COUNTY OF LOS ANGELES
OFFICE OF INSPECTOR GENERAL

312 SOUTH HILL STREET, THIRD FLOOR
LOS ANGELES, CALIFORNIA 90013
(213) 974-6100
http://oig.lacounty.gov

MAX HUNTSMAN
INSPECTOR GENERAL

February 4, 2019

TO: Supervisor Janice Hahn, Chair
Supervisor Hilda L. Solis
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Kathryn Barger

FROM: Max Huntsman
Inspector General

SUBJECT: REPORT BACK ON ENSURING SAFETY AND HUMANE TREATMENT IN THE COUNTY'S JUVENILE JUSTICE FACILITIES

Introduction

On December 18, 2018, the Los Angeles County Board of Supervisors (Board) directed the Office of the Inspector General (OIG) to investigate safety concerns in Los Angeles County Probation Department (Department) juvenile halls and camps, with an emphasis on use-of-force incidents involving oleoresin capsicum (OC) spray (also known as pepper spray), and to report back with findings and related recommendations. The Board also instructed the OIG to address de-escalation tools and any staffing issues that impede de-escalation efforts.

The Department maintained an open and collaborative approach throughout the OIG's review. Department staff, managers, and executive leadership were accommodating and transparent, and the Department responded to document and information requests thoroughly and quickly. Department personnel and executives made themselves available for inquiries, meetings, and follow-up at each step of the review. Many of the issues addressed in this review were articulated by Department executives at the outset, and input from Department members contributed to the development of OIG recommendations.

The majority of Department staff who spoke with the OIG expressed a passion for their work and a determination to positively affect the lives of youth. Some also shared challenges and frustrations. Conversations with youth, staff, and managers revealed many shared opinions regarding safety concerns, lack of resources, concerns about policies, training and practices, and the need for improved communication and ongoing dialogue within the Department.

The OIG's review confirms reports by Department executives, staff, and youth that some staff have engaged in inappropriate and avoidable uses of OC spray and have failed to properly decontaminate youth who have been exposed to OC. In those instances where egregious acts were suspected to have been committed, the Department reports that it has removed staff from direct contact with youth and will be taking disciplinary action if appropriate.

In some instances, staff who have not received effective training, including training on de-escalation techniques, may rely on OC spray as a default or as an intermediary step to obtain compliance rather than as a last resort in potentially or actively dangerous situations. In some instances, youth have been ineffectively decontaminated, or decontaminated long after exposure to OC spray.

Lack of adequate training, supervision, accountability systems, and policies, which may be exacerbated by an apparent lack of resources, likely contribute to out-of-policy use of and over-reliance on OC spray. In general, staff reported feeling unsupported and ill equipped to effectively interact with youth, especially those with acute mental health and behavioral needs. Specifically, staff consistently identified a lack of effective policies and training that would prepare them to attempt to de-escalate tense situations and avoid using OC spray.

Background

The Department is composed of approximately 6,000 staff members who work in more than eighty facilities across the county, including three juvenile halls, seven youth camps, and the Dorothy Kirby Center, a secured, residential facility that provides enhanced mental health services for youth. The Department interacts with an average daily population of approximately 7,750 youth in its camps, juvenile halls, and at-home placements, making it the largest probation department in the nation. Throughout 2018, approximately 900 of these youth were housed in its juvenile halls and camps on any given day.

The Department currently authorizes staff to use OC spray in its juvenile halls (Barry J. Nidorf Juvenile Hall, Central Juvenile Hall, and Los Padrinos Juvenile Hall) and two youth camps (Camp Ellison Onizuka and Camp Ronald

McNair, both a part of the Challenger Memorial Youth Center). Thirty-five states have banned the use of OC spray in juvenile facilities and California is one of six states (in addition to Illinois, Texas, South Carolina, Indiana and Minnesota) that allow staff in juvenile facilities to carry OC canisters.[1] The OIG spoke with several representatives from county probation departments throughout California regarding the use of OC spray and de-escalation tactics. San Francisco County, Santa Cruz County, Marin County, and Santa Clara County do not permit the use of OC spray in their juvenile facilities.

Representatives from all four county probation departments shared information regarding non-punitive alternatives to use-of-force that have reportedly served them well and stressed the importance of policies and practices that foster positive relationships between youth and staff. The OIG also spoke to systems that make use of OC spray.

In March of 2018, the Department reported a significant increase in the use of OC spray in its juvenile halls from 2015 through 2017:

- Central Juvenile Hall: 338%
- Los Padrinos Juvenile Hall: 214%
- Barry J. Nidorf: 192%[2]

At the time, the Department had not analyzed OC spray figures in its camps.[3] No changes to the Department's core use-of-force policy took place during that time. The Department also reported an increase in youth-on-youth assaults (66%) and youth assaults on staff (58%) from 2016 through 2017.[4]

In December of 2018, the Department cited a 20% decrease in the use of OC spray in juvenile halls and camps, when compared to 2017.[5] The Department reports that it is conducting on going internal review of OC related incidents and has generated additional data. The OIG has recommended and the Department has agreed to increase transparency by developing a plan to regularly publish use-of-force and violence data on the Department website.

---

[1] Report by Legislative Counsel David Billingsley presented to the Assembly Committee on Public Safety for hearing held April 17, 2018, pg. 4; *see also* Council of Juvenile Correctional Administrators, Issue Brief: Pepper Spray in Youth Facilities (May 2011), p.2, *available at* http://cjca.net/wp-content/uploads/2018/02/CJCA.Issue_.Brief_.OCSpray.pdf (last accessed January 30, 2019).
[2] County of Los Angeles Probation Commission, Minutes of Regular Meeting of March 22, 2018, *available at* http://file.lacounty.gov/SDSInter/probation/1039083_ProbationCommissionMinutes03-22-2018.pdf (last accessed January 22, 2019).
[3] *Ibid.*
[4] *Id.*
[5] County of Los Angeles Board of Supervisors, December 18, 2018 Meeting Transcript, pg. 133, *available at* http://file.lacounty.gov/SDSInter/bos/sop/transcripts/1048857_121818.pdf (last accessed January 22, 2019).

