EXHIBIT L

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INTRODUCTION

This Fifth Report sets forth the Mental Health Expert's assessments of the implementation of the terms of the Consent Decree, signed June 7, 2016, and associated Remedial Plan stemming from Gray v. County of Riverside. It covers Riverside County's (the County) reported results from the time of the fourth report through June 2019 (the "Fifth Reporting Period") and reflects the observations and analysis of the Mental Health Expert regarding the County's compliance during that period.

As used herein, "Substantial Compliance" means that the County has achieved compliance with the material components of the relevant provisions of the Remedial Plan in accordance with the agreed-upon Compliance Measures for assessing Substantial Compliance submitted by the Mental Health Expert. "Partial Compliance" means that the County has achieved compliance on some, but not all, of the material components of the relevant provision of the Remedial Plan or have not achieved the quantitative results specified in the Compliance Measures; and "Non-Compliance" means that the County has not met most or all the material components of the relevant provisions of this Agreement.

This Fifth Report is based upon the Mental Health Expert's review of provided policies, procedures and directives proposed and/or implemented by the County, observations and assessments of the Mental Health Expert based on tours of the jails, and review of medical records and data collected by the County. Site visits were conducted 2/19/19-2/20/19 and 2/28/19-3/1/19. I visited Smith Correctional Facility (SCF) for a day, Indio Jail for a half day, Blythe Jail for a half day, Robert Presley Detention Center (RPDC) for three quarters of a day, Cois Byrd Detention Center (CBDC) for a half day, and the Detention Care Unit (DCU) for two hours. I was provided full access to patients and staff and was assisted by staff knowledgeable in relevant topic areas including mental health, nursing, custody, classification, quality assurance, and administration.

I observed five groups (three at SCF, and one each at CBDC and RPDC); met with psychiatrists, Clinical Therapists, nurses, Recreation Therapists, and Behavioral Health Specialists; observed pill lines at RPDC and multi-disciplinary team meetings at RPDC and SCF; conducted group interviews on general population units; rounded on patients in the DCU; reviewed medical records; interviewed 12 patients in private; and spoke with many more patients during visits to

the units. In addition, I met with mental health and medical leadership and quality management staff at a County office for four hours.

All staff were forthcoming, helpful, and professional. I was provided unfettered access to facilities, patients, and records.

I reviewed medical records of selected patients (see APPENDIX) to assess elements of compliance (detailed in the body of the report).

The County provided the following information for my review:

- Riverside County Correctional Health Services Policy J-127: Restraints Applied by Custody Staff Requiring Nursing Assessment (Chair, Carotid)
    - I received copies specific to Blythe and CBDC, which were the same and presumably are the same for all facilities
- RUHS-CHS Pharmacy Policy/Procedures – P-106: Emergency Pharmacy Hours
- Riverside University Health System-Behavioral Health (RUHS-BH) Detention Services Policies:
    - Process for making changes to the Detention electronic health record knows as TechCare
    - Restraint and Seclusion
    - Safety Cell Placement
    - Behavioral Health Care Requests and Services
- List of urgent stock medications from Blythe
- Document entitled "RPDC Master Daily Assign Sch Rev. 1 2019.xlsx" – RPDC general daily schedule of medical and mental health activities
- Undated document showing RPDC schedule of groups for the 5th and 6th floors (mental health housing)
- Schedule of Clinical Therapist (CT) and Behavioral Health Specialist (BHS) coverage for RPDC dated 3.13.19
- Document entitled "Behavioral Health, Robert Presley Detention Center" detailing a plan for timely completion of mental health assessments and care plans (treatment plans) – no author, no date
- RUHS-BH document entitled "Behavioral Health Indicators" from 1/1/19 to 1/31/19
- Document entitled "Month SC Cleaning Report.xlsm" that shows safety cell cleaning from 5/20/18 to 5/31/18 for an unknown facility with 8 safety cells, likely RPDC
- Document entitled "Detention Chart Reviews first half 2019.xlsx" listing 21 patients with acuity ratings of Moderately Severe and higher
- Document entitled "Detention Chart Reviews Updated 4-22-19.xlsx" listing 20 patients with acuity ratings of Moderately Severe and higher
- Riverside County Correctional Health Services slide presentation entitled "Know Your HIPAA"

- Riverside County Sheriff's Department (RCSD) HIPAA training rosters from CBDC, RPDC, and SCF with dates of attendance from June 2018 to May 2019
- RCSD data on dayroom times:
    - CBDC from 1/6/19 to 1/19/19
    - RPDC from 1/7/19 to 1/11/19 and 1/14/19 to 1/18/19
    - SCF from 1/6/19 to 1/19/19
- RCSD data on recreation times from all five facilities for February 2019
- RCSD document entitled "15+ Year Sentence Oct 18 to Mar 19.pdf" detailing convictions for long sentences and whether the inmate was referred to RUHS-BH
- RCSD documents entitled "Administrative Segregation Review Log – RPDC" from October 2018 to March 2019
- RCSD documents entitled "Inmate Movement List" from RPDC from October 2018 to March 2019 and from SCF from October 2018 to January 2019 with transfers involving seriously mentally ill (SMI) inmate-patients highlighted
- RCSD policy 5-8.06 "Inmate Medical Care"
- A sample of RCSD Inmate Classification Assessments from RPDC and SCF involving inmate-patients with health issues
- Spreadsheets related to my data requests from RUHS-BH entitled:
    - AdMin Housing BH.xlsx
    - BH Housing PsyMeds Discharged.xlsx
    - LAIs STAT Q3.xlsx
    - Restraint Chair.xlsx
    - Safety Cell to DCU.xlsx
    - Safety Cell No DCU.xlsx
    - Bridge Meds Orders JAN-MAR 2019
    - Random Bridge Meds JAN-JUNE 2019.xlsx
- Safety cell logs
    - 15 inmate-patients from CBDC from February 2019
    - 19 inmate-patients from Indio from February 2019
    - 47 inmate-patients from RPDC from February 2019
    - 69 inmate-patients from SCF from February 2019
- Safety cell logs for seven inmate-patients placed in the restraint chair
- Safety cell logs for nine inmate patients placed in safety cells and sent to the DCU corresponding to the spreadsheet "Safety Cell to DCU.xlsx"
- Safety cell logs for 11 inmate patients placed in safety cells and not sent to the DCU corresponding to the spreadsheet "Safety Cell No DCU.xlsx"

EXECUTIVE SUMMARY

In this Fifth Report, I have continued the more quantitative approach to compliance measurement adopted for the Fourth Report. I provide some qualitative comments as well. The County is not yet fully able to provide proof of practice for all elements of the Remedial Plan but has continued to expand its capacity to support this more quantitative approach. However, much of the quantitative review still had to be done by my review of medical records, a very inefficient methodology. Records were again pre-selected according to criteria and then a random subset was selected from these records according to criteria that are included in the Appendix; these were modified slightly from the Fourth Report. Some of the cases requested were not provided.

I asked to meet with representatives from custody, medical, and mental health to discuss possible changes; during my site visit I did meet with representatives from medical and mental health services, but no custody staff were present.

As was the case for the Fourth Report, high-level items in the remedial plan were broken into smaller elements and subtopics within some of those elements. As noted previously, some of the elements were moved to different sections than they occupy in the Remedial Plan for ease of review. For example, mental health treatment of those on administrative segregation is covered under Mental Health Care rather than Custodial Environment. The 28 items and elements (referred to together as components) that are provided ratings (in **bold text**) in this report include:

- Health Care Generally (five scored elements)
    - **Intake Screening**
    - **Medication Administration and Monitoring**
    - **Confidentiality**
    - **Health Care Records**
    - **Timely Access to Care**
- Staffing (four scored elements)
    - **Staffing sufficient to execute the Remedial Plan**
    - **90% filled positions**
    - **Clinicians meet community standard of care**
    - **Annual assessment of the adequacy of staffing**
- Custodial Environment (seven scored elements)
    - **Policies and procedures to maximize dayroom time**
    - **Dayroom time**
    - **Recreation (yard) usage**
    - **Programming and structured activities in mental health housing**
    - **Self-isolating inmate training**
    - **Custody referrals to mental health**

- **Inmate classification**
- **Administrative segregation**

- **Review of in Custody Deaths** (scored as a single item)
- Continuous Quality Improvement (two scored elements)
    - **Peer review of psychiatrists**
    - **Quality Improvement Committee (mental health components)**
- Mental Health Care (six scored elements)
    - **Treatment according to a Program Guide** (including treatment of those in administrative segregation which was moved from Custodial Environment)
    - **Psychiatric care timelines**
    - **Housing of the seriously mentally ill**
    - **Treatment space**
    - **Suicide prevention**
    - **Restraint**
- **Policies and Procedures** (scored as a single item)
- **Consent Decree Training** (scored as a single item)

Overview

The County continues to make steady progress in almost all areas of the remedial plan. Riverside University Health System – Behavioral Health (RUHS-BH) continues to make steady progress in the development of data and reports. Mental health intakes are being done reliably and RUHS-BH clinicians are more consistently completing assessments and treatment plans; though the treatment plans are almost all quite generic, the assessments are generally sound.

One point that deserves mention is that inmates complained much more about medical care and medical responsiveness than mental health services. Many also complained of being charged co-pays even for clinician-requested follow-up, e.g., for assessment of wounds or efficacy of antibiotic therapy.

Service delivery remains similar to levels prior to June 2017. Access to care challenges persist and out of cell time in general remains relatively limited for the mentally ill, though County has been taking steps to address the limited out of cell time of the mentally ill on administrative segregation status. The County has largely overcome the limitations on access to mental health care stemming from enhanced security requirements for clinical contacts with the mentally ill and access to groups has improved as a result. As noted in previous reports, the County adopted security requirements for program rooms that had reduced access to care until electronic door locks were installed. Those door locks have continued to function well; there have been no significant safety problems or failures, so this system is not a barrier to access at this time. However, whether the requirement to have a deputy standing by for all groups will limit access as more groups are run remains a question. In that regard, mental health runners are more consistently available but are still sometimes unavailable to escort patients to

services. Access to patients has generally improved, but there continue to be problems with access in some areas, including at residential mental health units (more so at RPDC, primarily owing to space limitations) and for the mentally ill on administrative segregation, though it is too early to assess the effect of recent changes in managing the mentally ill on administrative segregation (e.g., the development of a new unit at CBDC to manage this population).

Cell front contacts continue to be excessive. Individual contact at CBDC has improved substantially due to the opening of program rooms to individual mental health contacts and the scheduling of the program rooms for medical and mental health.

The expansion of clinical space at RPDC and SCF continues forward but is not yet completed. The new clinic at SCF has been completed and the additional interview room on housing unit 16 (the residential mental health unit) has been started. The office build-out on the seventh floor of RPDC had been delayed several months due to needing some redesign but was recently completed. There has been some improvement in the space challenges at CBDC with some expanded availability of unit program rooms; the modifications to the intake area have not yet been started but should improve privacy and communication once completed. A new clinic is in the design phase at Blythe.

Program tables are being used and a bulletin was published on their use. This bulletin specifies that patients will be cuffed to the table when meeting with mental health clinicians, even if they would otherwise not be restrained for other clinical activities such as groups or medical appointments. Restraints should be used only when necessary and patients should not be routinely restrained for any treatment but only when there is some immediate concern based on behavior, the patient's classification requires restraint, or at the request of the clinician. Similarly, it is not clear why the Clinical Therapist at Blythe is not allowed to meet face-to-face with patients while, for instance, the chaplain is allowed to do so with the same inmate. These kinds of inconsistencies, especially when they interfere with access to care, must be resolved across the jails.

While group treatment has returned to previous levels, access and fragmentation remain a problem. There is both limited capacity (not enough groups to accommodate the numbers of patients) and custody practices that prevent patients from completing group curricula. The latter is related to limitations on mixing of patients, some of which are unnecessary, as well as frequent moves. It is far from clear how custody is deciding which patients may be in groups or in groups together; there is no formal process for making such designations and it seems to vary from facility to facility and even unit to unit. At Blythe, custody determines who may participate in groups (at the time I was visiting, only four patients were enrolled in an anger management group), but it is not clear how this determination was made. A formal process that clearly identifies inmate-patients who must be kept separate would help tremendously; some conflict in this population is inevitable but, in most instances, need not result in enduring separation. Careful attention to group enrollment that both addresses clinical need and potential interpersonal conflict is needed and requires collaboration between custody and

mental health. It is important to recognize that interpersonal conflict is much more of a risk in unstructured activities (e.g., unstructured dayroom or yard time) than in structured activities such as groups; thus, keeping inmates separate (e.g., by tiers) for the unstructured activities but allowing some mixing for structured activities is reasonable and promotes access to care and efficiency while addressing the risk of patient conflict. This not only serves treatment needs but provides a measure of readiness to advance to a lower level of care/custody; those who can succeed in structured group activities may be allowed a trial of conjoint unstructured activities in a more broadly mixed population. In general, the expectation should be that patients are allowed out to groups absent an imminent risk, in accordance with the movement requirements of their custody classification. The mentally ill should be treated no differently than others regarding access to all forms of treatment and other privileges and activities. Clearly, limitations are reasonable when based on current behavior (even if behavioral problems are related to mental illness) and formal classification, but not because of being on a residential mental health unit or being mentally ill. When behavioral problems limiting access are related to mental illness, it is incumbent on mental health staff, with the assistance of custody in gaining safe access to care, to provide treatment to reduce behavioral problems to allow greater access and privileges, including involuntary treatment when necessary.

There remain substantial problems in delivering services to the seriously mentally ill on administrative segregation. The greater collaboration between mental health and custody in reviewing the need for continued administrative segregation continues; documentation of this review has reportedly begun but the standards for determining who is placed on administrative segregation are very non-specific and it is not clear how or on what basis these decisions are being made. The remedial plan requirement for daily mental health contacts for patients on administrative segregation has continued to be very difficult to achieve and diverts resources from productive treatment; I understand the parties are revisiting this provision. While regular welfare checks (by both custody and healthcare staff) are important, they are not treatment; treatment cannot be administered at cell front.

The County continues to make progress in quality of care. The intake process is sound and most seriously mentally ill are being promptly identified; though initial medications are not always being promptly ordered, this is improving as well. More consistent availability of runners has reduced cancellations and facilitated access for some clinical contacts, especially scheduled groups.

The County has also made progress in expanding the data systems needed for proof of practice and improving relevant reports. RCSD has continued to use hand generated reports (spreadsheets) to track out of cell time; Information Technology (IT) support continues to be a challenge for RCSD. There remains limited conjoint Continuous Quality Improvement (CQI) between RCSD and both RUHS-CHS and RUHS-BH. RCSD participates in some CQI but there has been limited integration around critical issues such as access to care and management of the behaviorally disturbed. There has been some improvement in the collaboration between

RUHS-CHS and RUHS-BH. As noted previously, areas that are particularly important for robust collaboration include: CQI, referral, patient healthcare requests (kites), safety cell and restraint assessment, and medication administration. Assuring that relevant policies, procedures, charters, and the like address the relationship and responsibilities would help promote coordination and facilitate compliance with the Remedial Plan.

The County has begun to track the retrieval, triaging, and response to patient requests for mental health care, but the process continues to need refinement. Improved tracking of the process will be necessary to both troubleshoot and provide proof of practice. Automating reporting to the maximum extent possible will be important.

Safety cell management is generally sound except that required stepdown procedures, in terms of restoration of property and privileges during safety cell placement, are still not in place. Patient safety cell assessments are still occasionally being done at cell front (usually owing to patient refusal but documentation shows a substantial minority of such assessments being due to lack of available custody staff) and mental health contacts with those in safety cells are regular. Nursing monitoring is much more consistent; patients are being evaluated at least every 12 hours in almost all cases and on each shift in most cases. Safety cell logs are being completed consistently, though meals are occasionally not being noted as offered. Transitional mental health services for those leaving safety cells and returning from the DCU are administered consistently, though not reliably daily as intended. Nursing assessment of those in restraints needs to include neurovascular checks.

Patients are more often being better stabilized at the DCU prior to returning to the jail from the DCU, but record review revealed a substantial minority of patients that were returned to the jails still acutely psychotic. There is much better coordination of care since the posting of two Clinical Therapists at the DCU. However, the two Clinical Therapists are yet to be fully utilized. Though they are having more face-to-face contact with patients, this is generally just a single weekly meeting. Patients in the DCU remain largely isolated with very little activity or materials available to them, regardless of their custody status. The mentally ill are treated in a uniformly more restrictive fashion than the medically ill. Also, the psychiatric documentation that is returned with the patient is woefully inadequate. This is doubtless due, at least in part, to having different electronic health record (EHR) systems in the DCU and the jails. Regardless, this needs to be improved.

The County has not made any progress in providing emergency or involuntary medications in the jail, despite the recent statutory change permitting this. But the County has made substantial progress in administering long-acting injectable antipsychotics, which has helped stabilize several seriously ill patients and reduced their returns to the DCU.

Reentry services have also been improved. There is better documentation of both individual and group reentry services. But it is important to note that many EHR entries with titles related to reentry show no evidence of the delivery of any reentry services; thus, any demonstration of

reentry services based on the type of progress note will not be an accurate reflection of such services. There are still seriously mentally ill patients who have received no reentry services and medications are not consistently being provided at the time of release. A plan to have peers assist in reentry remains on hold; this is a method used by many systems to both augment traditional services and, more importantly, engage distrustful patients.

It is important to note that the County has filled over 90% of its mental health positions. While there is some turnover, many staff remain and retain a positive outlook on their jobs, with several commenting on the steady improvement they have seen in the ability to render services and the collaboration with custody. I continue to be impressed by the commitment of staff and the quality and integrity of the leadership.

I will note that it is not clear how to provide proof of practice regarding referral of self-isolating inmates. I recommend that the regular meetings between custody, medical, and mental health include brief minutes of patients and topics discussed, to include self-isolation.

In terms of formal compliance, I report on the following measures, consistent with the above 28 rated items and elements. The County previously achieved substantial compliance on the following and they remain substantially compliant:

- **Consent Decree Training**
- Health Care Generally
  - **Health Care Records**
- Mental Health Care
  - **Housing of the seriously mentally ill**
- Staffing (elements relevant to mental health services)
  - **90% filled positions**
- Custodial Environment (elements relevant to mental health services)
  - **Self-isolating inmate training**

The County is newly rated as substantially compliant on:

- Custodial Environment (elements relevant to mental health services)
  - **Administrative segregation** [Note: This only reflects substantial compliance in completing 30-day reviews; aspects of care related to administrative segregation are rated under mental health treatment.]

The County continues to achieve partial compliance on the following:

- Health Care Generally (elements relevant to mental health services)
  - **Intake Screening**
  - **Medication Administration and Monitoring**
  - **Confidentiality**
  - **Timely Access to Care**

- Staffing (elements relevant to mental health services)
  - **Clinicians meet community standard of care**
- Custodial Environment (elements relevant to mental health services)
  - **Dayroom time**
  - **Recreation (yard) usage**
  - **Custody referrals to mental health**
- **Continuous Quality Improvement** (elements relevant to mental health services)
- Mental Health Care
  - **Treatment according to a Program Guide** (including treatment of those in administrative segregation which was moved from Custodial Environment)
  - **Psychiatric care timelines**
  - **Treatment space**
  - **Suicide prevention**
  - **Restraint**
  - **Continuity of care**
- **Policies and Procedures**

The County is non-compliant on:

- Staffing (elements relevant to mental health services)
  - **Annual assessment of the adequacy of staffing**

The following were not rated:

- Staffing (elements relevant to mental health services)
  - **Staffing sufficient to execute the Remedial Plan**
- Custodial Environment (elements relevant to mental health services)
  - **Policies and procedures to maximize dayroom time**
  - **Programming and structured activities in mental health housing**
  - **Inmate classification**
- **Review of In Custody Deaths** (elements relevant to mental health services)

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HEALTH CARE GENERALLY (elements relevant to mental health services)

Some of the elements of this are themselves broad and are broken into subtopics for ease of discussion as follows (the scored elements are in bold):

- **Intake Screening**
  - Timeliness of mental health intake screening (done prior to placement with special provisions for Blythe)
  - Confidentiality of intake
  - Content of mental health intake
  - Bridge medications
- **Medication Administration and Monitoring**
  - Pill call
  - Court and transport medications
  - Medication monitoring
  - Prescription filling from the pharmacy
- **Confidentiality**
- **Health Care Records**
- **Timely Access to Care**
  - Inmate healthcare requests
  - Inmate declared emergencies
  - Clinician initiated follow-up

Intake Screening

The subtopics here are:

- Timeliness of mental health intake screening (done prior to placement with special provisions for Blythe)
- Confidentiality of intake
- Content of mental health intake
- Bridge medications

Observations and Interviews

There have been no significant changes to the intake process. A QMHP does the mental health portion of the intake except when there is no QMHP on duty, nurses do the screening (off hours at Blythe and Indio) and then contact a QMHP for verification of level of care; a QMHP later conducts an in-person screening of those screened by nurses.

Though the intake process is working smoothly, the physical plant limitations remain, primarily the poor audio quality and limited privacy at CBDC and limited space at SCF. The RPDC screening setting also has limited privacy due to traffic passing behind QMHPs while conducting intakes; however, patients cannot easily overhear each other as they can at CBDC. These should be corrected once planned construction is completed. All settings have access to medical records through wi-fi connections to laptops. Wi-fi coverage is spotty in the jails, but generally good in intake areas.

Clinical Therapists report that mental health intakes are rarely conducted beyond 12 hours after booking and I saw only a few instances in medical records. Processes have been put in place to assure that

inmates are not placed in housing until seen except in rare circumstances, e.g., a violent inmate, though many of these inmates are, appropriately, placed in safety cells prior to being housed. Unstable patients and those that need more immediate mental health assessment admitted to Blythe are transferred to Indio, usually within 12 hours. While awaiting transfer, they are placed in a cell directly across from the Deputy's station in intake; a restraint chair is available for at risk patients pending transfer.

The pre-booking screen is still done with the arresting officer present. The more complete nursing intake is generally conducted in a nursing office or exam room with custody outside the door.

Mental health screenings are done in private except in unusual circumstances, such as a restrained patient. But mental health staff report that in such cases, custody will generally remain at a distance to provide some privacy. Records do not always indicate whether screenings were private, but generally confirm these reports.

I observed a mental health intake at CBDC. The intake booths at CBDC have yet to be modified to provide for confidential interaction and adequate sight and sound. During the intake, the inmate had to stand to both see and hear the Clinical Therapist. The Clinical Therapist went through the screening questions and inquired more deeply into several issues and came to reasonable conclusions and made an appropriate disposition. It was a sound intake that included a limited, but adequate, supportive/crisis response element.

I also observed a routine mental health intake at RPDC. It was also sound.

Discussions with staff regarding bridge medications revealed that, other than at Blythe, mental health staff do most of the psychotropic medication verification rather than nursing staff.

RUHS-BH Data

The report "Behavioral Health Detention Indicators" from 1/1/19-1/31/19 shows that for inmates in custody for more than 24 hours, 2121/2176 = 97.9% are screened by a QMHP. All facilities were above 95% except Blythe, which was at 88/9%. These findings are similar to the previous reporting period.

Review of medical records showed that screenings were complete in almost all cases when patients were cooperative. The quality of the screening was consistently solid.

A new bridge medication verification report was included in this same report. Of 198 inmates that reported being on psychotropic medications at intake, all were verified without the necessity of inputting a sick call (done when initial verification not completed within 48 hours to assure subsequent verification or evaluation). Note that this is only a proxy measure of bridge medication verification and is dependent on staff inputting a sick call request. A more direct measure is being developed.

I also reviewed the records of 20 patients that reported being on psychotropic medications at the time of admission. Of these, 4 were not qualifying cases (three left almost immediately and one reported being on medications but then reported not taking medications for months). Of the remaining 16, 10/16 were bridged within the parameters of the remedial plan. Of those not bridged, most had never been seen by psychiatry (the shortest stay among these was five days but some were in for over a month).

I asked for, but did not receive, data verifying that patients are screened prior to placement.

Summary

Mental health intakes are likely reliably conducted prior to placement in housing but there is no proof of practice. Those done at Blythe are being done timely and Indio mental health staff continue to assist with assigning a level of care when nurses conduct intakes. The timeliness of intakes generally is within substantial compliance.

Intakes are being done in private settings in almost all instances. While confidentiality at CBDC continues to be limited, staff have adopted strategies to reduce problems while awaiting the changes to the physical plant. Once completed, this element will also likely be substantially compliant.

Mental health is generally doing a good job of detecting cases at intake and the screenings are providing reasonable acuity ratings and identifying inmates at risk of harm to self. The content of the mental health screening is adequate and within substantial compliance.

Bridge medications continue to represent a challenge, but the County is making progress on both getting this task done timely and reliably (both the bridge orders and prompt psychiatric follow-up) and in creating measures to accurately track this important function. Bridge medications are not at substantial compliance.

Thus, Intake Screening, with respect to the mental health component, remains in **partial compliance**.

Medication Administration and Monitoring

The subtopics here are:

- Pill call
- Court and transport medications
- Medication monitoring
- Prescription filling from the pharmacy

Observations and Interviews

I again observed morning medication administration at RPDC on a male residential mental health unit. It ran the same as during my last visit. Nurses go cell-to-cell for patients on administrative segregation. For top tier patients, the nurse carries envelopes of medications with patient names and cell numbers and then later inputs the information into the electronic medication administration record; I continue to have concerns about this process, but patient identification is more reliable than previously. On other units, deputies announce pill call and patients come to receive meds through a small port. The nurse properly identified patients. If patients are suspected of cheeking, custody reportedly usually does prompt cell searches. Nurses continue to be assigned to housing areas and continue to report that this has been beneficial in terms of familiarity with the clinical status of the patients; QMHPs also report that the teamwork benefits also persist.

The nurse I observed at RPDC did a very good job; she knew the patients, interacted with them professionally, and was attentive to their clinical status. The nurse did a much better job of mouth checks than previously. Deputies stood by during pill lines conducted through the dayroom port and assisted to a limited extent in assuring mouth checks were done. Though improved, not all patients did proper mouth checks. It remains difficult for the nurse to hear through the port and it was difficult to communicate with the patients. Those patients who do not push their call button are still not allowed

out of their cells and are marked as no show for medications whereas those who refuse face-to-face are marked as refusals; though the eMAR shows refusal for both, notes on the refusal form, when done, specify if it was a refusal or no show. Note also that patients are not asked to sign refusal forms which are simply signed by the nurse and the deputy, making it entirely uncertain whether the patient actually refused. For no shows, mental health will usually follow-up with a visit to cell front or in a booth, but the nurse usually does not go to the cell front to encourage adherence. There were a few patients that did not come out and the mental health clinician intended to check with them after pill call. Medications for one patient were missing and the nurse planned to get the medications from the seventh floor after pill call; QMHPs report that nurses are more consistently retrieving medications when this occurs. One patient's medications had expired, and the nurse electronically requested renewal from the doctor.

Staff and patients reported that expiration without renewal was uncommon across facilities. As was the case previously, nurses report that they enter patients into a queue for mental health review after missing three days of medications in a row. It remains unclear how reliably this is being done.

A nurse at RPDC explained that injections of long-acting injectable (LAI) antipsychotics are given in treatment rooms on the floors.

Patients report that medications are coming on time both in the morning and the evening at all facilities except RPDC, where evening pill call is still often late, though improved since the development of a master schedule. A variety of staff confirmed that pill call is generally running within an hour of the specified time (e.g., 0700-0900 and 1900-2100), though occasionally starts and ends late at SCF. Nursing staff at RPDC noted that they are required to submit an occurrence report if they do not complete pill call timely. Tallying these reports would assist in proof of practice.

Review of medical records shows MARs are being completed; it is not possible to determine their accuracy or timeliness from review of medical records.

Note that Pyxis machines (automated machines for dispensing medications) have been rolled out at RPDC and CBDC. This will make stocking of medications, including urgent stock, more reliable. I inspected urgent stock at all facilities and spot checks of psychotropics showed that almost all were in stock. However, I continue to have concerns that no benzodiazepines are included in floor stock; injectable lorazepam is an important emergency medication and should be included. At Blythe, there were no intramuscular antipsychotics in floor stock, though there were supposed to be; there were oral benzodiazepines with the controlled substances, though they are not listed as floor stock. Only haloperidol was available as an emergency intramuscular injectable antipsychotic which will be inadequate once emergency medications are provided at the jails. How stock medications are determined is not clear; the Remedial Plan requires that the Medical Director and pharmacy determine what is included in stock medications.

Psychiatrists had no concerns about the availability of laboratory examinations or specialty studies, though none reported accessing any (e.g., neuroimaging). I discussed medication monitoring and some psychiatrists reported that they would not get baseline laboratories if they had been done in the last year. Others reported that they routinely got them. I got inconsistent reports from psychiatrists on frequencies of monitoring after initiation of medications and on conducting AIMS.

There remains no formal way to track court medication administration; processes exist, though nursing staff continue to report that they do not always get notified when a patient is going out to court but are being notified more consistently. Typically, they receive a list the previous evening through JIMS and the night nurse administers medications prior to the patient leaving the facility. There are no provisions for administering medications while patients are away from the facility. I was this time informed that a "c" was placed in the MAR when medications were administered prior to normal medication administration when going to court; I was previously told that the "c" indicated that the patient did not receive the medication due to being out to court; consistency is needed.

Policies and Procedures Regarding Medication Administration and Monitoring

RUHS-CHS Policy P-106 provides for 24/7 access to stat medications within 6 hours at all facilities except Blythe, which is within 12 hours. I have not been provided policy and procedure regarding the provision of medications when out to court, in transit to outside appointments, or during transfer. Peer review documents adequately lay out expectations for monitoring of psychotropic medications.

RUHS-BH Data

The report "Behavioral Health Detention Indicators" from 1/1/19-1/31/19 includes a report based on electronic medication administration records (E-MAR). It shows recorded missed doses of psychotropic medications in only 1.14% of 74,105 administrations. Only 30 medications were missed three or more times. It is important to recall that the accuracy of this data is dependent on nurses reliably recording whether patients took medications, including the quality of mouth checks to assure that medications were swallowed. Regardless, these numbers are quite low and even slightly better than previous data. Note that this is not a measure of lapses of prescriptions, that is, when prescribers fail to timely update medications.

Medical record review shows that of 19 patients on LAI antipsychotics requiring monitoring, only 3/19 = 16% were properly monitored. Psychiatrists almost never obtain baseline laboratories and rarely monitor for metabolic syndrome (with the exception of the DCU and Indio where monitoring is done more reliably). Checking of levels for medications such as valproic acid and lithium is uneven. Abnormal Involuntary Movement Scales (AIMS) are being done more reliably. Of these 19, 14/19 = 74% received the LAI antipsychotic timely across the order period.

Chart reviews of those in residential settings more than 30-days (see APPENDIX) demonstrate that laboratory medication monitoring is adequate in 5/18 cases and AIMS were timely in 11/15 cases.

Summary

Twice daily pill lines are reportedly being provided at all housing units but there is no data or proof of practice. Psychiatrists reported no problems if special pill times are needed. While complaints of untimely medication administration are fewer, there are still numerous reports from staff and patients alike that medications are still coming more than an hour late, primarily at evening pill call at RPDC. MARs indicate that medications generally are being administered reliably. However, LAI are not being administered sufficiently reliably. The subtopic of pill call and alternative medication administration (e.g., LAI antipsychotics) is in partial compliance.

Policies, procedures, and published expectations (including peer review documents) are sufficient for medication monitoring. Psychiatrists are still challenged to see new patients and those just started on medications timely but are seeing established patients regularly and timely. Laboratory studies are still

not being done consistently for medications needing monitoring and AIMS are occasionally not done timely. Medication lapses also remain a problem. I have not received policy or procedure regarding court medications, in transit medications, or transfer medications.

There is also no proof of practice for court (and other transport) medications though there are some processes that have been established to assure medications are available during transport and court. Their efficacy is unknown.

I saw no evidence of problems filling orders from the pharmacy or with floor stock. However, I received no proof or practice of this element. This element is likely in or near substantial compliance.

In general, psychiatric performance regarding follow-up, including after bridge medications and other initiation of medication, has improved but is still short of targets. Medication monitoring remains uneven; AIMS are being done more reliably, but laboratory monitoring by most psychiatrists is poor.

Medication Administration and Monitoring, with respect to the mental health component, remains in **partial compliance**, largely owing to lack of proof of practice for pharmacy deliveries, pill line times, and court and other transit medications, as well as needing improvement needed in psychiatric follow-up and medication monitoring.

Confidentiality

There have been no significant changes or developments here. Progress will depend mostly on completion of planned construction at CBDC and RPDC. This should allow reduction of cell front visits, one of the chief problems with confidentiality, and improve access to care as well.

In general, respect for confidentiality on the part of most custody staff was reasonable. Clinicians note that this continues to be going well in most instances, though there remain challenges with some individual Deputies, especially around refusal to bring out patients, forcing cell front contacts. While this is sometimes reasonable and occasional challenges are to be expected, it is a recurrent problem, especially on HU-16 at SCF with certain teams.

When QMHP encounters are not at cell front but in provided booths and office spaces, confidentiality is adequate. As noted above, intake screening by QMHPs is confidential except at those locations where the intake area has not yet been modified, primarily CBDC and, to a lesser extent, RPDC. While custody attends pill call, clinical staff do a good job of limiting discussion of protected health information. It is reasonable for custody to attend pill call both for exchange of information and to assist in the process. Psychiatric visits are subject to the same limitations as QMHP visits; when not at cell front (cell front visits are primarily a problem at RPDC for both psychiatrists and QMHPs and at SCF for QMHPs), they are sufficiently confidential. Groups are being run in program rooms that are visible to others but provide for privacy of conversation; this is reasonable in the correctional setting.

Those custody staff that review grievances, which may include healthcare grievances, are supposed to have received training related to confidentiality of medical information. Previously provided information on HIPAA training was primarily a recitation of the statute itself rather than instruction on how to implement HIPAA. Custody staff I interviewed seemed to have a generally sound understanding of the need to know standard as did mental health staff, with almost all properly emphasizing the prevention of harm as the main general reason for breaching confidentiality. Previously, about half the sergeants were trained in HIPAA:

- Blythe – 4/9
- CBDC – 22/22
- Indio – 10/22
- RPDC – 16/49
- SCF – 36/40

A more recent training, entitled “Know Your HIPAA” from Riverside County Correctional Health Services provides a little more guidance regarding minimum necessary information and need to know. Rosters of custody participation in 2019 from CBDC, RPDC, and SCF (none were received from Indio or Blythe) shows that overall, 474/800 = 59% of custody staff at these facilities were trained. Both CBDC and RPDC were about 70% while SCF was about 40%. There were no significant differences between different categories of custody staff; those with access to healthcare grievances (that is, the grievance sergeants) are required to have confidentiality training but it is unclear which those are in the rosters provided. If only those sergeants who were trained in HIPAA are reviewing grievances, then this is adequate in terms of the remedial plan. All the sergeants I interviewed stated that they had had HIPAA training. One sergeant at Indio reported that there had been a HIPAA refresher 6-8 months previously for those who had not previously received this training.

The RCSD policy 508.06 Inmate Medical Care includes adequate provisions for confidentiality, even requiring that both custody and healthcare staff get permission when healthcare staff wish to have custody be within hearing distance. However, I saw many instances where custody staff were within listening, many of which were clearly routine, including cell front contacts by mental health, safety cell assessments, and pill call. As I have noted previously, this is not a problem for pill call but the excessive number of cell front contacts by mental health and the limited confidentiality of these visits remains a problem. As noted above, cell front wellness checks (rounds) are a reasonable component of health surveillance but are not treatment. Cell front assessment is also reasonable in some cases where patients are extremely agitated, but such situations should almost always result in some mental health intervention; if a patient is so dangerous owing to mental illness, treatment is required, potentially including involuntary and/or emergent treatment.

Summary

This element of Health Care Generally, with respect to the mental health component, remains in **partial compliance** but should be readily brought into substantial compliance once construction is completed, assuming there are adequate numbers of runners or other provisions for accessing confidential locations and cell front visits are substantially reduced. Confirmation that grievances are only collected and reviewed by sergeants who have received HIPAA training is also needed.

Health Care Records

There is now an EHR that both medical and mental health clinicians can fully access. The document “RUHS-BH Detention Services Policy – Process for making changes to the Detention electronic health record known as TechCare” provides for a committee that includes representatives from RUHS-BH and RUHS-CHS to work with RUHS-IT and the EHR vendor to make modifications to the EHR. And as noted in previous reports, changes have been made to the EHR in response to clinical and data needs.

Summary

The County provided policy that meets the terms of the Remedial Plan, this item is in **substantial compliance**.

Timely Access to Care

The subtopics of **Timely Access to Care** are:

- Inmate healthcare requests
- Inmate declared emergencies
- Clinician initiated follow-up

Note that access to care is also relevant to mental health treatment generally (without access, there is no care), rather than the limited areas officially designated under access to care in the Remedial Plan. Thus, this topic is also addressed in the section "Mental Health Care" below.

Observations and Interview

Health Care Request Forms are only available on the units, not in libraries and program rooms. The parties should revisit this requirement to determine whether spaces outside of living areas require these forms to be stocked. Health Care Request Forms were available on the vast majority of units I visited. They were missing on three dayrooms at SCF, though reportedly had been stocked that morning, and two at CBDC. These represented a small minority of the dayrooms visited. Most were well stocked. All housing units had lock boxes except medical floors, where they are collected by nurses, and units with one-man cells where nurses told me inmates generally put them in the slot of the door and they are collected by nurses. I was also told by administrative leadership that those in administrative segregation place forms in a lock box on the unit and that these are collected on the same schedule as other units (see below); they may also be collected during nursing rounds Mondays, Wednesdays, and Fridays.

Virtually no health care staff reported helping illiterate inmates write Health Care Request Forms, as required by the Remedial Plan, instead noting that other inmates provided this assistance. Staff at RPDC noted that they generally inform Deputies of inmates who cannot write and ask that Deputies solicit verbal requests for healthcare and then call a clinician, usually a nurse. This is despite the fact that policy RUHS-BH Detention Services Policy: Behavioral Health Care Requests and Services expressly provides that "Inmates are informed that they may request assistance in completing a healthcare request form from any Correctional Health Serviced (CHS) or Behavioral Health Services (BHS) staff member."

At Blythe, nurses collect Health Care Request Forms and triage them. If there is an immediate concern, they contact the Clinical Therapist or, after hours, a QMHP at Indio. Since they do not triage these at night, the lack of night QMHPs at Blythe or Indio does not present a problem for this method.

At Indio, night shift nursing staff collects and scans Health Care Request Forms. Those for mental health are sent to RPDC for review and the patient is placed in the mental health queue for local follow-up by a QMHP. For emergent cases, nurses either contact a local QMHP or, during the night, an RPDC QMHP.

Nurses collect Health Care Requests from lock boxes on night shift at CBDC and then triage them and forward them to RUHS-BH, also entering the case in the mental health queue in the EHR. A QMHP triages these in the morning.

At RPDC, nurses collect Health Care Request forms from lock boxes at about 0300 and triage them, sending them to RUHS-BH if they include mental health concerns and enter the case in the mental health queue in the EHR. A QMHP reviews these in the morning. Nurses call if there is an emergent issue.

At SCF, nursing staff collect Health Care Request forms from lock boxes typically at 2300 and triage them about 0100. Nursing staff reported that they collect them directly from those on administrative segregation during pill call or during routine rounds on Monday, Wednesday, and Friday. They then give them to RUHS-BH who signs for them and scans them into the EHR.

RUHS-CHS nursing staff have continued tracking the retrieval of Health Care Request Forms in logs detailing the disposition of each form.

RUHS-BH Data

The report "Behavioral Health Detention Indicators" from 1/1/19-1/31/19 shows the following with respect to response to inmate requests for mental health care:

- Of 135 patient generated Health Care Request Forms for behavioral health needs, the average days to completion was 1.4 days.
    - 68/83 (81.9%) of priority requests were seen within 48 hours (or 72 hours over weekends)
    - The computed time was from when the sick call request was entered in the EHR by a nurse; time from the actual Health Care Request was not included nor was the time the form was picked up by nursing staff. It was not clear from the data whether all 135 were responded to.

I requested, but did not receive, data on the timeliness of nurses picking up Health Care Request Forms and delivering them to mental health.

Developing a mechanism for tracking responses to psychiatric emergencies remains challenging. QMHP response to safety cell placements (see Suicide Prevention below) demonstrate prompt response. While this does not guarantee that a QMHP is responding promptly to all emergencies, it is likely a reasonable proxy.

In terms of follow-up, QMHPs regularly conduct follow-up visits without requiring a Health Care Request Form to be completed. These are sometimes regular and scheduled and other times contacts are simply made when convenient. Groups are being regularly scheduled and usually held on time. Psychiatrists are routinely scheduling patients for follow-up.

Summary

There is some lack of consistency in how Health Care Request Forms are collected from those on administrative segregation but as long as the County can demonstrate that the forms are collected daily and meets the requirements of direct viewing by healthcare staff if picked up by Custody (which no facility reported doing), the method is up to the County.

Policy has provided for, and mental health clinicians make, appointments for follow-up so this subtopic is compliant. Presumably, the previous policy "Riverside County Department of Mental Health, Mental Health Detention Services, Section III. Policy/Procedure 302: Follow Up Assessments" that provided for

clinicians to schedule appointments without an inmate request has a current counterpart in RUHS-BH; this should be verified.

It does not appear that health care staff are assisting inmates in completing Health Care Request Forms, as provided in policy and required by the remedial plan.

The County continues to make steady progress on responding to inmate Health Care Requests. There is still further work to do on proof of practice but logs demonstrating collection of forms is a good start, though I did not receive any of these or any aggregate data based on them. A conjoint quality management process will be necessary to fully comply with the requirement for tracking the timely collection, triaging, and response to such requests for mental health services.

There is still no mechanism for tracking inmate declared psychiatric emergencies.

Timely Access to Care remains in **partial compliance**.

STAFFING

Elements of staffing relevant to mental health care include:

- **Staffing sufficient to execute the Remedial Plan**
- **90% filled positions**
- **Clinicians meet community standard of care**
- **Annual assessment of the adequacy of staffing**

Observations and Interviews

The only mental health staff at Blythe is a single Clinical Therapist; the other Clinical Therapist position was never able to be filled and was moved. Psychiatric services are exclusively by telepsychiatry from Indio, which continues to work well.

SCF was in the process of hiring two new BHSs at the time of my visit. There were about 2.5 FTE psychiatrists for HU-16 and another 2 FTE for the rest of the facility.

Runners continue to be available at all facilities except Blythe. At Indio, there are two runners during the day, one each for mental health and medical, and one during swing shift. This is a big help but does not meet all the escorting needs so other staff assist; when unavailable, some appointments are cancelled or meetings are held at cell front.

SCF has one runner for HU-16 and four runners for the new clinic.

RUHS-BH Data

The document Riverside University Health System – Behavioral Health, Jail Staffing dated 1/7/19 shows the mental health staffing as of that date. The number of positions remains the same at 150 but the filled has increased from 128.48 to 136.64, putting the overall fill rate at 91%, over the 90% benchmark in the remedial plan. There were no significant changes in the general distribution of job classes. The biggest gains were in the Clinical Therapist job class, a welcome improvement.

The lowest fill rate is 84% at RPDC, which is also the site with the most seriously mentally ill patients, though there are many at SCF as well. The main shortages at RPDC are Clinical Therapists and Psychiatrists, the core clinical providers. The only other notable shortages were Recreation Therapists.

Below is a table of system-wide positions.

Position Type	Funded FTE	Number Filled	Percent Filled
Sr. Medical Records Technician	4	4	100%
Office Assistant II	7	6	86%
Office Assistant III	5	5	100%
Behavioral Health Service Supervisor	7	7	100%
Clinical Therapist II	76	69.5	91%
Behavioral Health Specialist III	4	3	75%
Behavioral Health Specialist II	21	20	95%
Senior Clinical Therapist	6	5	83%
Recreation Therapist	5	2	40%
Psychiatrist IV	13	13.14	101%
Medical Records Technician	2	2	100%
Total	150	136.64	91%

Summary

There is still no annual assessment of staffing that addresses the requirements in the remedial plan; this element is **non-compliant**. Largely owing to the lack of such a report and the fact that data are not sufficiently developed to determine whether failure to meet the requirements of the remedial plan are due to inadequate staffing; this element is **not rated.**

Mental health has more than 90% of positions filled, so this element is in **substantial compliance.**

Meeting the community standard of care is little different from meeting the terms of the remedial plan. However, a different way to view this, and the view taken here, is to differentiate the care provided in individual cases from the ability of the system to care for the total population. Put differently, the former answers the question whether care, when provided, meets the standard of care. This contemplates all realms of clinical activity from intake to treatment to discharge planning. It is also a largely qualitative assessment. This content is addressed in the relevant sections and in my case reviews in the Appendix. In general terms, there remain some shortcomings in the intake process (primarily bridge medications) and medication monitoring as above. The care provided by non-psychiatrists is uneven. In most cases, individual contacts and groups are sound, but there is room for improvement, especially with individual contacts which tend to consist in assessment but often show little evidence of treatment rendered. Treatment plans are being done in most cases but are quite generic and non-specific. In short, the quality of care usually does meet the standard of care when provided, just not yet consistently.

The other aspect, caring for the total population, can be equated with access to care at a population level. This primarily contemplates timeliness of care and ability to provide adequate treatment dosage. Timeliness data shows that most contacts are timely, but these data primarily track one-time events

such as intake, assessment, and health care request responses. The greater problem is that individual contacts and groups are far too infrequent to meet the standard of care, especially for the most seriously mentally ill. It is not clear whether this is attributable to limited mental health staffing, inability of the available staff to access patients, or both. Review of medical records (Mental Health Care, Treatment section below and Appendix) demonstrates that in some cases, gaining access to patients is a problem. Access is clearly a problem for those on administrative segregation where cell front contacts (that do not qualify as treatment) are the rule.

As there were no clinical productivity data provided, it is difficult to know whether the mental health staff are operating at full efficiency, but informal reports suggest that staff productivity is above average. While such data are not explicitly required by the Remedial Plan, an analysis of the adequacy of staffing would clearly require this as well as setting general benchmarks for treatment dosage. Benchmarks exist for the frequency of visits by Clinical Therapists and psychiatrists that are reasonable in general terms, but individual cases may require more frequent contact than the minimum contacts required by the benchmarks. For example, it is reasonable for a psychiatrist to see a stable patient every 90 days, but it is not reasonable for an acutely ill patient. The same is true for the monthly individual Clinical Therapist contacts required for those at higher levels of care; sometimes more than monthly visits are needed. Chart review demonstrates that, in many cases, more frequent contacts are being done when necessary, but not always. Here again, one of the main challenges is providing higher treatment dosage for those on administrative segregation, who are often the most ill. This is evident in the reviews of medical records summarized in the APPENDIX.

There are no benchmarks for providing groups, which are reaching only a small portion of the population in need, also evident in the medical records reviews in the APPENDIX.

As the standard of care is more often met than not, when care is provided, this element is rated **partially compliant.**

CUSTODIAL ENVIRONMENT

Though this item is listed under Health Care Generally, most of the elements have nothing to do with healthcare, so it is treated as a separate item. The item consists of the following elements:

- **Policies and procedures to maximize dayroom time**
- **Dayroom time**
- **Recreation (yard) usage**
- **Programming and structured activities in mental health housing**
- **Self-isolating inmate training**
- **Custody referrals to mental health**
- **Inmate classification**
- **Administrative segregation**

General Observations and Interviews

I note that the jails were somewhat less cleanly than on previous visits, especially RPDC and CBDC.

Inmates at Blythe were clearly the most satisfied with custodial conditions, including the professionalism of custody staff and promptness of response to problems such as plugged toilets. Inmates at Indio and SCF were most dissatisfied with the professionalism of custody staff with several inmates at SCF reporting excessive use of force by Deputies on some shifts. One patient at SCF reported that he had pushed his call button recently because of abdominal pain and diarrhea but got no answer; he also stated that he had been previously told to limit his use of the call button. Clinical staff echoed concerns about the professionalism and cooperation of some deputy teams at HU-16 and even noted retaliation when systems issues were raised, including name calling and slow responses to bringing out patients for clinical services. I noted that many patients had long nails at SCF and were unshaven; they told me that they were not allowed to use nail clippers and complained of difficulty getting a haircut and shave. However, both patients and clinical staff reported that most deputy teams were helpful and professional.

Custody staff uniformly reported dayroom times as beginning at 0800 and ending at 2300 except at Blythe where it reportedly began at 0700. At SCF, all units come out as the full dayroom regardless of classification except HU-16, the residential mental health unit. At CBDC, larger dayrooms also come out by tiers. Those on administrative segregation come out one at a time throughout the system. All similarly reported that suspension of dayroom time was rare and usually followed a fight with the dayroom opening that same shift unless there was a group disturbance, which might lead to suspension for 24 hours. Custody staff at Indio noted that dayroom suspension required supervisor approval.

Custody staff similarly reported that all inmates were offered yard twice a week for a total of three hours, except at SCF where yard times were sometimes noted to be one hour but reportedly were offered more than twice week (note that the yard for HU-16 is connected to the dayroom and generally available to inmate-patients during dayroom time). Staff at Blythe noted that sometimes yard is cancelled due to being short-staffed but that they tried to make it up later in the day, sometimes up to 2300 at night. Custody staff reported some problems with tracking yard usage and noted that, at least at Indio, tracking was returned to classification rather than floor staff to improve the quality of data. At CBDC, recreation is tracked by two recreation deputies who reportedly track this by individual inmate. Staff reported rare yard suspensions (it was suspended at Indio the day I was there, reportedly because an inmate had broken lights with a handball).

Inmates reported that yard times were generally offered at Blythe, though often at hours they did not want to attend. Those at Indio noted that yard times were sometimes cancelled but usually were conducted, though often for less than an hour and a half. Almost all inmates at both these facilities are in dormitory style units, so dayroom time is not an issue. The few that are not generally reported that dayroom times were offered as scheduled.

Patients on HU-16 gave varying reports about yard availability, but several noted that it was available most of the time when they were in the dayroom. Most reported very limited dayroom time, all reporting between 1.5 to 3 hours per day.

Patients at RPDC reported dayroom being available 3-4 times per day for 45 minutes to as much as two hours. They gave varying reports about yard access, but most reported it was offered twice each week, with several noting that it was available “too early” and that it was cold at that time.

Whether inmates are classified according to policy is unclear. No data on inmate classification were provided. Those with mental illness are subject to more restrictive conditions, e.g., on HU-16 where they are not allowed as much out of cell time as inmates of similar classification.

It is important to note that the mentally ill with higher acuity ratings on administrative segregation that were historically housed at RPDC are being transferred to a housing unit at CBDC. How this will be run and what impact it will have on out of cell time and access to care will be assessed at the next report.

I attended a five-minute morning meeting including custody, nursing, and mental health at 0900 at SCF. There was virtually no discussion. Only one case was discussed; an inmate who was upset about a new charge and potential long sentence. There was no discussion of inmates who were not coming out of their cells or not allowed to come out of their cells or the progress or lack of progress of any others. As I had noted previously, custody staff sat in the back of the room and clinical staff in the front. There was very little interaction. At 0905, there was a brief mental health and medical meeting that also discussed just one patient with chronic medical issues.

At RPDC, I attended two joint meetings between custody, medical, and mental health (male and female residential units). There was much more robust discussion of multiple patients, expected admissions, and discharges. They identified clogged plumbing, addressed three patients not wanting their cells cleaned and how to evaluate and address their cleanliness, and had good discussions about several patients. There was good interchange of relevant information between disciplines.

Policies and Procedures to Maximize Dayroom Time

I have not been provided a policy that expresses an intent to maximize dayroom time.

Dayroom and Recreation

Patient Reports

At Blythe, where almost all are in dormitories, dayroom is not a substantial issue. Inmates report that yard is usually available in one-hour sessions for a total of three hours per week. Though the schedule stated that morning yard time was 0800, staff and patients noted that it was sometimes done at 0630 (after breakfast) to allow yard before it got too hot.

At CBDC, inmates reported no problems with yard or dayroom access. They reported being offered yard twice weekly for 1 and a half to two hours.

Inmates at Indio reported that they get three hours of yard time per week. Most are in dorms so that dayroom time is not generally a problem.

Patients at RPDC gave varying reports; many of these individuals were severely mentally ill. Most reported getting out of their cells once daily for 30-60 minutes. They reported getting access to the yard once or twice each week.

Patients at SCF, many also severely mentally ill, gave varying reports on dayroom time, from 30-60 minutes to three hours daily. All reported coming out one tier at a time (different from general population units, such as housing unit 15, where both tiers come out at the same time). There were many complaints regarding limited out of cell time. They reported being offered yard usually twice weekly for 45 minutes, though some noted that it was usually available whenever they were in the

dayroom. The patients reported eating in their cells; the pilot of staff eating with patients seems to have been halted.

RCSD Reports

RCSD has been hand collecting data on dayroom time and yard usage. I again commend the effort but note that it is an inefficient and error-prone approach.

For dayroom time, RCSD provided information for two weeks in January from all facilities except Blythe and Indio, which have mostly open dayrooms. Inspection of the raw data reveals that dayroom times rarely start before 0800 or end past 2300. There was no report on suspension of dayroom and inspection of the raw data did not show any information on suspensions. There were occasional notations of cancellation and yard times varied quite widely with some being quite short; it is unclear if some of these are due to suspensions. Thus, it is not possible to comment on the extent of suspensions; however, for the weeks reviewed it did not appear that there were substantial limitations on dayroom time due to cancellations or suspensions of dayroom access.

At CBDC, results were similar to results at the time of the Fourth Report, though showing slightly less time out. Data was from Housing Units C, D, E, F, and G for 1/6/19-1/19/19 (except dayroom 2 from C and D). The raw data again show that inmates are coming out by tiers (upper and lower) for some dayrooms and both tiers for others, each generally in 30-60-minute blocks of time. Inmates coming out by tiers receive an average of between 3.0 and 3.7 hours per day and those coming out by dayroom receive an average of between 6.2 and 7.1 hours per day. Times are fairly consistent from day to day. However, as was the case for the last report, there were no data on individual times out of cell for those on administrative segregation, so it is not clear how much time out of cell this population receives at CBDC. Though this population did not historically include inmates with serious mental illness, beds were recently repurposed to house some of the mentally ill at RPDC that were on administrative segregation. It will be essential to track this population separately, even if they are not formally on administrative segregation.

As noted above, there were no data from Indio, including Housing Unit 18, the only unit without an open dayroom. Last time, this unit received only about an hour of dayroom time daily, but this unit does not house any seriously mentally ill.

At RPDC, data was provided for Housing Units 3A (male PC, level 3-5, and “GP GOALS”), 3B (“GP Trusty,” levels 1-4, 4 and GP males, levels 4-5), 4A dayroom 1 (female GP, level 3-5), 4A dayroom 3 (female mental health and PC, level 1-5), 4B (female mental health, level 1-5), 5A (male mental health, mental health PC, and Liberty, level 1-5), and 5B dayroom 2 (male mental health PC, level 1-5). This is again not complete data for the residential mental health units but gives some idea of how dayroom time is being managed and provides data from other units not designated as residential mental health for comparison.

Inmates come out by tiers on units 4A (sometimes), 4B, and 5B but both tiers come out together on the remainder, which are not mental health units. Note that no data were provided for the mentally ill on administrative segregation (5B dayroom 1 for males and 6A dayroom 2 for females).

Data were provided in aggregate, so it is unclear how long dayroom times lasted. Total daily out of cell time varied from either zero (or this was missing data – the report does not specify) or 1.5 hours to 12.57 hours.

RCSD reported the average hours out of cell daily for different populations. It is unclear whether this was based on 10 days or 14 days (which is moot if there is no dayroom time on weekends). They reported as follows:

- General Population (GP) = 6.72 hours/day (1/7-1/11) and 4.6 hours/day (1/14-1/18)
- Protection Custody (PC) = 6.28 hours/day (1/7-1/11) and 3.9 hours/day (1/14-1/18)
- GP SMI = 10.45 hours/day (1/7-1/11) and 6.33 hours/day (1/14-1/18)
- PC SMI = 9.71 hours/day (1/7-1/11) and 6.63 (1/14-1/18)

It is not clear how RCSD calculated average dayroom times. Out of cell time should be reported as the average (offered) per individual. However, it appears that the data were collapsed across different units and dayrooms with different populations, in which case the average time is not the average offered per individual because these locations house different numbers of inmates, so the data should be normalized to the population on each of the units included in the average. RCSD needs to include its methodology when sending data so that such calculations can be checked.

Doing my own calculations based on the raw data RCSD provided, I found the following by unit (and sometimes tier) across the two weeks of data:

- Unit 3A (PC males, levels 3-5, and "GP GOALS") = 10.0 hours/day
- Unit 3B ("GP Trusty," levels 1-4, 4 and GP males, levels 4-5) = 8.0 hours/day
- Unit 4A, dayroom 1, top tier (female GP, level 3-5) = 5.1 hours/day
- Unit 4A, dayroom 1, bottom tier (female GP, level 3-5) = 5.0 hours/day
- Unit 4A, dayroom 3, top tier (female mental health and PC, level 1-5) = 3.4 hours/day
- Unit 4A, dayroom 3, bottom tier (female mental health and PC, level 1-5) = 3.2 hours/day
- Unit 4B dayroom 1, top tier (female mental health, level 1-5) = 3.3 hours/day
- Unit 4B dayroom 1, bottom tier (female mental health, level 1-5) = 3.5 hours/day
- Unit 4B dayroom 2, top tier (female mental health, level 1-5) = 3.1 hours/day
- Unit 4B dayroom 2, bottom tier (female mental health, level 1-5) = 3.2 hours/day
- Unit 5A (male mental health, mental health PC, and Liberty, level 1-5) = 6.6 hours/day
- Unit 5B, top tier (male mental health PC, level 1-5) = 4.0 hours/day
- Unit 5B, bottom tier (male mental health PC, level 1-5) = 3.8 hours/day

This demonstrates the importance of tallying the data properly. Contrary to the averaged data presented by RCSD, this analysis clearly shows that those housed on the residentially mental health units consistently get less dayroom time. Note also that this does not include all male residential mental health units.

