments free of vermin, insects, filth, extreme temperatures, and breathable air; the imposition of excessive administrative or disciplinary segregation; the failure to provide minimally adequate healthcare services; and deliberately indifferent delays in and denials of treatment for serious medical, dental, and mental health conditions, causing pain, suffering, irreparable harm, and death.

273. These violations and the conditions, patterns, policies, practices, and customs that deprive incarcerated persons of the basic necessities of life and cause a substantial risk of serious harm to the health, safety, and welfare of incarcerated persons, are open and obvious. Defendants have long been aware of these conditions and/or have been given notice of these conditions by prior investigations, lawsuits, consent decrees, public reports, and oversight, yet have failed to take reasonable and necessary corrective action.

274. Defendants' violations are continuing and ongoing. Unless restrained by the Court, Defendants will continue to engage in the conduct, acts, omissions, policies, patterns, practices, and customs that deprive convicted persons of their rights, privileges, or immunities under these

provisions of the California and United States Constitutions and cause significant and irreparable harm. Accordingly, the Attorney General, on behalf of the People of the State of California, seeks injunctive and declaratory relief to remedy these pervasive violations.

THIRD CAUSE OF ACTION

Cruel and Unusual Conditions of Confinement and Deliberate Indifference to the Health, Safety, and Welfare of Convicted Persons in Violation of Article I, Section 17 of the California Constitution and the Eighth Amendment to the United States Constitution

Plaintiff Against All Defendants

275. Plaintiff repeats, realleges, and incorporates herein by reference all the allegations in all the preceding paragraphs of this complaint as though they were fully set forth herein.

276. Article I, Section 17 of the California Constitution and the Eighth Amendment of the United States Constitution prohibit the imposition of cruel and unusual punishment on persons who have been convicted.

277. Under these provisions, convicted persons in the LASD jails must be provided with humane conditions of confinement and the basic necessities of life, including but not limited to: adequate food, water, clothing, shelter, sanitation, personal hygiene, exercise, safety, and healthcare. These constitutional provisions also protect convicted persons from the unnecessary and wanton infliction of pain, humiliation, and treatment that is antithetical to human dignity. Officials violate the rights secured by these constitutional provisions where they act with deliberate indifference to the health, safety, and welfare of incarcerated persons, subject them to a substantial risk of serious harm, and/or recklessly disregard their serious medical, dental, and mental health needs.

278. Through the conduct, acts, omissions, policies, patterns, practices, and customs alleged in this complaint, Defendants have repeatedly violated the rights, privileges, and immunities of convicted persons in the LASD jails that are secured or protected by Article I, Section 17 of the California Constitution and the Eighth Amendment to the United States Constitution. These violations include, without limitation: the failure to provide potable water, minimally adequate nutrition, exercise, out-of-cell time, adequate and clean bedding, adequate and clean clothing, necessary personal hygiene supplies, and environments free of vermin,

insects, filth, extreme temperatures, and breathable air; the imposition of excessive administrative or disciplinary segregation; the failure to provide minimally adequate healthcare services; and deliberately indifferent delays in and denials of treatment for serious medical, dental, and mental health conditions, causing pain, suffering, irreparable harm, and death.

279. These violations and the conditions, patterns, policies, practices, and customs that deprive incarcerated persons of the basic necessities of life and cause a substantial risk of serious harm to the health, safety, and welfare of incarcerated persons, are open and obvious. Defendants have long been aware of these conditions and/or have been given notice of these conditions by prior investigations, lawsuits, consent decrees, public reports, and oversight, yet have failed to take reasonable and necessary corrective action.

280. Defendants' violations are continuing and ongoing. Unless restrained by the Court, Defendants will continue to engage in the conduct, acts, omissions, policies, patterns, practices, and customs that deprive convicted persons of their rights, privileges, or immunities under these provisions of the California and United States Constitutions and cause significant and irreparable harm. Accordingly, the Attorney General, on behalf of the People of the State of California, seeks injunctive and declaratory relief to remedy these pervasive violations.