The Department's Safe Crisis Management (SCM) policy currently governs the use-of-force (including use of OC spray) and its review in County juvenile justice facilities. The SCM policy addresses varied topics that include staff training requirements, reporting protocols, and the use of physical restraints and OC spray.[6] The SCM policy organizes force on a continuum, with six total levels that progress from less to more significant physical and chemical interventions (i.e. OC spray). It requires that force only be used as "necessary and appropriate to restore order and/or achieve and maintain control" and not as a form of "discipline, punishment or retaliation."[7] It also details a host of de-escalation approaches and prohibits certain kinds of force techniques, including the carotid restraint (commonly referred to as a "chokehold").[8]

OC spray is the most significant force option authorized by the Department, with the SCM policy describing it as "the final and ultimate authorized" method to "gain control of a situation and/or subdue" youth.[9] During "controlled situations," which the SCM policy generally defines as situations in which youth are not actively physically aggressive, OC spray may only be used at the discretion of a supervisor.[10] In "uncontrolled situations," which are defined as incidents during which staff must respond immediately, officers are authorized to rely on OC spray without supervisory approval.[11] The Department prohibits the use of OC spray on individuals who are receiving psychotropic medications, under the influence of stimulants, suffer from asthma or other respiratory issues, have a history of heart disease or seizures, are pregnant, or are clinically obese.[12]

The Department's senior leadership provided the OIG with information regarding its assessments of several force-related issues. In August of 2017, the Department prepared a report for the Board of Supervisors outlining targeted strategic initiatives for establishing greater accountability, rehabilitating youth, maintaining a core workforce of professionals by promoting development and wellness, and strengthening communities.

The Department identifies several key issues that echo concerns communicated to the OIG during conversations with leadership, staff, and youth. These issues, several of which are outlined below, include improving training infrastructure, creating a robust auditing function, and implementing systemic reform in the internal affairs processes and the grievance system, among other efforts.

---

[6] Probation Department Safe Crisis Management Policy Directive (SCM Directive), pg. 1.
[7] *Ibid.*
[8] *Id.* at 4.
[9] *Id.* at 23.
[10] *Id.* at 8.
[11] *Id.* at 33.
[12] *Id.* at 25-26.

The Department reports that it has also conducted an in-depth self-assessment of its accountability systems and related resource needs. The self-assessment included a review of recent problematic use-of-force incidents. As a result, the Department developed a detailed strategy to eliminate unnecessary or excessive uses of force in its facilities. The Department's self-assessments indicate an institutional awareness and willingness to identify and implement corrective measures. These fundamental qualities are critical to bringing about positive and sustainable change through systemic reform and demonstrate the Department's commitment to providing youth and staff with a safe environment.

Methods

OIG staff reviewed Department policies, training materials, and information related to particular uses of force and the reviews that followed. OIG staff reviewed existing assessments and evaluations, from internal and external sources, of Department organization, administration, and operations.

OIG staff visited every juvenile justice facility where the use of OC spray is authorized, and spoke with more than forty-five incarcerated youth representing each of the County's juvenile halls, Camp Ellison Onizuka, and Camp Ronald McNair. In order to ensure that applicable rights and privileges were safeguarded, representatives of the Public Defender, Alternate Public Defender, and the Los Angeles County Bar Association's Independent Juvenile Defender Program were present during conversations with youth. OIG staff also spoke with more than thirty line-level Department staff and managers at facilities visited, Department executive leadership including the Chief Probation Officer, facility mental health providers, and union representatives.

In addition, OIG staff reviewed twenty-one incidents that were identified through a Department audit of use-of-force reports and reviewed videos generated from October 2017 through November 2018 in the juvenile halls and camps. The Department initiated the audit following a series of troubling use-of-force incidents. The OIG reviewed available information, including reports, closed-circuit television (CCTV) footage of the incidents, and reviews that followed. The OIG did *not* conduct an independent audit of a representative sample of all reported uses of force for a given time period, nor did the OIG review the OC cases that the Department audit revealed were within policy. The below analysis follows a qualitative review of a specific set of Department identified incidents.

Regarding information provided by youth and staff, the OIG has neither verified nor independently investigated allegations detailed in this report. To

ensure confidentiality and safety, the OIG agreed not to document any identifying information unless a youth threatened harm to self or others.

Use-of-force Incidents and Safety Concerns

The OIG's onsite visits, conversations with staff and youth, and review of force incidents reveal several problematic practices. The problematic incidents identified by the department and reviewed by the OIG include several examples of OC spray applications and multiple instances of improper or ineffective decontamination practices that likely violate Department policy.[13]

Staff and youth interviewed detailed concerns with OC spray use, and with staff who may not be adequately prepared to prevent uses of force. Staff and youth recognized that strong relationships and healthy communication are crucial to creating a safe environment. Youth praised staff who treated them with respect and took the time to build constructive rapport. However, youth also reported that some staff were overly harsh or retaliatory, creating a culture based on punishment and force rather than rehabilitation and support. Safety concerns identified by staff and youth are discussed in more detail below.

OC Spray

Based on incidents reviewed and youth and staff reporting, OC spray appears to be a commonly used tool by some staff to obtain compliance; however, it is not always justified or used as the final and most significant force option consistent with Department policy. The twenty-one force incidents reviewed suggest a consistent use of OC spray as an initial or intermediary force option, rather than as one that follows a failure to de-escalate or the use of less significant force. Several of the incidents also involve the use of OC spray where there did not appear to be actual or potential threat of harm by youth. Some staff also acknowledged the common use of OC spray, and one line-level supervisor plainly stated that some staff were engaging in "justified overreliance" on OC spray.

Some incidents reviewed include uses of OC spray that likely violate Department policies, at times involving youth who appeared only passively non-compliant. In several incidents, the use-of-force reports filed by staff described youth behaviors as aggressive or threatening, even when available video footage showed that youth appeared to pose no threat to staff.

Other incidents involved staff who used OC spray before any attempts to use other, less significant force techniques. Similarly, several incidents involve

[13] Most incidents reviewed are currently being investigated and final determinations about policy violations or criminal conduct are pending.

situations in which de-escalation strategies, including the involvement of mental health professionals, may have been fruitful but where not attempted.

Several youth reported that some staff threaten the use of OC spray or retrieve and shake OC canisters in front of youth as the initial and sole effort to gain compliance without first giving verbal commands. Youth reports are consistent with video footage reviewed. While threatening the use of OC spray may achieve compliance in some situations, it appears to have unnecessarily escalated confrontations in others.

In some incidents reviewed, OC spray was used on youth who, under the Department's SCM policy, should not have been subject to OC spray unless all other alternatives to gain compliance had first been exhausted. The OIG reviewed incidents in which youth with identified respiratory conditions and youth taking psychotropic medications were subjects of OC spray.

In one incident reviewed, a youth with a mental health condition was engaging in self-harming behavior, and was OC sprayed in the groin and buttocks. Following the use of OC spray, the youth was left in a room, which apparently lacked running water, for approximately 20 minutes before being decontaminated. In violation of the SCM policy, staff did not make reasonable attempts at physical intervention before relying on OC spray during these incidents. Furthermore, the use-of-force reports that arose from this incident were found to be incomplete, failing to accurately describe the events that led to the use-of-force and OC deployment. The Department reports that the involved employee was subsequently terminated.