At SCF, data was provided for Housing Units 15 (GP, level 3-5), 16 (mental health, level 1-5), and 17 (GP, level 4-5); the other units have open dayrooms. On HU-15 and HU-17, top and bottom tiers come out at the same time and on HU-16 they come out separately. The data show the following average dayroom times for the two-week period:

- HU-15 = 5.7 hours/day
- HU-17 = 6.0 hours/day
- HU-16, top tier = 2.3 hours/day
- HU-16, bottom tier = 2.3 hours/day

In addition to the substantial difference created by universally doing dayroom by tiers on the mental health residential unit, the total average dayroom times for HU-16 are 2.3 + 2.3 = 4.6, which is less than the other units. This was a consistent finding across days rather than a difference created by substantial reductions on particular days. In general, there was less variation from day-to-day in dayroom times at SCF. The number of sessions of dayroom was similar to the previous report. The total hours out of cell were slightly greater than previously; it is unclear whether this reflects a trend or random fluctuation.

Individual dayroom time for administrative segregation inmates was not provided so it is not clear how much out of cell time they are receiving and how administrative segregation differentially affects the mentally ill and non-mentally ill. Out of cell time for those on administrative segregation and in the new CBDC unit housing mentally ill patients formerly on administrative segregation at RPDC also needs to be tracked.

These data clearly demonstrate, consistent with the reports of the patients themselves, that the mentally ill are provided substantially less dayroom time than other inmates. It is clear from the data that this is due in part because they are coming out by tier whereas other comparable units come out as the whole dayroom. Classification level cannot account for this as, for instance at SCF, the classification levels of the GP units are higher than the mentally ill residential units.

RCSD provided a report on yard times for February 2019 from all facilities. At Blythe, the data show that all dayrooms were offered two yard sessions per week and indicates that each session was offered for 90 minutes. A small minority of inmates attended yard and yard times were occasionally curtailed, reportedly by inmate request. Access to the yard was between 0635 and 1500. However, if no inmates attended yard, no start time was listed. This is important as it appears from the data that earlier times may be associated with lower attendance, which is understandable in the winter. While it is reasonable to offer early morning yard times in the summer, it is not reasonable in the winter. However, the remedial plan does not specify when yard recreation may be offered as it does for dayroom times.

At Indio, where there are no residential mental health units, of the housing units reporting, 95% of weekly yard quotas were met, including inmates on administrative segregation. Like Blythe, yard times often started as early as 0600 but there were also evening times finishing as late as 2303 and a number after 2000 when it would be dark. Fewer inmates appeared to refuse recreation than at Blythe, but refusal rates were still substantial.

The refusal rate was not as high at CBDC, with an overall refusal rate of 56.4%. The data show that about 75 yard sessions were cancelled due to rain. These were appropriately included in the average calculations and largely accounted for the failure to achieve 90 minutes per session. Three sessions were cancelled due to a "disturbance." The two weeks of data were aggregated by RCSD into dayrooms that served GP and PC inmates. The results were:

- GP: 173 sessions of recreation averaging 61.5 minutes
- PC: 82 sessions of recreation averaging 64 minutes

Even though these average yard hours were substantially below 90 minutes, all dayrooms were counted as compliant. It is reasonable to count yard sessions refused by all inmates as 90 minutes and yard times curtailed at inmate request as 90 minutes but if the reason for cancelling yard due to rain is failure to provide proper clothing or shelter, that is unreasonable; either proper clothing or shelter should be provided or the sessions made up.

RPDC made several housing moves related to construction. These results are tallied from the two weeks of raw RCSD data according to the RPDC housing profile at the time. The results were as follows:

- 3A dayroom 1 (PC males, level 3-4)
    - Inmates were offered 10 yard times, more than two yard times weekly
    - All inmates reportedly refused 4/10 = 40% of yard times
    - Inmates refused 76.5% of total yard slots (by "slot" I mean a yard session available to an individual)
    - Yard times were at least 90 minutes unless inmates requested to return before that (one instance)
- 3A dayroom 2 (PC males, level 4-5)
    - Inmates were offered 12 yard times, more than two yard times weekly
    - All inmates reportedly refused 3/12 = 25% of yard times
    - Inmates refused 79.3% of total yard slots
    - Yard times were at least 90 minutes unless inmates requested to return before that (two instances)
- 3A dayroom 3 (male "GP GOALS")
    - Inmates were offered 9 yard times, more than two yard times weekly
    - All inmates reportedly refused 0/9 = 0% of yard times
    - Inmates refused 33.5% of total yard slots
    - All but one yard times were at least 90 minutes unless inmates requested to return before that (one instance)
- 3B dayroom 1 (male "GB Trusty," level 1-4)
    - Inmates were offered 8 yard times, two yard times weekly
    - All inmates reportedly refused 2/8 = 25% of yard times
    - Inmates refused 88.3% of total yard slots
    - Yard times were at least 90 minutes unless inmates requested to return before that (six instances, all attended yard times)
- 3B dayroom 2 (GP males, level 4-5)
    - Inmates were offered 8 yard times, two yard times weekly
    - All inmates reportedly refused 3/8 = 37.5% of yard times
    - Inmates refused 87.5% of total yard slots
    - Yard times were at least 90 minutes unless inmates requested to return before that (two instances)
- 4A dayroom 1 (GP females, level 3-5)
    - Inmates were offered 8 yard times, two yard times weekly
    - All inmates reportedly refused 3/8 = 37.5% of yard times
    - Inmates refused 92% of total yard slots

  - Yard times were at least 90 minutes unless inmates requested to return before that (five instances, all attended yard times)
- 4A dayroom 3, bottom tier (female mental health and PC, level 1-5)
  - Inmates were offered 7 yard times, less than two yard times weekly
  - All inmates reportedly refused 2/7 = 28.6% of yard times
  - Inmates refused 79.5% of total yard slots
  - Yard times were at least 90 minutes unless inmates requested to return before that (three instances)
- 4A dayroom 3, top tier (female mental health and PC, level 1-5)
  - Inmates were offered 7 yard times, less than two yard times weekly
  - All inmates reportedly refused 5/7 = 71.4% of yard times
  - Inmates refused 90.9% of total yard slots
  - Yard times were at least 90 minutes unless inmates requested to return before that two instances, all attended yard times)
- 4B dayroom 1, bottom tier (female mental health, level 1-5)
  - Inmates were offered 8 yard times, two yard times weekly
  - All inmates reportedly refused 1/8 = 12.5% of yard times
  - Inmates refused 77.4% of total yard slots
  - Yard times were at least 90 minutes unless inmates requested to return before that (six instances)
- 4B dayroom 1, top tier (female mental health, level 1-5)
  - Inmates were offered 8 yard times, two yard times weekly
  - All inmates reportedly refused 0/8 = 0% of yard times
  - Inmates refused 62.5% of total yard slots
  - Yard times were at least 90 minutes unless inmates requested to return before that (five instances)
- 4B dayroom 2, bottom tier (female mental health, level 1-5)
  - Inmates were offered 8 yard times, two yard times weekly
  - All inmates reportedly refused 1/8 = 12.5% of yard times
  - Inmates refused 62.1% of total yard slots
  - Yard times were at least 90 minutes unless inmates requested to return before that (six instances)
- 4B dayroom 2, top tier (female mental health, level 1-5)
  - Inmates were offered 8 yard times, two yard times weekly
  - All inmates reportedly refused 0/8 = 0% of yard times
  - Inmates refused 64.5% of total yard slots
  - Yard times were at least 90 minutes unless inmates requested to return before that (eight instances, all attended yard times)
- 6A dayroom 1 (male mental health, level 1-5)
  - Inmates were offered 9 yard times, more than two yard times weekly
  - All inmates reportedly refused 1/8 = 25% of yard times
  - Inmates refused 86% of total yard slots
  - Yard times were at least 90 minutes unless inmates requested to return before that (three instances)

- 6A dayroom 3 (male mental health and Liberty, level 1-5)
  - Inmates were offered 9 yard times, more than two yard times weekly
  - All inmates reportedly refused 1/8 = 25% of yard times
  - Inmates refused 83.5% of total yard slots
  - Yard times were at least 90 minutes unless inmates requested to return before that (five instances)
- 6B dayroom 1, bottom tier (male mental health PC, level 1-5)
  - Inmates were offered 8 yard times, two yard times weekly
  - All inmates reportedly refused 0/8 = 0% of yard times
  - Inmates refused 71.4% of total yard slots
  - Yard times were at least 90 minutes unless inmates requested to return before that (five instances)
- 6B dayroom 1, top tier (male mental health PC, level 1-5)
  - Inmates were offered 8 yard times, two yard times weekly
  - All inmates reportedly refused 0/8 = 0% of yard times
  - Inmates refused 73.7% of total yard slots
  - Yard times were at least 90 minutes unless inmates requested to return before that (four instances)
- 6B dayroom 2 (mental health administrative segregation)
  - Inmates were offered 10 yard times, more than two yard times weekly
  - All inmates reportedly refused 2/10 = 20% of yard times (but yard times were marked as 0 minutes for an additional 3 sessions)
  - Inmates refused 92.9% of total yard slots
  - Yard times were at least 90 minutes unless inmates requested to return before that (eight instances, all attended yard times)

It is hard to know what to make of the data from 6B dayroom 2 given that those on administrative segregation are only allowed out singly but the data show from 1 to 4 coming out at a time (1 or 2 for yard times greater than 0). The times for this unit also vary widely from 0 minutes to 155 minutes.

The data also report that sometimes those on mental health units allow both tiers out for yard time including 4A dayroom 3 (female mental health and PC, level 1-5), 4B dayroom 2 (female mental health, level 1-5), and 6B dayroom 1 (male mental health PC, level 1-5). Thus, it is unclear why they cannot come out together for dayroom time.

The yard times offered for the mentally ill at RPDC appear to meet requirements and are similar to the yard times available to non-mentally ill inmates.

At SCF, the data are not as confounded by changes in unit profiles. The summaries provided by RCSD are correct except for unit 12C, which was incorrectly categorized as mental health residential on the report; it was converted back to GP and thus not included in the mental health tallies below.

The summary reports that no GP dayrooms were out of compliance. However, the majority of dayrooms had less than two yard sessions per week: 05D0, 06D0, 07D0, 09DA, 09DB, 09DC, 09DD, 10DA, 10DB, 10DC, 10DD, 11DA, 11DB, 11DD, 12DD, 12DE, 12DG, 15DB, 15DD, and 15DF. This was not due to inmate refusal, as these instances were counted as compliant. Inmates received an average of

35.3 minutes per session. The low numbers were almost all reportedly due to inmate requests to return, though there are several short yard times without specified reasons.

For PC dayrooms, the results were similar except that none of these dayrooms had two yard sessions per week. The average time per session was 36.7 minutes.

For non-PC mental health dayrooms, it is very difficult to make sense of the data. All are reported as compliant, yet the results are as follows:

- 12DA
    - Inmates were offered 5 yard sessions
    - All inmates reportedly refused 1/5
    - Inmates refused 80.4% of total dayroom slots
    - No yard times were for 90 minutes, all reportedly at inmate request
- 12DB
    - Inmates were offered 4 yard sessions
    - All inmates reportedly refused2/4
    - Inmates refused 88% of total dayroom slots
    - No yard times were for 90 minutes, all reportedly at inmate request
- 16DA
    - Inmates on both tiers were reportedly offered 8 yard sessions, all of which were attended by 100% of the dayroom (exceedingly unlikely) – but HU-16 comes out only by tiers
    - Inmates on the bottom and top tiers were each offered one yard session on 2/1/19 which only one inmate from the bottom tier reportedly attended
    - The amount of yard time offered was impossibly lengthy (480 minutes for the 8 sessions of both tiers, 780 minutes for the bottom tier)
- 16DC
    - Inmates on both tiers were reportedly offered 8 yard sessions, all of which were attended by 100% of the dayroom (exceedingly unlikely) – but HU-16 comes out only by tiers
    - Inmates on the bottom and top tiers were each offered one yard session on 2/1/19 which 12 inmates from the bottom tier and 11 inmates from the top tier reportedly attended, each for exactly 60 minutes
    - The amount of yard time offered was impossibly lengthy for most (480 minutes for the 8 sessions of both tiers)
- 16DD
    - Inmates on both tiers were reportedly offered 5 yard sessions, 4 of which were attended by 100% of the dayroom (exceedingly unlikely) and one by none – but HU-16 comes out only by tiers
    - Inmates on the bottom and top tiers were not offered separate yard times
    - The amount of yard time offered was impossibly lengthy for most (480 minutes for the 4 sessions of both tiers)

- 16DF
  - Inmates on both tiers were reportedly offered 4 yard sessions, all of which were attended by 100% of the dayroom (exceedingly unlikely) – but HU-16 comes out only by tiers
  - Inmates on the bottom and top tiers were each offered one yard session on 2/16/19 which no inmates from the bottom tier and 2 inmates from the top tier reportedly attended for 10 minutes
  - The amount of yard time offered was impossibly lengthy for most (480 minutes for the 4 sessions of both tiers)

The situation is similar for the mental health PC dayrooms:

- 14DC
  - Inmates were offered 5 yard sessions
  - All inmates reportedly refused 2/5
  - Inmates refused 92% of total dayroom slots
  - No yard times were for 90 minutes (none were more than 25 minutes), all reportedly at inmate request
- 14DD
  - Inmates were offered 6 yard sessions
  - All inmates reportedly refused 1/6
  - Inmates refused 78.6% of total dayroom slots
  - No yard times were for 90 minutes, all reportedly at inmate request
- 14DE
  - Inmates were offered 6 yard sessions
  - All inmates reportedly refused 1/6
  - Inmates refused 84% of total dayroom slots
  - No yard times were for 90 minutes, all reportedly at inmate request
- 16DE
  - Inmates on both tiers were reportedly offered 8 yard sessions, all of which were attended by 100% of the dayroom (exceedingly unlikely) – but HU-16 comes out only by tiers
  - Inmates on the bottom and top tiers were each offered one yard session on 2/1/19 which 2 inmates from the bottom tier and 1 inmates from the top tier reportedly attended, the former with no time noted and the latter for exactly 60 minutes
  - The amount of yard time offered was impossibly lengthy for most (480 minutes for the 8 sessions of both tiers)

These data for HU-16 are clearly erroneous. However, I was informed both while on site and subsequently that on HU-16, the door to the yard is generally open when patients are in the dayroom. Thus, access to the yard is the same as access to the dayroom. But this erroneous data seems to have been included in calculating the yard time per session and inmate refusal which were as follows:

- SMI
  - 268.1 minutes per yard session
  - 29.3% refusal rate

- SMI/PC
  - 195.4 minutes per yard session
  - 44% refusal rate

These results are clearly erroneous. If yard time for HU-16 is the same as dayroom time, and using the dayroom times from above, HU-16 patients received 2.3 hours of yard access per day. It is important to note that this is not time in addition to dayroom but is at the same time. Thus, it appears that those in HU-16 are getting a total of 2.3 hours out per day whereas on HU-15 and HU-17 (comparable to HU-16) are getting over twice as much dayroom time and yard time in addition that HU-16 does not get.

These data need to be clarified and continue to demonstrate the error-proneness of this method of collecting data.

Programming and structured activities in mental health housing

As noted above, I was provided no data on this topic. Observations and reports reveal that there is very little programming such as education or other custody programs on these units. There are some unit jobs, but it is unclear how many.

Self-Isolating Inmate Training

RCSD reports that "at least 75% of staff on each shift at every jail … received training from jail medical staff regarding the effects of segregation and self-isolation" during the "RSO Staff Training" cited in an April 2017 report. This included three slides on the effects of isolation but does not address self-isolation. The Phase IV Training on the remedial plan contained two slides on the self-isolating inmate; more than 90% of custody staff received this training in 2017. This training is also marginally adequate. None of the training really addressed the problem of self-isolation, that is, the problem of severely mentally patients not coming out of their cells because of their mental illness. It focused almost exclusively on the impact of custody-imposed isolation, which is important but does not get at the need to proactively respond when patients are isolating. That said, the Phase IV slides do operationalize self-isolation as three consecutive days in cell and indicate the expectation of referral to mental health.

From my reviews of charts and observations, mental health staff are aware of patients who are not coming out of their cells or not being allowed out of their cells due to concerns about their behavior, but a proactive approach in such cases was often not evident. Most of these were addressed by ultimate placement in the DCU, though this was sometimes after weeks of isolation in a cell, usually under administrative segregation. As noted elsewhere, the County has not yet implemented involuntary treatment within the jails, part of the reason DCU placement is the primary avenue to address these cases. But this requires that the patient meet criteria for civil commitment. Oftentimes, patients are not seen as meeting civil commitment criteria because they are eating and drinking, even though they are so ill that they are refusing social interaction or are considered so dangerous that they are not being allowed out of their cell. If they are that dangerous or engaging in self-isolation (i.e., high rates of yard or dayroom refusal) that is known to be detrimental to their health, then they should be considered for civil commitment. It should be noted that some of these patients are refusing medical treatment, which is sometimes not being considered in the evaluation of grave disability.

Custody staff on the residential mental health units at RPDC seem much more attuned to the condition and degree of self-isolation inmates are engaging in than at SCF. It is likely that this is due, at least in

part, to the more robust discussions at staff meetings between custody, mental health, and medical at RPDC.

Custody Referrals

There is currently no method to track referrals for self-isolating inmates. However, those on the residential mental health units are discussed in meetings between custody, medical, and mental health at RPDC. Whether this meets the requirement of the remedial plan is not clear.

Custody made referrals to RUHS-BH in 91.5% of cases of inmates receiving lengthy sentences from October 2018 through March 2019. Some without trackable referrals were nonetheless seen by a QMHP. However, the timeliness of the notification and QMHP follow-up are not tracked.

Inmate Classification

I was provided 21 raw classification assessments from RPDC and SCF. All but one had mental health issues noted on the form. Interestingly, all 10 at RPDC were either made PC or administrative segregation while only one of 11 at SCF was made PC. It appears that the classification tree was followed in all cases. However, I am unable to determine whether policy was followed as I do not have the raw data to review. I also do not know whether those placed on PC or administrative segregation were made so per policy. In the future, I request that RCSD conduct its own review of a random sample of 20 mentally ill and determine whether classification was done per policy (proof of practice) which I will then review.

Administrative Segregation

Clinical Therapists at CBDC report that there are some SMI patients in administrative segregation. However, they note that if their acuity requires, transfer to a residential setting is done promptly.

Those on administrative segregation at Indio are allowed 30 minutes out in the dayroom by themselves on a rotating basis through the day. The associated logbook showed this was generally adhered to. There was no other information on out of cell time for those on administrative segregation, including those on the residential mental health units. Thus, it must be presumed that the problems noted in my third report persist.

Regarding yard time, RCSD provided data as above, which was only for Indio (the RPDC data were not readily interpretable). What is not clear is whether those patients marked as refusing yard time were themselves refusing or were considered too unpredictable or violent to come out and were marked as refusing.

As noted in the section Medication Administration, I observed nurses giving medications cell-to-cell for the mentally health segregation unit at RPDC. I was not provided any data on delivery of medications by healthcare staff for all patients in administrative segregation.

I was provided data on the completion of 30-day reviews of those on administrative segregation, including a number on the mental health caseload. The results of these reviews were not included. A reviewed a sample of 20 patients on the mental health case load on administrative segregation for more than 30 days. They required a total of 106 30-day reviews and 102/106 = 96.2% of reviews were conducted. The provisions for placement on administrative segregation are so broad, it would be difficult to say that policy was not followed but nonetheless, the reviews are occurring. RUHS-BH staff

inform me that mental health and classification are jointly reviewing the mentally ill on administrative segregation in the residential mental health units on a regular basis; a tracking system for this is being developed. This should include at least the grounds for the decision regarding continuation of administrative segregation.

Behavior management plans, used to assist custody and mental health in providing consistent and complimentary services, have still not been instituted yet. These are required by the Remedial Plan.

Mental health services for those on administrative segregation are reviewed in the Mental health Care Section.

Summary

The jails were somewhat less cleanly than during my previous visits. However, inmate satisfaction was, if anything, somewhat higher, though I did no systematic review.

I have not been provided policy that specifically reflects "the intent to provide inmates with as much dayroom time as is consistent with institutional safety and security" so this element is **not rated**. If no such policy is produced by the next report, this item will be rated non-compliant.

Access to dayroom and yard remains a problem for those in residential mental health units. They are being systematically offered less time than the non-mentally ill. Dayroom times rarely begin before 0800 and do not extend beyond 2300. Suspension of dayroom time was not addressed in any of the materials provided, but it is also unclear how to assess whether any suspensions are unreasonably long. Yard times vary a good deal but are short of 1.5 hours in a substantial minority of instances, though they are usually provided twice per week (occasionally three times). These two elements are clearly not in substantial compliance. **Partial compliance** is justified for both, primarily due to the County's efforts to make changes to increase access to dayrooms especially and to track dayroom and yard time.

I have been provided no information on programming and structured activities in mental health housing. Observations demonstrate that there are limited programs, but there is not enough information to determine the degree of compliance, so this element is **not rated**. This item will also be rated non-compliant for the next reporting period if no data are produced demonstrating the availability of programming in mental health housing.

The training provided to custody staff regarding self-isolating inmates was marginal at best as it was more targeted at the effects of isolation than identifying and responding to self-isolating inmates, which appears to be the intent of the Remedial Plan. However, as it provides basic guidance to custody, including the expectation of referral and 90% of staff received this Phase IV training, I believe this element must be rated as in **substantial compliance**.

Custody referrals for those who have received lengthy sentences are being done remarkably reliably, given the opportunities for failure. Referrals for self-isolation are difficult to track and the need has been largely obviated by the regular mental health and custody meetings; awareness of self-isolation does not seem to be the problem; it is addressing the problem that is proving challenging. I request guidance regarding whether alternative means of detecting self-isolation (such as regular mental health, medical and custody meetings on residential mental health units) would be satisfactory. Note that referral of self-isolating inmates is not limited to those in residential mental health units so some alternative approach is needed in other settings, which will likely be ordinary custody referral. Referral

of those with long sentences is nearly meeting the compliance standard of 95%; if the measure were being seen by a QMHP, which is clearly most important, it would likely be meeting the standard. This element is rated as in **partial compliance** owing to the problem of tracking referrals for self-isolating inmates.

If the parties agree that the regular morning meetings at SCF and RPDC that address self-isolating inmates in mental health housing, assuming these meetings actually address such issues, coupled with standard custody referrals for other settings are an adequate means of detecting and referring the self-isolating inmate, some standards will be necessary for monitoring. I recommend specifying a frequency for the mental health housing meetings as well as brief minutes to demonstrate self-isolation is being considered. It is not clear how to assess custody referrals from other settings. It would be a helpful for the County to recommend an approach to this.

I was not provided any data on inmate classification generally or that would demonstrate that inmates are not being placed in restrictive settings solely because of mental illness. As noted in my last report, the mentally ill are disproportionately represented in administrative segregation but that does not necessarily mean they are so classified because of their mental illness; it may be their behavior. But until data is produced to demonstrate this, it is not possible to assess this element. Even though I received examples of classification reports, it was not possible to determine if the classification was done per policy without the raw data, so this element is **not rated**.

Those on administrative segregation remain highly isolated, raising concerns about the balance between custody limitations due to actual or presumed risk and mental health determinations of the need for commitment. In terms of those that are not allowed out due to a custody determination that the patient is a danger to others, either that determination is incorrect, or the patient should be committed to the DCU as surely if they are too dangerous to be let out by custody staff, they are dangerous enough to meet civil commitment criteria. For those that are self-isolating, much stronger consideration needs to be given to involuntary treatment in the jail and/or commitment to the DCU as gravely disabled. How much self-isolation is “enough” to determine grave disability is certainly a question, but given the degree of purported yard refusals, the number who are refusing over extended periods is clearly substantial. It can be argued that this should not count as grave disability, but the definition is poorly applicable to corrections; for instance it could be argued that such patients are not providing food, clothing, or shelter but being forcibly sheltered and given food and clothing such that an analysis of their ability to secure these for themselves or with the help of willing others (jails are not “willing” but mandated to provide food, clothing, and shelter) should be undertaken. A different, more expansive approach to grave disability that takes into account the nature of the correctional environment has been adopted by CDCR here in California. Most elements of administrative segregation have to do with treatment requirements and are thus included in the section “Mental Health Treatment” below. I was provided data showing that those in administrative segregation are re-evaluated every 30 days over 95% of the time. While it is not clear what this re-evaluation consisted of, the Remedial Plan only requires that this be done so this narrow element is in **substantial compliance**.

REVIEW OF IN CUSTODY DEATHS (elements relevant to mental health services)

I was not provided any death reviews. Thus, this item is **not rated**.

CONTINUOUS QUALITY IMPROVEMENT PROGRAM (elements relevant to mental health services)

The following are the elements of the Continuous Quality Improvement Program (CQIP) relevant to mental health are:

- Peer review of psychiatrists
- Quality Improvement Committee (mental health components)

RUHS-BH continues to conduct its own CQIP but there has been increased collaboration between RUHS-BH and RUHS-CHS. Custody still does not provide data for the healthcare CQIP and does not have any healthcare related measures. As mentioned before, custody participation is crucial, especially in the area of access to care and other areas where custody functions are relevant to mental health care such as safety cell monitoring, restraint, privacy and confidentiality, and access to out of cell activities (structured and unstructured). Achievement of substantial compliance will require greater collaboration.

I did not receive peer reviews or minutes (or other data) of CQIP meetings so cannot comment on their content or other aspects of the function of the committee. In fact, I received virtually no CQIP data for this reporting period.

Though I did not receive any meaningful CQIP data other than the document "Behavioral Health Detention Indicators" from 1/1/19-1/31/19, I continue to rate this as in **partial compliance** owing to the continued efforts of RUHS-BH to expand its reporting capacity.

MENTAL HEALTH CARE

The elements of mental healthcare include:

- **Treatment according to a Program Guide** (including treatment of those in administrative segregation, which was moved from Custodial Environment)
- **Psychiatric care timelines**
- **Housing of the SMI**
- **Treatment space**
- **Suicide prevention**
- **Restraint**
- **Continuity of care**

Treatment According to a Program Guide and Psychiatric Care Timelines

Observations and Interview

There is still no formal Program Guide.

Patients were generally very positive about their interactions with mental health staff, though expressed a wish for more frequent contacts, including individual contacts with QMHPs and psychiatrists and groups.

Groups continue to be conducted by Recreation Therapists and Behavioral Health Specialists. Clinical Therapists focus on intake, assessment, rounds (usually during pill call), crisis response, and individual contacts. Psychiatrists provide medication support services. The mainstay of treatment remains, appropriately, groups and medication management. The County still struggles to engage the seriously mentally ill in consistent programming; at any one time, most patients in the residential mental health units are in no groups. They primarily receive brief check-ins, often at cell front. Access to correctional programming is minimal on these units as well. At SCF, those patients in the so-called "med beds" on HU-12 and HU-14 have access to correctional programming that is similar to other inmates. Those on HU-16 have some access to limited on unit jobs and educational services. Those on the residential units at RPDC (they have been moving around due to construction and maintenance) also have limited access to correctional programming. That said, many of these patients have limited capacity to participate in traditional correctional programming, making it all the more important that they have more regular access to mental health groups. Most groups for the seriously mentally ill are recreation-oriented. This is reasonable for the most acute, but there is a need for some more structured groups such as psychoeducational groups, including medication education. Nursing is reportedly considering developing a medication education module. There are also groups on substance abuse, reentry, anger management, and skill development for patients able to avail themselves of these groups.

Throughout the system, admissions to groups are mostly rolling in order to maximize group attendance. This limits the ability to provide a complete curriculum and undermines fidelity to some groups but is reasonable for other groups, e.g., recreation therapy. Being able to provide more structured group with formal curricula for those who are likely to remain for extended periods (three months or greater) would require a concerted effort to reduce transfers and to allow patients from different living units to attend groups together, as is done in many correctional facilities.

The groups being run at Blythe include Dialectical Behavior Therapy (DBT), anger management, and a reentry group. There were 23 patients currently enrolled in DBT groups at the time of my visit. This is an improvement from previous visits. However, the Clinical Therapist reported that, reportedly due to lack of interest, there were not enough patients interested to run other groups, resulting in a focus on more individual contacts. The Clinical Therapist reported that while custody still cleared patients for groups, enrollment is more consistent with clinical need, though as noted above, only four patients had been cleared to attend the anger management group. The Clinical Therapist reported seeing patients on her caseload about twice monthly and is working on developing an in-reach program where community mental health staff would meet with patients in the attorney booth.

At Indio, groups included discharge planning, WRAP, DBT, and New Directions. These are reasonable groups for this population, but only 10 hours of groups are run per week owing to limited space. There are reportedly 5-10 patients in each group, so roughly serving 50 to 100 patients (though some are in more than one group, so it is likely at the lower end). Individual meetings vary but reportedly primarily consist of initial orientation to the jail and crisis response and brief check-ins. There are occasional courses of brief supportive therapy.

At CBDC, groups are still limited by lack of space (see below). Groups include Recreation Therapy, COLORS, New Directions, DBT, Seeking Safety, and Anger Management. 5-10 patients are enrolled in each group. I attended a Recreational Therapy group at CBDC; the group was run by two co-therapists. It was a well-run Recreational Therapy group. While the patients did not exhibit any significant

psychopathology, it is possible that their needs are more substantial than is apparent during a single group, though there was no evidence of active psychosis or mood disorder. However, the QMHPs were clear that they make every effort to assure that patients in groups have a moderate level of care (generally, the highest acuity at CBDC at the time).

Groups at SCF include Recreation Therapy, a hygiene group, New Direction, and Seeking Safety. On HU-14 and HU-16, New Direction is the primary group. Staff note that group attendance has fallen off on these latter units, possibly due to gang penetration of these units that were intended to provide a safe haven away from gang politics so that patients could take medications and attend treatment without fear of gang interference.

Groups at RPDC include DBT, Recreational Development, New Direction, Activities of Daily Living, Seeking Safety, COLOR, Anger Management, and Reentry.

I attended two groups at SCF HU-16. I came in at the end of a Recreation Group attended by only three patients with serious mental illness from HU-16F. The subsequent group included just two patients from HU-16E, both with serious mental illness. The two BHSs used a structured poetry activity to help patients explore their strengths they could build on. The group was run well. The group leaders noted that groups have gotten smaller in part because patients are only allowed to come out by tier from one unit. They also noted that they are often not allowed to go on the unit to ask if patients are willing to participate. This is unreasonable. Patients on HU-16 complain of limited access to groups as well.

I also attended one group at HU-14. The was New Direction. While the group leader did too much of the talking, it was sound content and relevant for the five patients in attendance, two of which were new to the group that day. These were not seriously mentally ill patients, but several had clear evidence of psychiatric symptoms.

I attended a Recreation Therapy group at CBDC attended by 8 inmates with primarily substance-related disorders; none had overt psychopathology. It was very well run, teaching coping skills through activities and using a drawing activity to prompt self-exploration and relatedness to others.

Clinical Therapists at RPDC report that, due to both increased staffing and better organization, they have been able to decrease crisis calls and increase assessments and treatment plans, as well as deliver more structured services. Permanent assignments have also increased familiarity with patients on their caseloads and provided better continuity of care. They also note that increased runners have provided much better access to both group and individual treatment services. They particularly noted how helpful the liaison sergeant had been in facilitating the custody end of many of these improvements.

At the DCU, no groups are yet being conducted, but Clinical Therapists attempt to meet with patients individually two or three times each week. There is also a book cart and those patients not restricted from them for clinical safety reasons are being allowed to check out books. Despite these small gains, patients remain largely isolated in their rooms with no activities, still far more isolated than medical patients. The DCU is still being run like a restrictive housing unit for the mentally ill. In medical records reviews, I saw several cases where patients were returned to the jail still very unstable. Charting from the DCU and the release summary accompanying patients back to the jails is exceedingly minimal and does not sufficiently capture the treatment and clinical course at the DCU. Clinical Therapists at the DCU are doing a better job of promoting continuity of care, but the supporting documentation is inadequate.

While I understand the DCU uses a different EHR, documentation for continuity of care purposes must be improved.

RUHS-BH Data

The group schedule and roster for RPDC for March shows the following (while it says for the fifth floor, the patients are from different locations but are all male residential mental health patients):

- Monday
  - 0900-1030 – DBT (to start later in the month)
  - 1430-1530 -- Activities of Daily Living (7 patients)
- Tuesday
  - 0900-? – Recreational Development (7 patients)
  - 1000-1100 – Jail In-Reach (no patients listed)
  - 1400-? – Seeking Safety (8 patients)
- Wednesday
  - 0915-1000 – Recreational Development (7 patients)
  - 1200-1330 – Activities of Daily Living (8 patients)
  - 1345-1500 – Recreational Development (7 patients)
- Thursday
  - 0900-? – New Direction (12 patients)
- Friday
  - 1215-1300 – Recreational Development (5 patients)

This represented a total of 61 patient slots with 42 different patients enrolled from housing units 5A, 6A, and 6B. Thus, most patients in groups are getting one group per week. The majority of patients were in no groups.

The group schedule and roster for RPDC for March shows the following (while it says for the sixth floor, the patients are from different locations but are all female residential mental health patients):

- Monday
  - 0915-1045 – Recreational Development (9 patients)
  - 1300-1400 -- Activities of Daily Living (8 patients)
  - 1400-1500 – COLOR (5 patients)
- Tuesday
  - 1100-1200 – Jail In-Reach (no patients listed)
  - 1200-1300 – Recreational Development (9 patients)
  - 1300-1400 – Seeking Safety (no patients listed)
  - 1415-1515 – Activities of Daily Living (9 patients)
- Wednesday
  - 0900-1030 – Activities of Daily Living (8 patients)
  - 1500-1630 – DBT (9 patients)
- Thursday
  - 1200-1330 – New Direction (no patients listed)
  - 1300-1430 – COLOR (8 patients)
  - 1400-1530 – Recreational Development (10 patients)

- Friday
  - 0900-1000 – Anger Management (5 patients)

This represented a total of 80 patient slots with 53 different patients enrolled from housing units 4A and 4B. Almost half of females with SMI in residential housing were in a group.

The report "Behavioral Health Detention Indicators" from 1/1/19-1/31/19 shows the following with respect to treatment provision:

- Behavioral Health Assessments: Of those inmates with a behavioral health flag (indicating the inmate is an identified mental health patient) in custody for more than 14 days with a level of care rating of moderately-severe or severe, 95.7% (112/117) had an assessment. The low of 95.7% was at CBDC; the highs of 100% were at Indo and SCF (no cases were reported for Blythe).
  - 105/112 (93.8%) were completed within 14 days.
  - Note that the denominator (total cases) is substantially decreased from June 2018 when it was 397. This is likely due to only reviewing patients with level of care ratings of moderately-severe and severe.
- Behavioral Health Care Plans: Of those inmates with a behavioral health flag in custody for more than 14 days with a level of care rating of moderately-severe or severe, 88.9% (104/117) had a care plan within the last year. The low was 86.6% at RPDC; the high was 100% at SCF.
  - Of the 104 assessments completed, 84.6% had a care plan within 14 days of booking.
  - Again, the number of total cases is about 30% of the number in June 2018. This is likely due to only reviewing patients with level of care ratings of moderately-severe and severe.
- 1772/2456 – 72% of expected individual contacts for the 105 mentally ill ever in administrative segregation for the month were done.
  - 34/105 = 32.4% of patients had all expected visits
  - Most missed days were for one day periods. There were 17 patients who missed 5 or more days in a row.

Review of medical records of those from those patients listed on "Random Bridge Meds JAN-JUNE 2019.xlsx" and ordered bridge medications at admission, 7/9 = 78% were seen within 7 days. Of those later started on medications, 6/8 = 75% were seen for follow-up by psychiatry within 30 days. I saw only rare instances of patients on long-term psychotropics who were not seen every 90 days (e.g., 2017010403522649).

In my detailed medical record reviews of 22 seriously mentally patients spending at least 30 days on a residential treatment unit, I found that 11/19 = 58% of patients in residential mental health units not on administrative segregation received adequate treatment (note that I exclude medication monitoring but do evaluate the adequacy of the medication regimen and individual and group therapy). Three cases were indeterminate. I had interviewed two of these patients, both of whom received adequate treatment and were seriously mentally ill.

I reviewed 10 patients in residential mental health units on administrative segregation. 2/6 = 33% received adequate treatment. Four were indeterminate. Access to care for these seriously ill was a major obstacle.

I noted that care rendered by the DCU was too often inadequate, again largely owing to poor access to care but also to failure to adequately stabilize a number of patients prior to returning them to the jail.

Summary

Treatment continues to slowly improve. Development of infrastructure continues, including group content (and staff trained in delivery), encounter tracking, structuring of staff resources to maximize treatment delivery, and access to care (which requires sufficient program space, runners, out of cell access to patients, and clinical staff). The primary determinate of expanding treatment resources to patients in need is, at this point, access to care, especially for the most ill and those on administrative segregation. Once access to care is maximized, it will be possible to determine if there are enough clinical staff to meet the basic needs of the mentally ill. In my opinion, the mental health service has done almost all it can to prepare to expand services once access to care barriers are eliminated.

While there is no program guide, there is a good deal of material indicating the kinds of services that are to be delivered as would be expected in a formal program guide. There are requirements that patients be seen individually every 30 days, but this alone is not adequate treatment and primarily consists of assessment and case management. Occasional patients receive more regular individual contact that would qualify as therapy. That said, there are no benchmarks regarding dosage expectations of overall treatment (though there are at least minimum standards for individual contacts) with no group requirements at all. Treatment in accordance with a program guide is in **partial compliance**.

As the data above shows, psychiatric care timelines are also in **partial compliance**, largely owing to challenges seeing patients promptly upon admission following initiation of medications. Psychiatrists are generally doing well in terms of 90-day follow-ups. As noted above, medication monitoring is also in need of improvement.

Housing of the Seriously Mentally Ill

There has been an increased to 610 beds designated as residential mental health units throughout the system. So-called “med beds” (units where patients not requiring residential level care but need a safe place to continue their medications, free from the influence of non-mentally ill inmates) have been expanded to 110 beds on HU-12 and HU-14 (if the SCF Housing Profile is accurate). There are still 192 residential mental health beds in HU-16. The remainder are at RPDC as follows (per the 3/9/19 RPDC Housing Unit Profile):

- 5A Dayroom 1 – 28 beds, GP, level 1-5 males
- 5A Dayroom 2 – 32 beds, GP/Liberty, level 1-5 males
- 5A Dayroom 3 – 28 beds, Liberty/PC ,level 1-5 males
- 5B Dayroom 1 – 40 beds, Ad Seg, level 1-5 males
- 5B Dayroom 2 – 40 beds, PC, level 1-5 males
- 6A Dayroom 2 – 32 beds, Ad Seg, level 1-6 females
- 6A Dayroom 3 – 28 beds, PC, level 1-5 females (includes some who are nonmentally ill PC)
- 6B Dayroom 1 – 40 beds, GP, level 1-5 females
- 6B Dayroom 2 – 40 beds, GP, level 1-5 females

While these all add up to 610 (with 308 at RPDC), some units, such as administrative segregation, include single-occupancy cells.

RCSD provided tables of transfers of patients with acuity ratings of moderately severe to acute from RPDC and SCF to other facilities. The data from SCF is explicit that mental health approved and provided the name of the approving clinician. 161 of 165 from October 2018 through January 2019 were approved for transfer, there was no entry for four, and none were marked as not approved. From RPDC, the data is less clear. Most entries under the column "Mental Health Review" were one of the following: "NEW BOOKING" or "PER HOUSING PROFILE." Upon inquiry, I was informed that:

> "New Booking means they were a new arrestee, was never housed at RPDC and Mental Health cleared them for transfer.
>
> Per Housing Profile means the inmate was removed from their unit at RPDC due to a conflict (unknown what conflict) and Mental Health cleared them to be housed at another facility per their housing profile (Mental Health acuity rating and classification rating).
>
> …Classification … stated the approval was implied because they were transferred."

However, there were other entries where a patient was disapproved by a mental health clinician but was still transferred. Thus, it is unclear how reliable this data is. RCSD plans to bring greater consistency to this process and I have encouraged the practice of specifying the approving or disapproving mental health clinician.

If the data on these transfers to other facilities are accurate, 613/620 = 98.9% were approved by mental health. No data were provided on what process occurred when mental health disapproved to demonstrate that there was time for consultation and resolution of differences between custody and mental health regarding the appropriateness of transfer.

No data were provided on transfers of the mentally ill within facilities or from the other three facilities (Blythe, Indio, or CBDC).

I confirmed that entrance and exit from residential mental health settings is driven by the acuity code; this is a reasonable means for mental health to provide input. However, proof of practice still needs to be provided but could simply consist of a cross-sectional report from a random sample of days reporting on the number of patients whose acuity codes matched their housing location.

In my opinion, transfers of those with acuity ratings below moderately-severe do not require approval for transfer by mental health. If the parties concur, I will conform future reports to that interpretation. I would also welcome input on the necessity and nature of the approval of transfers within the facility. In my view, if patient acuity codes drive placement, then transfers within facilities to settings matching those codes should not require additional mental health input. I would appreciate the parties' views on this as well.

Mental health staff report there continues to be good collaboration on transfers, but proof or practice remains to be solidified.

With the understanding that some components of this element of Mental Health Care have been moved elsewhere (out of cell time and correctional programming is covered in Custodial Environment and provision of structured treatment activities under Treatment According to a Program Guide), housing of the seriously mentally ill remains in **substantial compliance**, though subject to the above clarifications from the parties and return to clearer confirmation of mental health consultation prior to transfer. I

take the statement that SMI are to be "housed in units designated for such housing" to require adequate beds to meet the needs of the SMI population; in my opinion, the County has sufficient residential mental health beds at this time.

Treatment Space

Treatment space remains a problem but there is clear progress on this. A new clinic has opened at SCF and appears to be well-designed for workflow, confidentiality, and safety. Construction at RPDC is underway and will improve access to space, and thus access to care, substantially.

Clinical spaces are well lit and generally have access to medical records through wi-fi, though there are some problems with reception in certain locations such as some of the program rooms and the law library at CBDC and units 3A and 4 at RPDC. However, this has not been a substantial barrier as clinicians generally review records prior to patient contact and conduct charting after visits. Psychiatrists rarely have patient contacts in locations without medical records access except occasionally at RPDC.

The ability to fully utilize treatment space will be contingent on having enough custody staff (runners) to assure patient movement.

At Blythe, groups continue to be run in a single program room that is shared with others. This has limited group offerings, though the Clinical Therapist believes that more times could be scheduled; this will be necessary to review further as the other Clinical Therapist position at Blythe has been abolished, leaving only one to do all clinical work. As noted above, the Clinical Therapist is still not allowed to meet face-to-face with patients, though the Clinical Therapist is satisfied with the booth arrangement. However, I sat in the patient area of the booth and the sound system intermittently cut out and was not adequate for clinical work; the staff was unaware of this problem and it should be corrected. The setting for conducting telepsychiatry at Blythe remains sufficiently confidential. Interestingly, the QMHP is in the room with patients doing telepsychiatry, though not when meeting individually with patients.

At Indio, there are no program rooms. The only room available is the Briefing Room that is available to mental health two hours daily, the primary reason that relatively few groups are run at Indio for the population number. This should be remedied by the new jail. When the psychiatrist conducts telepsychiatry for Blythe, this is done from a private office space with full access to records. There are four booths available for mental health interactions, though two are attorney booths that are often unavailable. Psychiatric contacts are almost all done privately but many other mental health contacts are at cell front.

Program space has improved substantially at CBDC with the development of a schedule for use of the program rooms that divides time among different disciplines; the schedule is working well and provides adequate time for QMHPs to conduct their clinical work. Groups are being run in the Law Library and some recreation therapy is done in yards, both of which are shared with others. The program rooms are not being used for groups, though there is no reason they could not be used. There have not been any changes to the intake area yet, but this is work is reportedly still planned.

On the fifth floor at RPDC, which houses the most acutely mentally ill, there are only two interview booths that must be shared with attorneys and Liberty Health staff. There are also only one or two

program rooms available. Clinical staff note that sometimes the only way they can meet with their patients is at cell front.

There have been no changes to the intake area at SCF which remains limited to two interview booths. These are also used for safety cell interviews. This can result in delays in both functions. There are three interview booths on HU-16 (the mental health residential pods) and only one program room. Space is limited on other living units as well. However, the new clinic will be able to help mitigate some of these problems as will the planned additions of an interview room at HU-16. It will depend on how these additional spaces are used, but the addition of a group room in the clinic should help substantially if fully utilized. The current plan is to give lists of patients to sergeants who arrange for patients to be brought to the clinic in groups. SCF is also considering the addition of telepsychiatry in the new clinic, but this has yet to be implemented.

While there has been substantial progress here, this element of Mental Health Care remains in **partial compliance** but is expected to become substantially compliant upon completion of construction.

Suicide Prevention

Observations and Interviews

Stepdown procedures allowing restoration of property while in safety cells have not been implemented; there is no process for restoring property and privileges in a stepwise manner based on mental health assessment of risk. The RUHS-BH Detention Services Policy: Safety Cell Placement provides for restoration of property, but this is not being followed. All those in safety cells for danger to self are in suicide gowns with no property. While at SCF, there was a patient in a safety cell naked with nothing in the way of covering, blanket or mattress. This is unacceptable for any period of time.

I inspected safety cells at all four facilities having them. Those that were occupied had logs posted at the door that were generally complete. There are no safety cells at Blythe; a cell across from the Deputy's station in intake with direct visibility into the cell is used to temporarily house patients pending transfer, usually to Indio. The two safety cells at Indio were both clean. The safety cells at CBDC were not well cleaned but were not grossly dirty, though one was malodorous. Safety cells at SCF were fairly clean except one had feces in the drain and was malodorous. Those at RPDC were clean except some vents were quite dirty. Cameras in safety cells were functional. I did not receive safety cell cleaning logs, so it is unclear how often they are cleaned and whether these logs are being reviewed (some facilities reported sergeants review logs, others, lieutenants). Staff at Indio reported they were inspected by a sergeant before each usage and during safety checks. Staff at CBDC reported that sergeants inspect safety cells. At SCF, the safety cells are reportedly cleaned after each usage. At RPDC, they are reportedly regularly inspected and cleaned if needed. RCSD is developing a proof of practice for safety cell cleaning.

Staff and patients report that most safety cell assessments are not being done at cell front, unless patients refuse to come out or are highly agitated. Mental health staff report that custody staff are generally very good at bringing patients out but are sometimes unavailable, leading to delays (this was evident in medical records reviews). However, most patients are being seen regularly and within time frames for QMHP assessment. QMHPs report that they frequently do crisis interventions with those in safety cells in addition to assessments; medical records demonstrated uneven crisis intervention for this population.

Staff were uncertain and many seemed confused when questioned about the availability of one-to-one monitoring if needed, e.g., pending admission to the DCU for imminent suicidality. The RUHS-BH Detention Services Policy: Safety Cell Placement provides for one-to-one monitoring At Blythe, these patients are placed in the observation cell across from the Deputy's station. At Indio, they are reportedly removed from the safety cell and chained for observation from the Deputy's station in the intake area. At CBDC, none could recall an instance of needing a one-to-one, but the sergeant reported he could order that to be available. At SCF, staff were clear that a one-to-one could be ordered. There was no clear answer from staff at RPDC, who simply noted that patients were quickly transferred to the DCU. The general impression was that it was rarely being considered and it was unclear to staff whether it was available, the presumption being that use of the safety cell was sufficient. A few staff noted the restraint chair being used if a person was actively self-harming, but this is a different situation than imminent suicidality. The RUHS-BH Detention Services Policy: Safety Cell Placement provides for treatment to occur while patients are in safety cells and records reflect that patients are receiving some counseling with an emphasis on use of coping skills during the safety cell assessments occurring in non-contact booths but, as noted above, this is uneven. Virtually all patients transferred to the DCU are in safety cells pending transfer.

I observed a safety cell assessment at RPDC. The patient was seriously mentally ill with overt psychosis and had a history of assaults and suicidal ideation. The patient was planning to stop his medication and the Clinical Therapist planned to arrange a visit with the psychiatrist that day. The patient was, reasonably, not released from the safety cell.

I reviewed the records of 20 patients identified as being placed in safety cells, including 10 that were not sent to the DCU from the document "Safety Cell No DCU.xlsx" and 10 that were sent to the DCU from "Safety Cell to DCU.xlsx." I determined that none were in the safety cell longer than 48 hours. All those in safety cells are in a smock with no more than a mattress and blanket so all the 17/20 that were in for more than 12 hours met the operationalized definition of being in seclusion and were in over the time limit defined by the remedial plan. Consistent with the lack of stepdown procedures, I saw no evidence that property was restored during safety cell placements; all patients appear to go from being on full restrictions and then being placed back in their cells with property. Different than what staff reported to me, I found that only 9/20 cases were consistently assessed out of cell (I excluded instances where the patient refused to come out or when the patient was not allowed out of the safety cell due to dangerousness, as long as there was documentation that was consistent with possible dangerousness). There were occasional instances where patients were not evaluated timely. One patient was in the safety cell over 24 hours before being seen at cell front and was not seen face-to-face until over 30 hours. Two patients did not have an initial assessment until in a safety cell for more than six hours. In another case , a patient was initially assessed but was not later seen for a period of over 24 hours. Another patient was in the safety cell for over 24 hours and was seen only once. When reviewing these, I also excluded instances when the Clinical Therapist reasonably elected to allow a patient to continue sleeping. However, the majority pf patients were seen regularly and timely by a Clinical Therapist, just often at cell front. There were no cases that clearly had no face-to-face assessment during their placement in the safety cell. Documentation of treatment was seen in a minority of cases; almost all notes were assessments. That said, many patients were promptly referred to and seen by psychiatry and medications changed or ordered when indicated. For those patients going to the DCU, I saw two cases where the Clinical Therapist tried to provide some support and de-escalation. I saw no cases

where a Clinical Therapist ordered one-to-one or other special conditions or monitoring pending transfer to the DCU.

Seven of the eight patients in the sample that were on medications while in the safety cell received their medications. Nursing monitoring was done per policy in 14 of 20 cases. Most failures were because they were not timely, but many were incomplete assessments with many blanks and no explanation. Again, I excluded cases where patient refusal was documented, or the assessment was not allowed due to dangerousness. Only one case had no nursing assessment while in the safety cell. Note that timeliness was determined by chart entry here rather than safety cell log entry. It may be that nurses are not always documenting their safety cell checks in the medical record.

Clinical staff did not consistently assess for consumption of food or fluids. Many nursing assessments did not assess hydration status but wrote in the EHR field for fluid intake and hydration status "per custody." While it is reasonable for custody to be responsible for tracking meals and access to fluids, it is up to clinical staff to assess hydration.

RCSD Data

Review of safety cell logs demonstrates that patients are being regularly checked with few going more than 15 minutes. Check times are generally well staggered, though at SCF, many checks remained exactly 15 minutes, raising concern about the accuracy or the variation of these checks. Documentation of meals being offered was the most common shortcoming. However, the vast majority of these logs were well-done, thorough, and complete. I saw no evidence of patients staying in safety cells more than a few minutes past 48 hours.

At CBDC, safety cell logs are largely complete and document timely supervisor, QMHP, and medical assessments. Some show checks repeatedly at exactly 15 minutes, but most show variation. Many showed careful review by supervisors, noting the occasional problems with checks, though rarely commented on those lacking documentation of meals being offered. Documentation of being offered three meals per day remains inconsistent but is present on most logs. Offering of water is regularly documented.

At Indio, most logs were complete and without any problems except occasionally not documenting whether meals were offered. Supervisor, QMHP, and medical assessments were timely.

At RPDC, most logs were complete with only rare misses of meals being offered and rare untimely medical assessment. Supervisor, QMHP, and most medical assessments were timely.

At SCF, logs were less complete with inconsistent documentation of offering food and water. Supervisor, QMHP, and medical assessments were timely. There is provision for one-to-one observation when necessary at SCF.

Review of 10 patients in safety cells not sent to the DCU from the document "Safety Cell Restraint Chair DCU.xlsx" showed no evidence of step-down protocols. None of the 10 were in longer than 48 hours. 9/10 appeared to be in seclusion for more than 12 hours (operationalized as being in the safety cell with only a smock, mattress, and blanket).

RUHS-BH Data

The report "Behavioral Health Detention Indicators" from 1/1/19-1/31/19 includes a report entitled Safety Cell Transitional Follow-up that reports on how often a QMHP is meeting the RUHS-BH target of QMHP follow-up of those transitioning out of safety cells for five consecutive days. For the 168 safety cell placements that month, 62% had all five meetings or all required meetings up to a QMHP determination that further transitional follow-up was not needed. 21 (12.5%) had no follow-up, though some of these were determined not to need follow-up.

Summary

There continues to be steady improvement and more assiduous attention to detail regarding this provision. Continued careful attention to safety cell logs, especially to meal provision, and safety cell cleanliness will be crucial to achieving substantial compliance. In my opinion, the policy provision for one-to-one monitoring and for treatment in safety cells meets the criteria for treatment provision pending DCU transfer. However, clear verification of the availability of one-to-one monitoring, such as its demonstrated use or RSD policy that aligns with the RUHS-BH Detention Services Policy: Safety Cell Placement are needed to provide confidence that this degree of monitoring is available.

Once stepdown procedures are implemented (which should address the problem with seclusion) and with slight improvement in the timeliness of assessments, this element of Mental Health Care will likely be at or near substantial compliance but remains in **partial compliance** at this time.

Restraint

Policy J-127 specifies that health (nursing) monitoring is to be at "medically appropriate intervals" and that the inmate must be seen "…at the time of placement into a restraint chair and at a minimum of very two hours thereafter…." The policy specifies:

> "Assessment of the inmate shall include, but not be limited to the following:
>
> 1. Vital signs (temperature, pulse, respirations, blood pressure, oxygen saturation and capillary refill)
> 2. Neurological signs and symptoms, including loss of consciousness, seizures, mental status changes, amnesia, visual changes, cortical blindness, movement disorders, stroke like symptoms
> 3. Difficulty swallowing, difficulty or pain when speaking, shortness of breath, and/or respiratory distress
> 4. Extremity circulatory checks
> 5. Hydration status
> 6. Presence or absence of ligature marks, neck contusions, voice changes, and petechial hemorrhage"

These are comprehensive expectations and sufficient for monitoring those in restraint, with the exception of failing to require assessment of peripheral nerves that can be compressed by restraints.

Use of the emergency restraint chair continues to be relatively rare. I saw no instances of restraint lasting more than 8 hours in the cases I reviewed.

Restraint chairs were clean and operational; the restraint chair at Indio was somewhat worn.

QMHPs reported that face-to-face assessment of those in restraint was done except at SCF where it was done through the tray slot, often during limb rotations. In most instances the QMHP would stand at the safety cell door with the patient in the restraint chair in a safety cell except at Blythe where the chair is bolted to the floor in a hallway (it is rarely used) and on rare occasions in other facilities prior to placing the restraint chair in a safety cell. However, face-to-face assessment is sometimes denied "for safety reasons." Face-to-face assessment is a requirement of the Remedial Plan unless there is a likelihood of inmate violence; given that patients are restrained, it is hard to imagine a safety reason for denying face-to-face assessment. In my experience, I have never been unable to conduct a face-to-face assessment of a properly restrained patient and am unaware of this ever being the case. In general, the more agitated the patient, the more necessary it is to do an evaluation to assure that they are not at risk of imminent harm or suffering from a medical condition requiring emergent assessment and treatment.

I reviewed 10 medical records of those placed in restraints. I could verify at least some face-to-face assessment during the time of restraint in four cases. In two cases there was no face-to-face assessment. For the remaining four cases, the documentation was unclear. In no case did the nursing assessment meet the above standards. Only one case was there a circulatory check. In two cases, there was no nursing assessment at all. There was only one nursing assessment that I reviewed that was consistent with the above policy but there were no further assessments even though the patient remained restrained for five hours.

There were no data provided about restraint use at the DCU.

Because of the problems with assessments by QMHPs (not face-to-face) and by nursing staff (some very poor, virtually all lacking circulation checks), this item meets **partial compliance** currently. It could be argued that non-compliance is warranted, but patients are being monitored by healthcare staff to some degree in virtually every case (though sometimes only by a QMHP), so this is not a question of neglect but of not getting proper access to the patient to provide a thorough clinical assessment. Instances of restraint are high risk and due attention is required.

Continuity of Care

Observations and Interviews

Reentry initiatives continue. RUHS-BH continues to use both reentry groups and/or individual contacts addressing reentry planning. Reentry teams from the community are still coming to the jails (except Blythe) but peer reentry helpers are only being used in the community. Community reentry is being channeled through the AB109 clinics in the community.

Psychiatrists report that they order 30-45 days of release medications. If a release is unexpected, medications may be sent to a community address when available.

RUHS-BH Data

The report "Behavioral Health Detention Indicators" from 1/1/19-1/31/19 shows:

- 278/286 = 97.2% of releasing inmates with a behavioral health flag in custody more than 30 days received an individual encounter addressing discharge planning.
    - This included any note during the inmate's stay coded as "Discharge Planning" but does not differentiate types of notes; it includes notes where there was no patient contact.

Review of 10 cases from "BH Housing PsyMeds Discharged.xlsx" showed that only seven were actual cases of discharge, the others were transfers. Of these, 2/7 = 29% received release mediations and 4/7 = 57% received reentry planning services (one other patient received a packet of information, but this was considered inadequate for a seriously ill man with a rating of moderately severe).