FOURTH CAUSE OF ACTION

Failure To Meet Minimum Standards and Requirements for Local Detention Facilities in Violation of Code of Regulations, Title 15 and Title 24

Plaintiff Against All Defendants

281. Plaintiff repeats, realleges, and incorporates herein by reference all the allegations in all the preceding paragraphs of this complaint as though they were fully set forth herein.

282. Code of Regulations, Title 15 sets minimum standards for custodial facilities, including local detention facilities like the LASD jails. (Code Regs., tit. 15, §§ 1004 et seq.) Under a variety of sections, including but not limited to sections 1027, 1027.5, 1030, 1055, 1056, 1058, 1061, 1064, 1065, 1083, 1200, 1203, 1206, 1207, 1209, 1210, 1211, 1213, 1215, 1216, 1240, 1241, 1242, 1243, 1245, 1246, 1248, 1260, 1262, 1263, 1264, 1265, 1266, 1267, 1270, 1271, 1272, and 1280, local detention facilities must comply with statutory requirements for, inter

alia: (1) training, personnel, and management; (2) safety checks; (3) suicide prevention programs; (4) use of safety and sobering cells; (5) classification and separation; (6) programs and services; (7) disciplinary actions; (8) medical/mental health services; (9) food; (10) clothing and personal hygiene; (11) bedding and linens; and (12) facility sanitation and safety.

283. Code of Regulations, Title 24 establishes various physical, design, and capacity requirements for local detention facilities, including requirements for, inter alia, fire safety, holding cells, housing cells, dormitories, safety cells, sobering cells, dayrooms, exercise areas, medical examination rooms, dining facilities, furnishings, fixtures, and equipment. (Code Regs., tit. 24, §§ 13-102, 1231, et seq.) The regulations also limit the number of people that can be kept in the various holding areas of a jail facility.

284. Through the conduct, acts, omissions, policies, patterns, practices, and customs alleged in this complaint, Defendants have repeatedly and regularly violated the minimum standards and facility requirements set forth in the Code of Regulations, including without limitation by: failing to have sufficient staff; performing inadequate and untimely safety checks; failing to implement sufficient suicide precautions; misuse and inadequate supervision of safety and sobering cells; engaging in prohibited and inappropriate discipline; failing to provide minimally adequate medical, dental, and mental health services; employing or utilizing underqualified care providers; conducting untimely and inadequate intake screenings; providing deficient nutrition and inadequate meals; failing to provide clean bedding and clothing; failing to provide hygiene kits and menstrual supplies; impermissibly limiting showering; depriving persons of sufficient exercise and out of cell time; falling to comply with visiting requirements; having out-of-date and inadequate policies and procedures; leaving maintenance and sanitation issues uncorrected; permitting and failing to remedy overcrowding; allowing necessary fixtures and facilities to fall into disrepair; housing persons in inappropriate and non-compliant cells; and allowing vermin, mold, and other health and safety hazards to exist.

285. These violations of the Code of Regulations are open and obvious, and Defendants have long been aware of their failure to comply with the statutory standards for local detention facilities in California and/or have been given notice of their failure to comply with statutory

standards by prior investigations, lawsuits, consent decrees, public reports, and oversight, yet have failed to take reasonable and necessary corrective action.

286. Defendants' violations are continuing and ongoing. Unless restrained by the Court, Defendants will continue to engage in the conduct, acts, omissions, policies, patterns, practices, and customs that violate Titles 15 and 24 of the Code of Regulations and cause significant and irreparable harm. Accordingly, the Attorney General, on behalf of the People of the State of California, seeks injunctive and declaratory relief to remedy these pervasive violations.