OC Spray Warnings

The Department's SCM policy, which is in the process of being revised, contains conflicting and inconsistent requirements for OC spray warnings that staff are required to provide to youth before deploying OC spray. Some youth detailed issues with OC spray warnings by staff, citing instances in which they did and did not receive warnings before OC spray was deployed.

Some youth also expressed confusion over what constitutes a proper warning, stating that some staff relied on variations of "OC Warning," while others only instructed youth to get down on the floor or stop their behavior. One youth, who was recently the subject of OC use, stated the youth would have complied with an order if one had been issued.

Other youth stated that certain staff issue blanket warnings when they begin their shift or arrive on a unit, even if there are no incidents at that point that would justify a warning or the use-of-force. Some youth reported that blanket or

preemptive warnings made them uneasy, and they are unable to predict which specific conduct might result in OC spray.

Inadvertent Exposure to OC Spray

OIG staff received reports of Department personnel inadvertently exposing youth to OC spray. Several youth recounted being exposed to OC spray when staff were engaging with other youth, or when staff used OC spray while chasing youth. One youth spoke about being OC sprayed on the back, and another stated a significant amount of OC spray hit the youth's mouth. Both youth stated that, following the incident, staff indicated that the OC deployments were accidental.

Some incidents identified by the Department and reviewed by the OIG also involve unintended OC exposure of bystanders stemming from altercations between staff and a youth. Reports and available footage suggest that following the confrontations, staff members appeared to deploy OC despite the fact that the youth did not appear to pose an imminent physical threat to staff or surrounding youth.

OC Spray Decontamination

Youth described consistently negative experiences with decontamination in the juvenile halls and camps. The most common complaints from youth were related to delayed decontamination and the use of hot water to decontaminate youth. Several youth, at several facilities, reported being exposed to OC and then placed in their rooms for upwards of thirty minutes before any attempts to decontaminate were made.

One youth reported hearing others suffering in their rooms on several occasions following the application of OC spray. Several youth reported staff-led decontamination efforts that involved hot water or towels, two improper decontamination practices that may increase the discomfort that follows OC spray. Youth stated that staff often make use of shower facilities for decontamination, and that staff and youth often lack the ability to control the temperature of most showers. Others detailed being confined to their rooms for extended periods of time after an OC spray, and receiving only a wet towel to assist with decontamination. These practices, if true, would violate the Department's SCM policy.

Some use-of-force incidents identified by the Department as problematic indicate failures to timely and effectively decontaminate youth after OC spray exposure. Among incidents reviewed, staff appear to repeatedly place recently sprayed, un-decontaminated youth in their rooms. In several incidents, youth

appear to have been left in their rooms, visibly struggling, for periods exceeding fifteen to thirty minutes, without apparent efforts to decontaminate them.

In some instances, youth were exposed to OC spray and placed in rooms with toilet and sink units. The sink water was either not functioning or was turned off, and youth can be seen attempting to self-decontaminate from the toilet.

Staffing Issues

Some Department staff expressed having low morale. As described in detail below, reported morale issues may be exacerbated by a perceived lack of sufficient staffing and a lack of trust in existing accountability structures.

Staffing and Supervision Resources

Staff interviewed frequently expressed fear regarding their personal safety and consistently reported feeling outnumbered and overpowered by youth in juvenile halls and camps. Several staff cited inconsistent and inadequate staffing as a chief source of unease. Department managers and executives cited difficulties in recruitment and retention of staff and various labor-related issues as contributing to difficulties in maintaining ideal staffing ratios throughout its facilities.

Line-level staff expressed frustration with sometimes having to perform their duties without supervision. According to some staff, the lack of supervisors may be hindering the proper use of OC spray and force, since supervisors are required to authorize and direct force in certain situations. Some staff also believe that the strains that come with the lack of supervisory support and guidance contribute to low morale and performance. The Department reports that it has added some supervisors, but anticipates additional needs.

Insufficient staffing of supervisors may also negatively impact the Department's ability to adequately review uses of force. For example, several of the incidents reviewed were initially assessed by Department supervisors who failed to identify potential policy violations and refer the incidents for further review, despite indicators that force was inappropriate or excessive.

The Department reports that it has been working to standardize facility staffing, but that sick leave and long-term absences de-stablize the Department's workforce. The Department reports that it is working with the County Department of Human Resources to pilot new strategies for countywide leave practices that may reduce long-term absences and facility shortages, including permanent placement, medical retirements and other accommodation matters.

Accountability

Overreliance on and out-of-policy OC use may also be driven by a belief frequently communicated by staff during conversations with the OIG: physical uses of force are more likely to lead to injuries and result in internal affairs investigations. While policies identify OC spray as the final and most significant force option, several staff reported fear of physical injury as a driving reason for using OC in lieu of hands-on intervention. Some staff also stated that recent investigations and disciplinary actions by the Department led them to conclude that OC deployments invite less scrutiny than physical force.

Various staff and union representatives further expressed a lack of trust in the Department's accountability protocols. Staff interviewed routinely communicated a belief that internal affairs is poorly staffed and trained. They cited the length and quality of investigations as a serious concern, and a general perception that the results of investigations suffer because of it.

Training

Several staff reported feeling inadequately trained to effectively respond to crisis situations in a manner that may minimize the need to use force. In particular, staff reported a lack of training in de-escalation and physical intervention techniques. One recently hired probation officer expressed disappointment with the Department's new-hire training, stating that courses involving physical force techniques were insufficient and unrealistic. Staff recognized that de-escalation and physical intervention techniques are "perishable skills" that require regular and frequent training to master. As a result, staff expressed a strong desire for additional scenario-based training.

Some officers also articulated various kinds of unease or confusion in determining when and/or how to use force. Several cited a sense of crisis following the elimination of special housing units in County facilities, stating that the inability to place youth in a solitary confinement setting made dealing with problem behaviors difficult. They believed that workable alternatives were not provided, leaving staff scrambling for other ways to address problem youth behaviors.

The Department reports that due to significant increases in the use of OC spray, it is implementing multiple short and long term training initiatives, including: (1) trauma informed training, provided by the Center for the Empowerment of Families, (2) Non-Violent Crisis Intervention de-escalation training by the Crisis Prevention Institute, and (3) a training and technical assistance program, Youth in Custody Practice Model, by the Council of Juvenile Correctional Administrators and the Center for Juvenile Justice Reform at

Georgetown University's McCourt School of Public Policy. Lastly, the Department reports that it completed an internal analysis and identified that 36% of staff in the juvenile halls were responsible for most OC use and that, as of February 1, 2019, 56% of all full duty personnel in the halls, have received the refresher OC spray training.[14]

Mental Health Resources

Department staff generally reported being unprepared to deal with youth experiencing behavioral and mental health issues, which form an increasing percentage of the County's youth population. Several staff stated that the youth populations housed in the County's juvenile halls and camps suffer from more serious mental health conditions than previous groups, and that training and policies have not kept pace. Both Department and mental health staff also reported that facilities lack adequate mental health resources. Department staff reported that inadequate mental health staffing hinders de-escalation efforts. Deficiencies were reportedly more problematic on evenings, weekends, and holidays.