Many patients have notes with titles indicating that reentry services were the subject of the encounter but include no documentation of any reentry services. Sometimes they are notes regarding possible enrollment in groups (non-specific groups) and sometimes are simply notes saying that reentry services will be rendered, but then that often never occurs. This is almost certainly the source of the discrepancy between RUHS-BH data and my own review.

Summary

RUHS-BH is making substantial efforts in this area. One difficulty I previously noted is that the remedial plan calls for "connecting" to community services, which may not always be available. I will continue to interpret this as meaning that RUHS-BH has made necessary referrals and taken what steps it can to connect the SMI to treatment, social services, housing, and other appropriate services.

Continuity of care is in **partial compliance**.

POLICIES AND PROCEDURES

I was not provided with any new or updated policies or procedures since my previous report. The issues raised above regarding needed policy statements, e.g. to maximize out of cell time, remain to be addressed.

As I have been told that many are being modified, I will continue to rate this as in **partial compliance** at this time.

CONSENT DECREE TRAINING

The County was previously rated as in **substantial compliance** for this component.

CONCLUSION

This concludes my Fifth Report, again utilizing a quantitative approach supplemented by qualitative reviews as necessary. As in the Fourth Report, I assessed 28 components. The methodology was refined for this report based on experience from the Fourth Report. The components themselves remain subject to modification, in accordance with the remedial plan, if needed.

The County continues to make progress towards meeting the requirements of the Remedial Plan. The County has achieved substantial compliance on 6/28, is in partial compliance on 16/28 (with a few of those nearing substantial compliance), is non-compliant with 1/28, and 5/28 were not rated, primarily because no information on these was provided.

Respectfully submitted,

Bruce C. Gage, M.D.

APPENDIX

To follow

EXHIBIT M

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December 27, 2017

INTRODUCTION

This Second Report sets forth the Mental Health Expert's assessments of the implementation of the terms of the Consent Decree, signed June 7, 2016, and associated Remedial Plan stemming from Gray v County of Riverside. It covers the Riverside County's (the County) reported results from the time of entering the Consent Decree from January 31, 2017 through July 31, 2017 (the "Second Reporting Period"), and reflects the observations and analysis of the Mental Health Expert regarding the County's compliance during that period.

As used herein, "Substantial Compliance" means that the County has achieved compliance with the material components of the relevant provisions of the Remedial Plan in accordance with the agreed-upon Compliance Measures for assessing Substantial Compliance submitted by the Mental Health Expert. "Partial Compliance" means that the County has achieved compliance on some, but not all, of the material components of the relevant provision of the Remedial Plan or have not achieved the quantitative results specified in the Compliance Measures; and "Non-Compliance" means that the County has not met most or all the material components of the relevant provisions of this Agreement.

This Second Report is based upon the Mental Health Expert's review of provided policies, procedures and directives proposed and/or implemented by the County, observations and assessments of the Mental Health Expert based on tours of the jails, and review of medical records and data collected by the County. I visited Smith Correctional Facility (SCF) for one and a half days, Southwest Detention Center (SWDC) for a day, Robert Presley Detention Center (RPDC) for two days, the Detention Care Unit (DCU) for two hours, the Indio jail (Indio) for a half day, and the Blythe jail (Blythe) for a half day. I was provided full access to patients and staff and was assisted by staff knowledgeable in relevant topic areas including mental health, nursing, custody, classification, quality assurance, and administration.

I observed three groups (two at SWDC and one at RPDC; none were being held at the other facilities); met with psychiatrists, Clinical Therapists, nurses, Recreation Therapists, and Behavioral Health Specialists; observed pill lines and multi-disciplinary team meetings; conducted group interviews on general population units; rounded on patients in the DCU; and interviewed 26 patients in private. In addition, I met with mental health leadership at County offices for one hour.

The County provided the following information for my review:

- Response to issues raised in my February 2017 report and to a request pursuant to this assessment:
    - Presence of lock boxes for medical request forms
    - Riverside County Sheriff's Department (RCSD) Corrections Division Policy Manual, policy number 508.06 Inmate Medical Care dated 5/17/17
    - Physical plant barriers and remedies to confidentiality
    - RCSD Corrections Division Policy Manual, policy number 504.42 Dayroom Management dated 9/9/15
    - Training materials and reports of staff attendance regarding self-isolating inmates
    - RCSD Corrections Division Policy Manual, policy number 508.12 Mental Health Services
    - RCSD Corrections Division Policy Manual, policy number 503.07 Emergency Restraint Chair dated 6/6/16
    - Report of percent of staff who received training regarding the consent decree
- Copies of important forms
- Staffing data, including a 7/18/17 email from Assistant Sheriff Gutierrez to mental health leadership: Deborah Johnson, William Wilson, and Brian Betz
- Group therapy schedules
- Resource (curriculum) materials for some groups
- Results of a survey of Behavioral Health Detention staff dated 3/30/17
- Communique from Riverside University Health System Behavioral Health (RUHS-BH) to the Riverside Sheriff's office regarding request for assistance in providing behavioral health services – hand-written date of 6/20/17
- Ratings of mental health acuity at RPDC from 8/1/17
- Samples of dayroom logs from RPDC, SCF, SWDC, and Indio
- Email from Jerry Gutierrez to Deborah Johnson, William Wilson, and Brian Betz dated 7/18/17
- RUHS-BH Detention Survey dated 3/30/17
- RUHS-BH request to RCSD regarding support for mental health services (hand dated 6/20/17)
- Electronic document entitled "Clinical Therapist Training Manual 10-5-17 (1).pdf"
- Electronic document entitled "Data Request 10-5-17.pdf"
- Electronic document entitled "2017 Safety Cell Stats – July.pdf"
- Electronic document entitled "April and May SC Comparison.docx"
- Electronic document entitled "MH RATINGS BY FLOOR FROM JIMS HEAD COUNT.xls"
- Electronic document entitled "Referrals by urgency level.doc" (unclear which facilities are included or whether it is all facilities)

- Detention Mental Health Sheriff MOU Monthly Reports from July 2017 and September 2017
- Behavioral Health PLO Indicators Step by Step Status report: Draft Version 1.3
- Behavioral Health Detention Indicators (March through May 2017)
- The following from Blythe Jail:
  - Blythe Jail discharge data May 2017
  - FBH Blythe Jail Sick Call Response Time May 2017
  - Blythe Jail MH Screenings/FBH Ratings
- The following from Indio Jail:
  - Indio Jail CQI Data – MH Ratings and Discharge Planning May 2017
  - Indio Jail Safety Cell Step Down Stats (January through May 2017)
- The following from SCF:
  - SCF Jail Safety Cell Step Down Stats (January through May 2017)
  - SCF – Inmates' Response for Meals at Table Survey (and associated written responses)
  - Smith Correctional (SCF) CQI Studies
  - Electronic document entitled "May Sick calls completed SCR.xlsx"
- The following from RPDC:
  - Electronic document entitled "Number of days to triage.docx"
  - RPDC BH Screenings (for January through May 2017)
- The following from SWDC:
  - Electronic document entitled "Southwest Detention Center BH Screening Statistics APR17-JUN17.docx"
  - Electronic document entitled "SWDC Sick Call Response Time May 2017.xlsx"
  - Southwest Detention Center Behavioral Health Safety Cell Statistics
- Email from Jeb Brown to Bruce Gage, MD on 10/26/17 regarding card readers in program rooms
- Slides of CIT training by RUHS-BH and RCSD
- RSD CIT training rosters from 7/12/16, 11/29/16, 1/18/17, 5/22/17, 7/17/17, and 9/18/17
- Word documents from RUHS-BH entitled:
  - From the desk of AB109 new mgt. e-mail AB 109 new mgt..docx
  - Audit Smith HU 16.docx
  - Audit 2A July2017.docx
  - AdSeg Audit.docx
  - 7th floor1st audit 7-25-17.docx
  - 5B ad-seg 7-24-17.docx
  - 2AD3 Mental Health Audit_7.24.17.docx
  - RPDC Audit.docx

EXECUTIVE SUMMARY

While Riverside County has continued to make evident progress towards meeting the requirements of the mental health components of the Remedial Plan in most regards, the adoption of more stringent security requirements for clinicians seeing patients in contact areas has substantially reduced clinical services since implemented in June. The County mandated that contact spaces outside the living units where clinicians see patients (generally, program rooms) be locked. Because clinicians are not provided keys, this meant that they would be locked in the room with the patients. Custody was not able to routinely stand-by and monitor these settings. Because of concerns of the risk to clinicians, RUHS-BH made the decision to cancel treatment activities in the absence of direct custody monitoring. This was made more poignant by a serious fight that occurred during a group at SCF during which the mental health staff was unable to leave the room and had no means of calling for help. Thankfully, staff were not the target of any violence.

This change has substantially curtailed therapeutic activities, especially groups, most predominantly at SCF where the majority of the mentally ill needing such services are housed. It has also resulted in a substantial return to use of the non-contact booths for individual meetings, which has had the additional effect of reducing access to care due to competition for those limited spaces. Many patients reported on this to me, expressing their disappointment and hope that treatment activities, especially groups, can be restored.

The County is to be commended for reporting this problem directly. The County is actively seeking a solution to provide safety and security while not limiting access to care. One important initiative is to provide electronic locks that clinicians would be able to activate from inside the rooms. The County has already started at SWDC and is slated to be completed at RPDC by December and at SCF by January. This should permit the County to return to at least the level of service it was providing prior to this change.

Access to care has also been impacted by recent reductions in the "runners" (custody staff assigned to facilitate patient contacts primarily by escorting) available to assist mental health staff. The County had augmented this function but has been challenged to maintain adequate numbers of staff to fill the need. They have made an effort to retain runners for psychiatry, which has been largely successful at SCF, SWDC, and Indio, but less so at RPDC.

Taken together, this has resulted in a reduction in individual and group treatment and a return to primarily non-contact visits. In general, clinician access to mental health patients remains a problem especially at RPDC and, now, SCF, primarily because these are the sites that have residential mental health housing units. There are also challenges at SWDC with clinicians sometimes only able to see patients in the intake area (rather than on the living units), assuming there is custody staff to escort patients to the intake area. This is reportedly due to limited staffing on the units to bring patients out and provide security for the patient contacts. In this regard, I continue to observe that mental health has more limited access and is under

greater strictures with regard to direct patient contact than medical clinicians and other staff such as chaplain services.

In a July 18/2017 email, Assistant Sheriff Gutierrez laid out the plan for custody staff assigned to assist health care staff going into the future:

- Medical Sergeants at all facilities (except Blythe): 0730-1600 Monday through Friday
- Medical, Dental, and X-Ray runners at all facilities: 0730 to 1600 Monday through Friday
- Mental Health Sergeant at RPDC and SCF: 0830 to 1700 Monday through Friday
- Mental Health runners at all facilities: 0830 to 1700 Monday through Friday
- Two Mental Health nightshift runners at SCF: 1330 to 2200 Sunday through Thursday and 1330 to 2200 Tuesday through Saturday
- Liberty Health runner at RPDC: 0730 to 1600 Monday through Friday

Other than the nightshift runners at SCF, the numbers of runners were not specified.

Another challenge has been uncertainty about how to safely use the programming tables purchased by RUHS-BH. At present, these tables, which provide for restraint but allow face-to-face interaction, are not supposed to be used except for piloting of individual sessions at RPDC. The County is considering how to utilize this resource.

Most other aspects of the County's efforts to meet the requirements of the remedial plan continue to progress. It is important to again convey that the County has continued to focus on the development of systems and sustainable long-term solutions rather than endeavoring only to meet the requirements of the remedial plan in isolation.

As before, this focus on infrastructure limits the County's current ability to generate the documentation necessary for proof of practice of many of the more detailed requirements of the Remedial Plan. However, the County is beginning to develop the capacity to report on important measures, including access to care and other clinical measures, primarily through the application of information technology (IT) resources to mining the new electronic medical record. The County has generated several reports relevant to the remedial plan as well as other important measures of system function using their quality improvement processes. This is an area of substantial improvement from my previous visit.

The County is also working to track time out of cell (dayroom and recreation) but this remains a challenge due to the limited electronic data systems available to RCSD for this purpose. In general, the County is challenged to provide data with sufficient detail to either provide proof of practice or conduct its own QA/QI. The main thing the County must do in this regard is to demonstrate provision of recreation twice each week for at least 1.5 hours for all inmates (absent safety and security concerns) and to show that dayroom time is not being suspended longer than needed to ensure safety and security. One aspect of this is demonstrating that similar populations are being treated the same, for example the mentally ill and non-mentally ill with the same custody and classification designations receive comparable dayroom time.

While the new electronic medical record should provide the foundation for such functions in medical and mental health, the systems available to RCSD are very limited and not designed to facilitate the kind of individual or aggregate data needed for QA/QI or proof of practice of some components of the remedial plan.

The County has continued to customize the Electronic Health Record (EHR) to better serve its needs. While mental health must still retrieve information from three different record systems, all of the jail medical and mental health records are available to all clinicians. The integration of health services under the Riverside University Health System (RUHS) will also doubtless promote better processes and monitoring capacity as integrated systems develop.

In terms of mental health services, apart from the problems of access owing to the changes in security conditions for clinicians, the County has made some progress. This includes improvements in the intake process, better response to inmate requests for mental health services, improvements in the assessment process, and growth in treatment planning. There are also plans to begin to deliver services other than just medications at the DCU.

In general, I did not detect significant problems in the suicide-related provisions.

The collaboration between custody and mental health continues despite the understandable tension caused by the security changes. It is clear that there is growing recognition of the need for mental health must be embedded in the facilities in a different manner than medical services. To repeat a comment from my last report, the depth of this challenge and the necessity to sustain this collaboration cannot be overemphasized.

Two important examples of this collaboration are placement decisions and unit management. From my patient contacts, records reviews, and other reports, I did not see any significant problems with placement of the mentally ill in appropriate settings except for the still large number of mentally ill on administrative segregation. Regular meetings on the living units that include mental health and custody (classification and medical attend as well) address important management issues and discussions with staff demonstrate that mental health considerations are being taken seriously in placement and management decisions.

The substantial use of administrative segregation for behavioral problems related to mental illness continues to be a problem. Many needing protective custody due to their mental illness are also placed in the same settings as those on administrative segregation with the result that this population is also more restricted. It limits access to treatment, the very thing that is most likely to reduce the behavioral problems that resulted in these statuses. This amounts to restrictive placement for being ill. Clearly, there are times when clinical considerations require restriction. The County needs to develop greater clarity about restrictions necessary for clinical reasons versus those necessary for custodial or correctional reasons. The former should be determined by clinicians, the latter by custody and classification staff. A related issue is the need for the County to develop and implement step-down procedures for those placed in

safety cells where mental health should be determining their degree of restriction, subject to reasonable limitations based on a structured classification process.

In terms of formal compliance, I report on the following measures, most of which remain global at this time. The County has achieved substantial compliance on the following measures:

- **Consent Decree Training**

The County has achieved partial compliance on the following measures:

- **Intake Screening** (elements relevant to mental health services) – likely nearing substantial compliance
- **Timely Access to Care** (elements relevant to mental health services)
- **Medication Administration and Monitoring** (elements relevant to mental health services)
- **Confidentiality** (elements relevant to mental health services)
- **Health Care Records** – likely nearing substantial compliance
- **Staffing** (elements relevant to mental health services)
- **Custodial Environment** (elements relevant to mental health services)
- **Treatment** of the mentally ill
- **Housing** the mentally ill – likely nearing substantial compliance
- **Treatment Space** for mental health services
- **Suicide Prevention**
- **Restraint**
- **Continuity of Care** for the releasing mentally ill
- **Policies and Procedures**
- **Continuous Quality Improvement** (elements relevant to mental health services)

The following measures were not rated:

- **Review of In Custody Deaths** (elements relevant to mental health services)

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HEALTH CARE GENERALLY (elements relevant to mental health services)

Intake Screening

The County's plan to have a Qualified Mental Health Professionals (QMHP) do the mental health intake screening, except at times when there is no mental health on site when an RN will continue to provide that function, is proceeding but not fully implemented.

The Mental Health Screening form is generally sound but has some weaknesses that should be addressed. It could be clearer in distinguishing current from past issues both in terms of treatment and symptoms. Signs (observed) and symptoms (reported) could also be more clearly distinguished and conceptualized in a complementary fashion (e.g., complaints of auditory hallucinations and observations of responding to internal stimuli; complaints of anxiety and observations of signs of anxiety). Some of the questions are too high level or broad, especially with regard to current observations. There also needs to be a clearer assessment of the potential for victimization (which should also be added to the PREA training in the Clinical Therapist Training Guide as well). The County may make some alternative suggestions regarding the specific content that is listed in the Remedial Plan. Assuming the suggestions are reasonable and capture the essential content areas, I would not object.

It is not clear how MH is to notify custody of risk of (sexual) victimization. Whether the form Detention Health Services – Notice of Medical Restrictions or Special Housing is an appropriate vehicle is questionable but some mechanism is needed.

The County provided data on intake screenings using different approaches. The results vary substantially. The Behavioral Health PLO Indicators Step by Step Status report: Draft Version 1.3 indicates (in hand-written notes) that "In the last month" (the month is not specified), there were 2881 health screens and 2771 mental health screens (this likely represents the whole system). It goes on to report that 88 were not screened by mental health since January 2017. It is clear that this data was obtained from TechCare. However, the electronic document "Data Request 10-5-17.pdf" shows that at RPDC, mental health screenings were only completed on about 70% of those admitted during weeks in July and August. In yet another document (electronic file "Data Request 10-5-17"), the County reported mental health screenings of all admissions at all facilities to be at 93.5% from July through September of 2017. In that document, RPDC was shown at 94-95%, much higher than in the other report that included data from this same period. These data need to be reconciled and the methodology made explicit in order to interpret these numbers.

Another electronic report from SWDC speaks to a number of inmates being transferred to SWDC from RPDC without having been screened. The County demonstrated that it reduced this number from 29 (for only part of April 2017) to 13 in May and 10 in June.

I saw the locations where intake screening is being conducted at all five facilities I visited. Confidentiality of the intake process for mental health has been improved though remains a challenge at some locations.

At RPDC, the pre-booking screening continues to be conducted in the vehicle sally port with arresting officers standing by; in the one instance I observed, the officer stood apart enough to afford some modicum of privacy. After the pre-booking screening, I observed the full nurse initial screening of this man. The nurse stated that she calls mental health if the patient has acute needs but otherwise the patient proceeds to mental health routinely for the mental health screening. The nurse also forwards

medication verification to mental health if able to get it (the nurse reported that nurses do this primarily when patients bring their own pill bottles, which is uncommon).

The RPDC mental health intake area has five semi-private work stations with patients in private non-contact booths across from each work station. It was very difficult to hear patients in this setting. With the planned build-out noted in my first report, there will be six stations with improved privacy and improved audio connections. I observed QMHP screenings and interviewed the staff. Screenings were all adequate or better and QMHPs demonstrated diligence in reviewing records prior to screening as well as attempting to verify prescriptions. They also reported that when unable to verify prescriptions for patients on important psychotropics, the patient was prioritized for psychiatric assessment.

When patients screened at RPDC are psychiatrically unstable, the QMHP endeavors to expedite their placement but this is not always successful and patients may stay in the basement screening area for hours. Mental health attempts to manage them and if particularly unstable, they can contact the Medical Sergeant assigned to work with mental health or mental health leadership, who frontline staff report usually intervene promptly.

I observed an initial nurse screening and mental health intake at SCF. These were done in private settings with the nurse having a face-to-face contact while the mental health intake was in a non-contact booth. As noted in my previous report, the physical plant at SCF provides limited options for private screening other than the non-contact booths. Both of these were well-done.

At SWDC, the nurse screening process is unchanged. I observed a mental health intake in a non-contact booth; it was adequate but the clinician did not follow-up on several clinical issues raised by the prisoner. While the intake was conducted, deputies walked by clinicians repeatedly as the clinicians are in a series of open booths (with patients on the other side of the window) with traffic behind them. Patients complained about this lack of privacy. There is a plan to build non-contact intake booths at SWDC.

At Indio, mental health staff is on site from 0700 to 2400. I observed a mental health intake conducted in a non-contact booth. Despite there being an open mesh, the clinician had to use the telephone because the ventilation system was so loud.

At Blythe, pre-booking screenings are conducted in the outdoor sally port; there is a plan to install a modular building in this space for medical and mental health screening and additional office space. It is slated to be completed in about a year. Nurses conduct their initial screening in an office with custody standing by outside the room. Nurses also conduct mental health screenings after hours. The mental health clinician does an acuity rating based on the nurse screening and, if necessary, does additional assessment. On weekends, a Clinical Therapist at Indio is contacted to provide the acuity rating and to assist with bridge orders for medications when necessary. Medication verification is done both by the nurses and the Clinical Therapist. If a psychotropic medication is verified, they contact on-call psychiatrists for orders after hours, the Indio psychiatrist during regular working hours and Saturdays, and the SCF psychiatrist on Sundays. The Blythe Clinical Therapist does intakes in a non-contact booth; it is not clear why this is the case as nurses see intakes face-to-face.

Continuation of medications upon intake is variable but in most cases patients whose medications are verified are started promptly, either by obtaining a bridge order (generally a telephone order from a

psychiatrist) or following a face-to-face meeting with a psychiatrist, sometimes in the intake area. However, numerous patients complained that it took several weeks to get medications initiated; it is not clear how many of them had verifiable community prescriptions. Follow-up with a psychiatrist following bridge orders is variable. One patient at RPDC (201742387) had not been seen for over a month following an initial bridge order. Medical record review showed to psychiatrist appointments that he reportedly refused. However, the psychiatrist did not speak with him personally; it was based on deputy report. The patient had been meeting regularly with other clinicians, so it would be unclear why he refused to meet with the psychiatrist as he ultimately did. There was no discussion in the record of his refusals so it is not clear exactly what happened.

The County is modifying TechCare to better support verification and ordering of bridge medications. These modifications should also make it easier for the County to prove its practice. A RUHS-BH report from August 2017 demonstrates that in most cases where bridge medications were attempted (presumably, in cases where the patient reported current medications), 88% had medications ordered and 97% of those orders were within 24 hours. Only 21% received a follow-up visit within a week. This is the first clear data on bridge orders for psychotropic medications. However, during medical record review I saw a little evidence of attempts to verify medication. It may be that verification efforts are not being consistently charted or are in a section of the chart that I could not access.

Compliance contemplates patients receiving initial medications within 48 hours, getting them immediately from stock, or being seen by a psychiatrist within 24 hours. While this report does not clearly demonstrate that patients are receiving medications within 48 hours, it represents a substantial step in terms of measuring proof of practice and demonstrates that the County is likely nearing substantial compliance on this element.

Review of medical records demonstrates problems detecting the seriously mentally ill during the intake process, though less marked than before. Nursing assessments seem prone to missing serious mental illness, but these cases are being captured by having mental health staff redo the intake the next working day. Changes to the process and the content of the screening are necessary.

The County has taken sufficient steps towards implementation of the mental health elements of intake screening to be in **partial compliance** with this element.

Timely Access to Care

The County has not yet modified its approach to managing Health Care Request Forms for mental health. As I noted in my previous report, the intention is for RUHS-BH to take a more direct role in initial triage of Health Care Request Forms for mental health; how this will be operationalized is yet to be determined. At the present time, nurses continue to pick up Health Care Request Forms (custody performs this function in some instances but does not view the forms). They then sort them and set aside those for mental health who then triage them the following morning. Nurses reportedly respond to any that are emergent in nature. There is still no mechanism for tracking the nature or timeliness of responses to Health Care Request Forms through the whole process. However, the County reports that it is nearly ready to start reporting on this important function.

The County does not have a means of tracking response time to inmate declared emergencies. This will likely require coordination between custody, medical, and mental health in order to ascertain how to track this and with which data system(s).

An electronic report from RPDC entitled "Number of days to triage.docx" shows that of 241 cases from June 1-15, RUHS-BH received for triage, 229/241 (95%) were triaged the same day. Only 3 took four or more days. Thus, RUHS-BH is responding promptly to cases that it receives. Since urgent cases are to be seen within 24 hours, it is critical that the triage be done as soon as possible.

A CQI project at Blythe Jail in August 2017 demonstrated that while the average response time to urgent mental health referrals (once received by RUHS-BH) was less than a day, only 7/12 were actually seen within 24 hours with two waiting more than three days. Another CQI project looked at response times to routine and "priority" (urgent) mental health referrals at all facilities for August and September 2017. Response times to urgent referrals averaged 4 days. SCF and SWDC were at 5-6 days, which is unreasonably long. The report did not include a percentage of those that were within 24 hours so it is difficult to map this onto the compliance measure.

A similar CQI study at SCF for May 2017 showed 37 emergent (many of which were felt to be incorrectly categorized and no further analysis was provided), 73 urgent and 276 routine patient sick call requests. Response times averaged 8.83 days for urgent and 8.78 days for routine requests. The County reported 10% and 14% compliance respectively, however, it is not clear how that was computed. I reviewed what appears to be the underlying data for this in an Excel file entitled "May Sick calls completed SCF.xlsx" and found 204/276 (74%) to have been responded to within two weeks as required by the remedial plan.

A study from SWDC reported that responses to sick calls averaged 2.8 days for all calls and 1.9 days for urgent calls.

The average response time for all facilities was under 14 days for routine referrals, but the report does not include information on how many lay outside 14 days so it is not possible to determine whether this reflects substantial compliance but it is certainly consistent with at least partial compliance.

Here again, the County is to be commended for getting this data and beginning to use CQI processes to improve its practices.

At RPDC, Health Care Request Forms and lockboxes were generally available (except on the 7th floor that houses primarily those with medical problems so this is not a problem). However, patient reports as to picking up forms and responses were generally negative, though variable. It was difficult to interpret their reports but most expressed dissatisfaction with response times except there were mixed reports regarding Clinical Therapist response, which was generally better than for other disciplines. During my visit to RPDC, 21 Health Care Request Forms were delivered to mental health staff at the lunch hour. Of these, 10/21 were from that day but the rest were from 1-4 days earlier, demonstrating continued problems with timely delivery and response.

At SCF, patients were generally satisfied with responses and reported regular retrieval of forms. Their only complaint was that access to a psychiatric prescriber sometimes took several weeks, though all reported being seen, most at least monthly. Lockboxes were present except in areas with isolation cells where wall space is inadequate.

At SWDC, most units I visited were missing Health Care Request Forms as well as grievance forms. Lockboxes were present though RCSD reports there is not one in A-Pod (Sheltered Housing). Patients described being offered some groups but limited individual sessions.

At Blythe, prisoners reported that Health Care Request Forms were picked up twice daily or at pill call, depending on the location. They were available on the units and lockboxes were present except in smaller units. Mental health triages Health Care Request Forms on weekdays at 0730.

At Indio, prisoners reported that Health Care Request Forms were picked up reliably (mostly twice per day) and generally responded to promptly. Health Care Request Forms and lockboxes were available on all units visited but grievance forms were sometimes missing. There are several units at Indio that do not have lockboxes, which should be resolved once the new jail opens. One Indio patient reported being seen within a week by a Clinical Therapist and within two weeks by psychiatry; record review demonstrated a Health Care Request Form from 7/24/17, Clinical Therapist Contact 7/28/17, and a psychiatric visit 8/2/17.

Note that several patients at SWDC and SCF reported that gang members sometimes take all the Health Care Request Forms and hide or destroy them to prevent other gang members from asking for health care services or to keep for themselves. It is critical for custody staff to be attentive to this problem.

Patients report that mental health is generally responsive to requests to be seen, whether to Health Care Request Forms or direct requests to health care staff but response times were days to weeks, though rarely more than one week for Clinical Therapists and two weeks for psychiatrists. Reports were mixed regarding requests made directly to deputies with those at SCF, Blythe, and Indio reporting good responses most of the time but those at RPDC and SWDC offering that responses depended on the particular deputy.

Psychiatrists reported that they were usually able to see routine patients within 30 days and conduct follow-ups every 30 to 90 days. They noted there is no priority scheme for scheduling patients and sometimes schedulers reschedule patients to later dates when they should not. Other than at RPDC, psychiatrists report generally having good access to patients and reliable assistance from custody. Psychiatrists are afforded sufficient time to see patients by RUHS-BH but the time may be curtailed owing to the challenges with access to patients. Other than delays with initiation of medications, most patients described good access to psychiatrists, even if they would prefer more. Almost all described visits with a psychiatrist at least monthly, sometimes more often.

Patients at Blythe currently must go to Indio to see a psychiatrist. They are not always transferred to a different facility but are if they need more intensive care.

Psychiatric encounters have increased to 2063 in July and 1601 in September. However, the data does not include timeliness figures so all that can be said is that, on average, open cases are being seen monthly by a psychiatrist.

One issue that patients complained of repeatedly was co-pays, especially for medication refills. While not an explicit part of the remedial plan, it is important to note that co-pays are likely to limit access to care. Most research has also demonstrated that co-pays do not save money because of reduced health care usage resulting in patients being more ill when they seek care and thus costing more.

I also note that many patients complained of problems with access to medical care both in terms of timeliness and responsiveness to complaints. They were much more critical of medical staff than mental health staff. While this is not a positive finding, it does suggest that positive reports about mental health staff are likely to reflect the true impressions of the inmates.

In addition, the County provided information on open mental health cases, the number of new mental health cases opened monthly, the number of patients on psychotropic medications, the number of psychiatric encounters, and the number of mental health clinical encounters (other than psychiatry) from July and September of 2017. These numbers reflect open cases at about the same rate as previously (1595 and 1229 for these two months). Of these, 95% or more were on psychotropic medications.

Chart reviews demonstrated that in almost all instances, patients on psychotropic medications were being seen at least every 90 days, and almost always substantially more often. However, psychiatrists at RPDC report that accessing patients remains difficult and impairs productivity because of space limitations, challenges getting patients out to interview rooms, patients being out to court or other locations at the time of the appointment (there is little coordination between custody and health services in terms of scheduling), and because of the time it takes to move through the facility.

Despite the access challenges, other mental health encounters in general population settings have continued to increase to 6907 in July and 11,141 in September, doubtless reflecting the steady increase in staffing and improvements in information management and documentation. Here again, the timeliness of encounters is difficult to assess.

The average number of patients housed in residential mental health units has stabilized at around 400. The numbers of encounters on these units remains difficult to interpret but is about 1500 per month both at SCF and RPDC (though higher for both months at SCF), which house similar numbers of mentally ill.

These numbers demonstrate that the County has maintained increased mental health services compared to before the Consent Decree, predominantly with respect to non-pharmacologic treatment and expanding residential mental health units, despite the recent challenges to access. However, these numbers are likely to drop without the planned changes to security. It is also important to note that while the numbers of encounters are still high, the nature of those encounters has changed substantially in ways that reduce the efficacy of treatment, primarily owing to the growth in non-contact and cell front visits and the reduction in groups.

Patients in the residential units continued to report that mental health staff do rounds almost every day and ask how they are doing (often during pill call). They reported meeting with a Clinical Therapist individually at varied frequencies, mostly consisting of brief contacts on a monthly basis that were primarily focused on current symptoms or release planning. However, almost all felt the Clinical Therapists were helpful and had their best interests in mind; they simply wished for more contact and more opportunities for therapeutic sessions. Many lamented the loss of groups.

Review of medical records demonstrated consistency with the preceding: most patients are being seen sufficiently regularly by a psychiatrist, most patients are getting occasional case management contacts with a QMHP, and a few patients are getting active treatment either in group or, rarely, individual therapy.

In summary, the primary work for the County in the jails, in terms of access, is to address the security issues limiting access, complete the restructuring of the mental health intake and Health Care Request

processes, and achieve and demonstrate timeliness of treatment services. The treatment element is addressed in greater detail in the "Treatment" section of "MENTAL HEALTH CARE" below.

Here again, the County is in **partial compliance** with respect to the mental health services elements relevant to Timely Access to Care.

Medication Administration and Monitoring

I again observed morning medication administration at RPDC on a residential mental health unit. Prior to going to the unit, the nurse reviews the unit roster to see if there are any new patients and if so, reviews the EHR for the patient to check on any health conditions and review current medications. A QMHP and deputy accompany the nurse from cell-to-cell as the nurse administers medications. There was no change in the procedure from my previous visit. However, when asked for a Health Care Request Form, a patient was directed to the supply in the dayroom, though it was inaccessible to the patient at that time. Several patients at different facilities (RPDC, SCF, and SWDC) reported that nurses would sometimes not give them Health Care Request Forms during pill call and told them to get them from the supply in the dayroom. Nurses should hand out Health Care Request Forms during pill call.

Neither the nurse nor the QMHP spoke with the patients about protected health information other than some communication regarding medications that occasionally included medication names.

The mouth checks to assure adherence remained marginally adequate. In most cases, the nurse watched the patient take the medications but did not uniformly do a mouth check. But, as noted last time as well, the nurse was aware of which patients were prone to "cheeking" medications (appearing to take the medication but sequestering it, typically in the cheek) and did more thorough checks with these patients.

The nurse did not uniformly check identification but knew most of the patients. In one instance, the nurse did not know the patient and the patient did not have his identification bracelet; the nurse verified the patient's name with the accompanying deputy and Clinical Therapist.

When the nurse administered medications on a lower tier, the nurse had the medication cart and a computer with access to the medical record and medication administration record (MAR). When the nurse administered medications on an upper tier, the nurse did not have the medication cart or a computer with access to the medical record or to the MAR. The nurse had pre-packaged medications for each patient but this time they were in envelopes that had a post-it with patient names and cell numbers written on them. The nurse completed the administration on the upper tier and then entered the information in the MAR for the whole tier. While this remains a problematic practice, at least the envelopes had identifying information on them, though post-its could fall off. I continue to recommend that the County seek a remedy to this.

Review of a selection of MARs showed that they were almost always complete; it was not possible to verify their accuracy other than for the lower tier administrations I reviewed, which were accurate. In the residential mental health units, both nurses and QMHPs report adherence problems to the psychiatric prescribers. The general practice is to notify the prescriber after three days of refusal, either by using the sick call queue or email. Psychiatric prescribers reported that they were informed of adherence problems at RPDC and SCF but the psychiatrist at SWDC was uncertain how reliable the reporting was.

Medication administration is scheduled for reasonable times. Patients in all facilities reported that morning medication administration was generally timely (within an hour of the designated time) and that while evening medications were sometimes late, they reported much more timely administration than previously, though still more problematic at RPDC than other facilities. The County does not yet have access to summary statistics on medication administration so it is not possible to know how common the problems with timeliness are. This needs to be tracked.

The County is not yet able to demonstrate its compliance with the provisions for medication administration when patients are out to court, in transit to outside appointments, or upon transfer. The nurse I observed administering medications reported that when they know a patient is going to court and will need medications during that time, the pill line nurse contacts the intake nurse who is then responsible for assuring medications accompany the patient to court.

A number of patients reported that they had medications expire and were without them, though most report this was rectified within 1-4 days. However, all were clear that this was uncommon. The County also produced a report entitled E-MAR Psychotropic Medication Lapses showing that 93.6% had not lapses in medication administration; for those that did lapse, it was an average of two days before patients received another dose (the vast majority missed only 2 doses). This demonstrates fair performance on this indicator but the percentage of lapses can be improved.

I was not provided policies or procedures regarding medication monitoring. Psychiatrists report that they have full access to laboratory studies with the exception of imaging, electrophysiological studies, and ECG, all of which must be authorized by medical. Unless all physicians are subject to similar limitations, this is unreasonable; psychiatrists are specialized physicians and are best suited to know what studies are indicated for psychiatric care. Regardless, it impedes access to care, especially with regard to ECG which must be obtained prior to initiation of psychotropics in many instances. Psychiatrist continue to report that it may take up to two weeks to get ECG results. While this is not a requirement of the Remedial Plan, the current practice places barriers that may interfere with proper medication monitoring by psychiatrists.

Medical record review demonstrated that laboratory monitoring and administration of Abnormal Involuntary Movements Scales (AIMS) of patients on psychotropic medications is inconsistent. In addition to lack of baseline laboratories in most cases (not necessary when continuing community therapy but when starting medications de novo), there were many instances where there was a lack of or untimely monitoring of medication levels and potential adverse reactions such as metabolic syndrome, blood dyscrasias, hepatic dysfunction, and other complications. However, there was clear improvement in the number of AIMS being done and one psychiatrist reliably monitoring patients on antipsychotics for metabolic syndrome.

Owing to inconsistent medication monitoring and concerns about upper tier medication administration, the elements of Medication Administration and Monitoring relevant to mental health services is in **partial compliance**. This should be easily remedied.

Confidentiality

The County has not made any substantial changes since my previous report with regard to confidentiality of intake except at SCF. As noted above, intakes at SCF are now being done in the non-

contact booths. Though this causes other challenges, it is confidential. Once the planned construction noted in the section on intake is completed, this issue should be resolved.

Because access to care has been reduced by virtue of the security requirement for program rooms to be locked when clinicians are with patients, this has resulted in an increase in cell front interactions, which are inherently non-confidential. Clinicians endeavor to minimize discussion of personal health information at cell front. Patients at RPDC note this as a problem more than at other jail settings. It remains a major problem at the DCU where most patient contacts are at cell front.

There has been clear improvement in evaluations of those in safety cells who are now routinely being seen in a confidential setting.

As noted above, pill call is not confidential but clinicians reveal minimal protected health information during medication administration. In my opinion, the added communication that occurs during the conjoint rounds between nurses, QMHPs, and custody during medication administration is worth the loss of opportunity to discuss more personal medical or mental health problems as long as clinicians do, in fact, follow-up with requests for private interviews and sick call requests. Patients report that QMHPs generally do honor such requests.

Policy 508.05 Inmate Medical Care specifies that patients are afforded the same confidentiality as "…in the general community." However, it goes on to say that "When inmates are receiving medical services from a jail health care provider, custody staff shall maintain visual supervision but may not be close enough to overhear communication…." This is not consistent with the previous statement regarding being afforded the same confidentiality as in the community. It notes that custody staff may be close enough to overhear communication "…based on an individual determination of risk…" requiring closer supervision. The healthcare staff is then directed to document "[t]he reason(s) for allowing custody staff to be within hearing distance…." It does not specify who makes the decision to allow this proximity. I also note that I have seen numerous instances where custody is within earshot but I have seen no evidence of documentation of the reasons in any medical records. This needs to be clarified and managed.

With regard to the elements of confidentiality relevant to mental health services, the County is in **partial compliance** with improvements in some areas and losses in others.

Health Care Records

There is now an EHR that both medical a mental health clinicians can fully access. Policy to support needed modifications, maintenance, and improvements was not provided to me.

As noted previously, the County is making key modifications to the EHR and has a number of initiatives related to mental health. These modifications will be necessary in order to establish adequate quality improvement and quality assurance as well as proof of practice of a number of measures within the Remedial Plan.

Once policy is provided that meets the terms of the Remedial Plan, this item will be in substantial compliance; at this point **partial compliance** is warranted.

Staffing

The official staffing report I received from the County shows RUHS-BH having 150 full time equivalent positions (FTE) – unchanged from my previous report. As of 7/11/17, 85% were filled. Empty positions were relatively evenly distributed across disciplines. Notable empty positions included 3 of 6 Senior Clinical Therapists and only 3 of 5 Recreation Therapist positions. Other than only one of three positions being filled at Blythe, no other jail showed a notable difference from the others in terms of unfilled positions.

The County has not yet developed a report to assess the impact of staffing. Note that the fill rate is below the 90% target the County was expected to reach within 12 months of the Consent Decree.

The following is a table of funded FTE. Of note, there have been no changes since last time, likely demonstrating that the County has completed the basic restructuring of its mental health program.

	July 2015	May 2016	November 2016	February 2017	July 2017
Psychiatrists	9.8	12.76	13	13	13
Clinical Therapists	43.3	81	80	82	82
Support Staff	9	19	18	18	18
Behavioral Health Supervisors	3	7	7	7	7
Registered Nurses (RN)	1	1	1	0?	0?
Behavioral Health Specialists	2	24	25	25	25
Recreation Therapists	0	5	5	5	5
Total	68.1	149.76	149	150	127.48

The following shows actual staffing at the time of my first report and currently.

	February 2017	July 2017
Psychiatrists	11.32	10.98
Clinical Therapists	66.5	67.5
Support Staff	17	16
Behavioral Health Supervisors	7	8
Registered Nurses (RN)	0	0
Behavioral Health Specialists	23	23
Recreation Therapists	2	2
Total	126.82	127.48

There are three Clinical Therapists and two Behavioral Health Specialists at Indio providing services 7 days per week from 0700 to 2400.

There is currently one Clinical Therapist at Blythe; they are funded for two. Once hired, this will allow 12 hour coverage 7 days per week. RUHS-BH leadership noted that they are developing telepsychiatry capacity at Blythe to address the challenge of getting adequate psychiatric coverage there. The equipment is already on site.

SWDC reports that there are 8 Clinical Therapists on days (with four on duty at any one time) and four on evenings (two at a time); two positions are open. There are nine Behavioral Health Specialists working day shift with eight assigned to housing units and one floating. There is a psychiatrist on site seven days per week from 0830 to 1900 (2.5 FTE), though this may be reduced to five days per week due to custody runners only being available on weekdays.

The RCSD will likely need additional custody staff to meet the expanding needs represented by the growth in health care services in response to the Consent Decree. In this regard, it should be noted that I saw numerous entries in medical records regarding time spent waiting for patients and cancelled meetings because of custody limitations.

At this point, the County remains in **partial compliance** with the elements of Staffing relevant to mental health services.

Custodial Environment

I walked through the majority of residential mental health units and visited most cells on those units. While there were numerous patients whose cells were in some degree of disarray, I did not see any that were grossly unsanitary or malodorous and custody staff reported that they had to clean the cells of some patients repeatedly. Custody staff demonstrated familiarity with most of the population.

Custody staff were generally respectful and professional with staff and prisoners. Several patients in the residential units reported that a minority of custody staff were not respectful and even made fun of the mentally ill; with a few exceptions, most were reportedly not regularly assigned to these units.

The facilities themselves were generally clean though RPDC was notably less cleanly. Shower curtains at RPDC were in tatters and a shower was running continuously (maintenance had been called) but the showers themselves were clean.

Some patients complained that they were not given “fish kits” (basic supplies such as toiletries) at RPDC.

The RCSD policy Recreation specifies that inmates will receive three hours of recreation every seven days. The remedial plan specifies that each recreation period will be at least one and a half hours. The policy also specifies that for those on administrative segregation: “Only one cell at a time shall be allowed in the recreation area.”

The RCSD policy 504.42 Dayroom Management reflects that dayroom times extend from 0800 to 2300 as specified in the Remedial Plan. The policy does generally reflect an intention to maximize dayroom time. It does not specify how much time inmates are to be afforded in the dayroom or how dayroom time varies with custody or classification level. Thus it is difficult to determine what the expected amount of dayroom time is. This makes it impossible to determine if dayroom time is being offered according to policy. This leaves the only way to assess the dayroom time for the mentally ill is to compare it to dayroom time of other inmates. While this is not a formal measure, if there is a marked and consistent reduction of dayroom time for the mentally ill, this would suggest that dayroom time is

not being maximized for the mentally ill. While some reduction compared to general population inmates would be expected in higher acuity settings owing to an expected increase in behavioral disorder in this population, that should not be true for those in lower acuity settings.

The County provided some hand-collected data on dayroom times. There are problems with this data. In some cases, the time in and time out are reversed. There are other errors as well. While this does not undermine the credibility of the data entirely, it makes it clear that there are inaccuracies, the scope of which is unknown. Despite that, the data provides useful information and gives some picture of how dayroom time is being managed. I offer the following salient observations.

At SWDC, those on administrative segregation status are tracked individually. They appear to get 30-60 minutes (most are nearer 30 and many are exactly 30 minutes, raising concerns about the accuracy of the data) dayroom time on days when they get dayroom time. It is unclear whether all inmates get out daily as the data does not include a count of the inmates in a particular pod. Dayroom times occasionally occur outside of 0800-2300, beginning as early as 0654 and ending as late as 0007. On other units (B through G pods that are not administrative segregation), dayroom time is not tracked by individual and does not include the actual time in the dayroom, only a starting time. Thus it is not possible to determine actual dayroom time. Further, there seems to be no standard approach to dayroom. While almost all pods bring inmates out by upper and lower tier, sometimes it is also divided up by dayrooms but in varying ways. There is no reason for this variation given. In general, it appears that some inmates are out in the dayroom 6-12 times per day for some period of time, perhaps up to an hour. But it is not possible to say anything more than that from the data. Whether all inmates are offered dayroom is not clear.

In my interviews with patients, I asked about dayroom and yard times. Patients in residential mental health units at RPDC reported highly variable access to dayrooms, almost all noting that it depended on the deputy with some making a concerted effort to maximize dayroom time and others not. Those not on administrative segregation reported getting out in the dayroom one to three times daily, usually for an hour or nearly an hour. They reported usually come out one tier at a time but sometimes in smaller groups. They gave variable reports on access to the recreation area, most saying it was once per week for 90 minutes and others saying it was one to two times per week for about an hour.

Those on administrative segregation at RPDC report that they get 30-60 minutes in the dayroom each day (in one or two sessions). They reported that they get access to the recreation yard one to three times per week for varying amounts of time.

At SCF unit 16 (residential mental health), patients report that they get dayroom 2-4 times daily, up to an hour each, though some reported the frequency had dropped recently. There were several who reported that dayroom access was less on F pod (where the most ill are housed). They gave varying reports regarding access to the recreation yard (which is quite small) from once each week for about an hour to daily during morning dayroom time.

It is important to note that the County has endeavored to reduce the different types of inmates mixed on the residential mental health units in order to make it easier to maximize out of cell time. Their total out of cell time is unknown but since there are no other populations on this unit, the impact on those not on administrative segregation has been reduced. See "Housing" for further discussion.

At SWDC, patients reported limited access to the yard, usually once per week. They reported having access to the dayroom typically 2-3 times per day for 30-60 minutes, depending on their custody level.

Prisoners at Blythe were very satisfied with the services and conditions in the jail generally, though noted that programs were limited at Blythe except a few jobs. They are in dorm settings so dayroom is not an issue. They report access to the yard three times weekly.

Prisoners at Indio were mixed in their reports regarding access to the yard. Most reported weekly access to the yard for several hours. As most settings are dorms, dayroom access is not an issue. Conditions at the archaic Indio jail remain problematic but this will be remedied when the new jail opens.

Another problem with yard times is that they are sometimes very early in the morning. Because many psychotropic medications are sedating, it is unreasonable to ask those in the residential mental health units to utilize early morning yard times; it effectively limits their access. They should be scheduled for yard times no earlier than 0800, just as for dayroom times.

The DCU continues to be run like a restrictive housing unit and the comments from my previous report continue to apply. While there is now a Clinical Therapist there (and a second starting soon), they have limited access to patients even for individual meetings. Patient are still mostly locked in their rooms 24 hours per day. There is a plan to use one of the holding cells for patient meetings but this has not yet been implemented. As a result, Clinical Therapist work has primarily consisted of insuring continuity of care through communication with the jail mental health staff. Access to patients is also limited to some degree by requiring two deputy escorts for those on administrative segregation status (many seriously ill continue to be placed on this status owing to their mental illness resulting in problem behavior) and sometimes those not on administrative segregation are being required by custody to have two escorts for security reasons. In addition to the plans to increase treatment space and patient contact, the staff at the DCU is discussion expanded property options.

I attended two multi-disciplinary meetings at RPDC (for 5A/5B male residential mental health and 6A/6B for females, which is not exclusively for the mentally ill), each lasting about 15 minutes. These included mental health staff, nursing, unit custody staff, classification staff, and the Medical Sergeant working with mental health units. They discussed specific patients and those who were having problems. They discussed the possibility of removing two patients from administrative segregation; the discussion focused on behavior and classification but did not include changes in their mental health status. During the discussion, it emerged that there were 5-6 patients in the intake area for 1-2 days who were in need of beds. There was no other discussion of placement or transfer issues.

At SCF, staff use the multi-disciplinary meetings, which are held daily, to discuss transfers as well as review the status of the population. I also attended a core team meeting at SCF that was a facility-wide group of health care staff and custody staff. This meeting is used to address important health-related issues. It was notable that health care staff sat at the front of the room and custody staff stood separately at the back of the room.

In my first report, I noted that there are two trainings, one by custody (included in new Custodial Conflict Intervention Training (CCIT)) and by mental health in the suicide training module (IFT Suicide Prevention Training), that address the “self-isolating inmate.” The County reported that it would

complete the IFT Suicide Prevention Training by 10/31/16 but I have not received verification of completion or the curriculum demonstrating that self-isolation was covered. The County has offered CCIT since 7/24/16 and reports that it has trained 149 (rosters show 174); it is unclear what percentage of custody staff this represents but it does not appear to be nearly complete. I reviewed the slides for the training and they are adequate in terms of content and do address the self-isolating inmate. The training could be improved by the addition of a practicum component but this is beyond the scope of the remedial plan. The RCSD provided its training on the remedial plan; it includes two slides related to the self-isolating inmate. I was also provided a training for custody staff conducted by Correctional Healthcare Services that also addressed the self-isolating inmate; attendance records were not provided. The County cannot yet demonstrate its ability to consistently detect such inmates, but it remains clear that in residential mental health units there is a great deal of communication about such behavior and related problems, including poor hygiene, poor oral intake, and the manifestation of behavior indicative of mental illness. I heard such discussions during rounds and at meetings between mental health and custody.

The use of administrative segregation of the mentally ill within residential mental health units remains a logistical challenge and raises questions about limiting privileges because of mental illness. Those on this status are offered only one hour out of cell time per day, solo yard access, and cannot attend groups; in short, they are under conditions quite similar to restrictive housing. Clinicians note that access to those on this status for one-to-one meetings can also be limited, interfering with their ability to provide needed services; Clinical Therapists are conducting daily rounds on them but this is a brief cell front check-in, not treatment. Clearly, safety and security must be provided for patients and staff alike. However, it is necessary to be able to consistently meet the clinical needs of the patients, necessitating better access. There is a plan to procure classroom seating that provides for restraint to allow the most dangerous to begin attending groups, an important first step in determining their readiness to have more unrestricted access to peers and staff alike. The County has purchased correctional tables to serve this purpose and to provide options for meeting with patients individually, though as noted previously, the County is yet to make full use of these. Assuring ready access for individual meetings with clinicians is also necessary. While there is regular review of the need for continued administrative segregation (at least every 30 days), there must be access to care regardless of whether they are on this status or not.

Those who custody staff are concerned are in crisis, constituting an emergency, are evaluated by a QMHP at any time of day. As noted above in this regard, proof of practice is hampered by difficulty identifying qualifying cases.

Behavior management plans, used to assist custody and mental health in providing consistent and complimentary services, have not been instituted as yet. These are required by the Remedial Plan.

The elements of the Custodial Environment related to mental health services remains in **partial compliance**.

REVIEW OF IN CUSTODY DEATHS (elements relevant to mental health services)

I asked for information on any in-custody deaths that were suicides or possible suicides. BHDS staff replied that RCSD has this data. No data was provided.

As such, there is nothing to review at this time. This item is **not rated** with regard to the elements relevant to mental health services.

CONTINUOUS QUALITY IMPROVEMENT PROGRAM (elements relevant to mental health services)

The Continuous Quality Improvement Program (CQIP) remains in development but this is an area where the County has made substantial progress. The County has further expanded its data collection, developed TechCare reports, and engaged in facility-level CQI projects. Much of the needed data is still not readily available but progressively more, and better, information is being collected and analyzed.

Data collection and analysis is a much greater problem for custody whose data systems are antiquated and not designed to perform CQI functions. It is not clear where work towards developing a data warehouse stands. This will be a key element for both CQI and proof of practice, especially given the limitations of the custody databases. Robust coordination of CQI between mental health, custody, and medical remains to be developed.

The document Behavioral Health PLO Indicators Step by Step Status report: Draft Version 1.3 demonstrates the work RUHS-BH is doing to develop measures both related to the remedial plan and to the long term CQI needs of the system. The document Audit Smith HU 16.docx shows that RUHS-BH has done a good job of evaluating level of function and service needs on this unit. Additional CQI data was provided in the electronic document “Data Request 10-15-17.” This included an interesting study of fights and grievances in SCF housing unit 16 (mental health housing) which has seen a substantial increase in higher acuity patients. There is a high number of fights on the unit compared to others (which is consistent with the acuity of the population and also seemed to correspond to an influx of a large number of mentally ill from RPDC), but grievances dropped substantially with the influx of staff and programs.

Peer review processes remain in development for mental health.

However, I did not receive any minutes of the Quality Improvement Committee nor any Corrective Action Plans (CAPs) for mental health that were developed by the Quality Improvement Committee.

At this time, the County is **partially compliant** with this measure, owing primarily to the development of more reports and greater usage of the CQI process.

MENTAL HEALTH CARE

Treatment

It is important to note that the number of patients on the mental health caseload has changed very little since my initial report. This is reasonable as the number is consistent with data on the prevalence of mental illness in jails.

There is no formal Program Guide as yet but a draft is reportedly nearly complete. There is a comprehensive Clinical Therapist Training Guide which is more a compendium of important information than a guide but has many of the elements of a program guide. It provides good quality information on

the jails, jail practices and procedures, and, most importantly, sound evidence-based approaches to clinical work in the jails including crisis response, assessment of management of suicide risk, intake, general mental health assessment, acuity ratings, treatment planning, and discharge planning. It also includes a section on danger to others that needs development and a better evidence-based foundation.

This manual also addresses dosing of treatment adequately, specifically mandating 10 hours of behavioral health programming weekly for those with moderately-severe and severe acuity ratings. For those with less acute problems, the requirement is for a monthly individual contact, psychiatric treatment (as indicated - with monthly follow-up), and at least one group. It is unclear whether the one group is to be on-going or a single group; this needs to be clarified.

The section on acuity ratings represents sound training on making rating and also lays out the general architecture of the various treatment settings and how they relate to the acuity ratings. Guidance regarding care plans is sound but needs to be updated to reflect the change to TechCare. While the requirements for discharge planning are aspirational at present, this manual and the policy on Discharge Planning represent reasonable expectations.

Intake data was reported above in the corresponding section. Following intake, further assessment is needed for those with mental health problems. The County provided data on these assessments from some settings. Of assessments conducted on 6B (female mental health housing) 53% were done timely, 28% were late (more than two weeks following intake), 8% already had an assessment from a previous admission, and 11% had no assessment. A similar CQI study at SCF found that only 48 out of 544 inmates with behavioral health flags had no assessment.; further analysis showed that in actuality, only 9 were missing for no reasonable cause. It is difficult to know how to interpret these in light of the fact that there is some uncertainty regarding the numbers screened by mental health according to data presented above in the section Intake Screening. Presumably, the SCF study represents the number who had assessments that were screened by MH. If that interpretation is correct, it demonstrates that RUHS-BH is good at assuring follow-up assessment for those they have identified as having MH issues. Though improvement is needed, this is important data and it demonstrates fairly good performance, though not at the level of substantial compliance. In another CQI study included in the electronic file "Data Request 10-5-17" the County found that 60.5% of all those on the mental health caseload had an assessment for July through September 2017 (up from 46.6% in March through May). The percentages varied from a low of about 33% at Blythe to a high of about 75% at SCF with the others in the 50-60% range. As with the mental health intake assessments, these data need to be reconciled and the methodology provided in order to better interpret the findings. However, it is clear that the County is making improvements here.

The County also examined the timeliness of intake assessments following booking. Here, the County was only looking at completed assessments. It found that 85% were completed within 14 days (up from 66.6% in March through May) and demonstrated a small but significant continued increase from July to September at all facilities. This shows that when cases are identified and an assessment done, they are generally done promptly.

The County has recently begun to emphasize the need for care plans (treatment plans). In yet another CQI study, the County demonstrated that 52% (up from 37.2% in March through May) of those on the mental health caseload had such plans. While not a high number, this is really quite good given how recently this initiative has been undertaken. Further, of those done, 81% were completed within 14 days (up from 62.9% in March through May). Taken with the intake and assessment data, it is clear that the County is making substantial progress and is developing the capacity to track its own performance.

One challenge that the county faces in terms of developing adequate mental health treatment is continuity of providers. At this point the County remains oriented to crisis management. Patients are frequently seen by a variety of different Clinical Therapist and Behavioral Health Specialists. To provide structured mental health services, continuity of provider is very important in both group and individual therapy. The County has done well in assuring consistent group leadership and some of the structural changes being made in Clinical Therapist assignments should help provide the organizational foundation rendering structured treatment at an individual level.

The County is not yet able to report on the attendance, completion, or cancellation of groups, but they have developed group schedules (where they are still able to run groups) and were running up to three groups per day at SCF housing unit 16. The groups are evidence-based and address relevant topics. Attendance is determined by mental health, subject to custody limitations and availability. Patients report that, other than recent problems with cancellation and reduction of groups in general, the groups are run reliably, take the full time, and address the topic areas advertised. The groups I attended were sound. Other than at SWDC, those attending groups were clearly mentally ill and were generally appropriately placed in the groups, a clear improvement since my first report. This is almost certainly a function of implementation of the acuity scales, assuring that the needs of those on each unit are likely to be similar. There were also fewer complaints of being moved before finishing groups; even though lessened, it is not clear how often this is happening. Custody and mental health have been meeting to address this issue. The County is looking at how to capture this data.

The County reports that it has nearly completed a report that will detail the timeliness of psychiatric encounters. While many patients complained of inadequate psychiatric encounters, record review demonstrates that the vast majority of patients are being seen at regular intervals. While there remain challenges with bridge medications and prompt psychiatric assessment following intake, my reviews suggest that routine initial assessment and on-going psychiatric care are timely and clinically adequate.

The County provided data on the number of psychiatric visits and the number of patients receiving medications. Taken together, these show that patients are being seen more than monthly on average. The numbers of monthly psychiatric encounters has not changed significantly during that time so the main question is whether these encounters are better targeted to meet the needs of the patients and timelines required.