FIFTH CAUSE OF ACTION

Failure to Accommodate and Discrimination Against Qualified Individuals with Disabilities and Discrimination Against Other Protected Classes in Violation of Government Code Section 11135, the Dymally-Alatorre Bilingual Services Act (Government Code Section 7290 et seq.), the Americans with Disabilities Act (42 U.S.C. § 12101, et seq.), and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794)

Plaintiff Against All Defendants

287. Plaintiff repeats, realleges, and incorporates herein by reference all the allegations in all the preceding paragraphs of this complaint as though they were fully set forth herein.

288. Under Government Code section 11135, a person may not be denied, on account of "mental disability, physical disability, [or] medical condition," "full and equal access to the benefits of, or be unlawfully subjected to discrimination under, any program or activity that is . . . funded directly by the state, or receives any financial assistance from the state." Defendants receive financial assistance from the State of California through various statutes and funding mechanisms. Violations of the ADA also constitute violations of Government Code section 11135. (Gov. Code, § 11135, subd. (b).)

289. The ADA prohibits Defendants from denying a "qualified individual with a disability . . . the benefits of the services, programs, or activities of a public entity, or [causing such an individual to] be subjected to discrimination by any such entity" because of the individual's disability. (42 U.S.C. § 12132; see also 28 C.F.R. § 35.130, subds. (a) & (b)(1).) Under the ADA, Defendants must provide reasonable accommodations to incarcerated persons with disabilities and modifications so they can avail themselves of and participate in all programs and activities offered by Defendants. (28 C.F.R. §§ 35.133, subd. (a); 35.152, subd. (b).)

290. The ADA defines "a qualified individual with a disability" as a person who has a "physical or mental impairment that substantially limits one or more major life activities," including, but not limited to, "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working." (42 U.S.C. § 12102, subds. (1)(A), (2)(A).) The ADA Amendments Act of 2008 expanded the definition of "major life activities" to also include: "the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions."

291. Section 504 of the Rehabilitation Act of 1973 provides in pertinent part: "[N]o otherwise qualified individual with a disability … shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance…." (29 U.S.C. § 794.) The Rehabilitation Act requires all state and local governments receiving federal funds to reasonably accommodate individuals with disabilities in their facilities, program activities, and services, and to provide a grievance procedure. (29 U.S.C. § 794.) The Act further requires such entities to modify their facilities, services, and programs as necessary to accomplish the Act's purpose. Defendants are recipients of federal funding within the meaning of the Rehabilitation Act. Any "qualified individual with a disability" under the ADA is considered an "individual with a disability" for purposes of the provision of services under the Rehabilitation Act. (29 U.S.C. § 705, subd. (20)(B).)

292. During all relevant times and on an ongoing basis, qualified individuals with disabilities are confined in LASD jails. They are otherwise qualified to participate in the services, programs, or activities that are provided to persons confined in the LASD jails, including but not limited to: sleeping; eating; showering; toileting; communicating with those outside the jail by mail and telephone; exercising; entertainment; safety and security; the jail's administrative, disciplinary, and classification proceedings; medical, dental, and mental health services; the library; educational, vocational, substance use, and anger management classes; and discharge

services. These programs, services, and activities are covered by the state and federal anti-discrimination and accommodation laws.

293. Through the conduct, acts, omissions, policies, patterns, practices, and customs alleged in this complaint, Defendants have repeatedly discriminated against and failed to accommodate persons with disabilities confined in the LASD jails, in violation of Government Code section 11135, the ADA, and Section 504. Defendants exclude and deny qualified individuals with disabilities the benefit of and/or participation in the services, programs, and activities offered in the LASD jails by, without limitation, failing to: identify persons with disabilities and needed accommodations during the intake process; reasonably accommodate hearing, speech, vision, developmental, intellectual, and physical disabilities; ensure accessibility for those with mobility disabilities; ensure effective communication; and provide a functional and effective grievance system for individuals with disabilities.

294. California's Dymally-Alatorre Bilingual Services Act, Government Code § 7290 et seq., requires state and local agencies to explain or translate information and services into any language spoken by a substantial number of non-English speaking people. During all relevant times and on an ongoing basis, persons of limited English proficiency are confined in LASD jails in substantial numbers and are denied access to programs, activities, and services in the jails due to Defendants failure to provide necessary and appropriate translation and interpretation services.