One mental health professional working at a juvenile hall stated that it was difficult to work effectively with probation staff because of concerns about lack of both mental health and Department staff. According to that individual, mental health supervisors have discouraged providers from placing youth in crisis on one-on-one supervision because it strains Department staffing resources.

Culture

Youth and staff consistently spoke with one voice on a particular topic: the importance of relationships, interpersonal communication, and mutual respect in improving safety and preventing force. Several staff reported never having to rely on physical intervention or OC spray when dealing with youth, citing their "verbal judo" or "gift of gab" as attributes that allowed them to address problem behaviors and minimize the need to rely on force. Those staff members also consistently stated that they felt the Department's training did not provide them with effective use-of-force alternatives.

Youth similarly praised staff who, in their perspective, are respectful and willing to get to know youth. Various youth described staff members who go to great lengths to build rapport with them, and who avoid using OC spray and other force in interacting with them. However, several youth related stories of frequent disrespect and verbal mistreatment by staff, which some cited as creating tense

[14] The OIG has not verified the information provided by the Department regarding measures it has taken to improve training.

situations that might lead to aggressive behavior. Some youth reported receiving or hearing profanity-laden taunts from staff, including criticisms of their neighborhoods, their families, and, in some instances, threats. Youth at two different facilities stated that staff told them that if they did not behave, they would "join their dead homies."

Youth also reported some potentially retaliatory actions that they cited as creating an environment in which conflict between staff and youth is more likely to escalate into situations that require force. Chief among these were examples of denying access to programs. One youth stated that the youth had been denied the opportunity to attend church services, which were described as a "privilege" that the youth had failed to earn. OIG staff reviewed an OC spray incident that reportedly arose from similar facts. Lastly, some youth stated that they were occasionally subjected to group discipline, confined to their rooms for extended periods of time, and denied access to programing. If accurate and common, these incidents raise significant concerns regarding the legal rights of youth, collective punishment, and general conditions in County facilities.

Finally, some youth reported being denied timely access to toilets and having to rely on trash or other containers in their rooms to relieve themselves. These allegations raise issues about facility infrastructure (including the prevalence of rooms without toilets) and staffing resources (staff must escort youth in toilet-less rooms to appropriate facilities), which may result in the neglect of youths' basic human needs.

Some incidents reviewed involve clear misconduct. While some inappropriate conduct identified might be prevented through effective policy revision and training, the most problematic incidents detailed above are symptoms larger systemic and cultural issues that require immediate and extensive analysis and reform.

Policies, Practices, and Training Issues

The safety concerns and problematic uses of force described above are likely exacerbated by insufficient use-of-force policies, training, reporting, and accountability practices. Effective use-of-force policies and training provide a framework for officers to understand precisely how and when force can be used and how it might be avoided. They do so by identifying applicable laws, standards and limits, and by delineating the factors that should be considered before and after employing force. By providing clear requirements, use-of-force policies safeguard the well-being of both staff and youth by limiting force to situations in which it is necessary.

While comprehensive use-of-force policies are essential, their efficacy is wholly dependent on thorough, effective, and frequent training. Use-of-force training should aim to provide staff with the required knowledge, skills, and judgment to execute their duties and responsibilities in a safe and effective manner. Effective training should also utilize evidence-based techniques to minimize use-of-force incidents with a focus as much on scenario-based force prevention and de-escalation exercises.

Use-of-force and De-escalation Policies

The current SCM policy is hampered by a host of issues that likely contribute to avoidable OC spray incidents. As described above, the SCM policy is currently structured along a continuum. Use-of-force continuums can often lead law enforcement staff to automatically move through increasingly more severe force options when less severe options have proved ineffective. The Department's draft use-of-force policy reflects an understanding of this, and does away with the continuum. The Department reports that the draft policy is under review by labor unions and has committed to additional revisions based on OIG recommendations detailed below.

The SCM policy does not currently provide workable definitions of threshold terms that govern whether or not OC spray is authorized. For example, the SCM policy authorizes staff to use OC spray without supervisory authority during "uncontrolled situations," which are described as incidents in which "a major disturbance, fight, assault or escape attempt…occurs quickly, requiring staff to respond immediately and employ more restrictive alternatives on an escalating basis…"[15] Other sections of the SCM policy also state that OC spray is authorized for "serious disturbances" or "major facility disturbances."[16] The SCM policy does not provide a definition of "a major disturbance," requiring staff to use their discretion to identify such instances.

The Department's current SCM policy and draft use-of-force policy also include inconsistent requirements for OC spray warnings, which may frustrate their usefulness as de-escalation and force prevention tools. Department staff often cited the warnings as a tool to gain compliance from recalcitrant youth. Unfortunately, the required warning varies depending on the section of the SCM policy:

- Page 12: "Staff shall provide a warning to minors involved in the incident regarding the intended use of chemical intervention by clearly stating in a loud voice, 'O.C. warning!'"

[15] SCM Directive at 33.
[16] *Id.* at 4 and 26.

- Page 25: The Department "shall advise minors that…if staff instruct them to get down, take a knee, or use the words 'OC spray' they are to [comply] immediately" or they may be sprayed.
- Page 32: "[S]taff shall provide a warning regarding the intended use of chemical intervention by clearly stating in a loud, commanding voice: 'O.C. spray.'"

Based on conversations with youth, these inconsistent warnings have at times denied youth an opportunity to comply with staff instructions before being OC sprayed. The inconsistencies may also make it difficult to hold staff accountable when they fail to deliver appropriate warnings.

The Department is in the process of revising its SCM policy and other policies that will govern its use-of-force reviews. The draft use-of-force policy introduces several positive changes to the way officers are required to think about and use force. The draft moves away from the use of a rigid force continuum and structures all uses of force on the well-established "objectively reasonable" standard articulated by the United States Supreme Court. The draft use-of-force policy explains that reasonable force is "the force that an objective, trained and competent correctional employee, faced with similar facts and circumstances, would consider necessary and reasonable to gain compliance."[17] The draft use-of-force policy provides a non-exhaustive list of factors used to evaluate whether the use-of-force is objectively reasonable, including: "the nature and severity of the situation; whether the youth poses an immediate threat to the safety of the staff and/or others; and, whether the youth is actively resisting."[18]

In addition, the draft use-of-force policy delineates boundaries for how and when force may be objectively reasonable. First, the draft use-of-force policy eliminates the distinction between controlled and uncontrolled situations that currently governs whether the use-of-force is authorized for a given situation and draws a similar distinction between "directed use-of-force incidents" for "non-emergent situations" that require the presence of a supervisor to plan and direct the use-of-force, and "immediate use-of-force incidents" for situations that threaten the "safety and security of youth, staff and/or the public."[19] However, unlike the SCM policy, the draft use-of-force policy does not dictate a defined list of situations that fall within each category. Instead, it provides examples of situations that may fall within each category and ultimately predicates the authorized use of reasonable force on the facts of the situation at hand.