Those patients on administrative segregation continue to receive limited services. They are not eligible for groups and mental health staff report that it can be challenging to get access to these patients owing to custody challenges getting them out of their cells and limited space for meeting, especially at RPDC. Access to one-on-one meetings for treatment modules such as life skills has been reduced owing to the general impact on access to care discussed above. Patients on administrative segregation report that mental health visits them most days but not daily; this is almost always at cell front. The County produced a report entitled Administrative Segregation Follow-up showing that 71% of the mentally ill in administrative segregation received daily follow-up. However, almost 20% had no contacts for four or more days. This is clearly not substantial compliance but is well into partial compliance.

Psychiatrists note that collaboration with other mental health staff is very good but that there are challenges coordinating care with medical providers.

By using the new acuity codes and organizing units according to acuity and by mental health and custody paying greater attention to transfers, the problem of patients being transferred in the middle of groups has been reduced, though still occurs.

I observed a discharge planning group at RPDC. It included six patients from 5B and 5A – they were allowed to be in the same group because they had the same custody classification. Group participants were selected by review of patient requests, individual meetings to determine need, and whether the patient was to be released in the near future. While I was in this group, the door was open (contrary to the edict from RCSD) with a custody staff standing by outside the room. A radio was brought to the group leader 30 minutes into the group. One of the group leaders closed the door 45 minutes into the group. At the end of the group, the custody staff radioed to have the door open but it was several minutes before it was actually opened. The group was conducted by two Behavioral Health Specialists. The group was generally well done and the patients participated actively.

I also observed a recreation therapy group at RPDC. There were four women in the group, most of whom were higher functioning than the group was targeted to. The group was a word game similar to The Wheel of Fortune that was designed to promote teamwork, handling failure, and using cognitive skills. The leaders did a very good job of using this format for therapeutic purposes. The door was open during the group and a sergeant was standing by outside the room.

There were no groups running when I was at SCF.

I observed a recreation therapy group at SWDC. Two Behavioral Health Specialists ran the group for five patients who exhibited limited evidence of mental illness. They met in a recreation yard and after some stretching and warm up, engaged in a game-like activity that included responding to questions such as "What was a stressful experience that you got through?" They used this to discuss coping skills for different situations. The group members participated actively and expressed a wish for more such opportunities. The co-leaders told me that they identified potential participants from the AB109 population (there is a statutory requirement, whether mentally ill or not) and mental health rolls. They also tailor group recommendations to patient needs, such as chemical dependency. Groups have relatively consistent membership and group members may come from different units. Groups include recreation therapy (9-10 and 3-4 five days per week), chemical dependency groups (COLORS, an eight week program run two days per week), and discharge planning. I also observed a Life Skills group at SWDC co-led by two Behavioral Health Specialists. The group was well run and appropriately focused. Here again, there were no overtly mentally ill among the 10 attendees, though clearly some had anxiety disorders.

At Indio, Behavioral Health Specialists run daily groups, mostly discharge planning but some treatment groups as well. They provide individual discharge planning as well. Clinical Therapists focus on assessment, crisis response, and provide some individual therapy.

There are no groups at Blythe. The Clinical Therapist does some individual treatment.

At SWDC, most Clinical Therapists were recently assigned to particular pods rather than having facility-wide functions. There are three assigned to pods during days with one on crisis response. There are two Clinical Therapists on in the evenings, both with facility-wide responsibilities. Individual sessions have been substantially reduced owing to problems with accessing patients and inability to use program spaces due to the new security requirements.

Individual treatment is still largely lacking, especially in terms of structured individual interventions targeted at specific problems. The County intends to restructure services away from crisis response

towards a more balanced approach. This will also necessitate the implementation of more robust treatment planning which is, at present, largely absent or overly generic. There is no provision for treatment team meetings on residential mental health units. The County would do well to consider developing regular multi-disciplinary treatment planning conferences on these units; this approach helps assure consistency in treatment and coordination of care as well as providing a ready vehicle for communication. This would also be consistent with my earlier recommendation to develop a conjoint treatment plan.

Owing to the highly restrictive conditions at the DCU, there is essentially no treatment other than medications.

I also note that the RUHS-BH staff at SCF decided to engage in a practice of joining patients at meals. They then did a survey of the patients, most of whom approved of the practice. While not formal treatment, it is the sort of practice that helps bolster the treatment alliance and brings a more therapeutic atmosphere to the living units.

The County remains in **partial compliance** with the mental health treatment provisions of the Remedial Plan. There has been remarkable progress and the County is making very solid plans for the provision of sound treatment and for the management of the mentally ill population.

Housing

This is an area where there has been substantial progress and collaboration between mental health, custody, and classification. While mental health staff are not uniformly consulted regarding transfers, I continued to see little evidence of inmates without mental illness being housed in residential mental health units. I saw fewer less seriously ill patients being housed at RPDC, which is intended for the severely mentally ill, during this visit.

The seven-level acuity scheme maintained by mental health staff, and regularly reviewed by leadership, has continued to provide a sound basis for stratification of the population. However, there remains no policy detailing a formal transfer procedure for the mentally ill. Policy 508.12 Mental Health Services states that, absent an emergency, "inmates will not be transferred to or from a mental health housing unit unless mental health staff have been consulted beforehand to determine whether the transfer is beneficial or detrimental to the inmate's mental health care." It goes on to specify that "[c]onflicting recommendations may be resolved between mental health staff and the jail commander, or designee, for transfers between housing units in the same jail, or a mental health supervisor and the jail commander, or designee from the sending jail for transfers between jails." There is no tracking of this nor is there any guidance about how to make the decision. This process is opaque and fraught with the potential for an inconsistent, or even capricious, approach to transfers. However, it is consistent with the provisions of the remedial plan. But in order to achieve substantial compliance, the County must demonstrate actual adherence to this policy. The County also provided a training slide specifying that "[c]lassficiation will enter the mental health recommendation and the name of the mental health clinician or supervisor in JIMS classification notes." What the proof of practice will require is not clear; the County has not offered any verification that this policy is being followed.

More acutely ill are housed in RPDC (272 beds), less acutely ill at SCF (232 beds), and still less mentally ill in general population (with only the least ill permitted at Indio and Blythe). SCF continues to have units serving varying levels of acuity, providing both for a step-down process and a step-up process without

having to resort to transfer to RPDC except for the most decompensated mentally ill. It should be noted that the acuity at SCF has increased somewhat, though by design.

As noted in the previous section, RUHS-BH and custody have been working together to minimize transfers to allow patients to complete groups; it is not clear how successful they have been but it is important that this practice has begun. While this is likely to be effective at SCF where most mental health transfers are within the facility and there is currently limited pressure on bed space, it is a challenge at RPDC where beds are often full owing to there being a premium on high acuity beds and some continued difficulties effecting prompt transfer to lower acuity settings.

While appropriate placement of the mentally ill is now the norm and mental health staff report that patients are rarely transferred into or out of residential mental health settings without their involvement, there is no way to determine the consistency of the process as there is no way to track it. That said, the acuity ratings are a reasonable proxy of whether the mentally ill are being appropriately placed. Mental health staff reported that there had been a concerted effort at both SCF and RPDC to limit transfers and to consider group completion when making transfers, as well as other clinical issues. Mental health staff also let classification staff know when patients need to be moved to higher or lower levels of care and report that their recommendations are generally followed unless there are classification or other legitimate custody reasons. Further, patients in residential mental health units made fewer comments about sudden moves and felt that custody and mental health generally collaborated on placement changes. However, owing to limited space at RPDC, patients are sometimes moved or not moved when clinically indicated. Owing to limited bed space, there has been some overflow of the mentally ill to the seventh and second floors primarily.

As noted in “Custodial Environment” above, the County has endeavored to reduce the numbers of different types of inmates on residential mental health units, making it easier to maximize out of cell time. At RPDC, 5B dayroom 1 is administrative segregation, 5B dayroom 2 is protective custody (PC), 5A dayroom 2 is half PC and half general population (GP) mental health, and 5A dayrooms 1 and 3 are GP. Those on administrative segregation must come out singly. Those in 5B dayroom 2 come out one tier at a time. I was told that in other PC settings, inmates come out from both tiers simultaneously but because there are limited PC settings for the mentally ill, the tiers are divided in order to provide separation for incompatible inmates. The effect is to reduce their out of cell time but since out of cell time is not able to be fully tracked, it is not clear whether the impact is such that out of cell time targets cannot be achieved. Those in 5A dayroom 2 also come out one tier at a time. Those in 5A dayrooms 1 and 2 come out simultaneously.

There remain a large number of mentally ill on administrative segregation. In fact, the population has overflowed from 5B dayroom 1 (dayroom 2 is for protective custody) in RPDC to 2A, the 4th floor, and even the 7th floor (designated a medical setting). I saw a mentally ill man on the 7th floor that I had met previously who was there for no obvious reason; he was moved to another floor during my visit. The documents 7th floor1st audit 7-25-17.docx and 7th floor audit 7-25-17.docx provide basic information on four patients on the 7th floor who were all on administrative segregation; most had psychotic disorders and were of moderate or higher acuity. This is a seriously mentally ill population.

The document Audit 2A July2017.docx is a review of those on the mental health caseload on 2A. There were 11 in dayroom 1 and 11 in dayroom 2. They ranged in acuity from none (two were reduced to none at the time of this review) to severe, with most in between. These cases are reportedly reviewed every 30 days by custody, classification, and RUHS-BH; at these meetings, a decision is made whether to continue administrative segregation. This process is not formally tracked but RUHS-BH produced a document entitled AdSeg Audit.docx summarizing the clinical status of those on administrative segregation and tracks whether the patient was to remain on administrative segregation or be discontinued. Of the 20 included in the review, 14 were to be discontinued and 6 remain on administrative segregation. The document 2AD3 Mental Health Audit_7.24.17.docx provides the same information on 15 patients, though is not clear about whether the patient is to remain on administrative segregation. This group was more mixed with several showing no evidence of mental illness and others with serious mental illness.

The document 5B ad-seg 7-24-17.docx was another RUHS-BH review of 20 mentally ill on administrative segregation on 5B. Three were recommended to come off administrative segregation but it is unclear whether this was done. This report again documented the serious mental illness of this population.

These documents demonstrate that there is a thorough review of administrative segregation for the mentally ill but there is lack of clarity about decisions to continue patients on administrative segregation and who made these decisions. The decisions regarding placement and removal of the mentally ill on administrative segregation should be more formally tracked but this is a good beginning.

Mentally ill women are housed on 6A and 6B in RPDC, though they are mixed with non-mentally ill. This has caused some difficulty in that the mentally ill are sometimes ill-treated by the non-mentally ill, including some assaults (such an instance was reported during the multi-disciplinary team meeting I attended on those units). A significant number had had recent safety cell placements and DCU hospitalizations. Half of them had psychotic disorders and the remainder had primarily mood disorders. Most were on medications. In short, this is a population with substantial mental illness.

Issues related to restrictions on movement and programming are addressed under “Treatment Space” below.

With regard to limitations placed on those in residential housing, it is of note that when meeting individually face-to-face with mental health clinicians, patients at RPDC are required to be in cuffs even when custody is standing by. This is not true for medical contacts. It is not clear why this is being done for those not on administrative segregation status. It is an impediment to treatment.

At SCF, the 192 beds of unit 16 continue to be organized into six pods with a progressive stepdown in acuity. SCF recently developed a 40-bed dorm (unit 14) used to stepdown gang members who are trying to avoid gang pressures not to accept mental health treatment. This has proven very effective and the patients I spoke with there were quite grateful. However, they noted that after a fight on the unit, groups had been substantially curtailed.

While there are no formal residential mental health units at SWDC, the mentally ill are reportedly preferentially placed on pods D and E.

Please see my comments in this section of my previous report regarding the problems with classification, transfer, and administrative segregation policies which all continue to apply. I would add that during my medical records review for this report, I saw numerous documents entitled “Transfer Screening” completed by nurses at the time of transfer. There are checkboxes for confirming four action items: record review, notification of transfer sent to mental health, no further action required, and further action required. Nurses almost never check the box that indicates that mental health was notified, even for patients in residential mental health settings.

Here again, the County remains in **partial compliance** with this measure. Progress is substantial but there remain some problems with the housing process but most all should be easily remedied from a policy perspective; practice may be a greater challenge.

Treatment Space

The plan to augment treatment space at RPDC is still in place. There have been no significant changes in treatment space generally. However, as noted several times earlier, RCSD recently decreed that when mental health staff meet with a patient in program rooms and other treatment spaces off the units, the door must be closed and locked. As mental health staff do not have any means of unlocking the doors, mental health leadership directed their staff not to meet under such conditions without custody standing by should they need assistance. Prior to this decision by mental health leadership, there was an instance at SCF where patients in a group were fighting and the mental health staff were unable to exit and not custody was standing by to assist; staff were not hurt but it demonstrated the risk posed by such a situation. This has led to a substantial reduction in access to treatment space and, accordingly, access to treatment. Groups have been suspended at SCF and substantially reduced at RPDC and SWDC (no groups were being held at Blythe or Indio). Individual meetings have also been reduced for the same reason. It has also forced a return to the use of non-contact booths in settings where those are available. Cell front visits have also increased.

It is also important to note that custody had made a concerted effort to provide “runners” (deputies that assist in moving patients to treatment) at Indio, SWDC, SCF, and RPDC. However, this has been curtailed to some degree recently, notably at RPDC. This has had a further impact on groups at RPDC, which had been running at almost 100% of scheduled times but is now at about 75%.

Psychiatrists at RPDC noted that because of limited spaces to see patients and difficulty getting assistance from custody to take patients out of their cells, they are also sometimes forced to see patients at cell front. Because they have no dedicated space at RPDC, they move through the facility, reducing their efficiency substantially. This is not generally a problem at other facilities where psychiatrists have a dedicated space and custody has been more able to assist in getting patients out at other facilities.

These problems have also made it almost impossible to schedule individual meetings at RPDC as clinicians are forced to see whatever patients are available and where there is an available space to meet. This interferes with timely follow-up and regular, structured individual therapy.

When I met with patients at RPDC, I was asked to use the non-contact booths. The sound quality was poor and interfered with communication. The booths are also quite uncomfortable and have limited desk space and virtually no room for others, such as trainees. It would be difficult to have a series of individual patient meetings under these conditions. It is unreasonable to rely so heavily on such spaces for conducting routine clinical work.

At SCF the impact has been felt in other ways, in addition to holding no groups at present. Crisis response is now being done in non-contact booths as are all contacts on units 12, 14, and 16. Those from units 12 and 14 have to be moved to the intake area for these visits, which is sometimes not possible if no deputy is available. The lack of groups has necessitated increased individual contacts with Clinical Therapists seeing the most ill and Behavioral Health Specialists seeing the more stable patients. They endeavor to have weekly contacts but this has been challenging.

It should also be noted that there is a plan to add a contact interview room on unit 16 to augment the three non-contact booths. The new SCF medical building slated to be complete in a year will have 8 behavioral health rooms for treatment and 14 work stations for mental health staff.

At SWDC, the changes have reduced groups to a limited extent (they are running six groups five days per week) because groups are run in the library and clinical staff have electronic key cards so they can exit on their own, making it unnecessary for custody to stand by. However, owing to being unable to use the program rooms, groups have been reduced in frequency. Individual meetings have been reduced to almost none. Pod deputies are often unable to help mental health staff with bringing patients to treatment spaces and/or standing by owing to the locked door requirement. Most individual meetings are crisis responses in the non-contact booth. It has also force Clinical Therapists to conduct assessments in the booking area rather than on the units where the patients reside, necessitating special transport. Clinical Therapists try to meet with patients on the pods at least once per month.

The impact has been less at Indio and Blythe. At Blythe, the Clinical Therapist was only seeing patients in a non-contact booth so there has been no change there, though it is unclear why this is the case, especially given that patients at Blythe are low acuity and there is a program room available, which is also sufficiently large to run groups. Indio is also using a non-contact booth; they share this with investigators, limiting access to patients.

Patient reports were consistent with the above. Those at SCF especially lamented the loss of groups. Those at RPDC noted a decrease of out of cell contacts and increased cell front visits, including by psychiatrists. Virtually all those in the residential mental health units who had been there more than three months noted a reduction in clinical contact recently.

The County is about to start using telepsychiatry at Blythe. Once operational, I will assess the adequacy of the facilities and equipment.

The County is clearly taking reasonable steps to provide adequate treatment space but recent changes have set the County back with regard to its ability to use current spaces. The general provisions for treatment space meet **partial compliance** and will almost certainly be substantially compliant once the changes have been completed and the security provisions have been resolved.

Suicide Prevention

Policy and procedure for step-down from safety cells is not yet implemented. Mental health is not yet involved in setting the conditions of confinement in safety cells but this is to be part of the impending plan; RUHS-BH and custody are working jointly on how to operationalize this process and policy is reportedly pending. The Remedial Plan species that policy and procedures for a step-down program were to be in place one month after issuance of the Consent Decree. The specific language is:

> "Within one month of the date of the Consent Decree is issued by the Court, the County shall develop and implement policies and procedures to allow step-downs for inmates placed in safety cells because of potentially self-harming behavior. The step-down program shall gradually add property in privileges and programming consistent with clinical assessment of a [sic] inmate's condition, with the intent to minimize the time spent in the safety cells under conditions of total deprivation of property and programming."

The form "Safety Cell Visit Questions" provides reasonable basic guidance but may convey the sense that its completion is adequate in all cases, which it is not. Consider using more general topic headings allowing for narrative in a variety of domains that might be pertinent to placement in a safety cell or, alternatively, providing guidance through a protocol (this could be drawn from the materials in the Clinical Therapist Training Manual). It also does not indicate the need to consider gradual restoration of property and privileges as required for the step-down element of the remedial plan.

For the present, the provision for seclusion to last no more than 12 hours has been operationalized by defining seclusion as placement in a safety cell with no more than a smock, safety blanket, and mattress. The County cannot yet provide data on this in the jails or in DCU. Adherence will also be difficult to ascertain through auditing as the information will be difficult to obtain from records and inspection will not provide sufficient information.

One-to-one monitoring of those who are an imminent danger to self and are awaiting transfer to the DCU under 4011.6 commitment continues to be available if deemed necessary by a QMHP. RUHS-BH staff report no problems securing this when needed, which is, and should be, rare.

Safety cells were not as uniformly clean as during my last visit, vents were especially dirty. This was most problematic at RPDC. In one, the floor drain was plugged and the cell quite malodorous. Another had been recently vacated but not yet cleaned. There was also one accessible fixture without a cage that could have been broken or used as an anchor point (seventh floor of RPDC). The safety cells at SCF were fairly clean though one was less cleanly; staff pressure washed it while I was there. Those at Indio were clean and in good order. The County has taken measures to ensure oversight of their cleanliness, including more direct supervisory oversight. Supervisors had signed off on some of the uncleanly safety cells but not all.

Per the Remedial Plan, water is to be offered every two hours, meals offered three times per day, and medications offered as prescribed. I reviewed a number of safety cell logs at RPDC, SCF, and SWDC. I was also provided a sample of safety cell logs for those in restraints as noted in the section Restraint. Those reviewed demonstrated regular checks (almost always less than every 15 minutes and irregular), water offered every two hours, and custody supervisor reviews in almost all cases. Three meals per day were documented in a little more than half of cases and toileting was never documented, presumably because all safety cells had toileting provisions. Medication administration was not noted but health

care visits were documented to be timely in most cases but a number of initial assessments were undated and/or untimed. Logs demonstrated regular and timely QMHP assessment. Nursing assessments of those in safety cells are not uniformly done every 8 hours but most are within timeframes. They often do not include vital signs and the required elements are sometimes blank. Nurses general write on "per deputy" (or similar verbiage) under the section "Fluid Intake/Hydration Status;" this is not adequate as the charge is to assess their hydration status, which deputies are not qualified to do.

Almost all QMHP safety cell assessments are now being done in a private space rather than at cell front. Both mental health and custody are to be commended for this important change.

Once released from safety cells, mental health conducts transitional services (follow-up visits) for 5 consecutive days (unless deemed unnecessary with supervisory review), only occasionally missing them or conducting them late. I note parenthetically that the County is also conducting a series of five transitional visits for those patients returning to the jail from DCU; while not a part of the remedial plan this is an important step to assure the safety and stability of this vulnerable population, most of whom were in safety cells prior to admission to the DCU and who, because of the restrictive conditions in the DCU, have effectively been in isolation. The County produced a report demonstrating that only 45% of patients releasing from safety cells received any transitional services. Of those receiving any transitional services, a minority received all five visits.

There is no safety cell at Blythe and the observation cell there is not suicide proof and has no camera. Those needing safety cell placement are transferred to Indio, which normally takes 2-4 hours. Pending transfer, they are placed in the observation cell with 15-minute checks; the observation cell is across from the intake deputy's station which affords some view into the cell. If patients are acutely suicidal or harming themselves, they are place in a restraint chair; this occurs every few months. In July 2017, there were three patients that had to be transferred to Indio for a safety cell. Those pending commitment to the DCU are also placed in the observation cell or, if necessary, placed in the restraint chair.

The County is producing lists of those sentenced for longer than 15 years so that mental health can conduct an assessment and any needed intervention. The County produced data from December 2016 through August 2017, reporting that in 80-95% of cases, mental health was notified. Mental health saw the inmate at a similar percentage. It is clear that both custody and mental health are doing a good job on this and are nearing substantial compliance.

The County provided data on safety cell usage for January through August 2017. The number of inmates placed in safety cells is just over 200 per month. About 25% of those are for more than 24 hours. The percentage of those placed in safety cells that are civilly committed is also about 25%. These numbers and percentages have not changed significantly since my initial evaluation. While some reduction in safety cell usage is desirable, I do not see evidence that current usage levels are unreasonable.

Here again the County remains in **partial compliance.**

Restraint

While this is included in the section on suicide prevention, I have considered it separately since it applies to other situations as well.

Use of the emergency restraint chair is reportedly rare. Logs demonstrate that it is not uncommon but I received no data on overall use and it is not clear how the logs were selected so it is not possible to assess the frequency of usage for the data I have.

I witnessed a prisoner being placed into a restraint chair at SCF. He was agitated and possibly intoxicated. The restraint went smoothly and there were no injuries.

Restraint chairs were uniformly clean and in good working order.

Asked to provide the policy addressing monitoring of those in restraint, the County again forwarded Policy 503.07 Emergency Restraint Chair; it mandates limb exercises every 30 minutes (absent safety concerns), medical staff evaluation initially and every two hours, visual checks every 30 minutes, and use of toilet and access to water every two hours. However, it does not provide sufficient specificity with regard to the medical monitoring of those in restraint which should include regular neurovascular evaluation (including an assessment for blood clots), brief mental status examination, skin checks, vital signs, and consideration of any contraindications to restraint. It also does not specify access to food. The remedial plan specifies "continuous health care monitoring of inmates in restraints consistent with NCCHC standards." Since NCCHC does not mandate one-to-one or direct observation of those in restraint, I take this to mean on-going health care monitoring that meets NCCHC standards. NCCHC mandates apply only to "clinical restraints." Since the remedial plan speaks to the use of the restraint chair rather than restraint at the DCU and addresses monitoring of those in safety cells and the restraint chairs, I presume that the NCCHC standards are to apply to those in restraint chairs. With regard to monitoring, NCCHC requires 15 minute checks by "health-trained personnel or health services staff," checking circulatory and respiratory function, and providing nutrition, hydration, and toileting. They also speak to assuring that restraints are jeopardizing the health or mental health of the inmate. Standards in the field also require checking peripheral neurological function. These things need to be explicitly addressed in policy and tracked in logs. The addition of provisions in policy for nutrition, neurovascular monitoring, and skin checks as well as explicit provision for assessing whether restraint is jeopardizing the health or mental health of the inmate are all that is needed. The logs include all the components applicable to custody, including meals.

I was provided some logs of restraint chair and safety cell usage from Indio, RPDC, SWDC, and SCF. This was reportedly a complete set of logs for March 2017 – August 2017. The same logs are used for safety cells and restraint chair usage and it can be difficult to ascertain whether an inmate is in the restraint chair or just in a safety cell as there is no formal or consistent way to indicate restraint chair placement or removal; in some cases, these logs did not seem to indicate that the patient was in a restraint chair. The logs consistently demonstrate checks occurring at least every 15 minutes. While most show variable times, there remain some that are exactly every 15 minutes, casting doubt on their accuracy. They are variable in terms of demonstrating the provision of water, meals (the log is problematic as the code for meals and hygiene is the same so unless the deputy notes a meal, it is not possible to tell which it is), and toileting. Range of motion is also not consistently documented but is most often present and close to every 30 minutes. The logs corroborate reports that mental health is usually not conducting evaluations at cell front.

At the DCU, the standards are consistent with the Centers for Medicare and Medicaid Services standards. I did not receive any restraint logs from the DCU.

The documentation in the logs has improved somewhat though are still often incomplete and it is still difficult to determine if or when restraints were removed. The checks are being done frequently, restraints are clean, activity is being consistently documented, and supervisors are performing checks. The County also must develop the step-down protocol. For now, **partial compliance** remains appropriate.

Continuity of Care

With the reorganization of health care services, there have been changes to the processes around reentry. RUHS now encompasses all healthcare at the jail and also provides community mental health services. While there was previously a common administration of mental health in the jail and the community, this collaboration has continued to develop. Community mental health providers are providing some in-reach services to the jail population. They are even documenting some of their work in TechCare (the jail electronic health record). Those being released continue to receive a two-week supply of release medications (though sometimes they are provided a 30-day supply) and generally have an appointment with community mental health, though it is not clear whether they are able to uniformly get access to community medications within that two weeks.

Mental health staff conduct discharge planning groups and patients also note that mental health staff discuss discharge planning with them. The County provided tables (logs) demonstrating discharge planning efforts by frontline staff. The table are difficult to interpret demonstrate the County's clear effort to enhance discharge planning through the use of both groups and individual release planning. The table covers all important areas except finances. The tables also demonstrate the limitations of its efforts thus far, appearing to show that about half of mental health inmates get some discharge planning. It does provide some sense of the amount and types of services but is not collected in a manner that allows a quantitative evaluation of it accomplishments. It should be noted that it appears that there has been some reduction in penetration lately, likely reflecting the recent challenges of running groups. It is notable that the tables show that the provision of release medications is inconsistent. This is a critical function that needs to be better tracked and deficiencies addressed through corrective action.

A CQI project at SWDC showed that of 50 mentally ill inmates release, 14 were referred for services but only three followed through. This demonstrates that RUHS-BH is having difficulty getting discharge services to the mentally ill at SWDC. However, inspection also shows that many patients are refusing; the County should not be counting patient refusals as failure to provide the service. However, it is important to track this to assure that refusals are minimized.

The County looked at how many of those who received discharge planning actually followed through at facilities other than SWDC. With regard to keeping appointments at community mental health centers, the County found that only a small minority showed up for their appointments. While this is not a formal compliance measure, it is encouraging that the County is pursuing this information as the success rate of those needing discharge planning is arguably more important than the success rate of providing discharge planning to those who need it.

This open demonstration of its efforts is, once again, to be commended. One point to make is that the remedial plan speaks to discharge planning for those with "serious mental illness." The County needs to focus these resources on that population (the tables show a good deal of resource going to those with minimal to moderate mental health acuity and some with higher acuity going unserved). If there are

additional resources to provide discharge planning to the broader mentally ill population, I encourage that expansion.

I was not provided with new policy correcting the deficiencies noted previously.

Here again, the County remains in **partial compliance** and is taking appropriate steps to build out these services.

POLICIES AND PROCEDURES

I was provided two updated RCSD Corrections Division Policies: 508.06 Inmate Medical Care and 508.12 Mental Health Services. Both these policies continue to have problems. The former has problems in the confidentiality section as noted above and the latter does not adequately address the transfer process for the mentally ill. Most of the deficiencies noted in my previous report have not been addressed. These include: step-down procedures for safety cells, policy supporting direct observation of those pending DCU admission, refusal of mental health services (follow-up by mental health staff and competency to refuse), handling protected health information in the grievance process, policy to support needed changes to the EHR, policy on dayroom management does not address equity of dayroom time, inconsiste

ncy between the remedial plan and policy with regard to yard times, problems with the classification policy addressing mental health issues outside the reasonable scope of classification staff and elements related to housing the mentally ill, inadequate provisions for mental health staff participation in discipline and administrative segregation, policy addressing the full range of the provision regarding continuity of care, and insufficient language regarding mental illness in the ADA policy. These need to be corrected. Some are arguably not in the purview of the remedial plan; I am open to discussion with the parties to resolve any such issues. As I have been told that many are being modified, I will continue to rate this as in **partial compliance** at this time.

CONSENT DECREE TRAINING

The County provided additional data regarding training on the consent decree. Nearly 100% of staff received one phase of the Remedial Plan training and about 90% received all phases. In conjunction with the previously reported trainings, I believe the County is in **substantial compliance** for this component.

This concludes my second semi-annual self-assessment. In my opinion, despite the recent challenges with access to care, the County is taking appropriate steps to meet the terms of the Remedial Plan. The County has achieved partial compliance on almost all measures, substantial compliance on one, and is near substantial compliance on a number more.

Respectfully submitted,

Bruce C. Gage, M.D.

Appendix

The following medical record reviews are not intended to be thorough but to follow-up on certain patients, claims by some patients, and to review the provision of care in light of the remedial plan. I did not conduct as complete a review of records for this visit as the County has been clear that it is still developing its treatment program. I expected and saw little change from the general findings of my previous report. As before, this is reasonable considering the County's efforts to focus on infrastructure and the development of a sound system that will be sustainable beyond exit from this law suit.

I reviewed cases from each facility. In what follows, I provide some brief notes on some of the patient records and general observations of the records from each facility. I did not meet with the patients from Indio and Blythe but did meet with those from other facilities.

Note: I was unable to open scanned documents in the medical record. It is possible that these scanned documents contained evidence of treatment is not available to me.

Blythe

Ceja, A. 201722662

This man was admitted in June 2017. He had a history of anxiety and unspecified mood disorder as well as chronic methamphetamine use. He was appropriately screened and acuity rated. He was seen periodically by mental health initially in response to kites and subsequently as part of a treatment plan included both medications (lithium and trazodone) and periodic meetings with a Clinical Therapist. However, there is no evidence that he was seen in regular sessions with the Clinical Therapist or enrolled in any groups. He was seen periodically by various Clinical Therapists, but this was always in response to another staff's request to see the patient. He was seen regularly by psychiatry who ordered appropriate laboratory evaluations medications.

Estrada, V. 201729872

This man was admitted in August 2017. He was initially mental health screened by a nurse and subsequently screened by a Clinical Therapist. The latter made more findings, some of which were significant, including that the patient was drinking a 12 pack of beer a day and taking regular Xanax. In addition, the Clinical Therapist reported that the patient had a history of suicide attempts. The nurse had not detected these important issues but did make a referral to mental health. He was evaluated a Clinical Therapist and referred to a psychiatrist started him on an antidepressant and antipsychotic depression with psychotic features. A mental health care plan spoke only to the need for substance abuse treatment but referred to the need for an appointment with a psychiatrist and individual and/or group treatment. Subsequently, it was noted that he needed assistance with self-injurious behavior. The Clinical Therapist made repeated efforts to meet with the patient, but he refused almost all contacts. He did meet periodically with the psychiatrist and was continued on medications. Appropriate laboratory tests and AIMS (abnormal involuntary movement scale) were in the record.

Garcia, G. 201725940
This man was admitted in July 2017. He was appropriately screened and acuity rated by the Clinical Therapist. He reported being on a number of medications including mood stabilizers, antipsychotics, and antidepressants. However, the Clinical Therapist was unable to verify medications. He was referred to psychiatry but not seen for over two weeks. The psychiatrist diagnosed an affective disorder and started him on hydroxyzine (an antihistamine), mirtazapine (an antidepressant), and olanzapine (an antipsychotic). He had subsequent medication adjustments and changes done based on side effects and treatment response. Appropriate labs and AIMS were done.

There was a care plan but it does not speak to any mood disturbance or psychosis, only to symptoms of anxiety. The plan is very generic reading "FBH clinical staff will continue to follow up with the client to provide interventions and case management services." While the care plan was not updated as far as the records demonstrated, new goals for psychosis were added in progress notes. He was regularly seen by a psychiatrist and Clinical Therapist, though generally in response to his requests rather than planned follow-up. He was enrolled in a discharge planning group which he attended.

Gurney, O. 201711758
This man was admitted in March 2017. The admission mental health screening was uniformly negative (the note said repeatedly that he said "no" to questions) except for a comment that the patient reported he did not expect to be in jail for domestic violence charge. He was seen two weeks later after requesting to be seen with the complaint of auditory hallucinations. At that time, he was noted to have hallucinations, delusions, and depressed mood. He was referred to a psychiatrist started him on an antidepressant and antipsychotic. Appropriate labs and AIMS were done.

It is likely that these symptoms were present at intake. Whether they were missed because of an inadequate screening interview or the patient was essentially uncooperative and denying symptoms is unclear. However, the almost complete lack of information in the screening raises concerns. If the patient was uncooperative or appeared to be simply answering "no" to all questions, this should have been reported.

The Clinical Therapist met with him approximately monthly initially, though notes suggested there would be more frequent contact, but the patient later declined meetings. He continued to meet with the psychiatrist who reported a good response to medications.

Walker, T. 201720439
This young man was admitted in May 2017. His intake mental health screening was negative. He was found to have no mental health needs. Subsequently placed in a safety cell about a month after admission due to expressing thoughts of harming himself in the context of feeling ignored by deputies. He was appropriately assessed and moved from the safety cell. He was seen in follow-up and some limited skills development in crisis worked on with him. No further services were indicated.

Indio

Castro, S 201705740
This man was admitted in February 2017. The mental health screening was negative except for a history of substance use, primarily methamphetamine. No mental health appointment was said to be needed.

However, on that same date the Clinical Therapist wrote a note that indicated that he was to receive a mental health rating of moderate and was referred for a complete assessment; no reason was given. Upon assessment, the patient was noted to have symptoms consistent with mania don't know psychotic features. He was not interested in seeing a psychiatrist though was prescribed carbamazepine and topiramate, ostensibly for a seizure disorder, and he recognize that these may help with mood stabilization. A care plan from the same day indicated an intention to refer the patient to WRAP group and utilize coping skills that he learns.

He was later started on fluoxetine and mood stabilizers were adjusted by the psychiatrist. Appropriate laboratories were in the record.

Subsequent notes reflect regular meetings with a psychiatrist, individual sessions with a Clinical Therapist addressing relevant issues and skills, and enrollment in the WRAP group.

Granich, S 201710273
This woman was admitted in March 2017. During the mental health intake screening, she endorsed a history of PTSD and taking venlafaxine. There is no evidence of symptoms of current mental illness. The patient was seen the following day by a psychiatrist who reported that the patient had been on venlafaxine since 2013 little benefit. The psychiatrist started her on citalopram, buspirone, and trazodone. The psychiatrist subsequently adjusted and added medications, ultimately including mood stabilizers and antipsychotics. Appropriate medication monitoring with lab tests and AIMS was done.

For understandable reasons, the patient was placed in protective custody. She was seen regularly by Clinical Therapists and Behavioral Health Specialists, the latter using group curricula with her on a 1 to 1 basis due to being in protective custody. There was a generic care plan that did not well correspond to the treatment rendered. However, progress notes indicate appropriate services were delivered.

Maciel, E 201708688
This man was in March 2017. A nurse conducted the mental health intake screening; it was incomplete. No mental health symptoms were identified. He was rescreened by mental health the following day and noted to have suicidal ideation just prior to his arrest but not currently. He had some mild anxiety and depressive symptoms and a referral was made to mental health. He was seen by a psychiatrist the following day who started him on an antidepressant. A psychiatrist saw him regularly thereafter and adjusted doses and added medications appropriately.

Owing to his crime and being assaulted, he was placed on administrative segregation. A Clinical Therapist saw him almost every day during his time on administrative segregation. The Clinical Therapist working most closely with him ultimately recommended to custody that he be given a cellmate as his status was more consistent with protective custody. He was rehoused with the cellmate which seemed to help promote mental health stability. While he was not rendered any structured mental health treatment, he was seen regularly by Clinical Therapists for supportive contact and some limited skills development.

Jimenez, A 201732418
This woman was admitted in August 2017. The Clinical Therapist to screened her did not detect any evidence of significant mental illness but endorsed a history of hospitalization and mental health treatment, those not currently on any medications. She was referred to mental health owing primarily to her request for services. The patient had a history of substantial heroin use and subsequently evidenced signs of withdrawal. When seen for a full assessment by mental health, the patient endorsed psychotic symptomatology and was subsequently seen by the psychiatrist who described her as very psychotic with a paucity of speech. She was started on antipsychotics and an antidepressant as well as medications to reduce anxiety and treat side effects. She improved with medication. Medication monitoring included appropriate labs and AIMS testing.

Despite her symptomatology, she remained in general population at Indio. She often refused mental health contacts and had to be encouraged and rescheduled to see the psychiatrist. She expressed an interest in groups that did not begin until after her release. She had periodic contacts with a Clinical Therapist, but no structured treatment and she was likely not stable enough to receive such services. Had she stayed longer, residential mental health placement would have been indicated.

Vazquez, G 201724320
This man was admitted in June 2017. During intake mental health screening, the patient denied a mental health history and denied any mental health symptoms. He was not referred to mental health at that time. About two months later he submitted a kite for mental health care due to depression. He was promptly evaluated by the Clinical Therapist and referred to the psychiatrist started him on antidepressants and medication for anxiety. A month later he was seen again by a Clinical Therapist and Behavioral Health Specialist referred him to groups. There were no further notes.

SWDC
Hernandez, Raul 201719121
I saw this man with the psychiatrist. He was depressed and tearful, worried about his ill wife. The psychiatrist encouraged groups and planned to refer him. He was taking bupropion and olanzapine.

He had been admitted in May 2017. His intake mental health screening was negative and there was no referral for additional mental health assessment or treatment. He subsequently became more depressed and distraught and two months later was reevaluated and refer to a psychiatrist who started him on antidepressants and an antipsychotic depression with psychotic features though a history of previous diagnosis of bipolar disorder was also noted. He was not started on a stable despite some evidence mixed disturbance. Appropriate laboratory monitoring for metabolic syndrome was not done nor was an AIMS.

Lloyd, Matthew 201742214
This man had been jailed for two months and complained that he couldn't sleep. After submitting a kite, he reported being seen by a Clinical Therapist in week and a psychiatrist a week later with follow-up every 2-4 weeks. He had been offered individual and group treatment but declined because it interfered with his job. He was taking buspirone and mirtazapine, which he had taken in the past.

He had been admitted in March 2017. On mental health screening he denied any psychiatric problems though endorsed a long history of methamphetamine, marijuana, and alcohol use. He was not referred

to mental health though the note seems to indicate that he refused mental health assessment; it is not clear why further assessment was indicated based on the intake screening. He subsequent we kited for assistance as noted above and was promptly seen evaluated by Clinical Therapist and referred to psychiatry he was started on antidepressants and followed up regularly by psychiatry. He was seen monthly by a Clinical Therapist for case management services. Treatment was appropriate except that necessary laboratories for monitoring psychotropics were not ordered.

Ortiz, Moses 201710150
This man had been in jail for 5 months with three years left. He reported no access to any programming owing to being custody level 5. He had started mental health treatment just before being jailed but had not been ordered medications. He had been on medications in jail for two months, which included mirtazapine and something he could not remember. He stated that he had been offered individual therapy but refused due to "politics." However, he decided to participate in a recreation therapy group.

He reported that kites were often unavailable on the units and noted long delays before getting a response.

He reported that he received dayroom 2-3 times daily for 45 minutes each but was not sure about yard at it was often offered early in the morning.

He had been admitted in March 2017. He reported problems with anxiety, restlessness and insomnia and was referred for further mental health assessment. He refused the scheduled appointment a week later, but the Clinical Therapist checked on him to assure that he was functioning adequately, which he was. He was approached again a month later but again refused. The following month he expressed some interest in receiving treatment for depression and anxiety. He was evaluated by a psychiatrist and offered medications but refused initially though a month later agreed to start on antidepressants and antianxiety agents were added later. He was also enrolled in several groups and participated actively. His care was adequate and addressed his needs apart from medications not being properly monitored with laboratory studies.

Morrison, Ted 201714641
This middle-aged man had been in jail for five months with three years left. He reported being on medication in the community through a private psychiatrist. He stated that it took a month to get medications started after admission. He reported being ordered duloxetine (an antidepressant), asenapine (an antipsychotic), and something he could not recall. He reported now seeing the psychiatrist every few weeks. He was also in the COLORS group (for substance abuse) but getting no other treatment.

He had been admitted in April 2017. He endorsed a history of bipolar disorder but also substantial substance abuse including methamphetamine, heroin, and marijuana. He had been in past drug and mental health treatment. He was separately assessed and referred to Behavioral Health Specialist for group and the psychiatrist for medication. The psychiatrist found him to have a thought disorder and mood lability. The psychiatrist started an antidepressant and antipsychotic. The psychiatrist saw the patient numerous times thereafter and made many medication changes, primarily in response to numerous complaints of side effects. The patient also refused medications many times, also complaints of side effects, some of which were unlikely to be medication-induced side effects. The patient attended the COLOR group and completed the life skills group and was pending involvement in WRAP. He met approximately monthly with a Clinical Therapist for case management. In general, his treatment

was appropriate except for inadequate medication monitoring for a patient on antipsychotics; there was no AIMS and no laboratory monitoring for metabolic syndrome.

Brimmer, Reginald 201637226
This middle-aged man on pretrial detention had been in jail for a year. He had not been in treatment before jail but saw a psychiatrist a few days after admission when he complained of depression and decreased sleep. He also had individual therapy with a Clinical Therapist for some time but reported this stopped after he declined a visit. He had been offered groups but refused saying “I don’t want my business out there” and went on to say that he wanted the individual sessions again. He complained of a lack of privacy in many treatment settings.

He stated he was taking mirtazapine and saw the psychiatrist monthly.

He noted that sometimes the mentally ill are missed at intake and come to the GP units where they “may get hurt.” While he had often reported this to the deputies, he said they usually did nothing.

He was admitted in September 2016. On the mental health intake screen, he complained of depression and a history of suicide attempts. He was referred for further mental health assessment and psychiatric evaluation. The psychiatrist saw him promptly and started him on an antidepressant. He was seen every one to two months by psychiatry in medications adjusted appropriately and he showed a good response to treatment. However, he did not receive appropriate medication laboratory monitoring for metabolic syndrome.

He was offered groups but refused. He was seen periodically by Clinical Therapist to monitor his progress and to provide case management.

SCF
Morton 201724081 (number incorrect – unable to find patient in TechCare)
This man was in a safety cell and had a history of cutting. He had been in jail for two weeks but had many prior incarcerations. His primary problem was substance abuse though he was prescribed hydroxyzine (an antihistamine used for side effects, sedation, and anxiety) and mirtazapine (an antidepressant). However, he had been on Unit 16 D or E, residential mental health.

He reported having met one time each with a psychiatrist and a Clinical Therapist.

He reported access to the dayroom twice in the morning and twice in the evening for about an hour and yard access once a week for about an hour.

Timmons 201727523
This woman was also in a safety cell. She complained of getting no water; inspection of the log indicated that she had refused water. She demonstrated no evidence of mental illness.

Admitted July just prior to my visit. At intake, she endorsed depression and suicidal ideation during the mental health screening. She was tearful and endorsed a history of suicide attempts and psychiatric hospitalization related to suicidal ideation. She was placed directly in a safety cell. A psychiatrist saw her that day and started her on sertraline.

When evaluated the following day she was released to population with a mild mental health acuity rating. She had follow-up with psychiatry and Clinical Therapists over the next week and was then released. Of note she did receive discharge medications.

Marruffo, E. 201737174
This man on 16F had been admitted in February 2017 and had been at SCF since March. He demonstrated clear psychotic symptoms and was quite bizarre. He was malodorous with matted hair.

He reported seeing a psychiatrist "now and then" and meeting with a QMHP every 2-3 weeks. He noted that mental health responded promptly to kites but that medical was not prompt and often did not respond. He had been in groups but noted they had been discontinued.

He noted that dayroom time was "less and less," now at three times daily for varying times. He was uncertain about yard times.

During the mental health intake screening, the patient reported previous psychiatric hospitalizations and having been on paroxetine (an antidepressant). He was noted to be mildly unkempt, but no psychosis was noted. However, he was rated as moderate/severe and acuity and referred for mental health housing at RPDC. He was not seen by a psychiatrist until three weeks later when he was started on paroxetine.

He was ultimately placed at SCF. While there he was diagnosed with schizoaffective disorder and agreed to start on an antipsychotic. Monitoring for metabolic syndrome was not done, however an AIMS was completed.

He was generally uncooperative with treatment outside of taking medications (no groups were being offered at the time, but he also refused individual contacts). Clinical Therapists and Behavioral Health Specialist followed up with him periodically and endeavored to encourage engagement and improved hygiene. It was repeatedly noted that he was ill kempt, but the assessment was that he did not meet grave disability standards. Staff were clearly attending to this issue.

Berglund 201721080
This man was also on 16F. He had been in jail a little more than a month and had a month left. He had just begun working with staff on a discharge plan.

He exhibited poor eye contact and talked about past delusions (e.g., his parents were not actually his parents). He was taking risperidone, which he had been on since he was 18 years old, and that he got medications promptly after admission (which was not the case – see below). He met with the psychiatrist once (which was accurate). He also noted that he had been in groups, but they were discontinued. He felt fortunate that he was one of the patients who had regular individual meetings with a Clinical Therapist.

He reported access to the dayroom "at least" once per day, most days for a total of about an hour. He recalled that the hard was open "about half the time" it was supposed to be. He noted that they normally got to the yard once per week during cell searches.

This man was admitted in June 2017. During the intake mental health screening he was noted to be mildly unkempt and to have a history of treatment and hospitalization for mental health problems. He

had been taking a mood stabilizer and antipsychotic for 10 years though had been off it for the last three weeks. He was transferred from Blythe to SCF soon thereafter. He was not seen by a psychiatrist until four weeks after admission at which time he was started on the antipsychotic risperidone. An AIMS was done but no laboratory examinations for monitoring metabolic syndrome.

His acuity code was ultimately raised to severe. He was seen regularly by Clinical Therapist and Behavioral Health Specialists primarily focused on release planning given his impending discharge date. He received release medications at discharge.

Driskill 201739483
This middle-aged man had been admitted a few days before and now on 16F. He was clearly thought disordered, bizarre, and rambling. He reported being off medications for a year and half and was normally on sertraline, trazodone, and quetiapine. He had a history of extended psychiatric hospitalizations. He received medications his first night in jail, likely because he was "yelling in intake." He had met with a psychiatrist.

Of note, he had a clear anatomical abnormality of his right shoulder and could not lift his arm. I informed the jail staff.

During his initial mental health intake screening, the intake nurse noted that he was quite disorganized. He was placed in safety cell. He was seen that day by a psychiatrist to started him on olanzapine and trazodone and later added sertraline and hydroxyzine. There was a recent negative AIMS in the record; no laboratories for monitoring metabolic syndrome were in the record.

Mental health saw him the following day found him grossly psychotic, rated his acuity is severe, moved him from the safety cell and sought residential mental health placement. The client was released less than a week later and was referred for civil commitment under 5150.

Briseno 201722824
This man was housed on 16F, the step-down for gang dropouts. He was labile and had clear psychotic symptoms. Despite wanting treatment, he was fearful of meeting with mental health, believing it might lengthen his jail time. He was taking medications but could not recall what.

He reported dayroom on 16F about twice daily for 15-30 minutes but that on 16D, he had gotten out three times daily. He thought they got access to the yard during morning dayroom times.

He had been admitted in June 2017. The intake mental health screening initially conducted by a nurse was all negative. The following day mental health did the intake screening again and found that he had a history of self injury, was currently thinking of harming himself, endorsed auditory hallucinations, and had a history of treatment for mental health and substance abuse. He was placed in a safety cell. He also exhibited overt signs of mental illness. He was seen by a psychiatrist that day and started on an antipsychotic and antidepressant the psychiatrist ordered appropriate laboratory is for monitoring metabolic syndrome and did AIMS testing.

During his three-month stay, he was seen regularly by a psychiatrist and by Clinical Therapists and Behavioral Health Specialists. Meetings primarily focused on medication management and adherence. There was some evidence of release planning prior to his discharge, however it was not clear that he received discharge medications though there was a common in the final Clinical Therapist note about

receiving "post release medication instructions and encourage client to follow through on outpatient [behavioral health] services."

RPDC
Furr 201714779
This young man was on administrative segregation on unit 5B where I observed a Clinical Therapist conduct an assessment following return from the DCU owing to self-injury (head banging) and medication refusal. This was his third hospitalization during this stay.

After previous hospitalizations, chart review demonstrated that he did receive the five daily transitional visits upon his return to the jail. Otherwise, his treatment consisted of medications and daily brief visits (owing to his administrative segregation status) with no evidence of any plan to address his recurrent behavioral problems. It is likely that intellectual disability and or head trauma in the associated cognitive deficits contributed to his behavioral difficulties. There is no evidence of a behavioral plan are appropriate interventions to try to reduce his problem behavior. Likely lack of access to the patient because of administrative segregation at a good deal to do with this.

This man was admitted in April 2017. He had an extensive mental health history. While he denied most symptoms, he was clearly suffering from a psychotic disturbance and was responding to internal stimuli. His acuity rating at intake was severe and he was placed in a safety cell and referred for residential mental health treatment. He was seen the following day by a psychiatrist who also found clear evidence of psychosis. The psychiatrist started him on olanzapine, an antipsychotic. The psychiatrist did the AIMS and ordered laboratory screening to monitor metabolic syndrome.

He was on administrative segregation during his stay in placed on unit 5B in RPDC. He was back and forth to the DCU owing to recurrent self-harm and general instability.

Allen, Robert 201714719 (unable to find patient in TechCare)
This middle-aged man was on administrative segregation on unit 5B; he had been admitted in April 2017. He had previously been in prison for 29 years. He was arrested for staying in an abandoned building. In addition to evidence of hypomania and likely somatic delusions, this man has a history of substance use.

He was paranoid and concerned that custody listens in to all his conversations and relatedly reported that he had overheard a deputy talking with another patient about their medications, which he was able to overhear. He stated that one time when he tried to hang himself, deputies assaulted him when they came to stop him. He spoke of nurses having "favorites" that they would give additional or special snacks to at pill call. He reported that mental health staff joined nurses on pill call rounds. Regarding dayroom time, he reported this was highly variable but usually 1-3 times daily for about 30 minutes. He reported that mental health responded well to requests to be seen. He also noted responses to grievance but that they had no impact.

He reported taking bupropion and oxcarbazepine. He received no other treatment except occasional visits with a therapist but primarily cell front check-ins.

Montiel 201649964
This man was admitted in December 2016 and reported he was soon to be transferred to a state hospital (presumably for competency restoration). He was also on administrative segregation on 5B.

He stated he was on no medication. He reported being on medications and in groups in the community. His farther visited twice a week. He reported access to the dayroom only once a day, adding that he used to get out twice a day and that on occasion that would get a second session in the evening. Yard was offered "today and Friday." He said that it was usually offered 2-3 times per week for about 3 hours.

He reported that he met with a Clinical Therapist weekly and that they do "writing and coloring" in the non-contact booth. However, he stated that he was not visited daily. He used to have a life skills session weekly but that was stopped; he did not know why.

He was clearly intellectually limited.

He had been admitted in December 2016. On admission the patient reported being "developmentally disabled… Autistic." He was a client at the Regional Center. He was unable to remember the medications he was on but believed that his father knew what they were.

He was seen by a psychiatrist two weeks later, but he refused medications at that time. A psychiatrist saw him every one to two months thereafter; he continued to refuse medications in the psychiatrist ultimately opined that medications were not indicated.

Most of the meetings with clinical staff were at the cell front. The exception was weekly meetings with a Recreation Therapist that occurred in a noncontact booth, though occasionally these had to be at cell front as well due to unavailability of the booth or inability to escort the patient to the booth. Mental health staff endeavored to get permission to meet with him face-to-face to facilitate recreation therapy services were not permitted to do so.

He was not seen every day though on administrative segregation status. There are often several days between meetings in these were generally brief cell front check ins.

Frazier, Joaquin 201721185
This overtly psychotic man was on administrative segregation on 5B. He was hostile and refused to meet with me and refused medications during pill call.

He was admitted in June 2017. During the intake mental health screening, he refused to participate stating that he was falsely imprisoned. However, he was identified as mentally ill and referred for mental health housing. A psychiatrist saw him about a week later. He was continuing to refuse to participate both with Clinical Therapists and with the psychiatrist. The psychiatrist went to the cell front and tried to engage the patient with minimal success. No medications were ordered. Strangely, there was an AIMS done by the psychiatrist that day; it would not be possible to do an AIMS properly from cell front.

He was also said to have threatened deputies but did not require a safety cell. He was also refusing food and later throwing water. He was placed on administrative segregation, even though his behavior was highly likely due to his mental illness. There is no indication that DCU placement was considered a that time. He was not seen daily by mental health while on administrative segregation, but was seen every few days on average.

Of note, he was also refusing his HIV medications. I saw no evidence of an evaluation of his competency to refuse. This went on for over a month. During this time, a Clinical Therapist documented that the patient he had the delusional belief that his medications were being poisoned, clearly indicative of incompetency. This refusal was not noted in the record, other than nurses charting his refusal, until after 6 weeks of refusal. A week later, a Clinical Therapist documented consultation regarding possible commitment to the DCU and the patient was placed in a safety cell. That same day, he refused psychiatric contact, but the psychiatrist made no note of concerns regarding dangerousness or grave disability. However, committed to the DCU.

Notes from the DCU clinical staff clearly demonstrate that he was severely psychotic and that his delusional beliefs were directly related to his not eating and not taking medications.

Notes from medical staff detailed his refusals to be seen and medication refusals but there was no discussion of whether he was competent to refuse. There was no evidence in the medical record that mental health and medical ever discussed his medication refusal and steps to be taken to address his competency.

This case was clearly mismanaged.

Williams 201711352
This was another overtly mentally ill man on administrative segregation on 5B. He was reportedly isolative and deputies had to periodically clean his cell. He was admitted in March 2017. He was placed on administrative segregation in June due to inappropriate masturbation, not responding to deputies, and poor relations with cellmates. He had reportedly improved little since admission. He refused treatment and often refused to come out of his cell. He had been on the waiting list for competency restoration at Patton State Hospital since June. He refused contact when the Clinical Therapist came to the cell front to ask if he would come out to talk.

The Clinical Therapist conducting the intake mental health screening observed that the patient was a poor historian and found clear evidence of a history of serious mental illness including recent hospitalization. In addition, the patient had a history of traumatic brain injury with resulting deficits. He was admitted to SWDC but was quickly transferred to SCF's residential mental health unit. There, it became clear that he was grossly psychotic. It was at this point that he began engaging in the repetitive masturbatory behavior. Here again, this behavior was related to his mental illness that this did not seem to be considered in his placement on administrative segregation status.

Two weeks following his admission he was seen by a psychiatrist. He was started on olanzapine and hydroxyzine. In AIMS was completed, however there were no laboratories ordered to monitor for metabolic syndrome. He was poorly adherent to medications from the outset. Ultimately, he was in a fight with his cellmate following a period of disagreement with the cellmate. He was bizarre and repeatedly pressing the button and telling staff that he was supposed to be released from custody. Notes make it quite clear that he was very disorganized and did not well understand his situation.

He was ultimately placed in a safety cell and was transferred to RPDC. There, he continued his nonadherence and persisted in a decompensated state. He was next seen by a psychiatrist about a month after his first visit. The psychiatrist changed him to a rapidly absorbing form of olanzapine but there is no discussion of referral to the DCU. The psychiatrist did another AIMS, but did not order laboratory studies for monitoring metabolic syndrome.

He continued to be ill kempt, malodorous, disorganized, nonadherent with treatment, and largely isolative until he was finally transferred to Patton State Hospital for competency restoration at the end of July 2017.

Hankins 201714644
This deaf man on numerous medications was also on administrative segregation unit 5B, though presumably on protective custody (PC) status. He almost fell upon standing. He was sleeping on the floor instead of his assigned top bunk.

During mental health intake screening, the patient denied any problems. However, the screening was done handwritten notes owing to the patient's deafness. The Clinical Therapist noted a history of mental health treatment and psychiatric hospitalization. The patient was placed at SCF on unit 16, the residential mental health unit. He continued to communicate in writing for the next two months until an interpreter was finally secured.

Patient was not initially recommended for medications as it was not clear that he was suffering from a mental health problem. He was seen by a psychiatrist almost 2 months after admission at which point he was started on an antipsychotic and an antidepressant for depression with psychotic features. An AIMS was done but laboratories for monitoring metabolic syndrome were not ordered.

He had difficulty getting along with peers and frequently complained of being victimized some of which was verified. He was placed in a safety cell owing to expressions of suicidal ideation related to his difficulties managing in the jail setting. He was ultimately transferred to RPDC and housed on 5B, the administrative segregation mental health unit.

Clinical staff made some effort to bring in interpreters and had limited success with this but there were several sessions utilizing an interpreter.

There is no evidence that any release planning was done for this needy man.

Sanchez 201721893
This is another mentally ill man on administrative segregation on 5B. He was on numerous medications and was shifting from foot to foot, almost certainly a side effect of antipsychotic medications.

This man was admitted in June 2017. He was very unstable throughout his stay. During his intake mental health screening he endorsed constant suicidal ideation, history of suicide attempts, psychiatric hospitalizations, multiple losses, and a history of psychiatric outpatient treatment the was not currently taking medications. He was placed in a safety cell and shortly thereafter admitted to the DCU. Upon his return, he was placed in residential mental health on unit 5B on PC status.