295. These violations and the conditions, patterns, policies, practices, and customs that deprive individuals of equal access to programs, services, and activities in the LASD jails under state and federal law are open and obvious. Defendants have long been aware of these conditions and/or have been given notice of these conditions by prior investigations, lawsuits, consent decrees, public reports, and oversight, yet have failed to take reasonable and necessary corrective action.

296. Defendants' violations are continuing and ongoing. Unless restrained by the Court, Defendants will continue to engage in the conduct, acts, omissions, policies, patterns, practices, and customs that cause violations of Government Code section 11135, the Dymally-Alatorre Bilingual Services Act, Government Code § 7290 et seq., the ADA, and Section 504.

Accordingly, the Attorney General, on behalf of the People of the State of California, seeks injunctive and declaratory relief to remedy these pervasive violations.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully prays for the Court to enter judgment and for relief as follows:

1. Declare that the conditions, acts, omissions, patterns, policies, and practices of Defendants and their agents, officials, and employees are in violation of the Eighth and Fourteenth Amendments to the United States Constitution; Article I, Sections 7 and 17 of the California Constitution; Code of Regulations, Titles 15 and 24; the Americans with Disabilities Act (42 U.S.C. § 12101 et seq.); the Prison Rape Elimination Act (34 U.S.C. § 30301 et seq.); Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794); the Dymally-Alatorre Bilingual Services Act (Gov. Code § 7290 et seq.); Government Code section 11135; and federal and state laws guaranteeing due process, equal protection, and equal access to benefits, activities, and programs;

2. Order Defendants, their agents, officials, employees, and all persons acting in concert with them, under color of state law or otherwise, to provide minimally adequate medical, dental, and mental health care to incarcerated persons; to protect incarcerated persons from an unreasonable risk of harm; to provide incarcerated persons with minimally adequate habitable, humane, and safe conditions of confinement; to ensure adequate environmental health and safety conditions consistent with modern public health standards; to respect the dignity and health of incarcerated persons; to maintain an effective and accessible grievance procedure for incarcerated persons; to cease discriminating against and provide reasonable accommodations for incarcerated persons with disabilities, to ensure equal access to programs, services, and activities for incarcerated persons with disabilities; and to provide access to multi-lingual, interpretation, and translation services for incarcerated persons with limited English proficiency;

3. Enjoin Defendants, their agents, officials, employees, and all persons acting in concert with them, under color of state law or otherwise, from continuing the unlawful conditions, acts, omissions, patterns, policies, and practices described in this Complaint, and from failing to

provide minimally adequate mental, dental, and mental health care to incarcerated persons; failing to protect incarcerated persons from an unreasonable risk of harm; failing to provide incarcerated persons with minimally adequate habitable, humane, and safe conditions of confinement; failing to ensure adequate environmental health and safety conditions consistent with modern public health standards; failing to respect the dignity and health of incarcerated persons; failing to maintain an effective and accessible grievance procedure for incarcerated persons; discriminating against and failing to provide reasonable accommodations for incarcerated persons with disabilities and failing to ensure equal access to programs, services, and activities for incarcerated persons with disabilities; and failing to provide access to multi-lingual, interpretation, and translation services for incarcerated persons with limited English proficiency;

4. Exercise continuing jurisdiction over this action until Defendants have fully complied with the orders of this Court and there is a reasonable assurance that Defendants will continue to comply in the future absent continuing jurisdiction;

5. Award costs and attorneys' fees; and

6. Award any other relief that the Court deems just and proper.

Dated: September 8, 2025

Respectfully submitted,

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DANIELLE F. O'BANNON
Chief Assistant Attorney General
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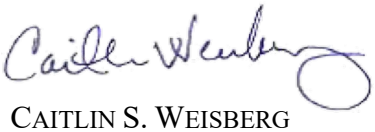

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