[17] Draft Use-of-force Policy, pg. 3
[18] *Ibid.*
[19] *Ibid.*

Next, the draft use-of-force policy provides that "[s]taff shall only utilize force as a last resort and shall only use that level of force which is objectively reasonable."[20] The draft use-of-force policy requires that staff utilize, where reasonably possible, de-escalation strategies when faced with a crisis situation and outlines an extensive list of de-escalation strategies. However, the draft use-of-force policy acknowledges that if staff "reasonably determine that de-escalation techniques are ineffective or cannot be utilized due to imminent danger," "the use of immediate physical or chemical intervention may be required."[21] If a use-of-force is necessary, the draft use-of-force policy prescribes a "dignity-based approach" requiring that all youth "continually be treated with dignity and respect" during the incident.[22] The "dignity-based approach" reflects the Department's commitment to an overall philosophy of preventing and limiting force.

Training

The Department's use-of-force training curriculum aims to provide staff with a broad range of knowledge and skills, including development and behavior theories, effective communication, self-management, misbehavior prevention strategies, de-escalation strategies, physical and chemical interventions, and report writing. All incoming staff assigned to juvenile facilities are required to participate in twenty-four hours of use-of-force training as part of their Juvenile Corrections Officer Core Training. In addition, the Department mandates sixteen hours of use-of-force retraining annually. The substantial increase in the use of OC spray generally, use-of-force incidents reviewed by the OIG, and reporting by staff and youth underscore the need to assess, revise, and bolster current training programs.

In reviewing use-of-force training material provided by the Department, the OIG noted a problematic slide that was included in both the new hire and annual training presentations. The slide, titled "DID YOU REALLY MEAN WHAT YOU WROTE?" displays an animated graphic of a masked criminal behind a red prohibitory sign.[23] The slide purports that certain terms should not be used when writing a use-of-force incident report because the terms may "unintentionally evoke suspicion."[24] The slide provides several examples of terms that should be avoided, including tackled, threw, dragged, twisted hands/arms, bent arms back, and pinned. Lastly, the slide explains that if a term is "unavoidable," staff should "fully describe the circumstances" and "justify" their actions.[25]

---

[20] *Ibid.*
[21] *Id.* at 8-9.
[22] *Id.* at 3.
[23] SCM Staff Training Presentation Slide 132, see Figure 1 (emphasis in original).
[24] *Id.*
[25] *Ibid.*

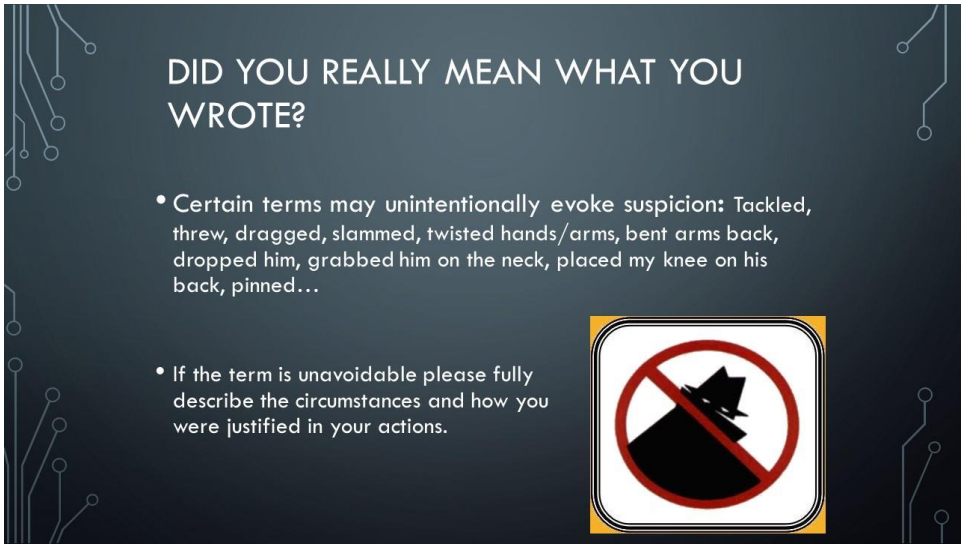

Fig. 1

A problematic example of a term the slide suggests staff avoid is "slammed." The Department's current use-of-force policy explicitly prohibits slamming youth.[26] Staff may interpret the slide to suggest that, if they believe a youth was slammed, they should use less-descriptive language to recount the incident in the use-of-force report. Trainees should be encouraged to avoid specific tactics where possible, but not to avoid accurate language in describing tactics used.

Use-of-force Reporting, Review, and Accountability Practices

The review of use-of-force incidents allows law enforcement agencies to test not only whether individual officers complied with policies and training, but also whether policies and training are sufficiently tailored to the needs of staff and youth. A comprehensive use-of-force review regimen rests on accurate and timely reporting by staff. Such reports and other available information, including video, are then reviewed to ensure accuracy, policy compliance, and the efficacy of policies and training. The incidents reviewed suggest serious deficiencies in the Department's current reporting and review procedures. The Department is currently revising its force review policies, and is working toward creating a standardized use-of-force review process that will seek to identify draft policy and training failures so that they can be addressed in a timely fashion. The Department's draft force review policy includes various improvements to its processes.

[26] SCM Directive at 4.

Use-of-force Reporting

Complete, accurate, and truthful reporting maintain the integrity and reliability of the Department's use-of-force reporting process. According to the SCM policy, staff who participated in a physical or chemical intervention are required to complete a Physical Intervention Report (PIR). In addition, staff who witness the incident, or who were assigned to the unit at the time the incident occurred, are required to complete a Supplemental Physical Intervention Report (SUP-PIR).

A majority of the staff-generated reports associated with the troubling incidents reviewed were not comprehensive and appeared to omit necessary information. Reports rarely described the events that led to the use-of-force, making it difficult for subsequent reviewers to assess the need for the force used. Additionally, several reports did not appear to accurately describe the youth behavior that necessitated the use of OC spray, stating generally that the subject youth moved aggressively in attempts to assault staff, though video shows a passive posture and no movement.