A psychiatrist saw him shortly after his return. He was yelling, crying and demonstrated substantial mood lability. The psychiatrist ordered an antipsychotic and antidepressant, presumably continuing therapy started at the DCU. The psychiatrist did an AIMS or laboratory studies for monitoring metabolic syndrome were not done. Psychiatric follow-up was regular and appropriate medication adjustments were made except for failing to address his akathisia (restlessness caused by antipsychotics).

Patient had regular meetings with mental health staff during his stay. They worked with him on skill development and crisis management.

Thomas 201725483
This man, also on 5B, was less overtly mentally ill at the time I saw him. When he asked the nurse for a "kite" the nurse declined and referred him to the box of kites on the wall of the dayroom, though he did not have access to the box at that time as he was locked in his cell.

He was admitted in July 2017. Note that in May 2017, he was overtly psychotic at the time of admission to Jail and upon release shortly thereafter was civilly committed on a 5150. He returned to jail in July 2017. He was again showing evidence of psychosis. He was placed in a safety cell at RPDC. He was seen the following day by a psychiatrist but refused to come out of the safety cell. The psychiatrist restarted olanzapine, an antipsychotic. There was no AIMS or laboratory testing for monitoring metabolic syndrome done.

Care plan was done but it was very generic, indicating only that he would receive individual therapy and case management. The goal was for him to be able to identify and explain to mental health symptoms per week. There is no evidence that this plan was followed through. However, various mental health staff saw him on a regular basis and provided some support and activities oriented interventions. He remained episodically hostile but showed some improvement in his symptomatology over time though continued to have auditory hallucinations and thought disorder.

Harris 201719883 (Unable to find medical record; name or number given were incorrect)
This middle-aged woman was admitted in May 2017 and had been on 6B since admission. She reported auditory hallucinations and talked about delusional beliefs she formerly held. She was on psychotropic medical before jail, receiving monthly injections of the antipsychotic Invega Sustenna. She reported not receiving any medication until the beginning of July. She reported meeting with a Clinical Therapist once, also in July, for 20 minutes and believe she met with a psychiatrist the week prior to our visit for 15 minutes. She reported not being offered any groups or therapy, though wished for such assistance.

I was unable to verify her reports as either she gave me the wrong name or number.

She reported that time in the dayroom varied from 1-3 times a day for up to an hour, depending on the deputy, naming one female deputy who worked to get the inmates out. She reported getting yard access once each week for an hour and a half.

Limar 201722428
This woman had been admitted a month before our visit and was slated to leave within days. She reported being homeless after her baby's father was deported; her children were taken from her. She demonstrated mood lability and odd beliefs likely of delusional proportions. She stated that she had been offered mental health services and placement in the community. However, she was told she would have to call the facilities herself but that the phone number was blocked by the jail.

She had been in a safety cell in late June due to suicidal ideation related to releasing homeless and with conditions for her release. She was in for a violation and reported that it was very difficult to meet her conditions when homeless.

She stated she was on olanzapine and trazodone and that these helped prevent mania. She stated that she had not seen a psychiatrist during this incarceration but had during previous ones. However, she did say she met with a Clinical Therapist weekly and worked on skill development.

She reported betting dayroom access several times per day for varying times and access to the yard about twice per month.

During her intake mental health screening in June 2017, the patient endorsed vague suicidal ideation and complained of depression and anxiety. She was categorized as moderate severe and referred to mental health housing and to the psychiatrist. A note by a psychiatrist seems to indicate declining to order bridge medications the following day, but there were orders for an antipsychotic and antidepressant placed immediately thereafter. The patient was seen two weeks later and regularly thereafter. The psychiatrist did an AIMS there was no laboratory monitoring for metabolic syndrome.

She was seen on a regular basis by mental health throughout her stay. However, there was no evidence of any structured treatment, encounters consisted primarily of crisis response.

Burke 201725470
This woman was admitted shortly before my visit and was housed on 6B. She reported a history of ADHD and problems with methamphetamine use. She reported that two jail psychiatrists told her they did not want to see her and that she had not had a visit with a psychiatrist, though had been on no medications in the community. She had some paranoid and likely delusional ideas about her art having been plagiarized and other themes. She reported being victimized repeatedly, primarily in the community.

She reported that she was about to start in some groups. She met with the Clinical Therapist “but not often enough.” She said she was offered dayroom 2-3 times daily for about an hour each and yard access 1-2 times per week for about an hour.

During the mental health intake screening, she did not endorse psychotic symptoms but was observed to exhibit thought disorder and have likely delusional beliefs. She was rated as having severe acuity and was directed to mental health residential housing.

A psychiatrist first attempted to see here week after admission, but she was at court. She was finally seen a month and a half after admission. At that time, she was started on an antipsychotic. The psychiatrist did an AIMS, but no laboratories were ordered for monitoring metabolic syndrome.

In the ensuing weeks, she was seen regularly by Clinical Therapists and Behavioral Health Specialists. She received some structured treatment designed to address her anxiety and coping skills. She improved some but was still slated for treatment in a competency restoration program due to her continued symptomatology.

Olson 201720226
This seriously mentally ill woman with poor dentition and likely Tardive Dyskinesia (a movement disorder caused by antipsychotic medications) was housed on 6B. She had been in jail for three months, initially at SCF but moved to RPDC within three days. She had regular mental health services at the Blythe clinic and had a protective payee, was on injectable antipsychotics (Invega Sustenna), and had her room and board provided through the clinic.

She made a variety of unlikely claims about having medical conditions as well as other clear evidence of a psychotic illness.

She stated she was ordered Invega Sustenna, divalproex sodium, and bupropion. The psychiatrist had met with her the day before our meeting. Groups included Dialectical Behavior Therapy (DBT) and another she could not recall.

She reported dayroom three times daily for about 45 minutes and yard once per week but could not recall for how long.

She was admitted in May 2017. She was overtly psychotic during the intake mental health screening and rated at moderate-severe acuity. As noted above, she was placed in residential mental health at RPDC within three days. She was ordered bridge medications two weeks after admission. She submitted a kite complaining of being allergic to one of the medications but when seen by the psychiatrist two days later, there was no discussion of this kite or the nature of her purported reaction; the medication was continued and she began to refuse it periodically. Clinical Therapists saw her multiple times but never commented on her medication refusal, despite notes speaking to monitoring her adherence to medications. A psychiatrist saw her about a month after starting the medication and made no comment on her adherence or any problems with medications reporting her adherence as "fair" (despite refusing several times that week and about 25% of the time generally) and no side effects. Later Clinical Therapist notes reported her as medication compliant despite continued periodic refusals. The psychiatrist did an AIMS but there was no laboratory monitoring for metabolic syndrome.

The patient was seen periodically by a Clinical Therapist for support and enrolled in two different groups. She also received some discharge planning, primarily housing assistance.

She was referred to the Liberty jail competency restoration program, though it took two months before she was enrolled. Records demonstrate that her medications were changed soon after entering their program.

Friedman, Christopher 201722052
This overtly manic man was on 5B on administrative segregation which he thought was because of having problems with another inmate. He had been there for one month. He reported past civil commitment and being prescribed an antipsychotic.

He reported he was currently prescribed olanzapine and diphenhydramine as well as a muscle relaxer and naproxen. He stated that he had not seen a psychiatrist but had visited two times with different Clinical Therapists while on 5A. He was in no groups because of being on administrative segregation but had been offered anger management and substance abuse treatment on 5A, though never started.

He stated that he got dayroom 1-2 times daily for 20-30 minutes and access to the yard about once weekly but irregularly.

Alvarez 201711012
This obviously mentally ill man with a history of spending 1.5 years at Patton State Hospital had been on 5B since March 2017 on administrative segregation. He reported that he had always been placed on administrative segregation since having a fight with a cellmate in 2014.

He stated he was on olanzapine and benztropine, which were helpful, though he noted note receiving medications for a day the previous week. He recalled the psychiatrist coming to his cell weekly when he "walks the tier" but having no private meetings. He met with the Clinical Therapist every other week.

He stated that he got 30 minutes of dayroom time daily and an hour of yard weekly.

He was admitted in March 2017 as a return from Patton State Hospital; intake mental health screening noted his severe mental health condition. The psychiatrist wrote bridge orders to continue his medications and saw him a week later at which time the patient was still overtly psychotic. The psychiatrist conducted an AIMS but there were no laboratories for monitoring metabolic syndrome. The psychiatrist saw him approximately monthly subsequently.

A generic case plan was entered a week later. He had occasional sessions with a Clinical Therapist that were consistent with a case management approach. He declined groups.

Over time he stabilized and was transferred to the second floor where he had monthly meetings with a Clinical Therapist.

He remained on administrative segregation despite doing well clinically and behaviorally. He was not seen daily by mental health but approximately 2-3 times per week on average for cell front check-ins.

Cole 201719161
This man was on administrative segregation, housed on the 7th floor (special housing for medical patients). I had met him during a previous visit.

While he stated he was ordered quetiapine and oxcarbazepine, he reported never having met with a psychiatrist but also stated he refused. He complained of receiving ordered snacks inconsistently. He was clear that he was not being seen daily by mental health.

He was frustrated with his continued placement on a medical unit.

During mental health intake, the patient denied all problems but was identified as having mental health needs owing to his extensive mental health history in jail and the community. Bridge medications were ordered on day 3. Multiple refusals ensued and his medications expired without being seen. He decompensated and was transferred to the more acute setting of 5B. He was seen by a psychiatrist a month after admission and continued on his medications. He later refused all but a mood stabilizer, which was continued.

He again decompensated and agreed to restart an antipsychotic. An AIMS was done as was laboratory testing for metabolic syndrome.

This patient made repeated threats to harm himself and exhibited other behaviors consistent with a severe personality disorder (in addition to his serious mental illness). He had multiple safety cell placements. No behavioral management plan was put in place. Responses continued to be primarily to emergencies, likely reinforcing his acting out. Mental health staff did attempt to engage him in groups and tried to help him develop and utilize coping skills.

He was not seen daily by mental health but about 3-4 times weekly for check-ins.

Ramirez 201727362
This grossly psychotic man was in a safety cell. He was clearly in need of hospitalization.

He was identified as seriously mentally ill and a danger to self upon admission and was placed in a safety cell and sent to the DCU shortly thereafter.

He remained quite unstable with frequent safety cell placements. He had repeated psychiatric and Clinical Therapist contacts. He was partially adherent to medications, including antipsychotics. The psychiatrist did an AIMS, but no laboratory studies were done for monitoring metabolic syndrome.

He eventually began to stabilize and became more cooperative with treatment, even engaging in some release planning.

While rehospitalization at the DCU might have been indicated, the team did a good job of stating in contact with the patient and trying to engage him in treatment, with some degree of success ultimately.

EXHIBIT N

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June 3, 2018

INTRODUCTION

This Third Report sets forth the Mental Health Expert's assessments of the implementation of the terms of the Consent Decree, signed June 7, 2016, and associated Remedial Plan stemming from Gray v County of Riverside. It covers the Riverside County's (the County) reported results from the time of entering the Consent Decree from July 31, 2017 through February 28, 2018 (the "Third Reporting Period") and reflects the observations and analysis of the Mental Health Expert regarding the County's compliance during that period.

As used herein, "Substantial Compliance" means that the County has achieved compliance with the material components of the relevant provisions of the Remedial Plan in accordance with the agreed-upon Compliance Measures for assessing Substantial Compliance submitted by the Mental Health Expert. "Partial Compliance" means that the County has achieved compliance on some, but not all, of the material components of the relevant provision of the Remedial Plan or have not achieved the quantitative results specified in the Compliance Measures; and "Non-Compliance" means that the County has not met most or all the material components of the relevant provisions of this Agreement.

This Third Report is based upon the Mental Health Expert's review of provided policies, procedures and directives proposed and/or implemented by the County, observations and assessments of the Mental Health Expert based on tours of the jails, and review of medical records and data collected by the County. I visited Smith Correctional Facility (SCF) for one days Cois Byrd Detention Center (CBDC – formerly Southwest Detention Center) for a half day, Robert Presley Detention Center (RPDC) for one and a half days, the Detention Care Unit (DCU) for three hours. I was provided full access to patients and staff and was assisted by staff knowledgeable in relevant topic areas including mental health, nursing, custody, classification, quality assurance, and administration.

I observed three groups (one at CBDC, one at RPDC and one at SCF); met with psychiatrists, Clinical Therapists, nurses, Recreation Therapists, and Behavioral Health Specialists; observed pill lines and multi-disciplinary team meetings; conducted group interviews on general population units; rounded on patients in the DCU; reviewed medical records; interviewed 14 patients in private; and spoke with many more patients during visits to the units. In addition, I met with mental health leadership at County offices for one hour, met with a variety of staff to discuss the Continuous Quality Improvement Program, and conducted a one-hour exit

interview. We also had a one-hour conference call with counsel from the Prison Law Offices and Riverside County and mental health leadership to discuss moving into the quantitative phase of review. Included in this report is a section outlining a plan for moving this forward.

I reviewed medical records of 13 patients that I also interviewed while on site. These are included as Appendix 1.

The County provided the following information for my review:

- Two DVD's of data from the County including:
  - Recreation (yard) statistics from August through December 2017 for each jail (RPDC and SCF were each missing one month)
  - Tabulation of notifications to mental health regarding lengthy sentences for 2017
  - Tabulation of mental health participation in transfers
  - Inmate Death Review policy 501.22
  - Two inmate death reviews
- RUHS-BH detention services staffing for March 2018
- Slides of RUHS-BH Detention Services trainings:
  - Professional Behavior
  - Risk Assessment
  - Self-Care
- RUHS-BH Detention Services 2017-2018 Detention Reports Catalog (draft)
- RUHS-BH Detention Services quality improvement meeting agendas and reports
  - Time studies
  - Chart reviews
  - Indio, RPDC, CBDC presentation summaries on Service Codes,
  - Indio presentation summaries on Client Care Plan
  - Indio, SCF, CBDC presentation summary on Documentation Workshop
  - Listing of CQI studies from each facility (local CQI initiatives)
- RUHS-CHS CQI minutes and supporting materials from January 2018 meeting
- Reports on mental health population:
  - Acuity ratings for all evaluated inmates and evaluated inmates in administrative segregation – countywide and by facility
  - February 2018 reports on:
    - Behavioral health screenings
    - Behavioral health needs requests
    - E-MAR psychotropic medication lapses
    - Bridge medication verification
    - Administrative segregation follow-up
    - Safety cell transitional follow-up
    - Open behavioral health cases

- Open cases with an assessment
- Psychiatric encounters
- Inmates on psychotropic medications

- Behavioral Health Indicators from 3/1/18 to 3/31/18, including
  - Behavioral health screenings
  - Behavioral health assessments (including timeliness data)
  - Behavioral health care plans (including timeliness data)
  - Behavioral health needs requests (including timeliness data)
  - Psychotropic medication lapses
  - Bridge medication verification
  - Safety cell transitional follow-up
  - Administrative segregation follow-up
  - Discharge planning for inmates release during that time period
  - Acuity level for inmates booked during that time period

- RUHS-BH Detention Services training rosters and training materials for comprehensive mental health services training from 10/2/17 at all sites
- RUHS-BH Detention Services training rosters and training materials for new Card Reader System Training
- RUHS-BH Detention Services Behavioral Health Specialist training manual for RPDC
- RUHS-BH Detention Services Clinical Therapist training manual for RPDC
- Group schedules for RPDC

EXECUTIVE SUMMARY

I begin by congratulating the County on achieving NCCHC accreditation at all five facilities. NCCHC accreditation demonstrates that the County has put in place policies in key healthcare areas. While the NCCHC accreditation is not quality oriented (i.e., does not depend substantially on the actual care delivered) and the standards lack some degree of specificity, largely because they must apply to all jurisdictions and all types of facilities, they address general and essential systems issues. In short, this accreditation reflects the County's efforts to develop the infrastructure needed to deliver care properly.

Riverside County has made a reasonable adaptation to the security requirements for clinicians seeing patients in contact areas that had substantially reduce patient contact at the time of my previous report. The County has installed electronic locks that clinicians are able to activate from inside the rooms; clinicians have radios as well. The County has also restored or added runners who are providing much needed access to care for the mentally ill, though access to patients on residential units, especially at RPDC (where neither mental health nor psychiatry are seeing patients in the clinic), remains a challenge owing in part to space limitations; the planned physical plant changes are not yet done. This has helped return services back to levels prior to June 2017.

Non-contact visits remain the rule at RPDC. The plans to expand RPDC and SCF clinical space continue forward. Space challenges have increased at CBDC owing to mental health staff now not being able to utilize some unit program rooms.

Program tables have begun to be used, but there remains some uncertainty about how they will be used. There is no consistent practice regarding their use, including when patient-inmates must be restrained to the table, and I have not been provided a RCSD policy or procedure covering their use. The practice should be consistent, and restraint used only when necessary; for example, if a patient would not be restrained for a medical appointment, they should similarly not be restrained to the table for mental health treatment.

The County has also made progress in other areas, including further development of the data systems needed for proof of practice. The County's ability to extract data from the Electronic Health Record (EHR) has continued to grow. Custody has also begun to develop some reports to track out of cell time more effectively, largely using spreadsheets they have created; Information Technology (IT) support would greatly speed and enhance this process, but RCSD is to be commended for moving this forward internally.

I note that coordination between medical and mental health could be stronger. While not an element of the remedial plan, solid coordination between mental health and medical is necessary to achieve substantial compliance. Areas that are particularly important in this regard are: CQI, referral, patient healthcare requests (kites), safety cell and restraint assessment, and medications generally. Assuring that relevant policies, procedures, charters, and the like address the relationship and responsibilities would help promote coordination.

Regarding access to care and quality of care, the County is making progress. The intake process is improved and most seriously mentally ill are being promptly identified, though initial medications are not always being promptly ordered. The improvements to the intake area at CBDC are not done but should help facilitate communication.

The retrieval, triaging, and response to patient requests for mental health care continues to need refinement. Improved tracking of the process will be necessary to both troubleshoot and provide proof of practice.

Safety cell management is sound except that stepdown procedures, in terms of restoration of property and privileges during safety cell placement, are not in place. Patients are being seen less frequently at cell front and mental health contacts are regular. Nursing monitoring is mixed, but patients are being evaluated at least every 12 hours in almost all cases. Logs are being completed consistently. Transitional services of those leaving safety cells and returning from the DCU are administered consistently, though not reliably on a daily basis as intended.

There remain substantial problems in delivering services to the seriously mentally ill on administrative segregation. One notable positive development is the greater collaboration between mental health and custody in reviewing the need for continued administrative segregation; documentation of this review is also being developed. The remedial plan requirement for daily mental health contacts for patients on administrative segregation has both proven very difficult to achieve and diverted resource from productive treatment. In addition, access to these patients to provide services remains a significant problem; even if more mental health resources were available, it is unlikely that current limitations on access would provide adequate access to render needed services. I noted some evidence that patients are being returned to the jail from the DCU without being fully stabilized, likely due to insufficient use of involuntary medications and longer-term commitment. There are now two Clinical Therapists at the DCU, but they are yet to be fully utilized; plans for providing greater access to patients are being developed. The County is also moving to develop mechanisms for providing emergency and, ultimately, involuntary medications in the jail, the latter in accordance with recent statutory change permitting this. In addition, the County is developing a clinic to administer long-acting injectable antipsychotics. These developments should help address the needs of the seriously mentally ill, especially those on administrative segregation and in the DCU.

While group treatment has returned to previous levels, access and fragmentation remain a problem. There is both limited capacity (not enough groups to accommodate the numbers of patients) and custody provisions that prevent patients from completing group curricula. The latter is related to limitations on mixing of patients, some of which are unnecessary, as well as frequent moves. For instance, at SCF (at least), patients on upper and lower tiers of a single unit are not allowed to attend groups together. A formal process that clearly identifies inmate-patients who must be kept separate would help tremendously; some conflict in this population is inevitable but, in most instances, need not result in enduring separation. Careful attention to

group enrollment that both addresses clinical need and potential interpersonal conflict is needed and requires collaboration between custody and mental health. Here, it must be recognized that interpersonal conflict is much more of a risk in unstructured activities (e.g., dayroom or yard with no formal, structured activity) than in structured activities such as groups; thus, keeping tiers separate for the unstructured activities but allowing some mixing for structured activities is reasonable and promotes access to care and efficiency while addressing the risk of patient conflict. This not only serves treatment needs but provides a measure of readiness to advance to a lower level of care/custody; those who can succeed in structured communal activities may be allowed a trial of communal unstructured activities in a more broadly mixed population.

Reentry services have also been improved. There is better documentation of both individual and group reentry services. However, there are still seriously mentally ill patients who have received no reentry services and medications are not consistently being provided at the time of release. A plan to have peers assist in reentry is currently on hold; this is a method used by many systems to both augment traditional services but, more importantly, serves as a

It is important to note that the County has not yet been able to fill 90% of its mental health positions. The County should consider what steps it can take to streamline the hiring process, make the positions more attractive, and widen the potential pool of candidates. Despite the staffing shortfall, the County has continued to make progress. I also note that while there is some turnover, a good many staff remain – a testimony to their commitment and to the quality of the leadership.

In terms of formal compliance, I report on the following measures, most of which remain global currently. The County previously achieved substantial compliance on the following measures:

- **Consent Decree Training**

In my opinion, the County is also now meeting substantial compliance on:

- **Health Care Records** (contingent on production policy on maintenance of the EHR)
- **Housing** the mentally ill

The County has achieved partial compliance on the following measures:

- **Intake Screening** (elements relevant to mental health services) – very near substantial compliance
- **Timely Access to Care** (elements relevant to mental health services)
- **Medication Administration and Monitoring** (elements relevant to mental health services)
- **Confidentiality** (elements relevant to mental health services)
- **Custodial Environment** (elements relevant to mental health services)

- **Treatment** of the mentally ill
- **Treatment Space** for mental health services
- **Suicide Prevention**
- **Continuity of Care** for the releasing mentally ill
- **Policies and Procedures**
- **Continuous Quality Improvement** (elements relevant to mental health services)
- **Review of In Custody Deaths** (elements relevant to mental health services)

The County is downgraded to non-compliant on:

- **Staffing** (elements relevant to mental health services)

The following is not rated owing to limited data:

- **Restraint**

In Appendix 2 of this report, I comment on plans to move towards a more quantitative approach to compliance monitoring; the County has made sufficient progress in infrastructure development to move in this direction. I welcome comments from the County and plaintiff regarding both the general plan and the County's ability to take on certain elements of the data collection, almost of which will support CQI initiatives in the future.

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HEALTH CARE GENERALLY (elements relevant to mental health services)

Intake Screening

The County's plan to have a Qualified Mental Health Professionals (QMHP) do the mental health intake screening, except at times when there is no mental health on site when an RN will continue to provide that function, is largely implemented.

The screening form still needs some minor modifications as mentioned in my previous report. However, review of medical records demonstrates continued improvement in detecting the seriously mentally ill during the intake process.

The first set of data the County provided on intake screenings was included with reports under the general title: 2017-2018 Detention Reports Catalog (the copy provided was in draft form). RUHS-BH leadership informed me that there are some methodological problems with some of the reports in the catalog; comments below regarding concerns about methodology or data from this catalog are offered to help refine the reports. It showed results for March and April of 2017 only. In those two months, of 4219 bookings, 91% received a behavioral health screening. Note that those jailed less than 10 hours were, reasonably, excluded (the County intends to extend this to those admitted for more than 24 hours which will eliminate the cite and release population, which is reasonable). Owing to inaccurate release dates in TechCare, the eligible population included those "between an inmate's time of booking and next booking." This would seem to exclude those who had no subsequent bookings. However, there is no reason to believe that this would create any systematic error. The numbers examined were also large enough that the percentage is likely an accurate reflection of practice. Most facilities were similar in terms of percentages, though Blythe was notably lower, likely reflecting both staffing and transport issues. The general figures are in line with date provided for my previous report. That data was from later in 2017 and showed some inconsistency.

RU-BHS also provided data for February and March 2018 in the document Behavioral Health Screening, Assessments, & Care Plans. While the complete methodology was not provided, it appears that the County has standardized its approach. The overall rate of completion was 93.4% in February and 95.2% in March with all facilities above 90%. No longer trend data were provided but the numbers suggest slight improvement and it is likely that mental health screening is consistently being done in more than 90% of cases. However, no timeliness data were provided. Record review showed that in almost all cases mental health screening was done within 24 hours of booking and most were within 8 hours.

The intake locations and confidentiality issues are largely unchanged. Plans to make modifications remain in place but are yet to be completed.

The County included a May 2017 report on bridge medications. The methodology appears to be that the County examined those patients on psychotropic medication currently (it is not clear what date or date ranges current included) and then determined the number of those booked in May: 600. Of those 600, they then queried TechCare to determine how many of those 600 stated that they were on psychotropic medications at the time of intake: 100. Then the percentage of those that had a sick call request generated within 48 hours; the purpose of this is that the expectation is that if a patient did not have medications verified within 48 hours, a sick call request was to be generated. The County found that 100% had no sick call, indicating that all had, presumably, been verified within 48 hours.

The Behavioral Health Indicators from March 2018 uses a better methodology in that it identifies patients that reported taking psychotropics at the time of booking, but it still uses the generation of sick calls to determine whether verification was done. Of 222 qualifying cases, only 1 had a sick call generated. It is highly unlikely that 221/222 (99.5%) had medications verified.

There were no data regarding psychiatric follow-up within 7 days for those patients receiving bridge medications nor on whether those verified but without and order for psychotropics were seen by psychiatry within 24 hours.

Psychiatrists report that medication verification is being done more reliably and that they are being notified quickly, usually within a day, of patient admission.

RU-BHS also provided data for February 2018 in the document Behavioral Health Screening, Assessments, & Care Plans showing that 87% had medications verified. This report also includes a pie chart indicating that 9% of patients reported being on psychotropics at intake, somewhat different than the 100/600 = 16.7% above); it is not clear if the methodology was changed.

The methodology is flawed. First, including only those on psychotropics would exclude those who reported being on psychotropics but never received any. Second, the report would mark as compliant any case where a sick call was not generated, whether or not the medications were verified. Third, there was no determination of whether positive verifications resulted in an actual order of medications within 48 hours. Lastly, it is virtually impossible that 100% of those patients reporting being on psychotropics at intake had this verified; the reduction to 87% suggests that staff are more assiduously placing non-verified patients on sick call, but it remains unclear how accurately these data reflect reality.

Chart review demonstrated that while most patients whose medications are verified are started promptly, but there were some cases where patients reported taking medications but there was no evidence of verification, ordering of psychotropics, or a visit with a psychiatrist within 48 hours. It was also not uncommon for the first psychiatric visit, and initial medication orders, to be at about two weeks after admission, even for patients rated at higher levels of acuity.

Compliance contemplates patients on psychotropics being seen by a psychiatrist within 24 hours, getting them immediately from stock, or receiving verified initial medications within 48 hours if ordered through the pharmacy.

The County continues to be in **partial compliance** with this element. The screening process is substantially improved. Medication verification, bridging orders, and initiation of appropriate medications are inconsistent. Once the County can better demonstrate prompt psychiatric

Timely Access to Care

The RU-BHS document Behavioral Health Screening, Assessments, & Care Plans showed 1,581 open cases as of 3/1/18: 20 at Blythe, 343 at CBDC, 117 at Indio, 477 at RPDC, and 624 at SCF; this is similar to previous data and in line with national statistics.

Health Care Request Forms are only available on the units, not in libraries and program rooms. Custody staff will examine the feasibility of expanding the availability of Health Care Request Forms, but there are legitimate logistical problems. The parties may want to revisit this requirement. There is also inconsistency in the process of accessing and collecting Health Care Request Forms in restrictive housing

settings with nurses collecting them from patients in some and patients putting them in dayroom collection boxes in others. This should be standardized in a manner that best assures promptness and accessibility.

The County has not modified its approach to managing Health Care Request Forms for mental health. Nurses continue to triage these requests and forward them to mental health. This is a legitimate approach but must have an accompanying proof of practice that includes verifying that the forms are picked up daily, triaged promptly and accurately, forwarded to mental health according to the acuity of the problem, and responded to timely by mental health. This is an essential CQI function.

At CBDC, Health Care Request Forms were available on all units. Nurses reportedly pick them up after midnight, triage them, scan them, and send them to mental health. Mental health reports getting these timely. Night shift mental health staff then review them; any reporting symptoms are placed in the triage queue for follow-up within 48 hours; there are usually four to five of these every day. Others are slated for routine follow-up within two weeks.

At SCF, Health Care Request Forms were available on all units I visited. At RPDC, Health Care Request Forms were available on almost all the units I visited. At both facilities, I had varying reports regarding the process, but it was generally the same as at CBDC. While at RPDC, I asked to see that day's Health Care Request Forms for mental health. Of the 10 that were delivered to mental health on the day of my visit, 9 were more than 24 hours old; of these, 4 were three days old and 1 was four days old. Clearly, this does not represent a timely process and does not comport with the CHS CQI report of 100% of health care requests collected, presuming that this is measuring timeliness as there would be no way to know if a health care request was not collected.

The RUHS-BH report 2017-2018 Detention Catalog Report (draft) showed that from 8/1/17 to 11/21/17 there were 4,512 Health Care Request Forms related to behavioral health, of which one third were priority requests. The percentage of priority requests (those reporting symptoms) completed within 48 hours (72 hours on weekends) was about 20% and the average time for all requests to be completed varied from 0.8 days to 8.8 days for different types of practitioners (these different queues are being eliminated with all going into either a behavioral health triage or psychiatry queue, which will simplify tracking and analysis).

These data are difficult to interpret as the numbers accounted for in the associated table are 2,913 and the associated bar graphs do not include the numbers for each type of practitioner. There were also problems and questions regarding the methodology; note that this is the catalog that RUHS-BH leadership is aware has some methodological problems. First, those pending sick call requests were excluded from the cases. If these include large numbers of cases that are greater than the timelines reported above, then this data may appear better than reality; at the least, the percent of pending reports and their average time pending should also be reported. Second, the time begins from the "creation date," but it is not clear from the report whether this is the date the patient made the request (the critical date), the date the nurse input the request, or the date mental health input the request. Third, the number of requests is substantially more than in subsequent months and it is unclear which is a more accurate reflection of numbers of patients submitting Health Care Request Forms for mental health reasons.

The CHS CQI minutes from 1/18/18 included response times for an unnamed facility for 11/8/17-12/6/17. 154/177 for those for Clinical Therapists were routine and were seen an average of six days, 22/177 were urgent and were seen in an average of five days, and the one emergent request was seen at four days. The BHS responses were all routine and seen in an average of 4.5 days. 81/102 routine psychiatrist responses were seen in an average of five days and 21/102 urgent responses were seen in an average of 3.7 days.

RU-BHS also provided data for February 2018 in the document Behavioral Health Screening, Assessments, & Care Plans. These data appear to have been collected in the same manner and show reductions in time to completion to an average of from 0.7 to 5.5 days for both routine and priority cases. The percent of priority cases seen within 48 hours was also improved to 35.9%, though some average wait times for the larger queues were around a week. Routine requests were often seen sooner.

The Behavioral Health Indicators from March 2018 show only 63 patient Health Care Request Forms for mental health, 34 or which were priority and 29 were routine. 88.2% of priority requests were seen within 48 hours and the average time to completion for all requests was 0.8 days. Note that the data excluded any incomplete requests, which would be expected to skew the data towards shorter times as cases that were never seen and were pending (likely to be more than one day) were excluded; these cases should be included in the analysis to give a more accurate picture of timeliness of response.

Though there are questions about the accuracy and completeness of the data, it appears that response times to Health Care Request Forms for priority requests have improved. Whether the County is including too many cases in the priority (urgent/emergent) category is a question. Even if a patient reports symptoms, a rapid response may not be necessary, though that is a best practice. Some symptoms, for example isolated insomnia, may be responded to on a routine basis, i.e., within two weeks.

The County continues to have no means of tracking response time to inmate declared emergencies. This will likely require coordination between custody, medical, and mental health to ascertain how to track this and with which data system(s).

Patients report that mental health is generally responsive to requests to be seen, whether to Health Care Request Forms or direct requests to health care staff and deputies. Reported response times were usually 1-5 days except for psychiatrists, which was typically reported as weeks. This is better than previous patient reports. Patients almost universally stated that mental health response times were much better than medical response times.

Psychiatrists continued to report that they were usually able to see routine patients within 30 days of an initial visit and conduct follow-ups every 30 to 90 days. Record review demonstrated that psychiatrists see patients regularly, though as noted above, initial visits were sometimes delayed given the acuity. In almost all instances, patients on psychotropic medications were being seen at least every 90 days, and almost always substantially more often. Psychiatrists at RPDC continue to report that accessing patients remains difficult and impairs productivity because of space limitations, challenges getting patients out to interview rooms, patients being out to court or other locations at the time of the appointment (there is little coordination between custody and health services in terms of scheduling), and because of the time it takes to move through the facility.

Patients in the residential units continued to report that mental health staff do rounds almost every day and ask how they are doing (almost always during pill call). They reported meeting with a Clinical Therapist individually at varied frequencies, mostly consisting of brief monthly contacts that were primarily focused on current symptoms or release planning. However, almost all felt the Clinical Therapists were helpful and had their best interests in mind; they simply wished for more contact and more opportunities for therapeutic sessions. Many lamented the loss of groups.

Consistent with my previous report, most patients are being seen sufficiently regularly by a psychiatrist. Most patients are getting occasional case management contacts with a QMHP, and a few patients are getting active treatment either in group or, rarely, individual therapy. The penetration and dosage of groups remains a challenge. There are too few groups to meet the needs of the population and many patients do not complete course of group therapy. It was not uncommon to see patients attending a single session of several different groups. Patient moves and custody limitations on which patients can be in groups together hamper the ability to provide appropriate services. For instance, patients at SCF on different tiers within the same pod are not allowed to attend groups together.

That said, with the increase in runners and the reasonable resolution of security requirements for program spaces, there are fewer groups being cancelled and they more often run on time and for the full session. Whether the County has sufficient staffing in both custody and mental health to provide access to all seriously mentally ill, given current policy and practice, remains a question.

The exception to the above are patients on administrative segregation whose access to care is limited. Many of these patients are severely mentally ill and doubtless are on administrative segregation due to behavioral problems related to their mental illness. In visiting unit 5B and attending the conjoint staff review of patients, it remained clear that many of these patients often refuse care, including medical care (I saw no assessments of patients' competency to refuse care), and often refuse to come out for other activities. They are substantially isolated. The day I was on the unit, it was malodorous, several patients' cells were filthy, including two smeared with feces, and several had days of food detritus. Medical records demonstrated significant problems with the care of one of the two patients reviewed, in part due to failures related to DCU services and not securing involuntary antipsychotic treatment. More aggressive treatment of this seriously ill population is needed.

Here again, the County remains in **partial compliance** with respect to the mental health services elements relevant to Timely Access to Care.

Medication Administration and Monitoring

I again observed morning medication administration at RPDC on a residential mental health unit. It ran the same as during my last visit except that the nurse handed out Health Care Request Forms, though some patients continued to complain at RPDC, SCF, and CBDC that nurses would sometimes not hand them out. Nurses go cell-to-cell for patients on administrative segregation (e.g., unit 5B at RPDC). For top tier patients, the nurse carried envelopes of medications with patient names and cell numbers and then later input the information into the electronic medication administration record; I continue to have concerns about this process, but it is being done better than before. On other units, deputies announce pill call and patients come to the unit door one by one. The nurse properly identified patients and did mouth checks most of the time. If patients are suspected of cheeking, custody reportedly usually does prompt cell searches.

One important change is that nurses are no longer frequently changing the floors where they do sick call. They reported that this had helped clinically both easing patient identification and allowing them to better monitor patient status. The nurse I observed at RPDC did a very good job; she knew the patients, interacted with them professionally, and was attentive to their clinical status. A deputy and mental health clinician accompanied us cell-to-cell on 5B; the mental health clinician had brief contacts and asked some patients if they would come out.

Review of medical records demonstrated that almost all MARs are complete; it is not possible to determine their accuracy.

Nursing staff reported that they send refusal notices (using a sick call notice) after three days of a patient refusing a medication. Psychiatrists reported that non-adherence was being reported fairly reliably, but more often by Clinical Therapists than nurses. Records showed that most charting on non-adherence was by Clinical Therapists.

Emergency medication orders are shipped from the pharmacy to the facility the same day; routine orders are by the next day. There is a regular monthly report that is monitored weekly to assure that medications are given daily.

Patient reports regarding medication administration varied some. Patients reported that pill call was generally on time except one female patient reported pill call was sometimes three hours late (the other two women I spoke to were too ill to reliably report). Custody and mental health staff also reported that sometimes the pill line at the female mental health unit is sometimes quite late.

Few patients reported that ordered medications were unavailable. Several reported that their medications had expired but if so were usually restarted within days, rarely longer; this was consistent with the County's report based on aggregate data reported below. One patient at RPDC reported waiting several days to get a newly ordered medication and being told by a staff member that the medication was available, but the nurse refused to go to the seventh floor to get it.

RU-BHS also provided data for February 2018 in the document Behavioral Health Screening, Assessments, & Care Plans showing that there were 1298 patients on psychotropics at the end of the month. The jail census at the time of my visit was 3905 so about 1298/3905 = 33% on psychotropics, which is slightly higher than would be expected, though it depends a good deal on the fraction of the population that is female as psychotropic use is about 50% in the female population (I did not receive data on the male/female distribution).

The report 2017-2018 Detention Reports Catalog includes a section on psychotropic medication lapses based on the electronic medication administration record. This appears to be a report showing when active prescriptions are unavailable to the nurse when the time of administration arrives. 71% had no lapses. Of the remaining number, almost all were single dose lapses. RU-BHS also provided data for February 2018 in the document Behavioral Health Screening, Assessments, & Care Plans which showed only 4.48% missing any doses (9/10 were just one dose). Similar data from March 2018 in the document Behavioral Health Indicators showed that 13.68% had lapses with an average of 1.6 doses missed; only 15 patients missed three or more doses. The report excludes many reasons for missing doses (e.g., not administered due to lockdown and not administered because the medication was not available), presumably because it is intended to capture only medication lapses, though lapses are not clearly

defined. While the County should not have even that many lapses, the fact that almost none were for more than a single dose and that the percent was dramatically reduced indicates that it is not a significant problem, especially from a purely pharmacologic perspective, though missed doses will be stressful for many patients. However, failure to administer ordered medications for any reason should also be tracked and falls under the provision in the remedial plan which only provides for lapses related to those "required by non-routine facility security concerns."

The County remains unable to demonstrate its compliance with the provisions for medication administration when patients are out to court, in transit to outside appointments, or upon transfer.

At the DCU, Clinical Therapists and nurses reported several problems with medication orders. After hours admission orders generally were often not timely because the psychiatrists who evaluate patients at the emergency room do not have admitting privileges so that orders must be written by a different psychiatrist; these admitting psychiatrists are often unwilling to order medications owing to not having evaluated the patient. This is a structural problem that needs to be addressed. The clinical staff also note difficulty getting long term involuntary medication orders; this likely needs to be addressed through supervision.

Psychiatrists report that laboratory results are returned timely but that they are sometimes not informed when patients refuse blood collection. For those patients on antipsychotics, most had completed AIMS. However, obtaining baseline laboratories and laboratory monitoring, especially for metabolic syndrome (a common problem for those taking antipsychotics) remains problematic.

Owing to inconsistent medication monitoring and concerns about upper tier medication administration, the elements of Medication Administration and Monitoring relevant to mental health services is in **partial compliance**. This should, still, be easily remedied.

Confidentiality

There have been no changes or developments here. Progress will depend mostly on completion of planned construction. This should allow reduction of cell front visits, one of the chief problems with confidentiality. Development of some intake areas will also help.

I did see a degree of greater respect for confidentiality on the part of some custody staff who purposefully maintained some distance to allow more private communication with clinicians, but it was not consistent.

This remains in **partial compliance**.

Health Care Records

There is now an EHR that both medical and mental health clinicians can fully access. Policy to support needed modifications, maintenance, and improvements was not provided to me.

As noted previously, the County is making key modifications to the EHR and has several initiatives related to mental health. These modifications will be necessary to establish adequate quality improvement and quality assurance as well as proof of practice of a number of measures within the Remedial Plan.

Once policy is provided that meets the terms of the Remedial Plan, this item will be in **substantial compliance**; this rating is contingently offered.

Staffing

A RUHS-BH jail staffing report from 5/15/17 is the most recent overall staffing I received this reporting period, though I previously received a 7/17 report that shows identical numbers of funded positions and about the same fill rate. The overall positions and filled positions are in the following table.

Position Type	Funded FTE	Number Filled	Percent Filled
Sr. Medical Records Technician	5	4	80%
Office Assistant II	7	6	86%
Office Assistant III	5	6	120%
Behavioral Health Service Supervisor	7	6	86%
Clinical Therapist II	76	63.5	84%
Behavioral Health Specialist III	4	4	100%
Behavioral Health Specialist II	21	21	100%
Senior Clinical Therapist	6	4	67%
Recreation Therapist	5	2	40%
Psychiatrist IV	13	10.98	84%
Medical Records Technician	1	1	100%
Total	150	128.48	86%

The total number of positions

At present, eight Clinical Therapist positions are empty but there are four pending hires. Behavioral Health Specialist Positions are full (actually, one over at 25). There remains only one mental health clinician at Blythe.

CBDC is down only one Senior Clinical Therapist; there are 14 Clinical Therapists total. Clinical Therapists are divided between intake and unit coverage, which has been effective for both getting intakes done timely and providing more consistent and structured coverage for the units. There are about 2.5 FTE psychiatrists, providing coverage six days per week. There are six Behavioral Health Specialists and one Recreation Therapist who run groups.

Overall, RUH-BH has still been unable to fill 90% of its positions.

I have not been provided an annual assessment of staffing corresponding to the requirements of the remedial plan.

At this point, largely owing to the failure to fill 90% of positions, challenges achieving substantial compliance that may readily be due to inadequate staffing, and the lack of an annual assessment, this element must be downgraded to **non-compliant**.

Custodial Environment

The total census of the jails was 3905 at the beginning of my site visit.

Custody staff were generally respectful and professional with staff and prisoners. Several patients in the residential units continued to report that a minority of custody staff were not respectful and made fun of the mentally ill.

In general, the facilities were clean, though RPDC less so than SCF and CBDC. As noted above, unit 5B at RPDC was malodorous and many cells were unreasonably filthy.

At CBDC, when patients are seen in the program rooms, they are uniformly cuffed to the program tables, even if not on administrative segregation. This interferes with treatment and is not consistent with practice in other clinical settings (e.g., medical clinics). The Recreation Therapist is also only able to provide treatment for those in administrative segregation at cell front; this clearly interferes with treatment and either forces breeching confidentiality or precludes discussion of any significant personal clinical issues.

Behavior management plans, used to assist custody and mental health in providing consistent and complimentary services, have not been instituted yet. These are required by the Remedial Plan. At SCF, they do what might be termed rudimentary behavior management plans through email, team meetings, and the use of the unit log books. RPDC does something similar for patients with self-injurious behavior but there are no formal plans.

Patients on 12A and 14G at SCF complain that they cannot work out on the units and cannot even stretch. They report having access to the yard 2-3 times weekly where they can exercise, though not on a set schedule and sometimes as early as 0600. These are dorm settings, so dayroom access is not an issue.

Unit 16 patients at SCF reports regarding access to the dayroom varied but most reported getting out for 30-60 minutes 2-3 times daily. Yard access was consistently reported to be 2-3 times weekly, usually for 30-45 minutes; some reported that it was available even more frequently.

Patients in the mental health units at RPDC reported access to the dayroom 2-3 times per day for 30-60 minutes.

SCF patients reported that custody staff were generally respectful and helpful, though one patient reported seeing custody beat another patient on evening shift but could not identify either the patient or the custody staff. RPDC patient reports regarding custody staff were more mixed.

Cell searches are conducted randomly about twice per month; the results are conveyed in team meetings with mental health staff. Clinical staff reports that if patients are suspected of hoarding, custody conducts cell searches promptly in most instances.

RCSD provided data on yard times from the last several months of 2017. The summary tables suggested that the those in mental health residential units, including those on administrative segregation, were almost always being offered or did receive 3 hours of yard time per week. The following table shows a summary of the data for the residential treatment units serving the seriously mentally ill (SMI) for those on administrative segregation in RPDC and those in GP residential mental health units for RPDC and SCF. The numbers in the table are the percent of the population receiving 3 hours of yard time that week.

	August 2017	September 2017	October 2017	November 2017	December 2017
RPDC SMI Ad Seg					

Week 1	85	90	100	100	Missing
Week 2	80	90	100	95	Missing
Week 3	95	100	100	100	Missing
Week 4	55	95	100	100	Missing
Week 5				100	
RPDC SMI GP					
Week 1	100	100	100	100	Missing
Week 2	100	100	100	100	Missing
Week 3	100	100	100	100	Missing
Week 4	100	100	100	100	Missing
Week 5				100	
SCF SMI GP	Missing				
Week 1	Missing	100	100	100	99
Week 2	Missing	100	100	100	100
Week 3	Missing	99	99	Missing	100
Week 4	Missing	100	49	Missing	100
Week 5				100	

Yard times varied; some were before 0700 and these were often unattended or had low attendance.

I reviewed the raw data for September and October for one tier on one unit at SCF in detail and inspected the whole raw data set: Unit 16E, bottom tier. I added up all the minutes of yard time, many of which were not reported because no patients went to the yard (the number going to the yard was reported for these units). For September, RCSD reported 12 yard periods for that particular tier. The shortest time was 10 minutes and the longest 65 minutes, but most were 40 to 60 minutes. For four of the 12, no patients went out. At most, 5 patients went out; most often it was one or two. The average documented yard time per week was 78 minutes (a total of 313 minutes were documented). Setting the times for the 4 sessions with no patients to 60 minutes, the average available time was 153 minutes per week. The results for October were similar, with 88 hours per week documented with five sessions showing zero patients attending yard. Substituting 60 minutes for those sessions, there were 165 minutes per week. Looking at each individual week, none of the weeks in September totaled more than 180 minutes, even using the 60 minutes when none went to yard, so it is clear that the 100% reported (see above table) cannot be correct. This is also the case for the second week in October; the first week reached 180 exactly if the -5 minutes reported for one session is changed to 60 minutes.

I also reviewed the administrative segregation data for RPDC unit 5B. RCSD examined 20 individual cells for this data. What stands out is that for most days, the majority of the in/out times are not indicated, which appears to indicate that they are not out of their cell. While for some data points, there is an indication that tiers or cells were "not cleared," presumably meaning that deputies cancelled yard time. But for the administrative segregation cells there is no such indication. I inspected the yard times for two cells in November 2018: 5B48 and 5B49. There were 10 possible yard times but neither cell showed any in and out time, only "R@[time]" where the time was filled in, presumably indicating this was when they were offered yard. However, all the cells having no in and out time had the same time entered for "R@[time]." There is no indication whether the patient refused to come out or whether they were denied yard time. It is unlikely that all were offered yard at that same time, so it is not clear

what this means or how it was counted. There was no day where more than half of the cells showed an in and out time and many days where none did.

RCSD also provided data for inmates not in residential housing units for comparison. While the questions regarding the accuracy of the data make it difficult to know how valid this comparison is, since the methodology used was the same, the relative times (if not the absolute differences) may reflect general practice. The data show that at RPDC, the GP/PC populations are offered similar yard opportunities, though the numbers reported coming out of the individual units are lower on the residential mental health units. Those on administrative segregation also appear to be treated similarly, though the percentage is notably lower in August 2017. At SCF, the GP/PC data show similar yard times, again with fewer utilizing the yard from the mental health units. Inspection of the data does not show any obvious differences, other than the lower numbers of mentally ill in the yard. For SCF units 9D and 10A, the weekly averages were 77 minutes and 90 minutes respectively. Thus, even on the GP units, inmates are not receiving three hours of yard time weekly.

The RCSD policy Recreation specifies that inmates will receive three hours of recreation every seven days. The remedial plan specifies that each recreation period will be at least one and a half hours. The above data shows that this is not yet being achieved.

In summary, it appears that the actual yard times were not used in the calculation of yard times offered to units (or tiers of units). And for those on administrative segregation, it is unknown whether yard times are being offered or not when there is no in and out time. Thus, it is highly unlikely that the percentage of the mentally ill are actually being offered 3 hours of yard time per week was as high as reported. That said, three points need to be made. First, RCSD is doing its best to collect this data without a proper system in place to do so. It is essentially a hand collection process and those doing this are to be commended for their substantial effort; with further refinement, it might be possible to make this methodology yield accurate data, but it is not sustainable and highly prone to error. There are clear errors in the raw data (e.g., in times before out times) and many missing data points. The second point is that RCSD does appear to be offering regular yard times, but it remains unclear for how long and how many patients are not being allowed out versus refusing time out, especially for those on administrative segregation. While the summary report included a column entitled "cells not cleared for recreation." I could not ascertain how this number was computed and it did not always account for the difference between numbers of inmates reported as receiving (or offered?) yard time and the number of cells. Lastly, there is no apparent difference between the yard times for the mentally ill, though fewer use the yard, which is to be expected to some degree.

The RCSD policy 504.42 Dayroom Management reflects that dayroom times extend from 0800 to 2300 as specified in the Remedial Plan. The policy does generally reflect an intention to maximize dayroom time. It does not specify how much time inmates are to be afforded in the dayroom or how dayroom time varies with custody or classification level. Thus, it remains difficult to determine what the expected amount of dayroom time is, so it is still impossible to determine if dayroom time is being offered according to policy. This leaves the only way to assess the dayroom time for the mentally ill is to compare it to dayroom time of other inmates. While this is not a formal measure, if there is a marked and consistent reduction of dayroom time for the mentally ill, this would suggest that dayroom time is not being maximized for the mentally ill. While some reduction compared to general population

inmates would be expected in higher acuity settings owing to an expected increase in behavioral disorder in this population, that should not be true for those in lower acuity settings.

I did not receive any data on dayroom times for this report.

In my interviews with patients, I asked about dayroom and yard times. As before, patients in residential mental health units at RPDC reported highly variable access to dayrooms, almost all noting that it depended on the deputy. Those not on administrative segregation continued to report getting out in the dayroom one to three times daily, usually for 30-60 minutes. They reported usually come out one tier at a time but sometimes in smaller groups. They gave variable reports on access to the recreation area (yard), most saying it was once per week for 90 minutes and others saying it was one to two times per week for about an hour.

Those on administrative segregation at RPDC continue to report that they get 30-60 minutes in the dayroom each day (in one or two sessions). They gave variable and likely unreliable reports regarding yard time.

At SCF unit 16 (residential mental health), patients continue to report that they get dayroom 2-4 times daily, up to an hour each. They gave more consistent reports regarding access to the recreation yard with most all reporting 30-60 minutes, 2-3 times weekly.

The DCU is slowly moving to be less like a restrictive housing unit. There is now a room with a program table where Clinical Therapists can meet with patients one-to-one. Additional opportunities are being developed.

I attended a multi-disciplinary meeting at RPDC (for 5A/5B male residential mental health); it lasted about 15 minutes. As before, mental health staff, nursing, unit custody staff, classification staff, and the Medical Sergeant working with mental health units were in attendance. They discussed specific patients and those who were having problems as well as admissions and discharges. It was clear that staff were aware of at least some of the most ill and were attending to both dangerousness and grave disability.

In my first report and reiterated in my second report, I noted that there are two trainings, one by custody (included in new Custodial Conflict Intervention Training (CCIT)) and by mental health in the suicide training module (IFT Suicide Prevention Training), that address the “self-isolating inmate.” The County reported that it would complete the IFT Suicide Prevention Training by 10/31/16 but I have not received verification of completion or the curriculum demonstrating that self-isolation was covered. The County has offered CCIT since 7/24/16 and reports that it has trained 149 (rosters show 174); it is unclear what percentage of custody staff this represents but it does not appear to be nearly complete.

The use of administrative segregation of the mentally ill within residential mental health units remains a logistical challenge and raises questions about limiting privileges because of mental illness. Those on this status are offered only one hour out of cell time per day, solo yard access, and cannot attend groups; in short, they are under conditions quite similar to restrictive housing. Clinicians note that access to those on this status for one-to-one meetings can also be limited, interfering with their ability to provide needed services; Clinical Therapists are conducting daily rounds on them, but this is a brief cell front check-in, not treatment. Clearly, safety and security must be provided for patients and staff alike. However, it is necessary to be able to consistently meet the clinical needs of the patients, necessitating better access. There is a plan to procure classroom seating that provides for restraint to

allow the most dangerous to begin attending groups, an important first step in determining their readiness to have more unrestricted access to peers and staff alike. The County has purchased correctional tables to serve this purpose and to provide options for meeting with patients individually, though as noted previously, the County is yet to make full use of these.

The elements of the Custodial Environment related to mental health services remain in **partial compliance**.

REVIEW OF IN CUSTODY DEATHS (elements relevant to mental health services)

I was told that there have been two deaths since my last report, one a suicide by ligature and the other related to rhabdomyolysis related to agitation. Death reviews on these were not provided.

Two death reviews of patients on the mental health caseload were provided. EH died in August 2016; the autopsy found the cause of death to be pneumonia and lung cancer. The death review found no problems. However, I have several concerns. First, the responding nurse found the body cold and with signs of rigor mortis. Rigor mortis rarely sets in less than two hours before death, especially in a person quiescent at the time of death. It is unlikely that the report that EH was seen alive 75 minutes before is accurate. Second, the patient was showing evidence of debilitation that appeared not to have been well evaluated. The review does not sufficiently address the possible causes of his lethargy or psychomotor retardation, poor cell care (to the point of smelling rotting food), lack of cooperation with forensic mental health evaluation, and psychotropic medication non-adherence. As these signs could have been caused by pneumonia, cancer, and/or depression, this should be explored in the review. This is especially important given that the illnesses causing his death were not detected. Depression itself is well-known to be associated with medical illness and it would be important to know whether this was considered, especially in a 58-year-old man with no known medical or mental health history. Third, there were no laboratory or other studies noted in the review. While that may have been reasonable, the review provides insufficient detail to determine whether such should have been ordered, whether by mental health or medical. Fourth, the potential impact of awaiting housing on the Behavioral Health Housing Unit was not considered, especially regarding possible differences in monitoring and treatment. In my opinion, the review is insufficient to determine whether there were problems with monitoring or mental health treatment.

SS died in January 2017. The autopsy found the cause of death to be peritonitis. There was no reason to believe that the patient's mental health condition was related to the cause of death. The mental health review was limited in scope but sufficient to make this determination.

The mental health component of the death reviews is in **partial compliance** owing to the shortcomings noted above.

CONTINUOUS QUALITY IMPROVEMENT PROGRAM (elements relevant to mental health services)

The Continuous Quality Improvement Program (CQIP) continues to develop soundly. I met with CQIP representatives from RUHS-CHS, RUHS-BH, and custody. Custody does not provide data for the healthcare CQIP and does not have any healthcare related measures. However, custody has started to

participate in the healthcare CQIP, hopefully heralding a more robust coordination that can both facilitate proof of practice for the purposes of achieving compliance with the terms of the remedial plan and, more important, to pave the way for continued healthcare operations enhancements in the jails in the future, especially access to care, which is a function of all elements of the system. Right now, access to care problems are tracked by unusual occurrence reports involving healthcare reports to custody when there are custody limitations that impact access. This is an inefficient and largely ineffective approach as it does not examine access generally and focuses only on failures in the existing system rather than also exploring opportunities for system improvement (in CQI language, it is a quality assurance approach, rather than a combined quality assurance and quality improvement approach).

As mentioned above in Timely Access to Care, tracking Health Care Request Forms assiduously from beginning of the process to the end is also an essential CQI function in correctional settings that is not fully tracked at this time.

There are certain RUHS-BH global reports that are not included in the combined CQIP reports. This includes important reports such as self-harm and staff injuries. While it is reasonable for local and limited CQIP projects to be developed and reviewed within each discipline or at a facility, key global reports and dashboard items for all disciplines should be part of the combined CQIP.

Current RUHS-BH CQI initiatives include: tracking a new substance abuse treatment program in the jails called “New Directions,” evaluation of a 12-session reentry group developed at RPDC, and collecting baseline data prior to initiating use of emergency psychotropic medications and starting the long-acting injectable antipsychotic clinics at RPDC and SCF.

RUHS-BH Detention Services produced CQI studies on a wide range of topics and measures, including: open cases, acuity, intakes, assessments, treatment plans, administrative segregation follow-up, safety cell follow-up, psychotropic usage, clinical supervision (primarily record review), and local CQI studies. Most of the data are covered in the relevant sections but some of these studies deserve comment here. Most notable was a very thorough set of reviews of clinical documentation from November and December of 2017; this is an important element of peer review. Each facility also conducted CQI studies (some the same across facilities, others unique to the facility) including: discharge planning outcome data, mental health screenings and resulting mental health acuity levels, safety cell outcome data, response times to urgent and routine sick calls, successful linkage to outpatient behavioral health clinic upon release, medication compliance of inmates, mental health assessment completion times, kite response times, grievance response times and process for appeal, percentage booked that were screened by RUHS-BH, bridge medication ordering times, duration of safety cell placements, timely access to care, total screenings in 2017, patient contact prior to civil commitment, review of man-down related to suicide or mental health issues, tracking treatment refusals, snack orders for antipsychotics, medication expiration, inaccurate sick call triage, time to completion of sick calls, study of problems with transport at release, safety cell usage, assessment of eating meals with patients, decline of encounters, impact of treatment on fights and grievances, AB 109 mental health services, length of stay in residential mental health unit, transfers without screening, sick call response by staff member, and hospital visits for self-harm not reported to mental health. While some of these were noted in my previous report, this list gives a sense of the breadth of issues RUHS-BH Detention Services is evaluating through its CQIP.