Use-of-force Review and Accountability Practices

The SCM policy details the Department's use-of-force report and review process. Staff members who are involved in or observed a use-of-force are required to prepare PIRs no later than the end of the eight-hour shift during which the incident occurred.[27] Reports must be clear and comprehensive, and staff must memorialize a host of factors, including: de-escalation attempts, the factors that gave rise to the need to use force, and the type of force used. Staff must also record a "full description of O.C. spray post-deployment decontamination."[28] The SCM policy does not require staff to photograph injuries of youth who are subjects of force.

Once submitted, PIRs and related documents are reviewed by the presiding shift leader and duty supervisor for completeness and accuracy.[29] If they are found lacking, they are returned to the relevant staff for necessary amendments. They are then passed on to the particular facility's SCM Supervising Coordinator, who reviews the documentation and conducts interviews with involved youth and witnesses.[30] If the underlying force incident appears to violate policy, it is then forwarded either to "the facility Director, facility Superintendent, or the Probation Department's Special Investigations Unit."[31]

---

[27] *Id.* at 13.
[28] *Id.* at 14.
[29] *Id.* at 15.
[30] *Id.* at 17.
[31] *Ibid.*

The SCM Supervising Coordinator is not explicitly required to view relevant videos of the incident.

The Department's draft force review policy addresses some of these significant issues. It calls for force reviewers to view available videos and assess the accuracy of any written reports. It also requires that a youth reporting injuries be photographed to ensure such necessary evidence is preserved. Significantly, it calls for the creation of Use-of-force Data Coordinators at each Department facility. The Data Coordinators will be tasked with ensuring that relevant force data is collected for input into the Department's various databases.

According to information provided by the Department and information gathered during site visits, Department facilities lack the necessary technology infrastructure to ensure that use-of-force incidents are captured on video. Staff further reported that when videos of force incidents exist, they are difficult to access and view. The Department is aware of this issue and is working to address it.

Department policy also provides for notifying executive Department leadership of certain force incidents that involve potentially problematic use-of-force or protocol violations or failures. The Department's Preliminary Incident Notification (PIN) directive requires that supervising line staff alert their superiors of incidents that involve various factors, including when: (1) there is "any major disturbance at the facility"; (2) an incident "may generate media interest or come to the attention of the Board of Supervisors"; and, (3) "it is likely that the Chief Probation Officer may be contacted."[32] The policy does not include a definition of what constitutes a "major disturbance," and does not provide other specific information or examples about what kinds of incidents fall into the prescribed categories.

In October of 2018, the Department implemented a Critical Incident Review (CIR) protocol that creates a routine assessment of particular incidents to "determine the effectiveness of existing policies and procedures before and after an event, to address the root causes of an event, and to prevent the incident from reoccurring."[33] Policies prescribe that reviews take place twice a month, and involve various Department managers and County counsel.[34] The CIR process is triggered, generally, by an escape, a disturbance involving ten or more people, a suicide or suicide attempt, death of an in-custody youth, and at the discretion of the Chief Probation Officer. It can also be initiated by incidents or situations in which it is likely the Chief Probation Officer may be contacted.

[32] Preliminary Incident Notification Directive, at 1.
[33] Critical Incident Review Process Directive (CIR Directive), at 1.
[34] *Id.* at 4.

An effective use-of-force review process rests, in part, on developed accountability and disciplinary infrastructure. Once spotted, actions that violate use-of-force-related policies should be dealt with in a timely, effective, and consistent manner. The OIG's review of Department-provided information suggests that Internal Affairs is understaffed and overburdened by a high caseload, leading to extensive delays in investigations and resolutions. Drawn out investigations by overworked staff may be a reason staff consistently expressed a distrust and dissatisfaction with Department accountability systems.

OIG discussions suggest that the Department should continue auditing and reviewing its force reporting practices. For example, line-level supervisors and more senior managers reported knowing of the PIN directive — but also had significantly different understandings of what types of incidents merit reporting. Furthermore, the incidents reviewed for this assessment routinely contained staff reports that failed to capture all relevant action, including particular uses of force by staff and descriptive details of decontamination procedures.

Several staff stated that it was difficult to view video because it is not readily accessible. Others reported losing access to the video database during 2017 and 2018. No staff assigned to work at a juvenile hall or camp reported viewing video from other juvenile facilities.

Recommendations

Los Angeles County should evaluate whether the use of OC spray in Department facilities aligns with the Department's philosophical shift toward rehabilitation and trauma informed care and its ongoing implementation of the LA Model. Department personnel and leadership express an awareness of OC spray's physical and emotional harm to youth and of its negative implications for staff-youth relationships and larger Department culture. Most also express, however, a firm belief that absent adequate alternatives, the use of OC spray is necessary to safeguard their personal safety.

Any plan to restrict or eliminate OC spray should prioritize institutional safety, with meticulous attention to youth and staff perceptions about their personal safety, and dedication of necessary resources. Any changes to the use of OC spray in juvenile halls and camps should be incremental and balance training and programmatic needs. The County should explore the feasibility, with significant input from all stakeholders, of restricting or eliminating the use of OC spray in Department juvenile facilities.

Based on the OIG review of existing safety concerns and examination of existing and proposed reporting and accountability practices, training and policies, the OIG makes the recommendations detailed below. While the

recommendations offered generally reference current policies, they have been tailored to ensure that they are relevant to the policy changes currently being considered by the Department.

Accountability and Reporting

Recommendation 1: *The Department should dedicate appropriate resources to finalize and implement its comprehensive use-of-force accountability improvements including its Force Intervention Response Support Team (FIRST) and Department Force Review Committee (DFRC) processes.*

In addition to the Department's existing CIR process, the Department is in the planning stages of a comprehensive force review process. This process includes a team of highly trained personnel who will be required to respond to use-of-force incidents and assist with real-time mentorship and evaluation of de-escalation efforts, tactics, reporting, among other tasks. The team is then responsible for referral of incidents for review by the CIR or what the draft use-of-force policy refers to as the Department Force Review Committee (DFRC). The FIRST should consist of proven effective leaders who possess operational and tactical expertise and who demonstrate an unyielding commitment to the rehabilitative approach. FIRST team members should be single assignment positions.

Every use-of-force incident reviewed should include review of available CCTV footage and should be evaluated for (1) force prevention opportunities, (2) de-escalation efforts, (3) pre-force conduct and tactics, (4) force tactics, (5) post-force incident tactics, (6) decontamination, (7) trauma informed critical incident counseling for and placement of youth as necessary, and (8) post-incident reporting.

The Department's draft use-of-force policy calls on the DFRC to review a selection of use-of-force incidents. The DFRC should analyze *every* OC deployment and the decontamination process following each incident. In assessing the use of OC spray, the DFRC should also evaluate whether staff exercised appropriate judgment and decontaminated youth as soon as possible following the incident. Where decontamination was delayed allegedly due to physical plant, staffing, or other systemic deficiencies, the DRFC should review, identify, and report deficiencies to Department executive leadership, who should take necessary remedial action and implement sustainable solutions as soon as possible.