For some of the RUHS-BH Detention Services CQI data in the topic sections elsewhere in this report, I note some problems with methodology. While there are problems, some are related to limitations in

information currently available through the EHR. However, the most important point is that there is substantial progress on the CQIP. This will make it more possible to take a more quantitative approach to proof of practice. It would be impossible to hand count many of the remedial plan requirements from individual medical records, so development of associated reports is critical.

I also reviewed the Correctional Health Services (CHS) Operational Indicators from the third quarter of 2017; most do not apply to mental health. I note that the Receiving Screening indicator is 99%; given data above showing lower percentages on mental health intake screening, that data was presumably not included in this indicator. The indicator Health Care Request Collected is reported at 100%, which is not at all consistent with what I found (see Timely Access to Care above). When we discussed this during the meeting with the CQI teams, it emerged that this indicator is not based on actual checks on form collection but on self-report of collection; this is not sound CQI methodology or proof of practice. The report also included several of the facility-specific RUHS-BH Detention Services reports noted above.

Data collection and analysis remains a much greater problem for custody whose data systems are antiquated and not designed to perform CQI functions. The difficulty of tracking yard time noted above and out of cell time generally is a clear marker of this challenge. It is not clear where whether a data warehouse is being developed, but without such an approach, it is unlikely that the existing systems will be able to produce and analyze aggregate data needed for CQI and proof of practice.

The County remains **partially compliant** with this measure, but it is important to note the substantial and commendable progress in this area.

MENTAL HEALTH CARE

Treatment

There is still no formal Program Guide. There are comprehensive Standards for Clinical Therapist Training and Standards for Behavioral Health Specialist Training which are more a compendium of important information than a guide, but they contain many of the elements of a program guide (there was an earlier version for Clinical Therapists called the Clinical Therapist Training Manual reviewed in the previous report). However, they indicate that they are for RPDC only. They provide good quality information on the jails, jail practices and procedures, and, most importantly, sound approaches and information for conducting clinical work in the jails including crisis response, assessment and management of suicide risk, intake, bridge medications, hospital returns, civil commitment, general mental health assessment, acuity ratings, treatment planning, and discharge planning. There is also a range of groups, most of which have a strong evidence base and are appropriate for the setting.

The content for Clinical Therapists has been augmented since last time; it is a sound and comprehensive document. The information for Behavioral Health Specialists is more limited, in line with their role, but does include good overviews of groups, including Anger Management, Discharge Planning, Life Skills, Seeking Safety, Wellness Recovery Action Plan (W.R.A.P.), and a brief outline of New Direction (the new substance abuse group that is designed to work for those with and without mental illness). It also has a section on Recreation Therapy. In terms of types of groups, the main thing that is needed is enhancement of offerings for the seriously mentally ill. While Recreation Therapy is a valuable tool with this population, other psychosocial rehabilitative and psychoeducational groups are needed, for

instance, medication education, and offerings designed to help patients manage in the correctional environment including relating to custody, getting needs met, self-care, and so on.

Both include a Prison Rape Elimination Act (PREA) training that adequately introduces the most important elements.

The section on acuity ratings represents sound training on generating ratings and succinctly lays out the general architecture of the various treatment settings and how they relate to the acuity ratings.

Guidance regarding care plans is sound but needs to be updated to reflect the change to TechCare. While some of the requirements for discharge planning are aspirational at present, this manual and the policy on Discharge Planning represent reasonable expectations.

The manual addresses overall dosing of treatment, specifically mandating 10 hours of behavioral health programming weekly for those with moderately-severe and severe acuity ratings. For those with less acute problems, the requirement is for a monthly individual contact, psychiatric treatment (as indicated - with monthly follow-up), and at least one group. It is unclear whether the one group is to be on-going or a single group session; this needs to be clarified as a single group session would not be sufficient. Attainment of this amount of programming, assuming it is properly structured treatment and targeted to patient needs, is an adequate amount of programming to address the needs of the mentally ill. Group manuals should clearly spell out numbers of sessions and distinguish groups with progressive curricula (which require regular attendance to be of any clinical value) from open-ended groups, such as some of the recreation therapy groups where each group session stands independently. There is a relationship between the type of group and patient acuity. More acutely ill patients often do not benefit from progressive groups. Correspondingly, and as noted above, group offerings should be targeted to acuity, which would also simplify group attendance as patients are aggregated by acuity in the residential mental health units. This is being done to some extent already but should be more formalized and specifically addressed in the Program Guide.

The manuals should more clearly distinguish different forms of individual contacts beyond screening and assessment. This is done to some degree, the section on crisis response being a good example. Many of the elements of individual contact are already laid out to some degree but organizing them more clearly would be helpful. One typical approach for the treatment component (as opposed to evaluation) is to distinguish case management (which is all most patients need), crisis management (sometimes broken into crisis response and crisis treatment), and psychotherapy (which will be limited and almost all short term). The interventions in the manual roughly correspond to these categories but could be spelled out more and each have general frequency and duration (dosage) expectations laid out. The transition follow-ups after safety cell placement could be viewed in this way as crisis treatment, which would help guide clinicians towards more focused treatment interventions (different types of which should be spelled out, e.g., solution focused therapy) to prevent viewing it simply as a check-in to assess risk, which is how many of the transition notes currently read. Specific treatments or interventions could also be attached to each type as well as to diagnosis or problem, making treatment planning easier and faster as well as providing more structured and clinically appropriate care. At present, most treatment plans are quite generic and refer to developing non-specific skills. A simple example would be a patient with the problem of medication non-adherence, a frequent issue in the jails. The long-term goal would be medication adherence. One appropriate intervention (that could be specified in the Program Manual) is Motivational Interviewing, which is often used to promote medication adherence. The short-term goal would depend on the stage (e.g., precontemplation) which then guides the intervention and charting can be simplified. A progress note would then simply consist of any key functional and mental

status information (e.g., "still non-adherent, psychotic symptoms unchanged, no dangerous behavior or intent to harm self or others") and the intervention (e.g., "used MI techniques to help patient clarify goals – identified getting a job in the kitchen"). The purpose of the example is to show how a Program Guide can help focus treatment at the appropriate level and simplify treatment planning and charting by referencing a specific type of recognized (preferably evidence-based) and agency sanctioned intervention.

Psychiatric services are not addressed in these manuals; they should be included in a complete Program Guide. In addition to the above comments, to convert these documents into a complete Program Guide for the whole system, the following content should be added or expanded (or addressed by reference to other documents such as treatment manuals, guidelines, protocols, procedures, and policies, which may or may not be included in the Program Guide itself, depending on how the county wishes to use it):

- The functions of different settings in all the jails (as has been done for the units at RPDC and to a limited extent in the acuity ratings for other facilities)
- Transfer procedures (addressed to a limited extent in the manuals, primarily to the DCU)
- Referral to other services (e.g., medical) and for specialized testing
- Involuntary medications
- Medication monitoring
- Coordination with competency restoration services

Before discussing treatment, consideration of the general illness burden is instructive. The County provided data on the acuity (level of care) of the populations presented in various ways: at the system level, in administrative segregation, and by facility. As intended, CBDC, Blythe, and Indio have fewer mentally ill and none with acuity ratings higher than moderate. RPDC has the highest percentage of mentally ill and the highest percentage of moderate-severe and severe patients (34% of the total RPDC population). One point that is important to make, and to take note of, is that the population in administrative segregation is disproportionately mentally ill (70% with any mental illness) compared to the total jail population (59% with any mental illness) and has a much higher percentage of moderate-severe/severe (27%) than the total population (12%). This demonstrates clearly that the mentally ill are almost certainly being placed on administrative segregation due to behavioral problems related to their mental illness. As noted below, this population also gets the least treatment. There are 117 mentally ill on administrative segregation. If the reason for those with moderate-severe/severe mental illness being on administrative segregation is due to true dangerousness, this population would often meet criteria for civil commitment. Put differently, if they are too dangerous to be out with others and their dangerousness is due to mental illness, this is almost the definition of meeting criteria for civil commitment. There are 45 of these moderate-severe and severe administrative segregation patients in the system.

While some form of limitation (external control) is necessary for some patients, owing to their agitation or propensity for violence related to mental illness, this needs to be managed more fluidly. There has been some improvement here in that mental health and custody are conjointly and regularly reviewing these cases and are starting to keep a log of their decisions. This needs to be a formal process that is driven by their current status only, absent a legitimate classification issue related to the patient's criminal history, violence history, and other ordinary classification considerations. Patients should also not be placed in segregation for their own protection; the County should not punish patients for being

vulnerable. Other mechanisms need to be developed for those that are vulnerable due to mental illness or cognitive limitations.

The Behavioral Health Indicators from March 2018 included a report on the average number of days at each acuity level for those booked during the month. The average time on each acuity level were about 10 days for all but the acute category, which was 3 days. The distribution was as expected: the vast majority were "none" with progressively fewer as acuity increased.

RU-BHS provided data for February 2018 in the document Behavioral Health Screening, Assessments, & Care Plans showing that 43% on administrative segregation received the required daily follow-ups. One of the associated graphs is cut off but appears to demonstrate for about 40% of those cases missed, it was missed only for one day.

These visits are almost exclusively at cell front; this population continues to receive very limited services and many of them are very ill. These daily cell front visits achieve no clinical end other than ascertaining how debilitated the patient is, which could be done with less than daily check-ins. What is needed is more active treatment, even if in non-contact booths or restrained to program tables. The parties may want to reconsider this aspect of the remedial plan.

Turning to treatment provision generally, the County has continued its drive to use groups as a primary modality of non-pharmacologic treatment. This is an efficient and effective approach.

Groups at CBDC run in the morning and the afternoon. The Recreation Therapist I spoke with reported that clinicians select patients for groups. Groups are reportedly rarely cancelled, and attendance is consistent. The recreation therapy group I saw was well-run and relevant. The Recreation Therapist also provides individual treatment to patients on administrative segregation (which is all done at cell front) and in A pod (the medical unit).

CBDC will soon roll out the "New Directions" chemical dependency group. In addition, CBDC is focusing on doing a better job of meeting timeliness of some types of clinical encounters and on developing treatment plans.

Groups at SCF reportedly run reliably from 0930-1100 and 1300-1430 (confirmed by interviews with staff and patients). Mental health staff select patients for groups depending on need. There are open-ended and curriculum-based groups, but all have a therapeutic function, including some Dialectical Behavior Therapy groups (a modality very appropriate for the severely personality disordered commonly found in correctional settings – Clinical Therapists are receiving important quarterly training on this difficult modality). I attended one group on unit 16 (COLORS – a chemical dependency group), run by two Behavioral Health Specialists; it was well-run and clinically relevant for the patients in attendance but could have gone into more depth.

Group schedules at RPDC were organized by floor. The third floor had six slots available (when listed, they were for an hour and a half) but only three groups of 5-6 running (Criminal and Addictive Behaviors, Anger Management, and "Open Group"). The fourth floor had five group slots available each week but only one group with four patients running (Anger Management). The fifth floor (almost all seriously mentally ill) had nine group slots available each week with seven groups of 5-10 patients running (two sessions of Anger Management, Life Skills, WRAP, Seeking Safety, and three sessions of Rec Therapy). The sixth floor (mixed female population) had thirteen group slots available each week with

nine groups of 5-10 patients running (Criminal and Addictive Thinking, “Open Group,” Anger Management, Life Skills, WRAP, two sessions of Seeking Safety, and three sessions of Rec Therapy).

I attended a WRAP (reentry group) at RPDC. Five patients attended; no restraints were used. Custody (a runner deputy) stood by in the hallway for most of the group. The group was on time and ran almost a full hour. The group was fairly well run and clinically relevant for the participants.

No data are yet available on the dosage of group treatment patients are receiving. Review of records shows that most patients are getting some group exposure, but most are not getting enough to provide significant benefit. Building sufficient capacity will require the planned additional program space and continued efforts to get patients out timely and consistently at group times.

Almost all patients reported meeting with a Clinical Therapist periodically. Though none reported receiving individual therapy (consistent with my medical record reviews), they did feel that the Clinical Therapists were respectful and concerned. Most reported being offered groups; most had very positive reports about the treatment they received in the groups and wished to have more access.

Regarding psychotropic medication management, patients reported regular meetings with psychiatrists and were generally satisfied with their medications as well as the care and attentiveness of the psychiatrists.

There are still no conjoint treatment team meetings where psychiatrists and other mental health providers discuss and formulate treatment plans. Treatment planning remains an area targeted for development; some training and has already begun.

Two Clinical Therapists are now assigned to the DCU. They have recently installed a program table in a designated treatment room and are about to start having individual sessions with patients. This is an important step that will both provide better treatment and make it easier to determine when a patient is capable of managing interpersonal engagement that is necessary to determine readiness for discharge and return to the jail.

Turning to data on treatment provided, the (draft) report Detention Reports Catalog 2017-2018 reports on assessments (these are more complete evaluations than an intake screening) completed by RUHS-BH in the jails. The data are from January and December of 2017, so are reasonably reflective of trend and current status. The methodology is difficult to determine from the report; note that this is the catalog of reports that RUHS-BH is aware has some methodological flaws. The related text speaks to “1,048 bookings between the months of December and January 2017 that were eligible” for assessment. Eligibility for assessment was determined the presence of a Behavioral Health Flag (a manual flag in TechCare indicating an open case; it is not automatically marked based on other information in TechCare) in those admitted for more than 10 hours.

However, a completed assessment is defined as the presence of any assessment within the last year or a new assessment at any time during the current incarceration. This definition does not rise to the level of “thorough assessment” required by the remedial plan. Much can change clinically in a year’s time. It would be reasonable to conduct an abbreviated assessment (update) of any patients having had an assessment within the last year that reports on any important psychosocial changes, community treatment, and current clinical status. It is also not reasonable to count as compliant cases for which there is an assessment at any time following admission or after identification of a potential case

following admission, regardless how much later after identifying the need it was done. Assessments should be completed promptly (within two weeks) following intake or later identification. There is also no information regarding the completeness or quality of assessments; this could be done through a peer review process or a more formal audit process.

The County also reported on the timeliness of assessments for March and April of 2017, reporting that of 1,424 completed assessments, 73.2% were completed within 14 days, with a slight drop from March to April of uncertain significance. Eligible cases included those with new assessments or updates but not those with existing assessments. It is difficult to reconcile the number of assessments in these two months with those in January and December, especially since the latter included those who had assessments within the last year and the former did not; that is, the number from January and December should have had more eligible cases. However, here again the methodology is somewhat unclear as in one place the report indicates that the measure examines those "being assessed within 14 days of their booking date" and the methodology note indicates that the time "was calculated from the time the behavioral health flag was placed on an inmate during their current stay." If the latter included patients who had behavioral health flags placed any time after booking, it is possible that this number would be larger.

The CHS CQI meeting minutes from 1/16/18 reported on timeliness of completed RUHS-BH assessments on RPDC unit 6B. 42/72 (58%) had a completed assessment within 14 days of booking (including 5 who had an assessment during the previous year). Only 5 (7%) did not have an assessment.

RU-BHS also provided data for February 2018 in the document Behavioral Health Screening, Assessments, & Care Plans. The methodology for the report is not completely shown, but it appears to be the number of open cases that had an assessment in the record. In February, there were 899 open cases with an assessment. As noted above, there were 1581 total open cases on 3/1/18 so about 899/1581 = 57% had assessments, with RPDC having less than 50%. It is not clear how recently an assessment had to be to be considered compliant for this report. This data appears to show a substantial drop in completion percentage from December 2017. Whether this reflects differences in methodology, a real drop in completion, or some combination is not clear. The March report indicates that there were 429 inmates booked in March with a behavioral health flag who remained in custody for more than 14 days. Of these, 318 (74.1%) "received an assessment." The data varied from a low of 60.9% at SCF to a high of 85.4% at CBDC. The majority of cases came from RPDC where 73% had assessments. 237/318 (74.5%) were completed within 14 days of booking.

Given that there are about 60,000 bookings per year and about half stay for more than one day, about (30,000/12) = 2500, then that the expected prevalence of serious mental illness is about 20%, 2500 * .2 = 500 is the expected number of assessments for one month, so the data are in line with expected numbers. The methodology for March 2018 appears sound and likely reflects the County's performance. While not outstanding, it is solid and likely reflects improvement, though it is difficult to be sure given changes in methodology.

The (draft) report Detention Reports Catalog 2017-2018 also included data on RUHS-BH care plans (treatment plans) for March and April 2017. The eligible cases for this were also 1, 424 (likely the same cases as reported for timeliness of assessments). This element indicates that the 1,424 eligible cases were reportedly identified as follows: "The overall number of bookings was calculated for inmates with a behavioral health flag, and who remained in custody for more than 10 hours." This would seem to

indicate that the first criterion applied was the presence of a behavioral health flag and then of these how many had been admitted for more than 10 hours. Of these, 56% had a current care plan. An active care plan was defined as having an active care plan within the previous year or a care completed at any time since admission.

As with assessments, this is not an adequate measure, but again RUHS-BH is aware of the limitations. As with assessments, care plans done within the past year need only be updated but must reflect the patient's current clinical needs, which often are substantially different upon admission. Also, a care plan should be done proximate to an assessment when the assessment indicates the need for a care plan.

On the other hand, the definition of eligible cases is also over-inclusive. It is unreasonable to expect a care plan to be completed on patients in jail for less than two weeks (the time it takes to complete an assessment and have a first psychiatric visit upon which the care plan should be based) or who have likely stays less than a month; patients with shorter stays may be managed without a care plan through crisis stabilization, support services, medication management, and reentry planning. Further, care plans of those in residential treatment units should be far more extensive than those in general population who are receiving primarily medication and support services. The latter need only a brief care plan specifying the degree of medication support services or case management needed by the patient and, for those few needing group or individual therapy, a brief explanation of the type(s) of therapy and goal(s) of therapy.

The County reported on the timeliness of care plans for January and December of 2017 as well. In these months, of 637 care plans developed, 417 (65.5%) were within 14 days of booking with a slight improvement in December. RPDC was notably below the other facilities, which is of concern given the acuity and numbers of mentally ill there. Note that here also, the language was unclear about exactly when the cases were drawn from ("between the months of December and January") but appear to be for those two months individually.

These figures likely represent a limited picture of the care planning process for 2017. The timeliness data is likely a more accurate reflection of reality than the completed care plan data. It is also difficult to get a picture of any trends due to the limited data points and stale data, but it appears the County is making some progress on timeliness of care plans.

The county also provided data on care plans from March 2018. These data report on the same 429 eligible cases for assessments from that month; 300/429 (69.9%) of those admitted that month who had a behavioral health flag had a care plan. 166 of those were at RPDC where 70% had care plans. The low was at SCF (53.1%) and the high at CBCD (82%). Of the 300 done, 214 (71.3%) were done within 14 days of booking. There was some variation between facilities, but all were above 60%. The methodology for this report is reasonable so the data are likely an accurate representation of practice.

RU-BHS also provided data for February 2018 on face-to-face psychiatric encounters (which included non-confidential contacts, presumably mostly at cell front) in the document Behavioral Health Screening, Assessments, & Care Plans. There were 842 contacts, or 842/1581 = .53 contacts/patient-month. Thus, patients are being seen, on average, about once every two months. However, no data were provided on distribution of time between visits. Thus, it is unclear if there are many who are seen much less frequently, which is reasonable provided it is not less than every 90 days.

In accordance with a recent statutory change, RUHS-BH plans to begin use of involuntary antipsychotics in the jails, beginning with use of emergency medications. As there is a new California statute providing for long-term involuntary treatment in the jails, this should be developed as well as it is both clinically indicated and promotes safety of both staff and patients. Further, failure to implement it places the county at risk should there be a bad outcome that could have been averted by use of involuntary medications. RUHS-BH is also started long-acting injectable antipsychotic clinics at RPDC and SCF. These are critical initiatives that should facilitate involuntary medications and the general use of these important medications as well as ensuring their safe administration. The County is to be commended for promptly moving forward on this.

The RUHS-BH report 2017-2018 Detention Reports Catalog includes a report on mental health follow-up of those on administrative segregation. The report shows that for 119 patients 57% of total expected daily visits (1534/2698) were completed, 29.4% received all the required visits. It is not clear for what time period this was conducted. No data on visits within 48 hours of placement on administrative segregation were provided. The Behavioral Health Indicators from March 2018 shoed that there were 122 patients in administrative segregation during that month for a total of 3,026 days (meaning most of the patients were on administrative segregation the whole month). There were 61% (1,857/3,026) of those encounters were completed. The vast majority of lapses were for one or two days, but there were 27 instances of lapses lasting 5 or more days. This was consistent with what I saw in medical record reviews and is likely an accurate representation of practice.

It important to note that the county has taken steps to promote continuity of providers, and thus continuity of care, by continuing to expand the practice of assigning a portion of mental health staff to specific units. Patients are still frequently seen by a variety of different Clinical Therapist and Behavioral Health Specialists, but there has been some reduction in fragmentation.

The County remains in **partial compliance** with the mental health treatment provisions of the Remedial Plan. There has been steady progress; expansion of offerings, continuity of care, and focus on targeting treatment based on patient need are the keys to achieving substantial compliance.

Housing

There have been no significant changes to beds designated as residential mental health units. Collaboration between mental health, custody, and classification on placement continues to be solid. While mental health staff are not uniformly consulted regarding transfers, I continued to see little evidence of inmates without mental illness being housed in residential mental health units. Mental health and custody have regular meetings at RPDC and SCF where housing is discussed; I attended one such meeting at RPDC where patient status and housing were addressed in a collaborative manner.

The most ill patients in the jails are housed at both RPDC and SCF. “Bouncing” of patients back from general population to residential settings has been decreased by mandating mental health supervisor review of level of care (acuity) codes. This has also reduced pressure on clinicians to increase acuity codes to force movement of inmates with behavioral problems but without significant mental health needs.

Transfer of the mentally ill in residential mental health units to other facilities is being tracked by RCSD. The data from December 2017 and January 2018 provided by RCSD showed transfers from RPDC and SCF. In all cases, mental health was consulted (the mental health clinician’s name is noted in the data

set). There were only two transfers out of 208 that mental disapproved. One, a patient on administrative segregation, was overridden by RCSD and moved from RPDC to SCF. The other was a patient slated to release from SCF; the transfer to RPDC was halted.

The progressive step-down on unit 16 at SCF continues to function well in terms of effectively sorting patients by the seven-level acuity scheme (level of care); mental health staff review group participation, medication adherence, and tenure on the unit when deciding who to stepdown, which is ultimately decided by the Senior Clinical Therapist who then works with custody and classification to effect the transfer. Staff report that violence has not been a significant problem over recent months at SCF. Placement decisions are reviewed by senior clinicians every two months to insure fidelity of decision-making. The special settings on 12A (GP) and 14G (PC) for gang dropouts and stepdown from unit 16 continue to function; though patients complain that they have no access to mental health groups and limited access to other programs, they appreciate being in a setting where they can continue taking medication without fear of gang reprisal.

In my opinion, this element is now in **substantial compliance**.

Treatment Space

While runners for mental health have been augmented or restored, it is important to note that no new custody positions have been added. It will be important to assure the sustainability of these runners provide consistent access to the treatment spaces, whether programming spaces, the clinic, or required escorts to interview rooms. This is an essential custody function without which access to care is undermined or safety compromised. The need for runners is likely to increase as treatment spaces are developed and full access to care becomes possible.

There are now four medical and four mental health runners at SCF. Mental health staff report that they are consistently available and facilitate access to treatment spaces and movement to the clinic. Having the program rooms available again has also reduced competition for the non-contact booths in intake, facilitating both the intake process and treatment.

The plan to augment treatment space at RPDC is still in place and construction has begun on the seventh floor. At SCF, the plans for a new healthcare building are moving forward (construction has begun) as are the plans to convert space near the residential treatment unit (Unit 16) to augment interview space there. Plans continue to be in place to improve intake at CBDC, but construction has not begun. But there has been no significant increase in treatment space yet.

The new electronic locks for program spaces have reportedly been functioning well, including tests of the fobs that mental health staff use to open the doors themselves during emergencies (there have been no actual emergencies). To facilitate movement, mental health staff primarily use their radios to contact custody who reportedly responds promptly and has been able to facilitate almost all scheduled groups. With the new electronic door locks, most treatment spaces have been restored to use.

However, at CBDC, only three of the seven available program rooms have been allowed to be used for patient contacts for the last few weeks (units B, C, and D); the reason for this is not clear as the rooms are reportedly not otherwise being used. While they are not optimal rooms for programming, they could be used for at least individual meetings. The newly purchased program tables (tables facilitating activities and having the option to restrain to the table) have been placed in the three program rooms in

use and have been functioning as expected. Patients are being uniformly restrained when in these program rooms, though it is not clear why. Patients on the other CBDC units must be seen in the upstairs non-contact attorney booths which mental health accesses by going outside security; custody has been sending a series of patients to reduce the need for mental health staff to have to move back and forth through security, but this is still impeding access to care and reducing productivity.

Groups are run only in the law library and recreation yards at CBDC. This limits the number of groups that can be run, though currently, mental health leadership is satisfied with the number of groups available for the population currently at CBDC. Given that the acuity at CBDC is kept low, this is probably reasonable.

Treatment space remains tight at RPDC. Psychiatrists continue to meet with patients in the non-contact booths. They report some improvement in having patients brought to the booths by the runners and that custody is almost never refusing to bring patients out. Seeing patients in booths also impairs clinical work for a variety of reasons, including inability to conduct a physical examination. Despite these efforts, psychiatrists still must visit patients at cell front about 25% of the time owing to lack of an available booth; this has especially been a problem on 5A. Having to move around the facility to see patients also reduces their productivity.

The lack of space for groups at RPDC continues to limit the number of group offerings, though scheduling of the group room has improved, allowing a few more groups and limiting conflicts with other services.

The County is clearly taking reasonable steps to expand treatment space, except for not using program rooms at CBDC, though programming requirements there are less than at SCF and RPDC. The general provisions for treatment space meet **partial compliance** and will almost certainly be substantially compliant once construction is done and the new spaces put into use.

Suicide Prevention

I inspected safety cells at all three facilities. Those that were occupied had logs posted at the door that were complete. Safety cells at CBDC and SCF were clean except the vents. Those at RPDC were not clean though were not grossly malodorous or feces smeared.

Staff and patients report that most safety cell assessments are not being done at cell front, an important improvement.

I observed a Clinical Therapist conducting a safety cell assessment of a patient just jailed. The assessment was conducted in a non-contact booth. The Clinical Therapist did an excellent job of quickly establishing rapport and then assessing the patient's clinical condition and risk and protective factors, finally developing a sound plan with the patient's participation.

In one instance, a male patient was left naked in a safety cell pending obtaining a safety gown (see Appendix 1). The initial safety cell assessment was not completed as the patient was naked; this was at least two hours after a note indicating placement in the safety cell. This is not reasonable.

Policy and procedure for step-down from safety cells is not yet implemented. Mental health is not yet involved in setting the conditions of confinement in safety cells, but this is reportedly still to be part of the impending plan; RUHS-BH and custody are working jointly on how to operationalize this process and

policy is pending. The Remedial Plan species that policy and procedures for a step-down program were to be in place one month after issuance of the Consent Decree. The specific language is:

> "Within one month of the date of the Consent Decree is issued by the Court, the County shall develop and implement policies and procedures to allow step-downs for inmates placed in safety cells because of potentially self-harming behavior. The step-down program shall gradually add property in privileges and programming consistent with clinical assessment of a [sic] inmate's condition, with the intent to minimize the time spent in the safety cells under conditions of total deprivation of property and programming."

For the present, the provision for seclusion to last no more than 12 hours has been operationalized by defining seclusion as placement in a safety cell with no more than a smock, safety blanket, and mattress. The County cannot yet provide data on this in the jails or in DCU. Adherence will also be difficult to ascertain through auditing as the information will be difficult to obtain from records and inspection will not provide sufficient information. At present, many of those placed in safety cells would qualify as being in seclusion under this definition; implementation of the step-down process must address this issue.

I saw no evidence of patients staying in safety cells for longer than 48 hours; most of those who approached that time were committed to the DCU. Nursing checks of those in safety cells were very inconsistent both in terms of timeliness and completeness.

The County endeavors to have patients released from safety cells followed-up for five consecutive days; this is not a requirement of the remedial plan. The RUHS-BH report 2017-2018 Detention Reports Catalog includes a report from March 2017 on the percentage receiving all five. Of 95 released from safety cells, one (1%) received all five (or had a note indicating no follow-up was necessary). By this report, none of the 95 received any services, which is highly unlikely. It is unclear what this report means; it may be that the type of TechCare notes counted do not capture safety cell follow-up.

RU-BHS also provided data for February 2018 in the document Behavioral Health Screening, Assessments, & Care Plans showing 51% of patient receiving all five transitional follow-ups, though about 25% received no follow-up. The Behavioral Health Indicators from March 2018 showed that of 227 safety cell discharges, 78 (34%) received five consecutive visits. 75% received some transitional services with over half receiving 4 or 5 visits. Of those whose records I reviewed, most received some follow-ups but rarely received them on five consecutive days. Though this is not a formal indicator in the remedial plan, this practice and the improvements in the data are clear indicators that the county is making substantial and sound efforts to respond to patients at risk of self-harm. Expanding structured treatment, especially for a subset of this population, would help reduce the number of crises and provide more appropriate overall treatment.

The County provided data from RCSD reporting on the number of notifications to mental health for inmates receiving sentences longer than 15 years. Only one month was below 90% and for the year, 95% of notifications were made. Mental health staff noted no issues with these notifications, so this is likely accurate.

Here again the County remains in **partial compliance.**

Restraint

Use of the emergency restraint chair continues to be rare, though I did not receive any data on restraint usage. The restraint chairs were uniformly clean and operational.

I saw evidence of two patients being restrained in the medical record. One was only in restraints during transport, so no healthcare interventions would have been expected. The other was evaluated by mental health, but the note indicates that the patient was to remain in restraint "per custody." There was no indication of collaborative decision-making. The patient was seen by nursing while in restraint but there was no documentation of appropriate physical assessment. Logs were not available in the record to verify continuous monitoring or other interventions.

There was no information on DCU restraint usage.

The data are too limited to make a rating.

Continuity of Care

Since the reorganization mentioned in my last report, the county has continued to develop reentry services. Reentry services were much more commonly documented in the medical records of more recently released patients. Reentry groups (mentioned above in the section Treatment) continue, but individual contacts were much more ubiquitous as well.

Reentry specialists (who are BHSs) & peers from community AB109 clinics were doing a 90-120 minute group every other week with jail MH staff for identified patients whose acuity rating is moderate or more severe (not just AB109) within 40 days of release. This has been put on hold owing to a demand that those entering have background checks. While the County is free to exclude peer counselors, it is important to note that other systems have effectively used peer counselors both to augment resources and to "legitimize" the activities of staff (or in this case, the value of community resources) in the eyes of the incarcerated. Jail mental health staff identified those who need such services beforehand using a 30-question screening in ELMR.

Another approach the County has taken is using AB109 clinics for all jail reentry, primarily to take advantage of existing infrastructure.

Psychiatrists report that they are being notified of impending releases more reliably and are ordering 30-day supplies of medication. However, some patient are still leaving jail without release medications.

The Behavioral Health Indicators from March 2018 showed that of 288 patients with a behavioral health flag that were released that month, 43.1% were offered discharge planning. The percentage varied from a low of 28.6% at RPDC (who had about half the discharges) to 63.9% at CBDC.

Here again, the County remains in **partial compliance** and is taking appropriate steps to build out these services.

POLICIES AND PROCEDURES

I was not provided with any new or updated policies since my previous report. The issues raised remain to be addressed.

As I have been told that many are being modified, I will continue to rate this as in **partial compliance** at this time.

CONSENT DECREE TRAINING

The County was previously rated as in **substantial compliance** for this component.

This concludes my second semi-annual self-assessment. In my opinion, the County continues to make progress towards meeting the requirements of the Remedial Plan. The County has achieved substantial compliance in three areas (contingent on production of a modified policy for one), is in partial compliance on 12 (with a few of those nearing substantial compliance), and one being reduced to non-compliance. The latter is the Staffing component; the failure to achieve 90% of positions filled and the lack of the required report mandate reduction to non-compliance. However, both may be achievable prior to my next report.

Respectfully submitted,

Bruce C. Gage, M.D.

APPENDIX 1

I was unable to access scanned documents embedded in the EHR. I sought assistance, but this was not resolved.

20180855

I interviewed this patient at SCF 2/21/18. It was clear that he suffered from a psychotic illness. He told me that he had been offered groups but has not availed himself of them. He reported having been in the safety cell at the time of admission because he was feeling suicidal and depressed. He reported regular contacts with psychiatry and periodic contacts with a counselor but wish to have more individual contact.

Medical Record Review

The patient was booked into RPDC on 1/7/18, three days after being leased from jail. The arresting officer report noted that he was under the influence of drugs or alcohol but was otherwise negative. The medical screening showed that he was taking olanzapine, reportedly taking the last dose four days before. It also indicated diagnosis of schizophrenia and that he denied suicidal or homicidal ideation.

Patient had a mental health screening approximately 13 hours later after he had been placed in a safety cell following expressions of suicidal ideation during the classification interview. The patient reported a high degree of depression and stated that he wanted "to hurt someone real bad." He reported a suicide attempt by overdose prior to his arrest and a previous history of cutting was noted. He was noted to be disoriented and confused. Medical records show past psychiatric hospitalizations in 2015. Despite the screening noting that he had been taking olanzapine during the previous incarceration, the screener marked that he was not on current psychotropic medication. His level of care was designated as acute.

There is no evidence that the overdose was further characterized or evaluated. The medical screening indicated that he had ingested methamphetamine and heroin and "came to medical office diaphoretic, irritable, restless, dilated pupils." His pulse was elevated at 122 but his blood pressure was within normal limits.

He was seen later that day by a psychiatrist in a face-to-face interview. He was noted to be depressed and angry with labile mood. He reported auditory hallucinations but now had no thoughts of harming himself and others. No delusions or thought disorder were found, though he exhibited obsessions/preoccupations. Though he had been on olanzapine previously, he was started on ziprasidone.

He was seen about every four hours while in the safety cell and received sound evaluations. Once he had sobered, the Clinical Therapist provided appropriate supportive therapy in suicide assessment. He was released from the safety cell about 24 hours after booking. He was changed to moderately severe level of care placed

While in the safety cell, he was seen by a nurse at the time of placement, five hours later, and 11 hours after that. He was then released from the safety cell.

He refused two doses of medications over the following 24 hours. He was seen daily for transitional care following safety cell placement except the second day was missed; this was around the time of his transfer from RPDC to SCF. Notes reflected a good balance of assessment and supportive therapy. There was a cursory treatment plan that consisted in the goal of reducing auditory hallucinations from seven days a week to four days per week; this is a goal that makes no sense given the nature of hallucinatory symptoms which do not come and go that way.

He was seen by a psychiatrist on 1/20/18. He continued to have auditory hallucinations, insomnia and depression. The psychiatrist added mirtazapine and continued the low dose of ziprasidone 20 mg twice daily.

He was transferred again on 2/6/18 then seen by a Clinical Therapist on 2/12/18. This was a brief visit that reported continued auditory hallucinations and depression. Limited supportive interventions were offered. The plan was to enroll him in a dialectical behavior therapy (DBT) group.

He was transferred again on 2/15/18.

He was next seen by a psychiatrist on 3/10/18. The psychiatrist reported decreased depression but did not comment on psychotic symptoms. It also stated “no AIMS change,” though it is uncertain what this means, and “no labs indicated.” However, no labs had ever been done and were in fact indicated.

A Clinical Therapist saw him on 3/15/18 and did a brief assessment. There is no evidence that any therapeutic services were rendered.

On 3/17/18, he was step down from SCF unit 16 to a medication support bed on SCF unit 14 G and the security code was changed to moderate. His last mental health contact before release on 4/6/18 was a “wellness check” by a Behavioral Health Specialist on 3/27/18. There was no evidence of reentry planning.

The patient never received any group therapy and other than the initial supportive therapy, received no individual therapy. However, it appears that he improved with medications and was monitored reasonably regularly.

201505914

I interviewed this patient at SCF 2/21/18. He showed evidence of a cluster B personality disorder, likely response to complex trauma. I did not see evidence of major mental illness he had many complaints. He claimed that he had not been evaluated but did say that he had refused medications.

Medical Record Review

The patient was booked into Indio on 2/13/18. During medical screening, the patient reported having bipolar disorder and depression and was on olanzapine and fluoxetine. He denied suicidal ideation but reported having been at Telecare two days previously; he would not answer questions about past suicide attempts. He reportedly denied any substance problems or use. He was screened by mental health four hours later, reportedly telling the Clinical Therapist that he had used methamphetamine. He was partially cooperative with the intake, still not wanting to speak about his history of suicide attempts. He flooded his cell and was banging on the cell door and exhibiting agitation and mood lability. He was responding to internal stimuli. He was found to have a level of care of severe and was placed in mental health housing after transfer to SCF2/14/18. He was seen the following day by the Clinical Therapist and continued to be largely uncooperative. He was referred urgently to a psychiatrist. The Clinical Therapist documented an extensive mental health history with various diagnoses including schizoaffective disorder, bipolar disorder, schizophrenia. He had been released from San Bernardino community Hospital on 1/26/18. The treatment goal was to "participate in behavioral health treatment and will be able to identify at three behavioral health symptoms over the next 12 months." While the goal to participate in treatment was important, the real issue was to develop the treatment alliance with the patient. Identifying three symptoms over 12 months is a meaningless goal.

He was next seen by a Clinical Therapist on 2/22/18. At that time, he was seen in relation to a possible PREA incident. He was initially possible and was agitated. He continued to refuse mental health treatment (and asked for transfer to GP) but admitted that he was having hallucinations. The Clinical Therapist use de-escalation techniques the patient was able to calm down enough and did not require safety cell placement. He continued to be agitated and uncooperative and was transferred the following day to RPDC where he remained in mental health housing.

He was seen by a Clinical Therapist on 2/26/18. He reported hallucinations but did not show any other evidence of psychosis. The plan was to follow-up in a week, see a psychiatrist on 3/5/18, and refer to the Behavioral Health Specialist for services. He initially refused group services and later agreed to start the group seeking safety but left the first group after just a few minutes.

He was not seen by a psychiatrist, or started on psychotropic medications, until 3/2/18 and was at that time started on risperidone, mirtazapine, and olanzapine, all at reasonable starting doses. However, appropriate laboratory studies for monitoring metabolic syndrome were not done. When seen in regular follow-up by the psychiatrist, the psychiatrist noted that he was responding well to medications and initially reported he was 100% adherent to medications but in fact the patient regularly refused medications though took most. The psychiatrist later noted that he exhibited "good compliance for the most part."

The patient continued to be resistant to treatment other than medications and clearly wanted medications for nighttime sedation primarily. He slowly became less hostile and belligerent and ultimately was transferred to a lower level of care and moved into a general population setting.

This patient was largely uncooperative with treatment other than medications, which he was only partially adherent to. Mental health staff attempted to engage him but ultimately ended up primarily responding to his urgent requests and misbehavior. It is likely that a structured behavior management plan would've been the most appropriate intervention for this patient.

2017100713580821

I interviewed this patient at SCF on 2/21/18. He had a clear psychotic disorder with active delusions and thought disorder. He told me that he was now taking his medications and attending some groups. He made reference to harming cellmates while at RPDC. While he complained about not having one to one meetings except for occasional check ins, he also said that he did not like to speak to staff because "their time dilation is different."

Medical Record Review

The patient was booked into RPDC on 10/7/17. He denied all problems on the medical intake screening. He was uncooperative with the mental health screening, but the Clinical Therapist rated him as moderately severe based on his history in ELMR and JIMS (electronic medical record and custody database). He had past diagnoses of schizoaffective disorder and schizophrenia. No medication information was included.

In the ensuing days he was screened for involvement in recreation therapy.

He was first seen by a psychiatrist on 10/21/17. The psychiatrist found that the patient had auditory hallucinations and depressed mood. He diagnosed schizoaffective disorder, depressed type started the patient on olanzapine 10 mg and sertraline 50 mg, medications the patient had taken previously. No delusions or thought disorder were identified. The psychiatrist also noted that the patient had cognitive limitations and was likely borderline intellectual functioning.

There were no laboratories for monitoring metabolic syndrome in the record but an AIMS was done which was zero.

Subsequent charting reveals that the patient was thought disordered and delusional. He had periodic placements in safety cells, primarily owing to agitation and disagreements with cellmates.

The patient was seen weekly for individual recreation therapy and nearly weekly by a Clinical Therapist until transferring to SCF on 12/18/17. The sessions addressed appropriate clinical issues, primarily development of coping skills such as relaxation techniques and anger management skills. They also addressed medication adherence.

The day prior to the transfer he had been placed in a safety cell owing to threats to his cellmate related to his cellmate's poor hygiene and other complaints. However, he was not seen for an assessment for almost 12 hours with notes indicating that custody was not able to get the patient out of the safety cell for assessment.

The first two days of transitional appointments were not completed, reportedly because the patient was "awaiting housing." Following the final three transitional meetings, the patient was not seen again until 1/1/18 when he was again placed in a safety cell after refusing to go back to sell from yard, complaining that the error in his cell had been cut off and that he could not breathe. He had been nonadherent with medications in the interim period. He was agitated, thought disordered, and paranoid. He was seen the following day by a psychiatrist and agreed to take aripiprazole and bust around instead of olanzapine. The sertraline was continued. He remained in the safety cell for just short of 48 hours he had regular checks by mental health and nursing.

The patient continued to refuse most medications. On 1/5/18, a treatment plan targeted his repeated safety cell placements. The interventions were generic and lacked clear short-term treatment target. The basic plan was to attend individual sessions and groups, though some specific skills were named. However, there was nothing regarding his psychotic symptoms, his lack of insight, and his medication nonadherence. In short, the treatment plan did not address the immediate and important issues leading to safety cell placement.

Subsequent charting shows that the patient was seen regularly by Clinical Therapists, though primarily at cell front following medication refusal. He had occasional one to one meetings that reflected some limited attention to development of skills. He was enrolled in a group and had weekly groups through February and then single groups in March and April. The groups addressed relevant topic issues.

He continued to refuse aripiprazole on the Swiss later stopped. He was continued on sertraline and buspirone.

He stabilized to a substantial degree after an initial rocky. Following is transferred to SCF.

This patient received a reasonable degree of contact an individual and group sessions. A motivational interviewing strategy might have been more effective, but he was ultimately stabilized and the supportive and group therapy provided was reasonably sound. The medications he was prescribed were reasonable, however he did not get proper laboratory monitoring.

201804547

I met this patient on 2/21/18 at SCF. He was somewhat hyperactive and thought disordered and appeared to be responding to internal stimuli. He had some odd and likely delusional ideas about symptoms that he was having being related to an ear surgery that he had when he was 17 years old. He spoke about going into a safety cell after expressing suicidal ideation but related that the true reason was that he was afraid of his cellmate reportedly said he would hit the patient. He stated he had been in no groups and could not call seeing a therapist.

<u>Medical Record Review</u>

The patient was booked into RPDC on 2/3/18. The initial medical screening was completely negative. During the mental health screening an hour and a half later, the patient denied

symptoms but was noted to be responding to internal stimuli and to be expressing delusional and paranoid ideation. He denied having treatment on the outside except for being hospitalized. He was categorized as severe and placed in a safety cell.

He was seen the following day by a psychiatrist who noted that he had been "yelling in the holding cell naked responding to [internal stimuli]." He was diagnosed as having an acute manic episode and started on olanzapine 20 mg, trazodone 100 mg, and valproic acid 500 mg starting dose.

He remained in the safety cell for almost 48 hours during which time he received involuntary medications to do his agitation. Mental health staff attempted to meet with the patient regularly, but he generally refused to refuse to come out of the safety cell. As he came up on the 48-hour mark, he finally came out and met with the Clinical Therapist. The Clinical Therapist discussed possible civil commitment with the supervisor and ultimately decided not to commit him. While the safety cell he had nursing checks almost every 12 hours but some were missed or late.

His treatment plan goals were to "reduce symptoms of anxiety from seven days per week to three days per week in a 12 month period" and "reduce symptoms of psychosis from seven days per week to three days per week and a 12 month period." Again, these goals make no sense given the nature of the symptoms; they do not come and go during a week in the manner suggested.

He was seen essentially every day for the following week, though usually at cell front because of his refusal to come out. He continued to show evidence of psychosis. He was again placed in the safety cell on 2/16/18 released the following day.

It appears that on 2/17/18, he was transferred to SCF.

The patient refused laboratory testing; an AIMS from 2/17/18 was zero.

For the remainder of his stay until discharge on 3/7/18, he was largely uncooperative with treatment. Clinical Therapists made regular attempts to speak with him which he would refuse. They came to the cell front to do welfare checks an attempt to engage him with little success. He was also largely nonadherent with medications. He remains psychotic. There is no evidence of any release planning in the record. There is no evidence he was assessed for possible civil commitment at the time of his release though all indications suggest that he remained floridly psychotic.

201803768

I met this patient on 2/21/18 at SCF. He showed evidence of thought disorder, mood lability and was at times tearful. He stated he had a history of Bipolar II Disorder and was in the Full Service Program. He complained that deputies were not helping him get a new PIN to make phone calls and reported that he had seen deputies mistreating another patient but did not know the patient's name. He also stated that he had been seen by psychiatry twice and buy a Clinical Therapist once.

Medical Record Review

He was booked into jail on 1/29/18. During the receiving screening by the nurse, he reported being on long-acting injectable Abilify and being in the Full Service Program for mental health in the community. He also reported that he had stabbed himself in the arm two months earlier. He was seen about seven hours later by mental health. The Clinical Therapist noted that he had multiple suicide attempts and chronic suicidal ideation as well as a strong family history of suicide. His community treatment was confirmed as well as an extensive hospitalization history. He was delusional and reported auditory hallucinations, both of the persecutor nature. His level of care was rated as severe.

He was not started on medications until 2/5/18, at which time he was put on Abilify, hydroxyzine, and trazodone. Appropriate labs were ordered, however there was no AIMS done.

On that date he had both a psychiatric visit and an assessment by a Clinical Therapist. His primary symptoms were paranoid psychosis, auditory hallucinations, and mood lability. A treatment plan from 2/6/18 demonstrated the intention to provide both individual therapy to focus on skill development, with a focus on Dialectical Behavior Therapy tools. On 2/7/18, he was given some worksheets for coping skills. He was next seen on 2/15/18 by the Clinical Therapist for a brief check-in. He had an individual therapy session on 2/20/18 that addressed appropriate issues. He was seen the following day by a Behavioral Health Specialists and also attended his first Dialectical Behavior Therapy group.

On 2/24/18, the patient received a six-year sentence and was closely followed by mental health provided appropriate support. He refused some sessions but mental health made a point of seeking him out and making sure he was doing alright given his history of self harm. He was transferred to prison on 3/1/18. A release summary from that day does not cover mental health issues and was therefore inadequate.

Other than getting medications later than he should have, care for this patient was reasonable and targeted his needs adequately.

201803602

I interviewed this patient at SCF on 2/21/18. At that time, he had no overt psychotic symptoms but did express some unusual ideas about spiritual realms and premonitions. He complained of fragmented sleep but had no other mental health complaints. He stated he had been seen twice by a Clinical Therapist. He noted that he had been to the emergency treatment center several times and described problems with methamphetamine use. He had been a forklift driver.

Medical Record Review

The patient was booked on 1/28/18. There was no arresting officer information in the receiving screening, though he was said to have been escorted by the arresting officer to the screening. The patient reportedly denied all medical and mental health problems, reporting being on no medications. He had a mental health screening about eight hours later. He was largely

uncooperative with the screening, though did report being depressed. He was noted to be irritable and angry and his history of hospitalization and emergency services as well as past safety cell placements were noted. He was categorized as level of care moderately severe and was placed in SCF HU16.

A Clinical Therapist did a mental health assessment on 2/2/18. There were good mental health and substance abuse histories, but the psychosocial history was very limited. He was noted to be irritable, logical, paranoid, and grandiose. He was referred to psychiatry. The treatment plan was done that same day and is very generic.

He was seen by a psychiatrist on 2/22/18 who noted that he had some ideas of reference and possible auditory hallucinations as well as some depressive symptoms. The psychiatrist started olanzapine and mirtazapine. There were no monitoring labs or AIMS in the record. The patient refused a psychiatric appointment on 3/20/18.

He was seen in individual sessions with a Clinical Therapist on 2/12/18, 2/26/18 (patient refused seen at cell front and given information), 3/19/18,

He attended a discharge planning group on 3/2/18.

The patient also had brief check-ins with a Clinical Therapist, typically during pill call 2/23/18, 3/18/18.

The patient refused an individual contact with Behavioral Health Specialist on 3/29/18.

There were several discharge planning notes in the following days, including arranging for release medications and mental health follow-up. He was released on 4/3/18.

This patient received adequate basic services. He was promptly identified as having mental health needs despite his denials and lack of cooperation. The psychiatrist placed him on reasonable medications, however did not do appropriate monitoring. He received good reentry supports and supportive contacts with mental health when he would agree to the meetings.

201800950

I interviewed this patient at SCF on 2/21/18. At that time, he showed no overt evidence of mental illness but reported flashbacks and reported having PTSD and problems with anger. He reported being seen twice by psychiatry but no individual therapy. He stated he had had groups when on HU16 D but not since moving to A, the lowest acuity pod.

<u>Medical Record Review</u>

The patient was booked on 1/8/18. The receiving screening noted only that he took Zyprexa for bipolar disorder. He had a mental health screening about six hours later and reported taking Zyprexa, trazodone, and Prozac and receiving treatment at a mental health clinic in Banning. The patient also reported having been civilly committed to times three weeks ago following self-harm attempts. He reported auditory hallucinations, but no other psychotic symptoms were noted. He

was rated as moderately severe. There was a mental health assessment from the following day that noted he had not been picking up medications per the batting mental health clinic. There was a reasonable summary of his mental health history including diagnostic considerations. It also noted inconsistency in his reports of history. He was noted to have primarily mood symptoms but also reported continued auditory hallucinations. He was diagnosed as having bipolar disorder and psychosis due to a substance. He was referred to a psychiatrist. There was a generic treatment plan that same day.

He was seen the following day by a psychiatrist who noted that he had delusions of being watched by the United States government. The psychiatrist started olanzapine for psychosis. No mood symptoms or history was included. The note was quite brief. The psychiatrist reported spending 30 minutes with the patient and 20 minutes on documentation. An AIMS from that date was zero; there were no labs for monitoring metabolic syndrome the record. He had psychiatric follow-ups on 2/7/18 and 4/6/18 but refused the latter.

He had an individual session with a Clinical Therapist on 1/17/18. The plan was to enroll the patient in individual and group therapy. He received no individual therapy but had brief individual contacts with mental health.

He attended single sessions of the following groups: life skills on 2/8/18, seeking safety on 2/24/18, discharge planning on 3/2/18, social skills on 3/19/18, and coping skills on 3/19/18. There was no reason given why he was discharged from the life skills group on 2/27/18. He was reportedly discharged from the seeking safety group on 3/2/18 because he had been moved to the top tier and patients from the top and bottom tiers "are unable to be mixed at this time for services." Why he was only in single sessions of the other groups is not indicated.

Prior to discharge on 4/10/18, the patient received several discharge planning contacts. These medications were ordered.

Given that this patient had relatively limited needs, the treatment provided was marginally adequate. However, it is important to note that it is of very limited value for patients to attend single groups for most of the types of groups that he was enrolled in.

201802808

I interviewed this patient at SCF on 2/21/18. At that time, he exhibited no obvious mental health symptoms but described a long history of methamphetamine use, including presently, though reported being clean for five years in the past. He was homeless and had been in and out of jail in prison. He reported having seen the psychiatrist 1 to 2 times in a Clinical Therapist twice. He was going to be starting groups in the next cycle. He reported that he was a trustee.

<u>Medical Record Review</u>

He was booked into jail on 1/22/18. The screening was negative for all medical and mental health problems except that the patient reported actively using methamphetamine. The mental health screening from about eight hours later was very limited and reported only that he was

mildly unkempt and had paranoid/psychotic behavior. Most of the items were completed with "unable to respond." He was rated as moderately severe and targeted to mental health housing. He refused mental health contact on 1/25/18 but had a mental health assessment on 1/31/18. He was more cooperative and reported that he had had some delusional beliefs around the time of his arrest that were felt likely due to methamphetamine use as they were no longer in evidence. Depression and anxiety were identified as the primary problem. The patient reported having been treated with benzodiazepines at the Avalon mental health clinic. A treatment plan from that same day indicated a plan to develop coping skills related to depression and anxiety.

A2/1/18 note indicated that the pharmacy was called for medication verification. The patient had not filled prescriptions for lorazepam, duloxetine, and ibuprofen since November 2017.

He was seen by a psychiatrist on 2/6/18. The psychiatrist noted that the delusional material from around the time of arrest was no longer in evidence and that the patient primarily presented with depressed mood. The psychiatrist started mirtazapine. An AIMS from that day was reported as zero, but it is unclear why it was done as the patient had not been on antipsychotics and was not being ordered antipsychotics. There were no laboratories for monitoring metabolic syndrome, which can occur with mirtazapine, but there is also a notation in the chart that he refused laboratories. He was seen in follow-up on 3/9/18 following submission of a healthcare quest. The psychiatrist added venlafaxine and buspirone to treat ADHD and PTSD symptoms.

He had an individual session with a Clinical Therapist on 2/16/18 where they discussed and practiced coping skills.

He had one session of the coping skills group on 3/22/18 and one session the jail in-reach group on 4/13/18 but was not selected to continue in this group, though the note does not say why.

He had a case management visits with a Behavioral Health Specialist on 3/19/18.

His acuity level was decreased to moderate and he was transferred out of the SCF residential treatment unit HU16 to the stepdown on 12A on 3/23/18. There were no subsequent individual mental health visits until May.

Here again, this patient had a limited mental health needs which were marginally but adequately met. He received appropriate medications, though it is not clear whether or not appropriate laboratory monitoring was ordered.

201748511

I interviewed this patient at SCF on 2/21/18. At that time, he showed no obvious mental health symptoms. He had been in a safety cell in RPDC after expressing a desire to commit suicide by cop. He had a history of heroin use and was homeless. He reported seeing a psychiatrist "occasionally." He did indicate that he had regular follow-up after being released from the safety cell but otherwise had rare contacts with mental health.

Medical Record Review

There are receiving screenings from both 12/19/17 and 12/20/17 at RPDC. Neither report any mental health history or symptoms. There was no mental health screening in the record until 12/26/17. However, he was placed in a safety cell on 12/20/18 after telling deputies "he wanted to hang himself once he got back from court. He stated he wanted to commit suicide by cop." He had also been placed in restraint chair due to becoming combative when leaving court but released upon return to the jail; thus, there was no health care documentation of restraint assessment. The initial safety cell assessment was not completed as the patient was naked and had not yet been given a safety gown; this was two hours after a note indicating placement in the safety cell. Then about eight hours after safety cell placement, the patient refused to meet with mental health. He was finally seen in the noncontact booth the following morning but was largely uncooperative. He continued to express suicidal ideation remained in safety cell. He was largely uncooperative with subsequent attempts to assess him. On 12/22/17 he did cooperate and stated that he was cold and close. Clinical Therapist "reminded client that while in [safety cell] for [danger to self] there are no close, however once client is out of [safety cell] he will be clothed." He continued to be uncooperative and was placed on a 4011.6 then transferred to the DCU.

While in the safety cell he was seen at varying intervals by nursing staff every 4 to 12 hours; the associated forms were completed to varying degrees.

He was returned to RPDC 12/26/17. He had his mental health intake screening done at that point and was rated as severe acuity level. The following day he was transferred to SCF and placed in the residential treatment unit HU16 on the acute, F pod. He was upset about this placement and subsequently brought to noncontact booth on 12/28/17 by deputies. He told Behavioral Health Specialist that he did not want to be on a mental health unit and explained that he was feeling better now that he had been off heroin for a week.

He was seen by a psychiatrist on 1/3/18. Mirtazapine had been started at the DCU and was continued by the psychiatrist. He had a lipid panel done in March 2018 that showed mild abnormalities. He had already been changed to venlafaxine and was subsequently changed to Wellbutrin.

He attended seeking safety regularly through February and March and was also involved in some other groups.

He was periodically disruptive and required crisis contacts, likely related to personality disorder. Mental health staff did a good job of preventing these from deteriorating into substantial use of force or safety cell placements.

In general, the mental health staff did a good job of managing this patient with very disruptive behaviors. They were able to minimize safety cell usage and other negative outcomes both by virtue of engaging the patient in more structured treatment, primarily group, and by appropriate crisis response.

201805831

I interviewed this middle-aged female at RPDC on 2/23/18. At that time, she was floridly psychotic and demonstrated labile mood. It was difficult to get any clear history or reports from her. She did say that she had seen a Clinical Therapist that day and, though she had met with a psychiatrist, did not want to be on any medications. She also reported refusing medications for diabetes.

Medical Record Review

The patient was booked into jail on 2/12/18. The receiving screening done by nursing staff indicated that she reported a history of PTSD and that she had been on Abilify, most recently in 2015. She also reported a remote history of sexual abuse. The checklist notes that she has in recent history of substance use, including benzodiazepines. However, the narrative states that the patient had no drug or alcohol problem mental illness problem. She was noted to be "very talkative, stated that since she came from Canada she does not take her medication." The mental health screening from about 8 hours later indicated that she was delusional, reporting that she was an Indian chief and was on sacred Indian ground. She also reported that she had been electrocuted at a hospital and made other bizarre statements. She denied psychiatric hospitalization, the records demonstrated she had a previous history of hospitalization three times during 2017 and as recently as November 2017 with diagnoses of schizophrenia and bipolar disorder. She exhibited thought disorder and was generally difficult to get a clear history from. She is recommended for mental health housing and was rated as moderately severe and acuity. She was placed on unit 6B in RPDC.