As necessary, the DFRC should also be empowered to require retraining of particular officers, and it should be tasked with tracking completion of all corrective action. Furthermore, force reviewers at all levels should identify staff

who have effectively prevented the use-of-force and de-escalated tense situations. The Department should recognize and reward these individuals and successes should be shared with all relevant Department personnel.

Recommendation 2: *The Department should dedicate necessary resources and training to effectively implement its Internal Affairs processes.*

The implementation of an effective force review process as described above is time and resource intensive. The Department provided information that strongly suggests that its Internal Affairs team is understaffed and overburdened. Department leadership should continue to work to identify and address unmet staffing needs, and should also continue working to procure necessary tools and training to aid its Internal Affairs staff.

Recommendation 3: *PIN and CIR Directives should more clearly guide staff in determining when to notify leadership of relevant force incidents.*

The PIN Directive serves the important function of creating a conduit for information to travel expeditiously from a juvenile hall or camp to the Department's senior leadership. As described above, the PIN Directive does not currently provide staff with sufficient clarity as to when such notices are required. Without a PIN, Department leadership may not be able to notify the Board of particular incidents.

The Department should revise the PIN Directive so that it provides definitions and instructive examples of factors that trigger a notice. Subjective analysis and judgement on such matters can vary wildly, evidenced in the lack of notices for the 2017 and 2018 incidents audited by the Department and reviewed here. The Department should establish bright line triggers for notice and review to ensure that policy, training, and supervision failures are identified in a timely fashion, and that the Chief Probation Officer and the Board are aware of them. The policy should also be amended to require notification to the DFRC and the CIR committee.

Recommendation 4: *The Department should introduce cameras in all of its juvenile justice facilities. It should also consider updating its CIR policy to require supervisors to view relevant videos of incidents.*

The Department currently lacks sufficient information technology infrastructure to ensure that all use-of-force incidents are captured on CCTV. It should continue to work to address this weakness, and improve access to existing videos by relevant supervisors and force reviewers. Department staff who have been involved in the force incidents should continue filing any necessary reports before viewing relevant videos.

In instances when videos are available, the Department's CIR Directive should require that CIR reports and presentations include them. Staff-generated use-of-force reports are a necessary and effective source of information — but videos can potentially provide reviewers with a new vantage point that might bring relevant information to light. Videos may also serve to help assess the efficacy of particular policies or practices.

Training

Recommendation 5: *The Department should address staff concerns regarding inadequate use-of-force training by developing comprehensive and fully integrated training curriculums and presentations that offer effective alternatives.*

Force prevention, de-escalation, and physical and chemical intervention techniques are important tools that safeguard against unnecessary uses of force. Poorly trained staff lack the ability to de-escalate situations, which likely contributes to avoidable OC spray incidents. Thus, the Department should assess staff concerns regarding insufficient training.

The Department should aim to develop comprehensive and fully integrated use-of-force training and retraining curriculums to ensure that staff have a complete understanding of all related policies and procedures. The presentations should also include slides pertaining to the zero tolerance policy for abuse and slides that encourage staff to report abuse and misconduct by other staff.

Training should also address troubling staff conduct. Several use-of-force incidents reviewed by the OIG involved a failure to timely decontaminate youth following the application of OC spray. Yet, the use-of-force training presentations reviewed lack discussion of decontamination. The Department should develop training that clearly details decontamination procedures and any prohibited practices, such as providing youth with hot or warm water for decontamination purposes. Furthermore, training should clearly articulate circumstances in which shaking a canister in the presence of youth is appropriate and when shaking should be prohibited, with or without deployment.

Recommendation 6: *The Department should assess and enhance training, including off-post training, in interacting with youth with mental health and behavioral needs, and youth in acute mental health crises.*

Several staff reported feeling inadequately trained to care for youth with mental health and behavioral needs. In addition, staff expressed a desire to learn specialized de-escalation techniques for use-of-force incidents involving youth

with mental health needs. The Department should collaborate with the Department of Mental Health (DMH) and, as necessary, mental health juvenile correctional consultants to assess training deficiencies and to provide staff with the tools they need to effectively care for the County's most vulnerable youth population.

Recommendation 7: *The Department should ensure that staff are effectively trained to accurately document all events that led up to the use-of-force, including staff and youth behaviors that precipitated force, and decontamination efforts.*

Several of the reports did not contain comprehensive information regarding the events that led up to the use-of-force. At best, they included cursory summaries of de-escalation attempts that failed. The Department should consider and implement strategies to ensure that its staff memorialize specific information regarding force prevention, de-escalation, and decontamination efforts. The Department should explicitly require probation officers to provide detailed descriptions of the interactions between staff and youth that preceded the use-of-force incident, including the nature of the conflict that led to the use-of-force, any and all ultimatums provided by staff to the youth that was the subject of OC spray, and youth reactions to those ultimatums. Force reports should also include detailed descriptions of decontamination efforts — if they do not, they should be consistently returned to staff for revision.

Recommendation 8: *The Department should revise training materials to remove language that inadvertently encourages incomplete or inaccurate reporting.*

The Department should review existing training materials and remove any problematic language that encourages undesirable behavior. As described above, current materials include language that may unintentionally encourage staff to file incomplete use-of-force reports. Training should continue to emphasize the importance of complete, accurate, and truthful reporting of use-of-force incidents, including in situations where prohibited force may be at issue.

Department Policies

Recommendation 9: *The Department should establish a unified training and policy development team.*

The Department does not currently have a single designated team tasked with developing or amending its training and policies as needed, including those related to force. The Department has identified this need, and has worked towards assessing the resources it would need to create one. In reviewing,

revising, or developing trainings and policies, the team should strongly consider including timely input from line-level staff, outside experts, representatives of other juvenile justice systems, and representative community stakeholders, including formerly incarcerated youth and relatives of currently incarcerated youth. Active participation and contribution to the policy development process may also result in positive cultural change by enabling all interested parties to invest in and value the rules that guide their work.

Recommendation 10: *The Department should ensure that its use-of-force policies clearly define keystone concepts.*

The Department's current and draft use-of-force policies fail to provide clear and workable definitions for terms that relate to when staff are allowed to use force. For example, the draft use-of-force policy states that force can be used when staff are confronted by "ongoing defiant behavior" that leads to a "major disturbance," but neither factor is defined. Concrete definitions of these terms, and others, would assist staff in determining whether or not physical or chemical force is authorized.

Recommendation 11: *The Department should consider amending its draft use-of-force policy so that its force standard goes beyond the minimum requirements of the Constitution and other applicable laws.*

The Department's draft use-of-force policy states that force used by its staff will be assessed through the "objectively reasonable" standard established by the U.S. Constitution and relevant case law. However, some probation departments have chosen to go beyond the floor created by the applicable law in guiding the use-of-force. San Francisco, for example, requires its officers to generally apply the minimum amount of force necessary in all applications of force. The Department's draft use-of-force policy requires that its staff use the minimum amount of force necessary. The Department should also consider limiting the use of OC spray to instances in which staff are confronted by potential or actual physically threatening behavior. The draft use-of-force policy currently allows staff to use OC spray to gain compliance, which may contribute to avoidable deployments.

Some law enforcement agencies require that any force used be proportional to the risk of harm faced by the subject of that force, and that it correspond in degree to the seriousness of the objective at issue. The concept of proportionality is already implicit in some of the Department's policies — for example, the Department generally prohibits the use of OC spray when the subject youth suffers from certain physical or mental health conditions. Such restrictions are anchored in an understanding that OC spray results in actual and potential harm that may not be justified given the objective of the force. The

Department would likely avoid unnecessary OC sprays by requiring officers to weigh the harm caused by OC spray with the intended objective in each discrete incident.

Recommendation 12: *The Department should ensure its draft use-of-force policy prohibits troubling decontamination practices.*

Following the use of OC spray, the Department currently requires that staff remove the youth to a safe area following the application of OC spray, apply cold water to the face, and change clothing following an OC spray.[35] It also requires that staff present youth for a medical assessment within thirty minutes.[36] Conversations with staff and youth and force incidents reviewed by the OIG suggest that staff may be waiting up to thirty minutes or longer before initiating decontamination procedures. The draft use-of-force policy should guide staff in caring for recently sprayed youth who resist or refuse decontamination. Such resistance should not result in unnecessary delays to decontamination.

The draft use-of-force policy should also explicitly prohibit the following decontamination practices:

- Confining a youth to a room without running water within thirty minutes of an OC spray application;
- Turning off water to a room occupied by a youth who was the subject of OC spray;
- Providing a wet towel to youth who are attempting to decontaminate, and allowing those youth to rub their face;
- Using facility showers or faucets to decontaminate youth when staff lack the ability to control the temperature of the water; and
- Leaving youth unattended and without supervision immediately after the deployment of the first burst of OC spray.

Recommendation 13: *The Department should assess its policies regarding youth access to religious programming*.

Conversations with youth suggest that Department staff may be denying access to certain programs, including religious services. Some youth stated that they were not able to attend available religious services at Department facilities due to staff who believed they did not deserve such a privilege. The Department should ensure that its policies effectively prohibit such acts, and that its practices reflect policy.

[35] SCM Directive at 28.
[36] *Id.*

Recommendation 14: *The Department should require staff to act appropriately when observing policy violations and deviations from training.*

The Department's draft use-of-force policy requires staff to report potential violations. The Department should consider also requiring staff to immediately take affirmative action to try and stop inappropriate uses of force that they observe, and to take steps to correct the situation. Several incidents reviewed by the OIG involved staff who were passive witnesses to troubling violations of Department policy, and who failed to intervene. Creating this requirement will ensure that staff understand expectations regarding the use-of-force, and their role in caring for youth.

Recommendation 15: *The Department should assess its implementation of its HOPE Centers to ensure that it aligns with intended goals.*

Conversations with staff and youth suggest that the Department's HOPE Centers, which are designed to assist staff and youth in dealing with problem behaviors and to mitigate the use for force, may not be achieving their intended goals. The Department should assess its HOPE Center-related policies and practices, with a focus on ensuring adequate staff training and supervisor and management commitment to their effective operations.

Staffing

Recommendation 16: *The Department should continue assessing its staff resources, with an emphasis on ensuring that sufficient and effective supervision is provided to line-staff and youth.*

Conversations with staff and Department leadership revealed a consistent concern for day-to-day staffing levels and, as a result, the availability of experienced and effective supervisors during every shift. The Department should ensure that its staff needs assessment takes into account the experience level of available staff members, so that the teams that work together during shifts are led by capable staff. Similarly, such analyses should also take into account the potential needs of a youth population that may require one-on-one supervision.

Recommendation 17: *The DMH should work with the Department to identify specific mental health staffing needs and increase provider-to-youth ratios.*

The Department's use-of-force and de-escalation practices identify very specific and important roles for mental health professionals. For example, the SCM policy prohibits the use of OC spray on youth who are receiving psychotropic medication. The SCM policy also calls on staff to enlist the assistance of mental health professionals when attempting to de-escalate

situations that may lead to the need for force. Force prevention efforts that include mental health and other service providers, such as teachers and chaplains, tend to be more successful. Indeed, youth reported that some mental health providers were among the few individuals they trusted in facilities. The ability to provide adequate care, and to make good on force policy requirements, hinges on training and sufficient mental health staffing. However, most of the Department staff members and youth communicated strong impressions that mental health provider availability and support is inadequate.

DMH and the Department should assess existing staffing and services, identify any shortages or deficiencies, and rectify them. Adequate mental health staffing should include continuous, 24-hour care that allows for timely crisis intervention efforts, medication prescription and compliance monitoring, regular youth counseling, and sufficient availability to proactively assist in force prevention and de-escalation.

Culture

Recommendation 18: *The Department should continue to implement measures that ensure its practices are consistent with its core values, and to ensure that staff at every level work to create a safer environment in the County's juvenile justice facilities.*

The Department is led by specific and articulated core values, which include treating youth, staff, and the public with dignity and respect, and acting with integrity.[37] Available information suggests that the Department's values are not consistently being practiced by all personnel.

The Department should continue to address and refine its recruitment, hiring, training, supervision, and accountability practices to align with its stated mission. The Department should identify and procure resources necessary to adequately train existing personnel in effective behavior management tools that emphasize rehabilitation over punishment. The Department should identify and procure necessary resources to identify, recruit, and hire individuals whose professional orientation and expertise more closely align with rehabilitative rather than punitive principles. Department policies and procedures should establish clear expectations for staff-youth interactions in all aspects of youth confinement. Consequences for non-compliance and incentives for compliance should be clearly communicated and consistently enforced.

[37] Los Angeles County Probation Department Core Values.

Conclusion

The information and recommendations provided in this report are intended to inform both the Board and the Department of issues related to the use-of-force within the County's juvenile justice facilities. During its time-sensitive and focused review, the OIG identified several other factors that may impact the use-of-force in County juvenile justice facilities, including: facility conditions, labor agreements, staff morale, general resource allocation and constraints, and organizational culture, among other issues. Further assessments of these subjects is likely warranted.

cc: Sachi A. Hamai, Chief Executive Officer
Celia Zavala, Executive Officer
Mary C. Wickham, County Counsel
Terri McDonald, Chief Probation Officer