The patient had a mental health assessment on 2/18/18 (she was out at court when previously attempted on 2/15/18). She remained grossly psychotic and largely uncooperative. The Clinical Therapist noted that deputies reported she was eating her meals. She refused diabetic care and medications. The plan was to refer to a psychiatrist. The treatment plan from that date noted her treatment refusal in the intention to continue to offer services and encourage participation in treatment. The Clinical Therapist also made a prayer report to custody staff owing to the patient stating that she had been raped by a police officer in Oklahoma in 2017.

A psychiatrist saw her on 2/21/18. The psychiatrist noted continued florid psychosis and minimal cooperation. The patient continued to refuse medication the plan was for follow-up in 2 to 3 weeks.

The next mental health contact was an attempted visit on 2/27/18, but the patient refused. Clinical Therapist spoke to the nurse reported that her blood sugars, when the patient allowed them to be checked, within normal limits. Follow-ups with a psychiatrist and Clinical Therapist were planned.

The next mental health note is from 3/13/18. In the intervening time the patient was refusing medications. The patient again refused to meet but the Clinical Therapist came to cell front and noted that while her cell was clean, the patient reported that she was not coming out for showers and was refusing all medications, including hypertensive medication she had been taking. The

patient was also refusing blood pressure and blood sugar checks. Her case had been discussed with custody owing to concerns about her well-being.

The patient came out to meet with the Clinical Therapist on 3/18/18. The meeting was in an Atty. booth owing to the absence of mental health runner that day. The patient continued to be floridly psychotic and to refuse treatment. The Clinical Therapist consulted with the supervisor and owing to the fact that the patient reportedly had no overt medical problems and sufficient self-care, no civil commitment was indicated.

On 3/21/18, the patient psychiatrist continued to refuse treatment. On 3/27/18, the patient refused to meet with the Clinical Therapist and the Clinical Therapist was not allowed to go to the cell front due to no escort being available. The Clinical Therapist discussed the case with custody and medical, identifying no urgent problems; the patient had come out to meet with a court appointed mental health professional. The psychiatrist met with her briefly on 4/4/18; the patient again refused medication and, owing to three consecutive refusals, the plan was not to follow up unless needed. A Clinical Therapist again attempted to meet with her on 4/10/18 and was only able to talk briefly with the patient at cell front. The Clinical Therapist noted that the patient was being monitored for grave disability. The patient had continued to refuse any medical checks and all medications.

There were no clinical contacts of any kind until 5/4/18. On that date, the patient again refused to meet but the Behavioral Health Specialist did not go to cell front. A Behavioral Health Specialist had a five-minute telephone call on the pod telephone, asking if the patient was interested in residential substance abuse treatment. The patient stated she was in the plan was to refer her.

On the morning of 5/15/18, the patient was combative with deputies when they asked her to return to her cell in order to respond to them medical emergency elsewhere on the unit. She was placed in restraint chair and in a safety cell at 0425. Per an 0510 mental health note, she was uncooperative with deputy's attempts to do range of motion while in restraint and was to remain in restraints "per custody." Soon thereafter, she became cooperative and was released from restraints at 0549, though remained in the safety cell. There was a nursing assessment at 0518 that states only that the patient was alert and agitated; there is no evidence that vital were attempted (though were done two hours later) or that there was any neurovascular assessment. No logs were available in the EHR to determine whether the patient was on continuous monitoring while in restraints. The patient repeatedly refused to speak with Clinical Therapists who regularly came to the safety cell that day. The patient refused to meet with the psychiatrist that day as well. She also refused her lunch and dinner in only acceptable water on one occasion, despite multiple offers. She finally agreed to meet with a Clinical Therapist shortly before midnight. The Clinical Therapist asked nursing to evaluate the patient, but the patient refused vital signs though did not appear obviously dehydrated. She continued to be overtly psychotic and several hours later was placed on a 4011.6 hold. She was sent to the DCU on 5/16/18.

This seriously mentally ill woman was promptly detected by mental health staff at intake. She was uncooperative and refused treatment. Mental health staff were appropriately concerned about grave disability and generally monitored her reasonably well, though the. Between

meetings was too long and failed to observe her in the cell when she refused to meet. Whether she should have been permitted to essentially isolate in her cell and refuse all medical attention for three months is questionable but a judgment call. There is no evidence that she was a danger to herself or others, perhaps because she was isolated in the cell, or at medical risk; thus, there is no clear evidence that this judgment was in error.

201721704

I interviewed this middle-aged female patient at RPDC on 2/23/18. At that time, she was grossly psychotic. It was difficult to get any clear reports from her, but she did say that she met with mental health staff approximately once per month.

Medical Record Review

The patient was booked into CBDC on 6/7/17. The nursing receiving screen noted only that she was taking vitamins and had problems with anxiety and urinary incontinence "when nervous." She denied medical problems but stated she was menopausal. She had a mental health screening about five hours later during which the patient reported that the "neighbor's house caught on fire and the roof fell down." There were no findings on mental status than that the patient was dirty and disheveled. She was placed in general population within level of care rating of minimal.

The patient was seen the following day by a Clinical Therapist, though the reason was not indicated. She was noted to be on and to have some memory problems, but not to mental health services. However, the patient was placed in a safety cell by custody on 6/11/17 at around 11 PM a nursing note at that time reports "bizarre behavior." She was seen about four hours later by a Clinical Therapist noted that the patient was not oriented and was demonstrating thought blocking. She was talking to herself and responding to internal stimuli. In that note it is reported that she was jailed for arson. A psychiatrist saw him following morning and noted that she was overtly psychotic and started her on risperidone 1 mg. It was a very brief note and concluded that she was "clear to house." She was released from the safety cell on the evening of 6/12/17 and recommended for mental health housing. She was transferred to RPDC, housing unit 6B. she received her transitional services daily following release from the safety cell. While in the safety cell she was seen by nursing staff about every four hours.

She began to refuse medications and mental health services in general. She remained bizarre but was only seen about weekly, in response to deputy referrals related to her bizarre behavior, outbursts, and difficulty getting along with cellmates. She continued to deteriorate was again placed in a safety cell on 7/13/18. On 7/15/18, she was committed to the DCU. Two days later she was returned to RPDC on Zyprexa 10 mg and risperidone 2 mg. She remained disorganized, rambling, incoherent, and delusional.

There was a minimum treatment plan on 7/19/17 that indicated only that the patient would be provided individual therapy and case management. She was soon medication nonadherent and deteriorated further. She was again committed to the DCU on 8/1/17. She was returned on 8/6/17, now on risperidone 1 mg.

Things continued much in this vein through April 2018. She refused medications and services, had episodic safety cell placements primarily due to agitation. She was seen anywhere from every day, following safety cell release, or every one to three weeks. She was entered into the Liberty competency restoration program in January and discharged in March. From the time of her 3/13/18 discharge from the competency restoration program until a release summary from 4/10/18, there are no clinical contacts whatsoever. The release summary does not indicate what the release plan is and includes virtually no information about her mental health condition.

It is likely that this seriously mentally ill should of been detected at receiving screening, but was identified shortly thereafter and appropriately placed in a residential mental health unit. She had to brief DCU hospitalizations with little evidence of improvement. Follow-up for the first several months was reasonable and included efforts to engage her (including offering different types of groups) but towards the end of her stay, the frequency of follow-up deteriorated, especially following her discharge from competency restoration treatment. The release summary is completely inadequate; there is no evidence of release planning and mental health issues were entirely left out, despite being her most serious problem. Note also that it is problematic that interventions and monitoring by Liberty are not included in the medical record, making the monitoring and evaluation of the adequacy of her treatment difficult to assess during the time they were involved.

2000052910455908

I interviewed this middle-aged male patient on administrative segregation at RPDC on 2/23/18. At that time, he was grossly psychotic and somewhat agitated. He stated he was being held there legally and reported that he was being poisoned. He stated that he had lost 25 pounds. He also stated that he was being forced to take Haldol but then stated he was not taking it and wanted to take Abilify or Geodon. He told me he was waiting to be admitted to Patton State Hospital.

Medical Record Review

The patient was booked into SCF on 6/3/17. The nurse receiving screening notes that he was largely uncooperative and would not reveal medical history but denied any mental health problems. He was placed in the sobering cell overnight, the denied using any drugs and there is no evidence of intoxication in the record. A nurse receiving screen done the following morning noted that he remained uncooperative and was wearing a spit mask. He was reportedly alert and oriented. The health assessment notes no problems and reported that he was appropriate and not in any distress. This assessment also noted that the initial mental health screening had been reviewed, but the patient had not yet been screened by mental health and had been refusing. The mental health screening form noted this refusal but indicated that he stated that he was being falsely held. He was noted to be mildly unkempt and hostile. He was referred to mental health housing, though it is not clear why. A progress note from several hours later has essentially no information in it, though states that records were reviewed.

He was transferred to RPDC 6/6/17. He was seen at that time by a Clinical Therapist and was marginally cooperative. There were no overt findings, though he showed delayed responses. He was placed on the medical floor on 6/13/17. The next attempt to see him was on 6/17/17 at which time he refused contact. He had been refusing all medications and labs, including important infectious disease medications. An attempt to see him the following day was met with an irritable refusal. A psychiatrist came to see him on 6/19/17 and though he refused contact, the psychiatrist came to his medical cell. He continued to be hostile and labile and refuse nor health treatment. The psychiatrist did not comment on his medical treatment refusal. The next attempt to see him was 7/6/17 after a referral from a Hu 5B deputy following the patient threatening custody staff. He was marginally cooperative but felt not to represent a danger to self or others. However, he was noted to be delusional, reporting "they are poisoning my meds and playing with my food."

The patient continued to refuse medications. He refused repeated attempts by mental health staff to interview him and conduct an assessment. He was placed on administrative segregation status on 7/13/17 "due to his threatening behavior towards cellmates." A 7/19/17 note finally reported on his significant mental health history, including contacts with emergency treatment services and hospitalizations for psychotic disorder. At that time his refusal of medical medications was noted as well. However, his competency to refuse was not indicated.

He was released from the medical floor on 7/22/17. Note that during that time, there are no notes from a medical provider despite his medication refusal and serious illness. He was simply allowed to refuse treatment and then discharged from the medical floor.

On 7/24/17, HU 5B deputies referred him to mental health because he was throwing water at them. He was finally coaxed to engage in interview and a noncontact booth. He continued to express the delusion that his food was being tampered with and was hostile and labile. He was placed in a safety cell. He refused to speak to a psychiatrist. He was committed to the DCU later that day on a 4011.6 hold.

He was returned to jail on 8/9/17. He continued to present does psychotic and paranoid. He refused medications and refused most mental health contact. He agreed to see a psychiatrist on 8/18/17 and the psychiatrist changed him to Depakote and Abilify, medications that he had requested previously but had not been given at the DCU. He continued to express paranoid ideas and to refuse medical medications. He was marginally cooperative with attempts to engage him by mental health, those these were almost exclusively at cell front. He also began refusing his psychotropic medications though agreed to start them again seen by a psychiatrist on 8/30/17. Despite this, he continued to refuse medications on a regular basis.

An AIMS was done 10/23/17 and scored as zero.

Things continued in this vein with frequent refusals of contact, refusal of almost all medication, continued paranoid ideation, and ultimately beginning to throw food in the toilet and demanding sack lunches. He was seen every 2 to 5 days throughout the time he was on administrative segregation, though almost all contacts were at cell front.

On 12/1/17, he was finally committed again to the DCU. In addition to refusing treatment and often not eating, wasn't even coming out of his cell. Cell is a mess. He had been gassing deputies as well. A DCU Clinical Therapist note from 12/18/17 reads:

> "Client's 5250 hold has expired and remains [sic] extremely paranoid, believing that he is being poisoned. Client only recently became men compliant [for] three days but, has refused Geodon last three days. DCU [Clinical Therapist] apprised contact liaisons at RPDC regarding client's [discharge] from DCU. DCU summary of care form completed with housing acuity rating; psychiatric [discharge] summary entered into TechCare. Client added to [transitional series] queue. Due to severity of continued paranoia, client should not be placed in holding cell with others. DCU [behavioral health] acuity rating: severe."

Not surprisingly, he continued to refuse treatment and was frequently not eating his meals, complaining that they were poisoned. Contacts continued every 2 to 5 days at cell front. He was once again committed to the DCU on 2/2/18. Documentation demonstrates that he was even more decompensated than he had been previously. The patient was returned to the jail on 2/18/18 with little to no evidence of improvement.

On 2/27/18, a release summary was done. It does not indicate where the patient is going. There is virtually no mental health information. It does not indicate that he has been refusing medications for delusional reasons.

The treatment of this patient was grossly inadequate. Though the intake documentation was poor, he was clearly identified as a mentally ill individual and was promptly placed in a residential treatment unit. However, for the following eight months, this man was allowed to languish essentially in isolation, refusing all treatment, including treatment for an infectious disease that represented a threat to his life. There was no assessment of his competency to refuse. Hospitalizations in the DCU proved no help; this man clearly needed long-term involuntary medication and hospitalization. Though the documentation does not say so, it is likely that he was finally transferred to Patton State Hospital, as he reported to me was pending.

201745991

I interviewed this male patient on administrative segregation at RPDC on 2/23/18. At that time, he was delusional about being a rapper and exhibited thought blocking. He stated that he was waiting for admission to Patton State Hospital. He stated that he saw a psychiatrist about once a month and that mental health would only visit him at morning pill call.

<u>Medical Record Review</u>

This patient was booked into RPDC on 11/30/17. Of note, he had been released a week previously but had not gotten release medications as documented by an 11/29/17 note. The nurse receiving screening noted that he had a mental health history and that he was prescribed Topamax and olanzapine. He had a mental health screening the following morning, though less

than 24 hours from admission. However, he refused to participate. Because of his well-known history including hospitalization at Patton State Hospital and assaultiveness, he was rated as severe. He was placed on administrative segregation. Bridge orders for psychotropic medications were obtained that day. He met briefly with the psychiatrist and agreed to restart his medications. He presented primarily with negative symptoms; no mood or psychotic symptoms were reported. The plan was to start him on Zyprexa, Zoloft, and Artane.

The patient reported suicidal ideation to deputies on 12/6/17 and after a Clinical Therapist assessment was placed in the safety cell. He expressed paranoid delusions as well as suicidal intent. He initially met with Clinical Therapists and gave mixed reports about whether he was having command hallucinations to harm himself. However, he continued to express suicidal ideation. Over the following hours, he refused to come out and was placed on a 4011.6 and committed to the DCU the following day. While in the safety cell, he was not evaluated by nursing staff until he had been in there for almost 24 hours and then was seen every 3 to 8 hours.

He was returned to the jail on 12/14/17.

He remained on administrative segregation through the end of the record in May 2018. There was no evidence of any significant behavioral problems, but he continued to exhibit psychotic symptoms including delusions and thought disorder, though the thought disorder appeared to diminish with time. He also continued to complain of hallucinations but did not seem to be is preoccupied and reported them reducing as well. While his medication adherence was not outstanding, it was sufficient to get a pharmacologic response. He was not seen daily while in administrative segregation but was most often seen daily or every other day with the longest. Being about five days between visits. Mental health staff made repeated efforts to engage him in groups, but he continued to refuse. Clinical Therapists occasionally brought him out for face-to-face visits. He saw a psychiatrist about every month. An AIMS was done 4/23/18 and was scored as zero. Most laboratories were done, however there were no metabolic studies done to monitor for metabolic syndrome though he remained on second generation antipsychotics.

In general, treatment of this patient was sound. Mental health staff monitored him on a regular basis and attempted to engage him in appropriate group treatment. Medication management was appropriate, except for the failure to monitor for metabolic syndrome.

APPENDIX 2

Outline of Quantitative Mental Health Compliance Monitoring

This outline is offered as a proposal. It needs to be reviewed in light of the terms of the remedial plan and modified in accordance to the availability of information. It is based on the mental health elements of an outline submitted in November 2016. Following the outline is a draft of an associated data request to the County. The goal would be to have this done prior to my next site visits in July and August of this year.

Bold text indicates the essential provision of the compliance measure
Red text indicates suggested clarifications, definitions, or additions
Violet text indicates suggested methods for compliance monitoring

Random record identification should be done in advance by the County in most cases because many of the measures will first require pulling a subset of records from which to select the random sample. Note, unless otherwise specified, the pool for data pulls will consist only in inmates admitted for at least one week.

I. Intake MH Screening – changed to reflect 100% screening by MH staff
   a. **Prior to placement** in jail housing (95%) –
      i. Random selection of medical records with booking admissions for previous 6 months and pulling corresponding jail placement time stamp (From JIMS?)
         1. At **Blythe**, done within 14 h when RN not on duty at time of booking (90%) – Random selection of medical records with booking admissions for previous 6 months (if booking time stamp in EHR is accurate)
   b. **Confidential setting for intake** (custody visual supervision allowed) unless security risk (90% of intakes confidential) – direct observation
   c. **MH intake content** (95%) – Random selection of medical records with booking admissions for previous 6 months
      i. Mental health does screening for all patients now; elements to be consistent with initial report (in general terms below):
         1. Mood/affect
            a. Patient report
            b. Observation
         2. Psychosis (including delusions, thought disorder, hallucinations)
            a. Patient report
            b. Observation
         3. Suicide and self-harm
            a. Current SI
            b. Hx self-harm behavior
         4. Current psychotropics
            a. What
            b. Adherence

5. Current MH services (including related services, such as for ID, SA)
6. Current MH complaints
7. Hx of MH services
    a. Inpatient
    b. Outpatient
8. Substance abuse
    a. Current (may be in medical portion)
    b. Past
9. Sexual behavior
    a. History of aggressive sexual behavior
    b. History of sexual victimization
    c. Risk of sexual victimization

ii. Other observations
1. Neurocognitive
    a. Slow speech/lack of comprehension indicative of DD
    b. Level of consciousness
    c. Orientation
2. Self-care
    a. Hygiene
    b. Clothing
3. Behavior
    a. Cooperativeness
    b. Communication
    c. Psychomotor

d. Psychotropics at intake

i. Staff take reasonable **steps to verify current prescriptions by each of the following methods when applicable**
1. Review of RUHS-BH data on Rx verification for previous 6 months
    a. Verify methodology
    b. Spot check random charts of those admitted in the last six months for more than 72 hours
2. Content
    a. County's electronic mental health records (95%)
    b. Call pharmacy (95%)
    c. Call practitioner (95%)
    d. Paper prescriptions provided by inmates or families at booking (95%)

ii. Three options (One occurs 90%) – review of random medical records from previous 6 months where a patient reported taking psychotropic medications prior to arrest during the intake assessment
1. **Seen by a psychiatrist within 24 hours**,
2. **Community meds or meds considered medically necessary by psychiatrist are ordered and offered immediately if in jail stock** – unclear how this would be determined (suggestion?)

3. **If not in jail stock, community meds or meds considered medically necessary by psychiatrist are ordered and offered within 48 hours**

II. Access to Care (note: timelines and completeness set at 90% to correspond to mandated staffing assessment captured under Staffing below)
   a. Inmate healthcare requests
      i. **Health Care Request Forms available** in:
         1. All housing units (95%) – direct observation
         2. All dayrooms (95%) – direct observation
         3. All program rooms (85%) – direct observation
         4. All libraries (85%) – direct observation
      ii. **Locked boxes in all housing units** (95%) – direct observation
         1. **Emptied by nursing staff every 24 h** (90%) –review of random log entries or other tracking system from previous 6 months (proof of practice may have to be developed)
      iii. Sheltered housing
         1. **Health Care Request Forms picked up by healthcare staff directly from inmates every 24 h** (90%) –review of random log entries or other tracking system for previous 6 months (proof of practice may have to be developed)
            a. **Custody may collect if dayroom closed** to healthcare if healthcare observes and receives directly from custody (90%) –review of random log entries or other tracking system for previous 6 months (proof of practice may have to be developed)
      iv. **Health care staff provide writing assistance to inmates** requiring accommodation to complete Health Care Request Forms upon request (90%) – staff and inmate interview
      v. **Health Care Request Form triage by QMHP** for MH requests (95% are triaged by QMHP) – review of RUHS-BH data and methodology; spot check random medical records involving Health Care Request Forms for mental health reasons from previous 6 months (current RUHS-BH data does not clearly specify time of receiving request from nursing or time of QMHP triage)
            a. Within 24 hours if collected from patients by healthcare staff (90%)
            b. Same day if collected from lockbox (90%) – recommend making this 24 hours as well
      vi. **Timeliness of QMHP response following RN referral** or QMHP triage of Health Care Request Form – review of RUHS-BH data and methodology; spot check random medical records involving Health Care Request Forms for mental health reasons from previous 6 months
         1. **Emergent** – immediate unless to ER/hospital (90%)
         2. **Urgent** – within 24 h (90%)
         3. **Clinical Symptom Described** – within 72 hours (90%)
         4. **Routine** – 2 weeks (90%)

vii. County **tracking of Health Care Request Form response** – must be "regular" (quarterly) (y/n) – review of county tracking data and associated CQIP review from the previous 6 months
1. **Collection** of Health Care Request Forms (90% of reviews include)
2. **Triage** of Health Care Request Forms (90% of reviews include)
3. **RN response** times – by review of nursing sick calls (90% of reviews include)
4. **Clinician response** times – by review of clinician sick calls (90% of reviews include)

b. Inmate declared medical or psychiatric emergency (including "man down" call by other inmates)
i. **RN or higher sees inmate or interviews inmate** by telephone ASAP (90%) – review of random medical records involving a patient declared mental health emergency or a "man down" scenario for self-harm behavior during the previous 6 months

c. Policy provides for **clinicians to request follow-up** without requiring inmate Health Care Request Form (y/n) – review of policy

III. Clinical settings (mental health) – direct observation, staff interview, random medical record review of patients on MH case load during previous 6 months

a. In-person
i. **Proper lighting** (99%)
ii. **Medical record access** (95%)
iii. **Confidential setting** unless documented threats, intimidation, or violence towards staff or individual determination including consideration of healthcare request (95% confidential where none of documented problems exist)

b. Telemedicine
i. **Appropriate equipment** (99%)
ii. **Adequate space** (99%)
iii. **Computer records access** (95%)
iv. **Confidential setting** unless documented threats, intimidation, or violence towards staff or individual determination including consideration of healthcare request (95% confidential where none of documented problems exist)

IV. Medication administration and monitoring

a. Pill call – direct observation, staff interview, review of logs
i. **BID pill lines** provided in each housing unit (99%) – direct observation, staff interview, review of logs from the previous 6 months
ii. **Regular times** (within 1 h of designated time 90%) – direct observation, staff interview, review of logs from the previous 6 months
iii. Policies provide **for therapeutically appropriate times as determined by the ordering physician** (y/n) – review of policy
1. Alternate **pill times ordered by physician honor**ed (90%) – review of MAR for psychotropic medications ordered for administration at times other than routine pill times during the

previous 6 months (possible sources include standing orders for QID medications, now/stat orders, LAI clinics)

b. Court medications
   i. Policies and procedures to ensure inmates provided medications at therapeutically appropriate times – review of policy
      1. When **out to court** (y/n)
      2. In **transit** to outside appointments (y/n)
      3. During **transfer** (y/n)
   ii. Medications administered "as close as possible to the regular administration time" (within 2 hours) –review of random records of inmates on medications that have gone out to court, been in transit to an outside appointment, or transferred to another institution during the previous 6 months (proof of practice and/or mechanism to identify cases may need to be developed)
      1. **Staff administered psychotropic medication** (90%)
c. Policies and procedures to ensure **medication side effects and efficacy monitored and reviewed** at appropriate intervals (y/n) – review of policies and procedures
   i. **Medication monitoring is done** per policy (85%) –review of random records of inmates on psychotropic medications during the previous 6 months
d. Prescription filling from pharmacy
   i. Done **by RUMC** (y/n) – review of relevant documentation
   ii. **Filled on all weekdays** (90%) – review relevant pharmacy logs and/or random records of inmates on medications
   iii. Stock medications at jails
      1. **Every jail** (y/n for each) – direct observation, review of logs
      2. **Determined by Medical Director and pharmacy** (y/n) – review of relevant documentation
      3. **Consistent with State Board of Pharmacy regulations** for newly arrived patients or missed deliveries (y/n) – review of relevant documentation
   iv. If ordinary delivery times would compromise care –review of random records of inmates on medications with "stat," "next day," or equivalent orders for psychotropic medications during the previous 6 months
      1. **Staff call RUMC** pharmacy to obtain (90%)
      2. **Medications arrive** the following day (90%)

V. Confidentiality

a. Policies and procedures ensure appropriate confidentiality for health care services – review of policies and procedures, direct observation, staff interview
   i. **Clinical encounters** by QMHP (y/n)
      1. **Confidentiality is provided** (95%)
   ii. **Health care intake screening** by QMHP (y/n)
      1. **Confidentiality is provided** (90%)
   iii. **Pill call** – on residential mental health units (y/n)
      1. **Confidentiality is provided** (95%)

iv. **Provider sick call** by psychiatrists (y/n)
1. **Confidentiality is provided** (95%)
v. **Mental health treatment** during groups (y/n)
1. **Confidentiality is provided** (95%)

b. Custody staff tracking the filing and disposition of grievances
i. Are appropriately **trained** (85%) – review of training materials and training logs
ii. Are subject to the same patient **confidentiality** as health care staff (y/n) – review of policy and confidentiality statements, staff interview

c. Identification of inmates with a mental health need is accessible to appropriate staff on a **need to know** basis (y/n) – direct observation, staff interview

VI. Health Care Records

a. There is an **Electronic Health Record System with medical and mental health information** in a single record within 12 months of the date of the Consent Decree (y/n) – direct observation, staff interview
i. There is policy and procedure to **monitor the deployment of the CHS Electronic Health Records** to ensure the system is modified, maintained, and improved as needed on an ongoing basis including IT support for network infrastructure and end users (y/n) – review of policies and procedures
1. This policy and procedure is **implemented** (y/n) – review of relevant documentation

b. Prior to 12 months:
i. Policies and procedures have been implemented allowing medical and mental health **staff access to medical and mental health information** need to perform their clinical duties (y/n) – review of policies and procedures
1. Medical and mental health staff are **trained** within one month of the Consent Decree (85%) – review of training materials and training logs

VII. Staffing

a. **Staffing is sufficient** to execute the health care components of the Remedial Plan (y/n) – expert assessment

b. Within 12 months of the Consent Decree, 90% of positions in the following categories are filled with staff attending work
i. Exhibit A – or current agreed upon staff positions

c. Healthcare staff provide community standard of care
i. **Mental health** (95% of records, y/n for materials) – review of random medical records for the previous 6 months, review of mental health guidelines, review of manualized treatments, review of mental health group curricula

d. There is an **annual assessment of adequacy of staffing** – review of annual assessment and associated recommendations and corrective action plans, review of positions filled and empty
i. In all categories of medical and mental health (including clinical and support staff) to assure adequacy of services and includes:

1. Provision of **clinical supervision** (y/n)
2. Review of compliance with:
   a. **Chronic care guidelin**es (y/n)
   b. **Sick call triage timelines** (y/n)
   c. **Medication refusal polices** (y/n)
   d. **Delays in prescription renewals** (y/n)
   e. **Daily pill call policies** (y/n)
   f. **Wait times to see nurses and providers** (y/n)
3. If any category is less than 90%, the assessment **reviews hiring and retention and indicates steps** to be taken to fill positions (y/n)
4. Custody staffing is adequate to assist with
   a. **Medication administration** (y/n)
   b. **Movement of inmates to health care services** (y/n)
   c. Custody staff performing these and any other health care functions are **included in the annual assessments** (y/n)

ii. The **assessment is done** (y/n)

iii. The assessment **recommendations are undertaken** (y/n)

1. If any category is less than 80% for three consecutive months, county will take all steps required to **fill vacancies** within 12 months, including, if needed, adjustments to compensation (y/n)
   a. Pending hiring, the county **will fill vacancies with temporary staff** so that the category is higher than 80% within 3 months (y/n)

VIII. Custodial Environment

a. Policies, procedures, and other provisions reflect the intent to provide inmates with as much **dayroom time** as is consistent with institutional safety and security (y/n) – review of policies and procedures

b. Dayroom time

i. **Begins no later than 0800 and ends at 2300** (85%) – review of TITLE 15 or similar logs for the previous 6 months, interview of staff and inmates

1. Timelines exclude individual cell returns, group disturbances, or institutional emergency (unclear how to measure compliance)
   a. **Suspension of dayroom** access shall last only so long as needed to ensure safety and security (85%) (unclear how to verify compliance)

c. Recreation area

i. Inmates are offered recreation area – review of TITLE 15 or similar logs for the previous 6 months, interview of staff and inmates

1. **Twice each week** (85%)
2. Each session is **at least 1.5 h** (85%)
   a. Times exclude institutional emergencies requiring temporary suspension of rec time (unclear how to measure compliance)

b. **Suspension of recreation** access shall last only so long as needed to ensure safety and security (85%) (unclear how to verify compliance)

d. Custody staff are **trained** in identifying inmates who self-isolate (85%) – review of training and training logs
e. Custody staff make referrals to mental health for:
   i. **Self-isolating inmates** (inmates not leaving their cell for 3 consecutive days) (95%) – identify inmates not leaving their cell for 3 consecutive days from TITLE 15 or similar logs for those in residential mental health settings; review associated medical records for evidence of referral. (not clear if this methodology is possible; if not, recommend alternative approaches)
   ii. Those who have recently (3 working days) received **lengthy sentences** (more than 15 years) or a **death sentence** (95%) – review of medical records of random selection of qualifying cases
      1. Within one month of the Consent Decree, there is policy and procedure for this referral (y/n) – review of policies and procedures
f. Inmates are **classified** per the classification policy (y/n?) – review of classification reports
   i. Inmates are not placed in more restrictive custody solely because – direct observation, interviews of staff and inmates, review of records of random selection of cases with qualifying disability on administrative segregation, review of determinations of administrative segregation status
      1. They have a **mental illness** (y/n)
g. Administrative segregation
   i. Inmates on mental health caseload are seen **daily** by mental health staff at Clinical Therapist or higher (85%) – review of medical records of random selection of those in ad seg during the last 6 months that were on the mental health caseload (consider revisiting daily requirement)
   ii. Inmates placed in administrative segregation who are not receiving mental health services are **evaluated** by a Clinical Therapist or higher within 48 hours of housing (95%) – review of medical records of random selection of those placed in ad seg during the last 6 months that were not on the mental health caseload
   iii. Inmates on prescription Rx **receive medications from medical staff at the cell** (y/n) – direct observation, staff and inmate interview
   iv. Inmates who report or demonstrate decompensation or distress are **seen** within 24 hours by an appropriate clinician (95%) – review of random medical records of custody referrals, Health Care Request Forms triaged as urgent/emergent by a QMHP, or inmate declared emergencies during the last 6 months for inmates on administrative segregation
      1. The **clinician shall confer with the medical liaison Lt or facility commander/designee** when there is evidence of decompensation or distress to determine if alterations to placement and living conditions are appropriate (85%)

2. This provision may be modified by an appropriate behavior management plan

v. Assignment to administrative segregation is be **re-evaluated every 30 days** (95%) – review of relevant records or reports

IX. Quality Management

a. Continuous Quality Improvement Program (CQIP)

i. The following are evaluated annually by peer review – review of peer review logs

1. Physicians (85%)
2. Physician's Assistants (85%)
3. Nurse Practitioners (85%)

ii. The Quality Improvement Committee – review of CQI minutes

1. Includes the Correctional Health Services Administrator, Correctional Health Services Medical Director, a mental health representative, a registered nurse, a pharmacy representative, a Sheriff's Department representative (85%)
2. Meets quarterly (90%)
3. Provides systematic monitoring and analysis of health services for the purpose of improving processes (y/n)
4. Each of the following are reviewed at least annually

a. Intake screenings

i. Number performed (2 consecutive years)
ii. Number not done prior to housing (2 consecutive years)

b. Health needs requests

i. Number submitted monthly (2 consecutive years)
ii. Number triaged same day (2 consecutive years)
iii. Number of emergent conditions (2 consecutive years)
iv. Number of emergency conditions seen immediately (2 consecutive years)
v. Number of urgent conditions (2 consecutive years)
vi. Number of urgent conditions seen the same day (2 consecutive years)
vii. Number who received visits with providers within 14 calendar days of receipt (2 consecutive years)
viii. Number of "man down" responses (2 consecutive years)
ix. Number of inmate requests indicating a clinical symptom not seen by an RN within 48/72 hours (2 consecutive years)

c. Percent inmates not receiving first dose of essential medication within 24 hours of order (2 consecutive years)

d. Percent inmates with medication lapses due to untimely renewal (2 consecutive years)

e. Number of inmates verified on psychotropics at booking not receiving first dose within 48 hours of order or seen by psychiatrist within 24 hours (2 consecutive years)
f. Number inmates stating taking psychotropic medications at booking but staff did not take reasonable steps to verify prescription (2 consecutive years)
g. Length of time from specialty referral to completed appointment by service (2 consecutive years)
h. Number of inmates with chronic illnesses who did not receive medications within a day of order (2 consecutive years)
i. Number of inmates with chronic illnesses who did not receive H&P by RN, PA, NP, or physician within 2 weeks of booking (2 consecutive years)
j. Grievances over health care complaints and institutional responses (2 consecutive years)
k. Court orders for health care and institutional responses (2 consecutive years)

5. Corrective Action Plans (CAP)
   a. Appropriate CAP recommended for all deficiencies (95%)
      i. Deficiencies are based on reasonable targets (y/n)
         1. Note: some are recommended under other items
   b. The Administrator ensures that CAP recommended by the committee are implemented and completed within 30 days of the recommendation unless extenuating circumstances (85%)

b. Reviews of in-custody deaths
   i. Preliminary review – review of Preliminary reviews of all in-custody deaths (focus on mental health elements)
      1. Done within 30 days (95%)
      2. Includes a written report
         a. Circumstances and events (95%)
         b. Reports whether there were any preventable causes of death or any potential systematic problems identified (95%)
            i. Remedy for any identifiable problems recommended (95%)
   ii. Mortality review includes – review of Mortality reviews for all in-custody deaths (focus on mental health elements)
      1. Detailed assessment of events occurring prior to death (95%)
      2. Analysis of any acts or omissions by any staff or inmates which might have contributed to the death (95%)
      3. Psychological autopsies performed on any suspected suicide (95%)
      4. Identifies any problems for which corrective action should be undertaken (95%)
         a. CAP created, implemented and completed (95%)

X. Mental health care

a. Mental Health Program Guide – review of Mental Health Program Guide
   i. Completed within 6 months of Consent Decree (y/n)
   ii. Conforms to community standards of care (y/n)
   iii. Specifies the following components
      1. Assessment (y/n)
      2. Structured treatment
         a. Face-to-face clinical contacts (y/n)
         b. Group therapy (y/n)
         c. Individual therapy as clinically indicated (y/n)
         d. For mental health housing units (y/n)
         e. For other settings (y/n)

b. Psychiatric prescribers (see also Access to Care) – review of random medical records of inmates receiving psychotropic medications during the previous 6 months including a sample of those ordered at booking
   i. See patients started on psychotropics at booking within 7 days (85%)
   ii. See patients within 30 days of an initial visit when medications are ordered or as otherwise indicated (85%)
   iii. See patients at least every 90 days when on psychotropic medications (90%)

c. Housing
   i. SMI are housed in units designated for such housing unless otherwise recommended by MH (95%) – review of random selection of medical records and housing assignments of those identified as level of care severe or moderate-severe
   ii. Mental health housing will provide movement consistent with classification level (95%) – review of TITLE 15 or equivalent logs for the previous 6 months, direct observation, interviews with staff and inmates
      1. Maximum out of cell time is provided (85%)
   iii. Mental health housing provides programming and structured activities – review random selection of encounters and/or medical records of treatment activities of those in mental health housing for a minimum of 30 days during the previous 6 months, direct observation, review of manuals/curricula
      1. Appropriate for acuity (y/n)
      2. Consistent with community standard of care (y/n)
   iv. Transfers of mentally ill
      1. Policies and procedures ensure clinical input prior to transfers of mentally ill inmates (y/n) – review of policies and procedures
         a. Policy provides adequate time for clinical staff to consult with facility commander/designee (for within facility transfers) or sending facility commander/designee and DMH supervisor prior to transfer (for between facility transfers), absent an emergency (y/n) – review of policies and procedures

b. Absent emergency transfer, MH staff are consulted prior to transfer into or out of mental health housing and determine if transfer is therapeutically indicated (95%) – review of reports of transfers during the previous 6 months
    i. If conflicting recommendations, there is sufficient time to consult (95%)

d. Treatment space
    i. Adequate treatment space exists to provide individual and group treatment and has access to health care records at each facility (y/n) – direct observation, interviews with staff, review of group schedules
        1. Space provides appropriate privacy (y/n)

e. Suicide prevention
    i. Within one month of the Consent Decree, there is policy and procedure providing for step-down from safety cells (y/n)
        1. The policy and procedure provide for gradual restoration of property and privileges consistent with the clinical assessment (y/n) – review of policies and procedures
        2. The policy and procedure demonstrate intent to minimize time in safety cells (y/n) – review of policies and procedures
        3. Policy is implemented –review of medical records and conditions of confinement of random selection of inmates placed in safety cells during the previous 6 months
            a. Records reflect clinical assessment of restoration of property and privileges (95%)
            b. Records and observation reflect that restoration of property and privileges is consistent with the clinical assessment (95%)
    ii. Records and observations reflect that inmates in safety cells – direct observation, interviews with staff and inmates, review of safety cell logs and MAR for random selection of inmates placed in safety cells during the previous 6 months
        1. Are offered meals three times per day (95%)
        2. Are provided all prescribed medications (99%)
    iii. Seclusion shall last no more than 12 hours (95%) – seclusion is defined as placement in a safety cell with no more than a smock, mattress, and blanket
    iv. Within one month of the Consent Decree, there is policy and procedure providing for inmates awaiting transfer to RUMC due to serious risk of self-harm to receive treatment and attention consistent with MH determination (y/n) – review of policies and procedures
        1. Provides for one-on-one observation (y/n) – review of policies and procedures
        2. Determination of conditions and treatment determined by MH (y/n) – review of policies and procedures

3. Policy is implemented – review of medical records and conditions of confinement of a random selection of those referred to RUMC for DTS during the previous 6 months, direct observation
    a. Records reflect determination of conditions and treatment pending transfer is done by MH clinician (95%)
    b. Records and observation reflect that conditions and treatment is consistent with the clinical determination (95%)

v. Records and observations reflect that safety cells are cleaned and sanitized on regular basis, including after each use and when conditions of an occupied cell are unsanitary (85%) – direct observation, review of safety cell cleaning logs

vi. Custody supervisors regularly inspect, at least each shift, safety cells and safety cell logs (85%)– review of safety cell logs of those placed in safety cells during the previous 6 months, direct observation
    1. These inspections are reviewed at least weekly by a lieutenant (85%) – review of safety cell logs

vii. MH clinicians conduct face-to-face assessments and treatment of inmates in safety cells, unless there is a likelihood of inmate violence (95%) – review of safety cell logs and/or medical records of those placed in safety cells during the previous 6 months, direct observation, interviews with staff and inmates

f. Restraints
    i. There is policy and procedure that ensures continuous monitoring of inmates in restraints (y/n) – review of policies and procedures
        1. Records and observations reflect continuous monitoring of inmates in restraints (95%) – review of restraint logs of those placed in safety cells during the previous 6 months, interview of staff and inmates
    ii. Records and observations reflect that restraint chairs are cleaned and sanitized on regular basis, including after each use and when conditions of an occupied chair are unsanitary (85%) – review of safety restraint chair cleaning logs from the previous 6 months, direct observation
    iii. MH clinicians conduct face-to-face assessments and treatment of inmates in restraints, unless there is a likelihood of inmate violence (95%) – review of restraint logs and/or medical records of inmates placed in restraints during the previous 6 months, direct observation, interview of staff and inmates

g. Continuity of care
    i. Continuity of care is provided to all sentenced inmates and unsentenced inmates when there is enough time (length of stay more than 14 days) – review of random selection of medical records of those released during the last 6 months who had stays of at least 14 days
        1. Referrals to community-based providers are done when determined by a jail provider to be needed (85%)

2. Those with SMI receive discharge planning, when indicated, including connecting the inmate to:
    a. Community health care providers (85%)
    b. Community social services (85%)
    c. Community-based housing (85%)
    d. Other appropriate services (85%)

ii. Release psychiatric medications will be available to inmates ASAP following release (within 2 days) (85%) – review of pharmacy data for a random sample of released inmates, review protocol for release medications, interview staff and inmates

XI. Policies and procedures
  a. Policies and procedures support all the provisions of the remedial plan – expert review
    i. Policies and procedures are revised as necessary within 6 months of the Consent Decree (y/n) – review of policies and procedures
  b. The county follows policies and procedures
    i. The county follows current policies and procedures (y/n) – expert review
    ii. Revised policies and procedures are implemented within 9 months of the Consent Decree (y/n) – review of policies and procedures
      1. Staff received training in revised policies and procedures within 9 months of the consent decree (85%) – review of training materials and training logs

XII. Consent Decree training
  a. Staff are trained in the provisions of the Consent Decree within 9 months of its issuance (85%) – review of training materials and training logs
  b. The correctional health services budget is sufficient to finance adequate health care and custody staff to comply with the Remedial Plan (y/n) – expert review

Draft Information Request

The following is a listing of information needed prior to the upcoming semi-annual mental health assessment regarding Gray v County of Riverside. Some require production of data while others require identification of a pool of random subjects for subsequent review (e.g., medical record numbers for different categories of patients). Unless otherwise specified, the pool for data pulls will consist only in inmates admitted for at least one week and inmates should be drawn from all facilities whenever possible.

The information is combined whenever possible to promote efficiency. For this reason, the order of the information request is not the same as the ordering of items in the remedial plan or other related documents. However, the topic area will be indicated to facilitate locating responsive information.

Intake

- Provide 40 random medical record numbers of inmates booked into the jail during the last 6 months.
    - For each of those 20, also include the time of initial cell placement (housing)
- Provide 20 random medical record numbers of inmates booked into the jail during the last 6 months who reported being on psychotropic medications in the community at the time of booking

Inmate Healthcare Requests

- Provide (quarterly) CQIP reports or other review of the County's tracking of Inmate Healthcare Request From responses
- Provide summary data and methodology ***or*** log books for one of the previous six months (including dates and times) for each of the following
    - Pick up of Inmate Healthcare Requests from lock boxes
        - By custody
        - By nursing
    - Pick up of Inmate Healthcare Requests of inmates in sheltered housing
        - By custody
        - By nursing

    Note: If summary data and methodology are provided, include a random sample of medical record numbers of 20 patients who submitted Inmate Healthcare Requests for mental health.
- Provide summary data and methodology ***or*** log books for one of the previous six months including dates and times of for each of the following
    - Delivery of Inmate Healthcare Requests to mental health
    - Triage of Inmate Healthcare Requests by a QMHP
    - 40 random medical record numbers of inmates submitting Inmate Healthcare Requests for mental health during the last 6 months

        - 10 with emergent needs
        - 10 with urgent needs
        - 10 with a clinical symptom described
        - 10 with routine needs

Note: If summary data and methodology are provided, include a random sample of medical record numbers of 20 patients who submitted Inmate Healthcare Requests for mental health.

Medication Administration

- Provide 20 random medical record numbers of inmates ordered psychotropics in any of the following ways
    - Stat or now
    - QID
    - Long-acting injectable antipsychotics
- Provide 20 random medical record numbers of inmates provided medications when outside a jail for any of the following reasons
    - Court
    - Outside appointment
    - Transfer
- Provide 20 random medical record numbers of inmates ordered any of the following medications (alone, sequentially, or concurrently) by a psychiatric prescriber for a period of 30 days or longer: antipsychotics, lithium, valproic acid/sodium valproate, carbamazepine, mirtazapine, tricyclic antidepressants
- Pharmacy
    - Provide a summary report of medication deliveries to each jail for two random weeks during the last 6 months
    - Provide a list of stock medications to be maintained at each jail and any documentation related to maintaining each jail's supply during the previous 6 months
    - Provide a summary report of medication order dates and fill dates (or equivalent) for two random weeks during the last 6 months
    - Provide a list of 20 inmates on psychotropic medications at the time of release
        - Include date of release
        - Include medications provided at the time of release or within two days of release

Mental Health Treatment

- Provide the Mental Health Program Guide or equivalent
- Provide 20 random medical record numbers for inmates spending at least 30 days on a residential mental health unit during the previous 6 months
    - At least 10 from RPDC
    - At least 5 females

- Administrative segregation
    - Provide 10 random medical record numbers of inmates not on the mental health caseload that were placed on administrative segregation during the previous 6 months
    - Provide 10 random medical record numbers of inmates on administrative segregation who were seen (urgently or emergently) by a QMHP following custody referral, that submitted a Health Care Request Form that were triaged by a QMHP as urgent or emergent, or who declared a mental health emergency during the previous 6 months
    - Provide 10 random medical record numbers of inmates on administrative segregation longer than 30 days with level of care moderate-severe or severe during the previous 6 months
- Provide 20 random medical record numbers of inmates placed in safety cells during the previous 6 months
    - For these, provide the safety cell logs
    - Include at least 10 who were committed to the DCU before the expiration of their time in the safety cell
- Provide 10 random medical record numbers of inmates placed in restraints in the jails during the previous 6 months
    - For these, provide the safety cell logs
- Continuity of care
    - Provide 20 random medical record numbers of inmates released within the previous 6 months who had level of care ratings of moderate-severe, severe, or acute

Man Down

- Provide 10 random medical record numbers of "man down" calls involving self-injurious behavior or inmate-declared mental health emergencies

Custody and Classification

- Confidentiality of healthcare grievances
    - Provide documentation of confidentiality training for staff with access to healthcare grievances
    - Provide a log or copies of confidentiality agreements for staff with access to healthcare grievances
- Dayroom and yard time (information may be provided in a form convenient to RCSD as long as the data are clearly labeled and organized)
    - Provide summary reports of dayroom time or logs of two random weeks of dayroom time for four units at each facility (at least two of which are residential mental health units at RPDC and SCF)
    - Provide summary reports of yard time or logs of two random weeks of dayroom time for four units at each facility (at least two of which are residential mental health units at RPDC and SCF)

- Identify 20 random inmates not leaving their cell for 3 consecutive days during the previous 6 months and their medical record numbers
- Provide a report of notification of mental health regarding inmates who received sentences longer than 15 years or a death sentence during the last 6 months; the report should include the date of notification and their medical record numbers
- Administrative Segregation
    - Provide random medical record numbers of 10 patients on administrative segregation during the previous 6 months who were on the mental health caseload
    - Provide 30-day reviews of inmates on administrative segregation who were on the mental health caseload
- Provide dates of transfers of inmates into or out of residential mental health settings and
    - Their medical record numbers ***or***
    - Verification that a QMHP was consulted prior to transfer and the outcome of that consultation
- Safety cell inspection
    - Provide one random month of logs of safety cell inspections by custody supervisors from the previous 6 months
    - Provide one random month of logs of weekly safety cell inspections by Lts. from the previous 6 months
- Provide one random month of restraint chair cleaning logs from the previous 6 months

Staffing

- Provide the most recent annual assessment of the adequacy of staffing
- Provide a current list of all funded mental health positions, the number of positions filled, and any pending hires.
-

Quality Management

- Provide minutes of CQIP meetings for the previous 6 months
- Provide peer review logs or peer reviews for mental health staff for the previous 6 months
- Provide reviews of in-custody deaths

EXHIBIT O

STATE OF CALIFORNIA
BOARD OF STATE AND COMMUNITY CORRECTIONS
2590 VENTURE OAKS WAY, SUITE 200 ♦ SACRAMENTO CA 95833 ♦ 916.445.5073 ♦ BSCC.CA.GOV

LINDA M. PENNER
Chair

KATHLEEN T. HOWARD
Executive Director

GAVIN NEWSOM
Governor

December 6, 2019

Chad Bianco, Sheriff
Riverside County Sheriff's Department
P.O. Box 512
Riverside, CA 92051

2018-2020 BIENNIAL INSPECTION OF RIVERSIDE COUNTY SHERIFF'S OFFICE JAIL AND COURT HOLDING FACILITIES, PENAL CODE 6031

Dear Sheriff Bianco,

On September 16-26, 2019, staff of the Board of State and Community Corrections (BSCC) conducted the 2018-2020 biennial inspection of the Riverside County Jails and Court Holding Facilities. To prepare staff for the inspection, a pre-inspection briefing was held for both Corrections and Court Services divisions on March 13, 2019. The following facilities were inspected:

Detention Facility	BSCC #	Courthouse Facility	BSCC #
Robert Presley Detention Center	3910	Hall of Justice	3916
Smith Correctional Facility	3920	Southwest Justice Court	3935
Southwest Detention Center	3930	3934 Southwest Juv Court	3937
Blythe Jail	3940	Family Law Court	3950
Indio Jail	3960	Larson Justice Center	3970
		Banning Court	3974
		Blythe Court	3975

Pursuant to Penal Code Section 6031, this inspection was performed to determine compliance with the Minimum Standards for Local Detention Facilities as outlined in Titles 15 and 24, California Code of Regulations (CCR). In addition, BSCC staff conducted compliance monitoring pursuant to Welfare and Institutions Code Section 209(f) for the federal Juvenile Justice and Delinquency Prevention Act (JJDPA).

The complete BSCC inspection report is enclosed and consists of: this transmittal letter; the Title 15 Procedures Checklist outlining applicable minimum standards; a Physical Plant Evaluation outlining Title 24 requirements for design; and, a Living Area Space Evaluation summarizing the physical plant configuration and showing the capacity of the facility. Refer to the Title 15 Checklist for indication of compliance status and evidence used to determine compliance.

LOCAL INSPECTIONS

In addition to the biennial inspection by the BSCC, inspections are also required annually by the County Health Officer and biennially by the State Fire Marshal or an authorized representative (Health and Safety Code Sections 101045 and 13146.1). Please consider our report in conjunction with the reports from the County Health Officer and the respective fire authorities for a comprehensive perspective of your facilities. Each of the local inspections were current.

BSCC INPECTION

Title 15, CCR Inspection

Our evaluation consisted of reviewing only those policies and procedures related specifically to the applicable regulations included in Title 15, CCR. We found the following items of noncompliance:

- Title 15, Section 1027.5 Safety Checks: Safety checks shall be conducted at least hourly through direct visual observation of all inmates. There shall be no more than a 60-minute lapse between safety checks. The below facilities exceeded the 60-minute safety checks requirements.

  Robert Presley Detention Center
  Cois Byrd Correctional Center
  Larry D. Smith Correctional Facility

- Title 15, Section 1058 Restraints Devices: In part the facility watch commander and responsible health care staff conduct a retention review a minimum of every hour. The below facilities exceeded the one-hour retention review:

  Robert Presley Detention Center
  Cois Byrd Correctional Center
  Larry D. Smith Correctional Facility

Please refer to the Procedures Checklist for detailed information.

Title 24, CCR Physical Plant

The population of inmates continues to decrease in each jail. However, due to Blythe jail closing a housing unit for maintenance several inmates were transferred throughout the county's jail system. "Stack-a-bunk" (with a mattress) is used for those inmates that are not assigned a bed that meets regulation. With the new 1536 rated capacity facility, John J. Benoit Detention Center, scheduled to open in early 2020 will allow the department to gain control of the crowding situation.

We identified the following items of non-compliance with Title 24:

Robert Presley Detention Center: Although the facility was not over the RC, there were four stack-a-bunk floor sleepers 3B1 and 3B2. As a result, the following areas of non-compliance:

- 1231.2.9 Dayrooms – Contained more inmates than tables and seating to accommodate the number of inmates;
- 1231.3.5 Beds must be elevated off the floor, have a solid bottom, and a sleeping surface of at least 30 inches wide and 76 inches. Stack-a-bunks do not meet this requirement.

Cois Byrd Detention Center: Although the facility was not over the RC, there were Ten stack-a-bunk floor sleepers in housing unit C4. As a result, the following areas of non-compliance:

- 1231.3.5 Beds must be elevated off the floor, have a solid bottom, and a sleeping surface of at least 30 inches wide and 76 inches. Stack-a-bunks do not meet this requirement.

Larry D. Smith Correctional Facility: Although the facility was not over the RC, there were four stack-a-bunk floor sleepers in housing Dormitories 14G and Building 9B & 9C. As a result, the following areas of non-compliance:

- 1231.2.8 Dormitories – Failed to provide 70 square feet of floor area per inmate
- 1231.2.9 Dayrooms – Failed to provide 35 square feet of floor area per inmate
- 1231.3.5 Beds must be elevated off the floor, have a solid bottom, and a sleeping surface of at least 30 inches wide and 76 inches. Stack-a-bunks do not meet this requirement

Indio Jail: The facility continues to be over the rated capacity. The RC for the Indio Jail is 240. On the day of the inspection the population was 359. As a result, the following areas of non-compliance:

- 1231.2.8 Dormitories – Failed to provide 70 square feet of floor area per inmate
- 1231.2.9 Dayrooms – Failed to provide enough tables and seating to accommodate the maximum number of Inmates out in the dayroom.
- 1231.3.4 Showers-Showers

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Blythe Jail: Housing Dormitory A was closed for maintenance. This kept the facility under the rated capacity. However, the facility had one extra inmates in housing C1, C2, C3, D1 & D2. As a result, the following areas of non-compliance:

- 1231.2.6 Single-occupancy cells
- Multiple Occupancy Cells (8227)

Please refer to the Physical Plant Checklist for detailed information.

Court Services Bureau

No areas of non-compliance were found in the Riverside County Court holding facilities. Five (5) out of seven (7) court facilities do not use its court holding cells like a traditional court holding facility. Inmates are held in the court holding cells for a very limited amount of time (less than 60 minutes), not long enough to log an hourly check. Therefore, many of the areas in Title 15 do not apply to these facilities except for the Banning courthouse and the newly opened Southwest Juvenile Court which is a stand-alone court facility. Juveniles are held at the Southwest Juvenile facility, but probation staff are responsible for their supervision. The court system is an efficient operation and all the facilities looked clean and orderly.

CORRECTIVE ACTION PLAN

Should efforts be made to remedy these issues please submit a Corrective Action plan by February 3, 2020.

This concludes our inspection report for the 2018 – 2020 inspection cycle. We would like to thank everyone involved in the inspection process for the hospitality and courtesy they extended during the inspection. If I can be of further assistance to you or your agency, please do not hesitate to call me at (916) 324-9861 or email me at michael.bush@bscc.ca.gov.

Sincerely,

Michael J. Bush
Field Representative
Facilities Standards and Operations Division

Enclosures

cc: Chairperson, Board of Supervisors, County of Riverside*
Chief Administrative Officer, County of Riverside*
Presiding Judge, Superior Court, County of Riverside*
Grand Jury Foreman, Superior Court, County of Riverside*
Raul Vergara, Assistant Sheriff, Riverside County Sheriff's Department
Edward Delgado, Chief Deputy, Riverside County Sheriff's Department
Donald Sharp, Chief Deputy, Riverside County Sheriff's Department

**Copies of report can be access via BSCC website.*

TYPE II AND III FACILITIES
Board of State and Community Corrections
PROCEDURES[1]

FACILITY NAME: Robert Presley Detention Center	Type II	**BSCC** # 3910	DATE: 09/18/2019
FACILITY NAME: Larry Smith Correctional Facility	Type II	**BSCC** # 3920	DATE: 09/20/2019
FACILITY NAME: Cois Byrd Detention Center	Type II	**BSCC** # 3930	DATE: 09/19/2019
FACILITY NAME: Blythe Jail	Type II	**BSCC** # 3940	DATE: 09/24/2019
FACILITY NAME: Indio Jail	Type II	**BSCC** # 3960	DATE: 09/23/2019
FIELD REPRESENTATIVE: Michael J. Bush			

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
1020 CORRECTIONS OFFICER CORE COURSE[2] (a) In addition to the provisions of California Penal Code Section 831.5, all custodial personnel of a Type I, II, III, or IV facility shall successfully complete the "Corrections Officer Core Course" as described in Section 179 of Title 15, CCR, within one year from the date of assignment.	Yes	Yes	Yes	Yes	Yes	503.06 (1.0 – 3.0) The STC Division found the department in compliance with Title 15 Sections 1020-1025. 503.06, Section 1.0 Personnel Training
(b) Custodial Personnel who have successfully completed the course of instruction required by Penal Code Section 832.3 shall also successfully complete the "Corrections Officer Basic Academy Supplemental Core Course" as described in Section 180 of Title 15, CCR, within one year from the date of assignment.	Yes	Yes	Yes	Yes	Yes	
1021 JAIL SUPERVISORY TRAINING Prior to assuming supervisory duties, jail supervisors shall complete the core training requirements pursuant to Section 1020, Corrections Officer Core Course.	Yes	Yes	Yes	Yes	Yes	503.06 (4.0)

[1] This document is intended for use as a tool during the inspection process; this worksheet may not contain each Title 15 regulation that is required. Additionally, many regulations on this worksheet are SUMMARIES of the regulation; the text on this worksheet may not contain the entire text of the actual regulation. Please refer to the complete California Code of Regulations, Title 15, Minimum Standards for Local Facilities, Division 1, Chapter 1, Subchapter 4 for the complete list and text of regulations.

[2] For STC participating agencies, consistency with training sections 1020, 1023 & 1025 is annually assessed by the STC Division. Unless otherwise indicated, the regulatory intent is for training to occur within one year from the date of assignment.

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In addition, supervisory personnel of any Type I, II, III or IV jail shall also be required to complete either the STC Supervisory Course (as described in Section 181, Title 15, CCR) or the POST supervisory course within one year from date of assignment.	Yes	Yes	Yes	Yes	Yes	
1023 JAIL MANAGEMENT TRAINING Managerial personnel of any Type I, II, III or IV jail shall be required to complete either the STC management course (as described in Section 182, Title 15, CCR) or the POST management course within one year from date of assignment.	Yes	Yes	Yes	Yes	Yes	503.06 (5.0)
1025 CONTINUING PROFESSIONAL TRAINING With the exception of any year that a core training module is successfully completed, all facility/system administrators, managers, supervisors, and custody personnel of a Type I, II, III, or IV facility shall successfully complete the "annual required training" specified in Section 184 of Title 15, CCR.	Yes	Yes	Yes	Yes	Yes	503.06 (3.0)
1027 NUMBER OF PERSONNEL A sufficient number of personnel shall be employed in each local detention facility to ensure the implementation and operation of the programs and activities required by these regulations.	Yes	Yes	Yes	Yes	Yes	BSCC reviewed a variety of time-oriented documents to include safety check logs, grievances, incident reports, classification histories, screening documents and floor logs.
Whenever there is an inmate in custody, there shall be at least one employee on duty at all times in a local detention facility or in the building which houses a local detention facility who shall be immediately available and accessible to inmates in the event of an emergency.	Yes	Yes	Yes	Yes	Yes	502.10 (1.0 & 3.0) Security Logs/Checks All shifts have non-posted staff available to respond to an emergency
Such an employee shall not have any other duties which would conflict with the supervision and care of inmates in the event of an emergency.	Yes	Yes	Yes	Yes	Yes	
Whenever one or more female inmates are in custody, there shall be at least one female employee who shall be immediately available and accessible to such females. *Note: Reference PC§ 4021.*	Yes	Yes	Yes	Yes	Yes	
To determine if there is a sufficient number of personnel for a specific facility, the facility administrator shall prepare and retain a staffing plan indicating the personnel assigned in the facility and their duties. Such a staffing plan shall be reviewed by the Board staff at the time of their biennial inspection. The results of such a review and recommendations shall be reported to the local jurisdiction having fiscal responsibility for the facility.	Yes	Yes	Yes	Yes	Yes	501.08 BSCC reviewed staffing assignments, the duty roster and the Correctional Sergeant's Log to verify staffing patterns. All information appeared appropriate.

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
1027.5 SAFETY CHECKS Safety checks shall be conducted at least hourly through direct visual observation of all inmates. There shall be no more than a 60-minute lapse between safety checks.	Yes	Yes	Yes	Yes	Yes	502.10 Security Logs/Checks – Custody staff shall conduct a walk-through security check of their respective areas at least once every hour.
There is a written plan that includes the documentation of routine safety checks.	No	No	No	Yes	Yes	RPDC, LSC and CBD faculties observation logs revealed housing safety checks were over the required hour limit.
1028 FIRE AND LIFE SAFETY STAFF Pursuant to Penal Code Section 6030(c), whenever there is an inmate in custody, there shall be at least one person on duty at all times who meets the training standards established by the BSCC for general fire and life safety.	Yes	Yes	Yes	Yes	Yes	505.06 (4) Fire Suppression Preplanning Staff has completed Core training, which includes fire and life safety training adequate to satisfy this regulation. At least one Core trained person is always available on-site.
The facility manager shall ensure that there is at least one person on duty who trained in fire and life safety procedures that relate specifically to the facility.	Yes	Yes	Yes	Yes	Yes	505.05 Section 4
1029 POLICY AND PROCEDURES MANUAL [3] Facility administrator(s) shall develop and publish a manual of policy and procedures for the facility. The policy and procedures manual shall address all applicable Title 15 and Title 24 regulations and shall be comprehensively reviewed and updated at least every two years. Such a manual shall be made available to all employees. *The policies and procedures required in subsections (a)(6) and (a)(7) may be placed in a separate manual to ensure confidentiality. Subsections c and d do not apply and have been deleted.* (a) The manual for Temporary Holding, Type I, II, and III facilities shall provide for, but not be limited to, the following:	Yes	Yes	Yes	Yes	Yes	The Riverside County Sheriff's Department Corrections Division continues to update the correctional detention policy manual, which is approved by the Div Chief. Each correctional facility will have additional post orders specifically for their facility.
(1) Table of organization, including channels of communications.	Yes	Yes	Yes	Yes	Yes	502.04 Facility Inspections
(2) Inspections and operations reviews by the facility administrator/manager.	Yes	Yes	Yes	Yes	Yes	
(3) Policy on the use of force.	Yes	Yes	Yes	Yes	Yes	503.09 Use of Force
(4) Policy on the use of restraint equipment, including the restraint of pregnant inmates as referenced in Penal Code Section 3407.	Yes	Yes	Yes	Yes	Yes	503.08 Restraint Devices

[3] Procedures related to security and emergency response may be in a separate manual to ensure confidentiality by limiting general access.

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
(5) Procedure and criteria for screening newly received inmates for release per Penal Code sections 849(b)(2) and 853.6, and any other such processes as the facility administrator is empowered to use.	Yes	Yes	Yes	Yes	Yes	504.16 Misdemeanor Citation and Releases
(6) Security and control including:	Yes	Yes	Yes	Yes	Yes	504.07 Headcounts
(A) physical counts of inmates,	Yes	Yes	Yes	Yes	Yes	2.06 Housing Searches
(B) searches of the facility and inmates,	Yes	Yes	Yes	Yes	Yes	502.11 Inmate Searches
(C) contraband control, and,	Yes	Yes	Yes	Yes	Yes	502.02 Contraband
(D) key control.	Yes	Yes	Yes	Yes	Yes	502.08 Key control
Each facility administrator shall, at least annually, review, evaluate, and make a record of security measures. The review and evaluation shall include internal and external security measures of the facility including security measures specific to prevention of sexual abuse and sexual harassment.	Yes	Yes	Yes	Yes	Yes	502.04 Facility Inspections
(7) Emergency procedures include: (A) fire suppression preplan as required by section 1032 of these regulations;	Yes	Yes	Yes	Yes	Yes	502.03 Escapes
(B) escape, disturbances, and the taking of hostages;	Yes	Yes	Yes	Yes	Yes	505.07 Riot/Facility Disturbances
(C) mass arrests;	Yes	Yes	Yes	Yes	Yes	502.05
(D) natural disasters;	Yes	Yes	Yes	Yes	Yes	505.01 Critical Incidents
(E) periodic testing of emergency equipment; and,	Yes	Yes	Yes	Yes	Yes	505.06 Fire Suppression Pre-Plan
(F) storage, issue, and use of weapons, ammunition, chemical agents, and related security devices.	Yes	Yes	Yes	Yes	Yes	503.03 Less Lethal Weapons and Munitions
(8) Suicide Prevention.	Yes	Yes	Yes	Yes	Yes	508.15 Suicide Prevention Program
(9) Segregation of Inmates.	Yes	Yes	Yes	Yes	Yes	504.02 Administrative Segregation
(10) Zero tolerance in the prevention of sexual abuse and sexual harassment.	Yes	Yes	Yes	Yes	Yes	501.24 Sexual Assault 507.11 Orientation 508.10 Medical Screening/Medical Release
(11) Policy and procedure to detect, prevent, and respond to retaliation against any staff or inmate after reporting any abuse.	Yes	Yes	Yes	Yes	Yes	
(e) The manual for Temporary Holding, Court Holding, Type I, II, III, and IV facilities shall provide for, but not be limited to, the following: (1) multiple internal ways for inmates to privately report sexual abuse and sexual harassment, retaliation by other inmates or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents,	Yes	Yes	Yes	Yes	Yes	
(2) a method for uninvolved inmates, family, community members, and other interested third-parties to report sexual abuse or sexual harassment. The method for reporting shall be publicly posted at the facility.	Yes	Yes	Yes	Yes	Yes	

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
1030 SUICIDE PREVENTION PROGRAM The facility shall have a comprehensive written suicide prevention program developed by the facility administrator, in conjunction with the health authority and mental health director, to identify, monitor, and provide treatment to those inmates who present a suicide risk. The program shall include the following:	Yes	Yes	Yes	Yes	Yes	508.15 Suicide Prevention Program
(a) Suicide prevention training for all staff that have direct contact with inmates.	Yes	Yes	Yes	Yes	Yes	
(b) Intake screening for suicide risk immediately upon intake and prior to housing assignment.	Yes	Yes	Yes	Yes	Yes	
(c) Provisions facilitating communication among arresting/transporting officers, facility staff, medical and mental health personnel in relation to suicide risk.	Yes	Yes	Yes	Yes	Yes	
(d) Housing recommendations for inmates at risk of suicide.	Yes	Yes	Yes	Yes	Yes	
(e) Supervision depending on level of suicide risk.	Yes	Yes	Yes	Yes	Yes	
(f) Suicide attempt and suicide intervention policies and procedures.	Yes	Yes	Yes	Yes	Yes	
(g) Provisions for reporting suicides and suicides attempts.	Yes	Yes	Yes	Yes	Yes	
(h) Multi-disciplinary administrative review of suicides and attempted suicides as defined by the facility administrator.	Yes	Yes	Yes	Yes	Yes	
1032 FIRE SUPPRESSION PREPLANNING Pursuant to Penal Code Section 6031.1(b), the facility administrator shall consult with the local fire department having jurisdiction over the facility, with the State Fire Marshal, or both, in developing a plan for fire suppression which shall include, but not be limited to:	Yes	Yes	Yes	Yes	Yes	505.06 Fire Suppression and Pre-Planning
(a) a fire suppression pre-plan developed with the local fire department to be included as part of the policy and procedures manual (Title 15, California Code of Regulations Section 1029);	Yes	Yes	Yes	Yes	Yes	Each jail also has a Fire and Life Safety manual specific to the facility.
(b) regular fire prevention inspections by facility staff on a monthly basis with two-year retention of the inspection record;	Yes	Yes	Yes	Yes	Yes	BSCC reviewed records; all information was appropriate.
(c) fire prevention inspections as required by Health and Safety Code Section 13146.1(a) and (b) which requires inspections at least once every two years;	Yes	Yes	Yes	Yes	Yes	RPDC – 11/30/2018 LSC – 02/20/2019 CBC – 02/27/2018 BJ – 04/02/2015 IJ – 07/06/2019

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
(d) an evacuation plan; and,	Yes	Yes	Yes	Yes	Yes	505.04 Each facility has a Fire and Life Safety Manual specific to the facility. Each shift will provide in-service training in fire drill procedures, including practical exercises. Each shift will conduct at least one drill per month.
(e) a plan for the emergency housing of inmates in the case of fire.	Yes	Yes	Yes	Yes	Yes	504.07 Headcount 505.04 Evacuation Plan
1040 POPULATION ACCOUNTING Each facility administrator shall maintain an inmate demographics accounting system which reflects the monthly average daily population of sentenced and non-sentenced inmates by categories of male, female and juvenile.	Yes	Yes	Yes	Yes	Yes	504.07 Headcounts
Facility administrators shall provide the BSCC with applicable inmate demographic information as described in the Jail Profile Survey.	Yes	Yes	Yes	Yes	Yes	
1041 INMATE RECORDS (a) Each facility administrator of a Type I, II, III or IV facility shall develop written policies and procedures for the maintenance of individual inmate records which shall include, but not be limited to, intake information, personal property receipts, commitment papers, court orders, reports of disciplinary actions taken, medical orders issued by the responsible physician and staff response, and non-medical information regarding disabilities and other limitations.	Yes	Yes	Yes	Yes	Yes	506.04 Booking File organization 506.14 Purging of Records
(b) Each facility administrator shall collect accurate, uniform data for every allegation of sexual abuse at facilities under its direct control and from other facilities with which it contracts for the confinement of its inmates. The data collected shall include, at a minimum, the data necessary to satisfy the reporting requirements of 34 U.S.C. section 30303(a)(1) (federal survey on sexual violence).	Yes	Yes	Yes	Yes	Yes	
1044 INCIDENT REPORTS Each facility administrator shall develop written policies and procedures for the maintenance of written records and reporting of all incidents which result in physical harm, or serious threat of physical harm, to an employee or inmate of a detention facility or other person.	Yes	Yes	Yes	Yes	Yes	501.01 Administrative Log 501.07 Crime Reports 501.14 Incidents/Pass on Log
Such records shall include the names of the persons involved, a description of the incident, the actions taken, and the date and time of the occurrence.	Yes	Yes	Yes	Yes	Yes	

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
Such a written record shall be prepared by the staff assigned to investigate the incident and submitted to the facility manager or his/her designee.	Yes	Yes	Yes	Yes	Yes	Incident reports must be submitted within 24 hours. BSCC reviewed several incidents reports, all information was available and appropriate.
1045 PUBLIC INFORMATION PLAN Each facility administrator of a Type I, II, III or IV facility shall develop written policies and procedures for the dissemination of information to the public, to other government agencies, and to the news media. The public and inmates shall have available for review the following material:	Yes	Yes	Yes	Yes	Yes	501.18 Release of Information / Media Interviews
(a) The Board of State and Community Corrections Minimum Standards for Local Detention Facilities as found in Title 15 of the California Code of Regulations.	Yes	Yes	Yes	Yes	Yes	507.07 Law Library 507.11 Orientation
(b) Facility rules and procedures affecting inmates as specified in sections:	Yes	Yes	Yes	Yes	Yes	Orientation handbook.
(1) 1045, Public Information Plan	Yes	Yes	Yes	Yes	Yes	
(2) 1061, Inmate Education Plan	Yes	Yes	Yes	Yes	Yes	
(3) 1062, Visiting	Yes	Yes	Yes	Yes	Yes	
(4) 1063, Correspondence	Yes	Yes	Yes	Yes	Yes	
(5) 1064, Library Service	Yes	Yes	Yes	Yes	Yes	
(6) 1065, Exercise and Recreation	Yes	Yes	Yes	Yes	Yes	
(7) 1066, Books, Newspapers, Periodicals and Writings	Yes	Yes	Yes	Yes	Yes	
(8) 1067, Access to Telephone	Yes	Yes	Yes	Yes	Yes	
(9) 1068, Access to Courts and Counsel	Yes	Yes	Yes	Yes	Yes	
(10) 1069, Inmate Orientation	Yes	Yes	Yes	Yes	Yes	
(11) 1070, Individual/Family Service Programs	Yes	Yes	Yes	Yes	Yes	
(12) 1071, Voting	Yes	Yes	Yes	Yes	Yes	
(13) 1072, Religious Observance	Yes	Yes	Yes	Yes	Yes	
(14) 1073, Inmate Grievance Procedure	Yes	Yes	Yes	Yes	Yes	
(15) 1080, Rules and Disciplinary Penalties	Yes	Yes	Yes	Yes	Yes	
(16) 1081, Plan for Inmate Discipline	Yes	Yes	Yes	Yes	Yes	
(17) 1082, Forms of Discipline	Yes	Yes	Yes	Yes	Yes	
(18) 1083, Limitations on Discipline	Yes	Yes	Yes	Yes	Yes	
(19) 1200, Responsibility for Health Care Services	Yes	Yes	Yes	Yes	Yes	

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
1046 DEATH IN CUSTODY (a) Death in Custody Reviews for Adults and Minors. The facility administrator, in cooperation with the health administrator, shall develop written policy and procedures to ensure that there is an initial review of every in-custody death within 30 days. The review team shall include the facility administrator and/or the facility manager, the health administrator, the responsible physician and other health care and supervision staff who are relevant to the incident.	Yes	Yes	Yes	Yes	Yes	501.22 (1.1) Inmate Deaths
Deaths shall be reviewed to determine the appropriateness of clinical care; whether changes to policies, procedures, or practices are warranted; and to identify issues that require further study.	Yes	Yes	Yes	Yes	Yes	501.22 Inmate Death Review Meeting
(b) Death of a Minor In any case in which a minor dies while detained in a jail, lockup, or court holding facility:	Yes	Yes	Yes	Yes	Yes	510.10.8 Juvenile in Adult Court Holding
(1) The administrator of the facility shall provide to the Board a copy of the report submitted to the Attorney General under Government Code Section 12525. A copy of the report shall be submitted within 10 calendar days after the death.	Yes	Yes	Yes	Yes	Yes	504.02 Classification All facilities complete the Jail Information management system (JIMS) Medical History/Suicide Assessment Form.
(2) Upon receipt of a report of death of a minor from the administrator, the Board may within 30 calendar days inspect and evaluate the jail, lockup, or court holding facility pursuant to the provisions of this subchapter. Any inquiry made by the Board shall be limited to the standards and requirements set forth in these regulations.	Yes	Yes	Yes	Yes	Yes	
1050 CLASSIFICATION PLAN (a) Each administrator of a temporary holding, Type I, II, or III facility shall develop and implement a written classification plan designed to properly assign inmates to housing units and activities according to the categories of sex, age, criminal sophistication, seriousness of crime charged, physical or mental health needs, assaultive/non-assaultive behavior, risk of being sexually abused, or sexually harassed and other criteria which will provide for the safety of the inmates and staff. Such housing unit assignment shall be accomplished to the extent possible within the limits of the available number of distinct housing units or cells in a facility. The written classification plan shall be based on objective criteria and include receiving screening performed at the time of intake by trained personnel, and a record of each inmate's classification level, housing restrictions, and housing assignments.	Yes	Yes	Yes	Yes	Yes	504.02 Classification A preliminary screen is performed during booking. Inmates are separated based on charges, sex, and any known medical or gang-related issues until they are interviewed, classified and assigned housing by the Classification Officer.

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
Each administrator of a Type II or III facility shall establish and implement a classification system which will include the use of classification officers or a classification committee in order to properly assign inmates to housing, work, rehabilitation programs, and leisure activities. Such a plan shall include the use of as much information as is available about the inmate and from the inmate and shall provide for a channel of appeal by the inmate to the facility administrator or designee. An inmate who has been sentenced to more than 60 days may request a review of his classification plan no more often than 30 days from his last review. *Subsection b does not apply and has been deleted.*	Yes	Yes	Yes	Yes	Yes	
(c) In deciding whether to assign an inmate to a housing area for male or female inmates, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems. An inmate's own views with respect to his or her own safety shall be given serious consideration.	Yes	Yes	Yes	Yes	Yes	504.02 (2.0) Classification
1051 COMMUNICABLE DISEASES The facility administrator, in cooperation with the responsible physician, shall develop written policies and procedures specifying those symptoms that require segregation of an inmate until a medical evaluation is completed.	Yes	Yes	Yes	Yes	Yes	508.02 Communicable Disease The Intake/Release Correctional Deputy completes a Medical Pre-Screening Form for every arrestee. The form is forwarded to Medical Staff. If there are emergencies, Medical or Mental Health Staff will be notified immediately.
At the time of intake into the facility, an inquiry shall be made of the person being booked as to whether or not he/she has or has had any communicable diseases, such as tuberculosis or has observable symptoms of tuberculosis or any other communicable diseases, or other special medical problem identified by the health authority. The response shall be noted on the booking form and/or screening device.	Yes	Yes	Yes	Yes	Yes	508.10 Medical Screening/Medical Release
1052 MENTALLY DISORDERED INMATES The facility administrator, in cooperation with the responsible physician, shall develop written policies and procedures to identify and evaluate all mentally disordered inmates, and may include telehealth.	Yes	Yes	Yes	Yes	Yes	508.12 Mental Health Services Any staff member may recommend mental health counseling by filling out a Request for Psychiatric Attention or by notifying Mental Health Staff. Mobile Crisis Service is available if Mental Health Staff is unavailable.

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
If an evaluation from medical or mental health staff is not readily available, an inmate shall be considered mentally disordered for the purpose of this section if he or she appears to be a danger to himself/herself or others or if he/she appears gravely disabled. An evaluation from medical or mental health staff shall be secured within 24 hours of identification or at the next daily sick call, whichever is earliest.	Yes	Yes	Yes	Yes	Yes	508.14 Routine Medical Treatment 504.24 Safety Cells
Segregation may be used if necessary to protect the safety of the inmate or others.	Yes	Yes	Yes	Yes	Yes	504.02 (2.0) Classification 508.10 Medical Screening/Medical Release
1053 ADMINISTRATIVE SEGREGATION Except in Type IV facilities, each facility administrator shall develop written policies and procedures which provide for the administrative segregation of inmates who are determined to be prone to: promote activity or behavior that is criminal in nature or disruptive to facility operations; demonstrate influence over other inmates, including influence to promote or direct action or behavior that is criminal in nature or disruptive to the safety and security of other inmates or facility staff, as well as to the safe operation of the facility; escape; assault, attempted assault, or participation in a conspiracy to assault or harm other inmates or facility staff; or likely to need protection from other inmates, if such administrative segregation is determined to be necessary in order to obtain the objective of protecting the welfare of inmates and staff.	Yes	Yes	Yes	Yes	Yes	504.01 Administrative Segregation Inmates who are psychologically or mentally impaired, may pose an escape or serious violent threat, who have known gang affiliations or are a known management problem, are a suicide risk, have medical problems, are examples of those who may be placed in administrative segregation
Administrative segregation shall consist of separate and secure housing but shall not involve any other deprivation of privileges than is necessary to obtain the objective of protecting the inmates and staff.	Yes	Yes	Yes	Yes	Yes	504.11 Isolation Cells 504.02 (4.2) Classification
1055 USE OF SAFETY CELL The safety cell described in Title 24, Part 2, Section 1231.2.5, shall be used to hold only those inmates who display behavior which results in the destruction of property or reveals an intent to cause physical harm to self or others.	Yes	Yes	Yes	Yes	Yes	504.24 Safety Cells 508.12 Safety cells at the jail are used for inmates displaying behavior that reveals intent to cause physical harm to self or others or which results in the destruction or property. “Blythe” Inmates needing placement into a safety cell, shall be transferred to “Indio” Correction facility.
The facility administrator, in cooperation with the responsible physician, shall develop written policies and procedures governing safety cell use and may delegate authority to place an inmate in a safety cell to a physician.	Yes	Yes	Yes	Yes	Yes	

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
In no case shall the safety cell be used for punishment or as a substitute for treatment.	Yes	Yes	Yes	Yes	Yes	
An inmate shall be placed in a safety cell only with the approval of the facility manager or designee, or responsible health care staff; continued retention shall be reviewed a minimum of every four hours.	Yes	Yes	Yes	Yes	Yes	504.24 (2.1) Safety Cells
A medical assessment shall be completed within a maximum of 12 hours of placement in the safety cell or at the next daily sick call, whichever is earliest.	Yes	Yes	Yes	Yes	Yes	CDPM 504.24 Medical assessments shall be completed every 8 hours and medical clearance for continued retention occurs every 24 hours.
The inmate shall be medically cleared for continued retention every 24 hours thereafter.	Yes	Yes	Yes	Yes	Yes	504.24. (2.1) The facility commander or designee must approve continued retention in the safety cell every 8 hours, the documentation appeared thorough and complete.
The facility manager, designee or responsible health care staff shall obtain a mental health opinion/consultation with responsible health care staff on placement and retention, which shall be secured within 12 hours of placement.	Yes	Yes	Yes	Yes	Yes	504.24 (1.1) Safety Cells 504.24 Safety Cells 508.12 Mental Health Services
Direct visual observation shall be conducted at least twice every thirty minutes. Such observation shall be documented.	Yes	Yes	Yes	Yes	Yes	504.24. (2.4.1) BSCC reviewed a sample of observation logs. All were within the required time frame.
Procedures shall be established to assure administration of necessary nutrition and fluids.	Yes	Yes	Yes	Yes	Yes	
Inmates shall be allowed to retain sufficient clothing, or be provided with a suitably designed "safety garment," to provide for their personal privacy unless specific identifiable risks to the inmate's safety or to the security of the facility are documented.	Yes	Yes	Yes	Yes	Yes	504.24.2.1 (2.5 – 2.6)
1056 USE OF SOBERING CELL The sobering cell described in Title 24, Part 2, Section 1231.2.4, shall be used for the holding of inmates who are a threat to their own safety or the safety of others due to their state of intoxication and pursuant to written policies and procedures developed by the facility administrator.	Yes	Yes	Yes	Yes	Yes	504.05 Sobering Cells
Such inmates shall be removed from the sobering cell as they are able to continue in the processing.	Yes	Yes	Yes	Yes	Yes	

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
In no case shall an inmate remain in a sobering cell over six hours without an evaluation by a medical staff person or an evaluation by custody staff, pursuant to written medical procedures in accordance with section 1213 of these regulations, to determine whether the prisoner has an urgent medical problem.	Yes	Yes	Yes	Yes	Yes	In no case will an inmate remain in a sobering cell more than six hour without a recorded evaluation by a medical staff member.
At 12 hours from the time of placement, all inmates will receive an evaluation by responsible health care staff.	Yes	Yes	Yes	Yes	Yes	
Intermittent direct visual observation of inmates held in the sobering cell shall be conducted no less than every half hour. Such observation shall be documented.	Yes	Yes	Yes	Yes	Yes	Direct visual supervision is conducted once every thirty minutes and noted on the sobering cell log. BSCC reviewed a sample of observation logs. All was within the required time frame. Supervisor will review the sobering cell log at least once every four hours and document time on the sobering cell log.
1057 DEVELOPMENTALLY DISABLED INMATES The facility administrator, in cooperation with the responsible physician, shall develop written policies and procedures for the identification and evaluation, appropriate classification and housing, protection, and nondiscrimination of all developmentally disabled inmates.	Yes	Yes	Yes	Yes	Yes	508.04 Developmentally Disabled Inmates
The health authority or designee shall contact the regional center on any inmate suspected or confirmed to be developmentally disabled for the purposes of diagnosis and/or treatment within 24 hours of such determination, excluding holidays and weekends.	Yes	Yes	Yes	Yes	Yes	
1058 USE OF RESTRAINT DEVICES The facility administrator, in cooperation with the responsible physician, shall develop written policies and procedures for the use of restraint devices and may delegate authority to place an inmate in restraints to a responsible health care staff.	Yes	Yes	Yes	Yes	Yes	503.08 503.07 Fluids and sanitation offered every two hours. Range of motion is conducted every thirty minutes. Incidents are documented on the Corrections Division Use of Force Report.
In addition to the areas specifically outlined in this regulation, at a minimum, the policy shall address the following areas: acceptable restraint devices;	Yes	Yes	Yes	Yes	Yes	Restraint Chair

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
signs or symptoms which should result in immediate medical/mental health referral;	Yes	Yes	Yes	Yes	Yes	503.07 (6.2.1)
availability of cardiopulmonary resuscitation equipment;	Yes	Yes	Yes	Yes	Yes	
protective housing of restrained persons;	Yes	Yes	Yes	Yes	Yes	
provision for hydration and sanitation needs; and	Yes	Yes	Yes	Yes	Yes	503.08 (6.6)
exercising of extremities.	Yes	Yes	Yes	Yes	Yes	503.7 (5.1)
In no case shall restraints be used for punishment or as a substitute for treatment.	Yes	Yes	Yes	Yes	Yes	
Restraint devices shall only be used on inmates who display behavior which results in the destruction of property or reveal an intent to cause physical harm to self or others. Restraint devices include any devices which immobilize an inmate's extremities and/or prevent the inmate from being ambulatory. Physical restraints should be utilized only when it appears less restrictive alternatives would be ineffective in controlling the disordered behavior.	Yes	Yes	Yes	Yes	Yes	503.07 (1.3)
Inmates shall be placed in restraints only with the approval of the facility manager, the facility watch commander, responsible health care staff; continued retention shall be reviewed a minimum of every hour.	No	No	No	Yes	Yes	503.07 (6.7) Emergency Restraint Chair Observation logs reveals retention review were past the required hour review.
A medical opinion on placement and retention shall be secured within one hour from the time of placement.	No	No	No	Yes	Yes	503.08 (6.2) Restraint Devices RPDC, LSC and CDB facilities observation logs reveals retention review were past the required hour review.
A medical assessment shall be completed within four hours of placement.	Yes	Yes	Yes	Yes	Yes	503.07 (6.2) Emergency Restraint Chair Health Services staff shall evaluate the inmate upon initial placement in the emergency restraint chair, and every hour thereafter.
If the facility manager, or designee, in consultation with responsible health care staff determines that an inmate cannot be safely removed from restraints after eight hours, the inmate shall be taken to a medical facility for further evaluation.	Yes	Yes	Yes	Yes	Yes	503.07 (6.7.3 Emergency Restraint Chair

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
Direct visual observation shall be conducted at least twice every thirty minutes to ensure that the restraints are properly employed, and to ensure the safety and well-being of the inmate. Such observation shall be documented.	Yes	Yes	Yes	Yes	Yes	503.07 (.1) Emergency Restraint Chair A Safety Cell Log (504.24 Attachment #1), or Special Housing log (RSD Form 563) recording the direct observation by facility staff shall be kept for every person restrained in the chair. 503.07 (6.2) Emergency Restraint Chair Corrections staff shall visually check the inmate at least twice every thirty minutes to ensure the safety and well-being of the inmate The documentation is thorough and complete.
While in restraint devices all inmates shall be housed alone or in a specified housing area for restrained inmates which makes provisions to protect the inmate from abuse.	Yes	Yes	Yes	Yes	Yes	5.08 Restraint Devices 503.07 Emergency Restraint Chair 503.08 Restraint Devices
The provisions of this section do not apply to the use of handcuffs, shackles or other restraint devices when used to restrain inmates for security reasons.	Yes	Yes	Yes	Yes	Yes	503.08 (6.0)
1058.5 RESTRAINTS AND PREGNANT INMATES The facility administrator, in cooperation with the responsible physician, shall develop written policies and procedures for the use of restraint devices on pregnant inmates. In accordance with Penal Code 3407 the policy shall include reference to the following:	Yes	Yes	Yes	Yes	Yes	508.19
(1) An inmate known to be pregnant or in recovery after delivery shall not be restrained by the use of leg irons, waist chains, or handcuffs behind the body.	Yes	Yes	Yes	Yes	Yes	508.19 (2.1)
(2) A pregnant inmate in labor, during delivery, or in recovery after delivery, shall not be restrained by the wrists, ankles, or both, unless deemed necessary for the safety and security of the inmate, the staff, or the public.	Yes	Yes	Yes	Yes	Yes	
(3) Restraints shall be removed when a professional who is currently responsible for the medical care of a pregnant inmate during a medical emergency, labor, delivery, or recovery after delivery determines that the removal of restraints is medically necessary.	Yes	Yes	Yes	Yes	Yes	50.19 (2.1)
(4) Upon confirmation of an inmate's pregnancy, she shall be advised, orally or in writing, of the standards and policies governing pregnant inmates.	Yes	Yes	Yes	Yes	Yes	50.19 (2.1)

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
1059 USE OF REASONABLE FORCE TO COLLECT DNA SPECIMENS, SAMPLES, IMPRESSIONS (a) Pursuant to Penal Code Section 298.1, authorized law enforcement, custodial, or corrections personnel including peace officers, may employ reasonable force to collect blood specimens, saliva samples, or thumb or palm print impressions from individuals who are required to provide such samples, specimens or impressions pursuant to Penal Code Section 296 and who refuse following written or oral request.	Yes	Yes	Yes	Yes	Yes	504.06 DNA Samples
(1) For the purpose of this regulation, the "use of reasonable force" shall be defined as the force that an objective, trained and competent correctional employee, faced with similar facts and circumstances, would consider necessary and reasonable to gain compliance with this regulation.	Yes	Yes	Yes	Yes	Yes	504.06.9.0 DNA Samples If after the inmate's case of 298.1 (a) PC is adjudicated and the court remands the inmate into the sheriff's custody for collection, the DNA sample will be taken.
(2) The use of reasonable force shall be preceded by efforts to secure voluntary compliance. Efforts to secure voluntary compliance shall be documented and include an advisement of the legal obligation to provide the requisite specimen, sample or impression and the consequences of refusal.	Yes	Yes	Yes	Yes	Yes	504.06.9.1.2 DNA Samples A sergeant will be notified to respond to the area.
(b) The force shall not be used without the prior written authorization of the facility watch commander on duty. The authorization shall include information that reflects the fact that the offender was asked to provide the requisite specimen, sample, or impression and refused.	Yes	Yes	Yes	Yes	Yes	Corrections Division Policy § 504.06.9.1.3 DNA Samples Any time force is used to obtain a DNA sample, it shall be videotaped and archived for current year plus one.
(c) If the use of reasonable force includes a cell extraction, the extraction shall be videotaped, including audio. Video shall be directed at the cell extraction event. The videotape shall be retained by the agency for the length of time required by statute. Notwithstanding the use of the video as evidence in a criminal proceeding, the tape shall be retained administratively.	Yes	Yes	Yes	Yes	Yes	
1061 INMATE EDUCATION PROGRAM The facility administrator of any Type II or III facility shall plan and shall request of appropriate public officials an inmate education program.	Yes	Yes	Yes	Yes	Yes	507.04 Inmate Education Programs Chaplain Religious Volunteer Services NA/AA Volunteer Services Library Book Cart Residential Substance Abuse Treatment (RSAT) Program Education Adult Basic Education Vocational Education GED testing
When such services are not made available by the appropriate public officials, then the facility administrator shall develop and implement an education program with available resources.	Yes	Yes	Yes	Yes	Yes	
Such a plan shall provide for the voluntary academic and/or vocational education of housed inmates.	Yes	Yes	Yes	Yes	Yes	

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
Reasonable criteria for program eligibility shall be established and an inmate may be excluded or removed based on sound security practices or failure to abide by facility rules and regulations.	Yes	Yes	Yes	Yes	Yes	
1062 VISITING (a) The facility administrator shall develop written policies and procedures for inmate visiting which shall provide for as many visits and visitors as facility schedules, space, and number of personnel will allow.	Yes	Yes	Yes	Yes	Yes	Corrections Division Policy § 507.17 Visiting Visits are by appointment only. Visitors must call the day before the requested visiting day to set an appointment
(TYPE II ONLY) All inmates in Type II facilities are allowed at least two visits totaling at least one hour per inmate each week.	Yes	Yes	Yes	Yes	Yes	Each inmate is allowed two visits per day (50 minutes per visit).
(TYPE III ONLY) Inmates in Type III facilities are allowed one or more visits, totaling at least one hour per week.	Yes	Yes	Yes	Yes	Yes	
(c) The visiting policies developed pursuant to this section shall include provision for visitation by minor children of the inmate.	Yes	Yes	Yes	Yes	Yes	507.17 (2.1) Personal Visits
(d) Video visitation may be used to supplement existing visitation programs, but shall not be used to fulfill the requirements of this section if in-person visitation is requested by an inmate.	Yes	Yes	N/A	N/A	N/A	RPDC and LSC facilities only.
(e) Facilities shall not charge for visitation when visitors are onsite and participating in either in-person or video visitation. For purposes of this subsection, "onsite" is defined as the location where the inmate is housed.	Yes	Yes	N/A	N/A	N/A	
(f) Subdivision (d) shall not apply to facilities which (1) exclusively used video visitation prior to January 1, 2017 or (2) had been designed without in-person visitation space and conditionally awarded by the Board prior to June 27, 2017.	Yes	Yes	N/A	N/A	N/A	
(g) If a local detention facility offered video visitation only as of January 1, 2017, the first hour of remote video visitation per week shall be offered free of charge.	Yes	Yes	N/A	N/A	N/A	
Types and availability of visitation, including: *Note: Reference PC § 6031.1 (June 2017)*	Yes	Yes	Yes	Yes	Yes	
Mode of visitation;	Yes	Yes	Yes	Yes	Yes	Each facilities has non-contact visits.
Visitation hours;	Yes	Yes	Yes	Yes	Yes	Visiting appointments are scheduled daily from 9:00 am to 5:00 pm
Time inmates are allowed for visitation; and,	Yes	Yes	Yes	Yes	Yes	Inmates are allowed a maximum of two visits per week and each visit is approximately 45 minutes.
Any restrictions on inmate visitation.	Yes	Yes	Yes	Yes	Yes	

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
1063 CORRESPONDENCE The facility administrator shall develop written policies and procedures for inmate correspondence which provide that:	Yes	Yes	Yes	Yes	Yes	507.09 Mail 504.02 Classification
(a) there is no limitation on the volume of mail that an inmate may send or receive;	Yes	Yes	Yes	Yes	Yes	507.09 (1.2) Mail
(b) inmate correspondence may be read when there is a valid security reason and the facility manager or his/her designee approves;	Yes	Yes	Yes	Yes	Yes	507.09 (1.4) Mail
(c) jail staff shall not review inmate correspondence to or from state and federal courts, any member of the State Bar or holder of public office, and the State Board of State and Community Corrections; however, jail authorities may open and inspect such mail only to search for contraband, cash, checks, or money orders and in the presence of the inmate;	Yes	Yes	Yes	Yes	Yes	507.09 (1.3) Mail
(d) inmates may correspond, confidentially, with the facility manager or the facility administrator; and,	Yes	Yes	Yes	Yes	Yes	
(e) those inmates who are without funds shall be permitted at least two postage paid envelopes and two sheets of paper each week to permit correspondence with family members and friends but without limitation on the number of postage paid envelopes and sheets of paper to his or her attorney and to the courts.	Yes	Yes	Yes	Yes	Yes	
1064 LIBRARY SERVICES The facility administrator shall develop written policies and procedures for library service in all Type II, III, and IV facilities. The scope of such service shall be determined by the facility administrator. The library service shall include access to legal reference materials, current information on community services and resources, and religious, educational, and recreational reading material. In Type IV facilities such a program can be either in-house or provided through access to the community.	Yes	Yes	Yes	Yes	Yes	507.07 Law Library
1065 EXERCISE AND RECREATION (a) The facility administrator of a Type II or III facility shall develop written policies and procedures for an exercise and recreation program, in an area designed for recreation, which will allow a minimum of three hours of exercise distributed over a period of seven days. Such regulations as are reasonable and necessary to protect the facility's security and the inmates' welfare shall be included in such a program.	Yes	Yes	Yes	Yes	Yes	507.13 Recreation

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
1066 BOOKS, NEWSPAPERS, PERIODICALS, AND WRITINGS The facility administrator of a Type II or III facility shall develop written policies and procedures which will permit inmates to purchase, receive and read any book, newspaper, periodical, or writing accepted for distribution by the United States Postal Service. Nothing herein shall be construed as limiting the right of a facility administrator to:	Yes	Yes	Yes	Yes	Yes	507.13 (2.0) Recreation
(1) exclude any publications or writings based on any legitimate penological interest;	Yes	Yes	Yes	Yes	Yes	
(2) exclude obscene publications or writings, and mail containing information concerning where, how, or from whom such matter may be obtained; and any matter of a character tending to incite murder, arson, riot, violent racism, or any other form of violence; any matter of a character tending to incite crimes against children; any matter concerning unlawful gambling or an unlawful lottery; the manufacture or use of weapons, narcotics, or explosives; or any other unlawful activity;	Yes	Yes	Yes	Yes	Yes	
(3) open and inspect any publications or packages received by an inmate; and	Yes	Yes	Yes	Yes	Yes	
(4) restrict the number of books, newspapers, periodicals, or writings the inmate may have in his/her cell or elsewhere in the facility at one time.	Yes	Yes	Yes	Yes	Yes	
1067 ACCESS TO TELEPHONE The facility administrator shall develop written policies and procedures which allow reasonable access to a telephone beyond those telephone calls which are required by Section 851.5 of the Penal Code.	Yes	Yes	Yes	Yes	Yes	507.15 Telephones
1068 ACCESS TO COURTS AND COUNSEL The facility administrator shall develop written policies and procedures to ensure inmates have access to the court and to legal counsel. Such access shall consist of:	Yes	Yes	Yes	Yes	Yes	507.20 Official Visits
(a) unlimited mail as provided in Section 1063 of these regulations, and,	Yes	Yes	Yes	Yes	Yes	507.09 (1.3) Mail
(b) confidential consultation with attorneys.	Yes	Yes	Yes	Yes	Yes	507.20 Official Visits
1069 INMATE ORIENTATION In Type II, III, and IV facilities, the facility administrator shall develop written policies and procedures for the implementation of a program reasonably understandable to inmates designed to orient a newly received inmate at the time of placement in a living area.	Yes	Yes	Yes	Yes	Yes	507.11 Orientation

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
Such a program shall be published and include, but not be limited to, the following:	Yes	Yes	Yes	Yes	Yes	Each inmate receives an inmate orientation booklet.
(1) correspondence, visiting, and telephone usage rules;	Yes	Yes	Yes	Yes	Yes	
(2) rules and disciplinary procedures;	Yes	Yes	Yes	Yes	Yes	507.11 (2.2) Orientation
(3) inmate grievance procedures;	Yes	Yes	Yes	Yes	Yes	507.11 (2.3) Orientation
(4) programs and activities available and method of application;	Yes	Yes	Yes	Yes	Yes	507.11 (2.4) Orientation
(5) medical services;	Yes	Yes	Yes	Yes	Yes	507.11 (2.5) Orientation
(6) classification/housing assignments;	Yes	Yes	Yes	Yes	Yes	507.11 (2.6) Orientation
(7) court appearance where scheduled, if known;	Yes	Yes	Yes	Yes	Yes	507.11 (2.7) Orientation
(8) voting, including registration; and,	Yes	Yes	Yes	Yes	Yes	507.19
(9) zero tolerance policy against sexual abuse and sexual harassment.	Yes	Yes	Yes	Yes	Yes	
1070 INDIVIDUAL/FAMILY SERVICE PROGRAMS The facility administrator of a Type II, III, or IV facility shall develop written policies and procedures which facilitate cooperation with appropriate public or private agencies for individual and/or family social service programs for inmates. Such a program shall utilize the services and resources available in the community and may be in the form of a resource guide and/or actual service delivery.	Yes	Yes	Yes	Yes	Yes	507.18 Volunteers The Sheriff's Inmate Training and Education Bureau (SITE-B) provides educational, counseling Chaplains, detention volunteers, transitional programs, occupational technologies and inmate support services to inmates within the Riverside Sheriff's system.
The range and source of such services shall be at the discretion of the facility administrator and may include: (a) risk and needs assessments; (b) best practices in: (1) individual, group and/or family counseling; (2) drug and alcohol abuse counseling; (3) cognitive behavioral interventions; (4) vocational testing and counseling; (5) employment counseling; (c) referral to community resources and programs; (d) reentry planning and service development; (e) legal assistance; (f) regional center services for the developmentally disabled; and, (g) community volunteers.	Yes	Yes	Yes	Yes	Yes	
1071 VOTING The facility administrator of a Type I (holding sentenced inmate workers) II, III or IV facility shall develop written policies and procedures whereby the county registrar of voters allows qualified voters to vote in local, state, and federal elections, pursuant to election codes.	Yes	Yes	Yes	Yes	Yes	507.19 Voting

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
1072 RELIGIOUS OBSERVANCES The facility administrator of a Type I, II, III or IV facility shall develop written policies and procedures to provide opportunities for inmates to participate in religious services, practices and counseling on a voluntary basis.	Yes	Yes	Yes	Yes	Yes	507.14 Religious Services
1073 INMATE GRIEVANCE PROCEDURE (a) Each administrator of a Type II, III, or IV facility and Type I facilities which hold inmate workers shall develop written policies and procedures whereby any inmate may appeal and have resolved grievances relating to any conditions of confinement, including but not limited to: medical care; classification actions; disciplinary actions; program participation; telephone, mail, and visiting procedures; and food, clothing, and bedding. Such policies and procedures shall include:	Yes	Yes	Yes	Yes	Yes	507.02 Grievance/ Writ Petition
(1) a grievance form or instructions for registering a grievance;	Yes	Yes	Yes	Yes	Yes	507.02 (2.1) Grievance/ Writ Petition
(2) resolution of the grievance at the lowest appropriate staff level;	Yes	Yes	Yes	Yes	Yes	507.02 (1.0) Grievance/ Writ Petition
(3) appeal to the next level of review;	Yes	Yes	Yes	Yes	Yes	507.02(2.9.4) Grievance/ Writ Petition Inmates may submit a hand-written appeal at the supervisor level within seven days. 507 02 (2.9.4) Grievance/ Writ Petition Grievances not resolved at the lieutenant level may be appealed to the facility commander within seven days.
(4) written reasons for denial of grievance at each level of review which acts on the grievance;	Yes	Yes	Yes	Yes	Yes	
(5) provision for response within a reasonable time limit; and,	Yes	Yes	Yes	Yes	Yes	
(6) provision for resolving questions of jurisdiction within the facility.	Yes	Yes	Yes	Yes	Yes	
(b) Grievance System Abuse: The facility may establish written policy and procedure to control the submission of an excessive number of grievances.	Yes	Yes	Yes	Yes	Yes	
1080 RULES AND DISCIPLINARY PENALTIES Wherever discipline is administered, each facility administrator shall establish written rules and disciplinary penalties to guide inmate conduct.	Yes	Yes	Yes	Yes	Yes	504.09 Inmate Discipline Reviewed several discipline files from each facility.

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
Such rules and disciplinary penalties shall be stated simply and affirmatively, and posted conspicuously in housing units and the booking area or issued to each inmate upon booking.	Yes	Yes	Yes	Yes	Yes	
For those inmates who are illiterate or unable to read English, and for persons with disabilities, provision shall be made for the jail staff to instruct them verbally or provide them with material in an understandable form regarding jail rules and disciplinary procedures and penalties.	Yes	Yes	Yes	Yes	Yes	
1081 PLAN FOR INMATE DISCIPLINE Each facility administrator shall develop written policies and procedures for inmate discipline. The plan shall include, but not be limited to, the following elements:	Yes	Yes	Yes	Yes	Yes	Corrections Division Policy § 504.09 Inmate Discipline
(a) Temporary Loss of Privileges: For minor acts of non-conformance or minor violations of facility rules, staff may impose a temporary loss of privileges, such as access to television, telephones, commissary, or lockdown for less than 24 hours, provided there is written documentation and supervisory approval.	Yes	Yes	Yes	Yes	Yes	Senior CD II or Corporal will serve the inmate with the proposed discipline.
(b) Punitive Actions: Major violations of facility rules or repetitive minor acts of non-conformance or repetitive minor violations of facility rules shall be reported in writing by the staff member observing the act and submitted to the disciplinary officer. The consequences of such violations may include, but are not limited to:	Yes	Yes	Yes	Yes	Yes	
1. Loss of good time/work time.	Yes	Yes	Yes	Yes	Yes	Sergeants will approve all disciplinary actions.
2. Placement in disciplinary separation.	Yes	Yes	Yes	Yes	Yes	
3. Disciplinary separation diet.	Yes	Yes	Yes	Yes	Yes	
4. Loss of privileges mandated by regulations.	Yes	Yes	Yes	Yes	Yes	
A staff member with investigative and punitive authority shall be designated as a disciplinary officer to impose such consequences.	Yes	Yes	Yes	Yes	Yes	
Staff shall not participate in disciplinary review if they are involved in the charges.	Yes	Yes	Yes	Yes	Yes	
Such charges pending against an inmate shall be acted on with the following provisions and within specified timeframes:	Yes	Yes	Yes	Yes	Yes	
1. A copy of the report, and/or a separate written notice of the violation(s), shall be provided to the inmate.	Yes	Yes	Yes	Yes	Yes	
2. Unless declined by the inmate, a hearing shall be provided no sooner than 24 hours after the report has been submitted to the disciplinary officer and the inmate has been informed of the charges in writing. The hearing may be postponed or continued for a reasonable time through a written waiver by the inmate, or for good cause.	Yes	Yes	Yes	Yes	Yes	504.09 (5.2) Inmate Discipline 504.09 (5.2.2) Inmate Discipline

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
3. The inmate shall be permitted to appear on his/her own behalf at the time of hearing and present witnesses and documentary evidence. The inmate shall have access to staff or inmate assistance when the inmate is illiterate or the issues are complex.	Yes	Yes	Yes	Yes	Yes	
4. A charge(s) shall be acted on no later than 72 hours after an inmate has been informed of the charge(s) in writing.	Yes	Yes	Yes	Yes	Yes	504.09 (5.2.2) Inmate Discipline
5. Subsequent to final disposition of disciplinary charges by the disciplinary officer, the charges and the action taken shall be reviewed by the facility manager or designee.	Yes	Yes	Yes	Yes	Yes	
6. The inmate shall be advised in a written statement by the fact-finders about the evidence relied on and the reasons for the disciplinary action. A copy of the record shall be kept pursuant to Penal Code Section 4019.5.	Yes	Yes	Yes	Yes	Yes	504.09 (5.1) Inmate Discipline
7. There shall be a policy of review and appeal to a supervisor on all disciplinary action.	Yes	Yes	Yes	Yes	Yes	
(c) Nothing in this section precludes a facility administrator from administratively segregating any inmate from the general population or program for reasons of personal, mental, or physical health, or under any circumstance in which the safety of the inmates, staff, program, or community is endangered, pending disciplinary action or a review as required by Section 1053 of these regulations.	Yes	Yes	Yes	Yes	Yes	
(d) Nothing in this section precludes the imposition of conditions or restrictions that reasonably relate to a legitimate, non-punitive administrative purpose.	Yes	Yes	Yes	Yes	Yes	
1082 FORMS OF DISCIPLINE The degree of punitive actions taken by the disciplinary officer shall be directly related to the severity of the rule infraction. Acceptable forms of discipline shall consist of, but not be limited to, the following: (a) Loss of privileges. (b) Extra work detail. (c) Short term lockdown for less than 24 hours. (d) Removal from work details. (e) Forfeiture of "good time" credits earned under Penal Code Section 4019. (f) Forfeiture of "work time" credits earned under Penal Code Section 4019. (g) Disciplinary separation. (h) Disciplinary separation diet.	Yes	Yes	Yes	Yes	Yes	504.09 (8.7) Inmate Discipline

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
1083 LIMITATIONS ON DISCIPLINARY ACTIONS The Penal Code and the State Constitution expressly prohibit all cruel and unusual punishment. Additionally, there shall be the following limitations: (a) If an inmate is on disciplinary separation status for 30 consecutive days there shall be a review by the facility manager before the disciplinary separation status is continued. This review shall include a consultation with health care staff. Such reviews shall continue at least every fifteen days thereafter until the disciplinary status has ended. This review shall be documented.	Yes	Yes	Yes	Yes	Yes	
(b) The disciplinary separation cells or cell shall have the minimum furnishings and space specified in Title 24, Part 2, 1231.2.6 and 2.7. Occupants shall be issued clothing and bedding as specified in Articles 13 and 14 of these regulations and shall not be deprived of them through any portion of the day except that those inmates who engage in the destruction of bedding or clothing may be deprived of such articles. The decision to deprive inmates of such articles of clothing and bedding shall be reviewed by the facility manager or designee during each 24-hour period.	Yes	Yes	Yes	Yes	Yes	
(c) The delegation of authority to any inmate or group of inmates to exercise the right of punishment over any other inmate or group of inmates (Penal Code section 4019.5)	Yes	Yes	Yes	Yes	Yes	
(d) In no case shall a safety cell, as specified in Title 24, Part 2, 1231.2.5, or any restraint device be used for disciplinary purposes.	Yes	Yes	Yes	Yes	Yes	
(e) No inmate may be deprived of the implements necessary to maintain an acceptable level of personal hygiene as specified in Section 1265 of these regulations	Yes	Yes	Yes	Yes	Yes	
(f) Food shall not be withheld as a disciplinary measure.	Yes	Yes	Yes	Yes	Yes	
(g) The disciplinary separation diet described in section 1247 of these regulations shall only be utilized for major violations of institutional rules.	Yes	Yes	Yes	Yes	Yes	
(1) In addition to the provisions of Section 1247, the facility manager shall approve the initial placement on the disciplinary separation diet and ensure that medical staff is notified.	Yes	Yes	Yes	Yes	Yes	
(2) In consultation with medical care staff, the facility manager shall approve any continuation on that diet every 72 hours after the initial placement.	Yes	Yes	Yes	Yes	Yes	

TITLE 15 SECTION	RPDC	LSC	CBD	BJ	IJ	P/P REFERENCE – COMMENTS
(h) Correspondence privileges shall not be withheld except in cases where the inmate has violated correspondence regulations, in which case correspondence may be suspended for no longer than 72 hours, without the review and approval of the facility manager.	Yes	Yes	Yes	Yes	Yes	
(i) In no case shall access to courts and legal counsel be suspended as a disciplinary measure.	Yes	Yes	Yes	Yes	Yes	
1084 DISCIPLINARY RECORDS Penal Code Section 4019.5 requires that a record is kept of all disciplinary infractions and punishment administered therefore. This requirement may be satisfied by retaining copies of rule violation reports and report of the disposition of each.	Yes	Yes	Yes	Yes	Yes	504.09 Inmate Discipline § 506.14 Purging of Records
DETENTION OF MINORS						
Are minors held in this facility? If yes, the following sections including those summarizing the regulations identified in Title 15, Article 8 of these regulations apply (Minors in Jails). *Note: Reference PC § 207.1(b), 207.6, 707.1*						Minors are not held in any facilities.

ADULT TYPE I, II, III AND IV FACILITIES
PHYSICAL PLANT EVALUATION
Board of State and Community Corrections

Applicable Title 24 Regulations: 3/80; 8/86; 5/88; 1/91/94

BSCC Code: 3910

FACILITY NAME: Robert Presley Detention Center					**FACILITY TYPE:** II
APPLICABLE REGULATIONS (Check All That Apply):	**3/80:** X	**8/86:** X	**5/88:** X	**1/91: X**	**OTHER:** 94
FIELD REPRESENTATIVE: Michael J. Bush					**DATE:** 09/18/2019

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Temporary Holding Cells (2.2) Contain 10 square feet of floor per inmate	X			
Limited to no more than 16 inmates	X			
No smaller than 40 square feet	X			
Contain sufficient seating to accommodate all inmates	X			Includes court holding cells (1986 Standards)
Toilet accessible	X			
Water fountain accessible	X			
Wash basin accessible	X			
Provides clear visual supervision	X			
Telephone accessible	X			
Weapons Locker (3.12) External to the security area and equipped with individual compartments, locks and keys	X			
Temporary Staging Cell or Room (2.3) 1-91: Added provision for temporary staging cells-rooms Holds inmates classified and segregated per Title 15 § 1050 and § 1053			X	
Limited to holding inmates up to 4 hours			X	
Maximum capacity of no more than 80 inmates			X	
Contains 10 square feet of floor space per inmate and has a ceiling height of at least 8 feet			X	
No smaller than 160 square feet			X	
Contains seating to accommodate all inmates			X	
Contains water closet, wash basin and drinking fountain			X	
Provides unobstructed visual supervision of inmates by staff			X	
Detoxification/Sobering Cells (2.4) 01: Name change to "sobering cell" Contain 20 square feet of floor per inmate	X			
Limited to no more than 8 inmates	X			
No smaller than 60 square feet	X			
Contain toilet	X			
Contain washbasin	X			
Contain drinking fountain	X			
Partitions or handrails located next to toilet fixture to provide support	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Provide easy, unobstructed visual observation	X			
Padding on the floor	X			
Shower-Delousing Room (3.4) Available in reception/booking	X			
Secure Vault or Storage Space (2.1) Available for inmate valuables	X			
Telephone (2.1) Available for inmate use per Penal Code § 851.5	X			
Safety Cells (2.5) Contain 48 square feet with one floor dimension at least 6 feet and ceiling height of at least 8 feet	X			
Limited to no more than one inmate	X			
Contain flush ring toilet with controls located outside the cell	X			
Padded floor, door and walls	X			
Equipped with variable intensity, security light, inaccessible to occupant	X			
Vertical view panel not more than 4 inches wide and at least 24 inches long, in or adjacent to the door	X			
Provide a food pass with lockable shutter no more than 4 inches high and located at least 30 inches above the floor	X			
Single Occupancy Cells (2.6) Maximum capacity of one inmate	X			1994 Standards
Contain a minimum of 60 square feet of floor area in Type I facilities and 70 square feet in Type II and III facilities	X			
Have a minimum ceiling height of 8 feet	X			
Contain toilet, washbasin and drinking fountain	X			
Contain a bunk, desk and seat (Desk and seat not required in Type I in later, less restrictive 1986 standards)	X			
Multiple Occupancy Cells (8227) 8-86: Deleted provision for multiple occupancy cells Contain 35 square feet per person	X			
Limited to no more than 8 inmates	X			
No smaller than 100 square feet	X			
Minimum ceiling height of 8 feet	X			
Water closet separate from washbasin and drinking fountain	X			
Sufficient bunks to accommodate each occupant	X			
Provide storage space for each occupant's personal items	X			
Multiple Occupancy Rooms (8229) 8-86: Deleted provision for multiple occupancy rooms Limited to housing persons in Type III and IV facilities and workers in Type I and II facilities			X	
Contain 50 square feet of floor area per person and a minimum of 8 feet ceiling height			X	

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Limited to no more than 16 persons			X	
Access to toilets separate from washbasins (ratio 1:8) and drinking fountains			X	
Provide storage space for each occupant's personal items			X	
Double Occupancy Cells (2.7) 5-88: Added provision for double occupancy cells Maximum capacity of two inmates		X		3 inmates in 3B1 & 3B2 over the rated capacity. Inmates were sleeping in the dayroom on a stack-a-bunk.
Contain a minimum of 60 square feet of floor space in Type I facilities and 70 square feet in Type II and III facilities	X			
Have a minimum ceiling height of 8 feet and one floor dimension at least 6 feet	X			
Contain toilet, washbasin and drinking fountain	X			
Contain 2 bunks, 1 desk and seat (Desk and seat not required in Type I facilities)	X			
Dormitories (2.8) 8-86: Provision for dormitories added Contain 50 square feet of floor area per inmate and a minimum of 8 feet ceiling height			X	
Be designed for no fewer than 8 and no more than 64 inmates			X	
Facilities having a total rated capacity of 80 inmates or less, may design dormitories for no fewer than 4 inmates			X	
Access to toilets separate from washbasins (ratio 1:8) and drinking fountains 01: Ratio changed to 1:10			X	
Provide storage space for each inmate's personal items			X	
Dayrooms (2.9) 8-86: Added requirement for 3-foot-wide corridors in front of cells-rooms 99: Corridor requirement deleted	X			
35 square feet of floor area per inmate	X			
Contain tables and seating to accommodate the maximum number of inmates served		X		Housing unit 2A, 2C and 3B had more inmates out in the dayroom than the table and chairs allowed.
Access to toilets, washbasins and drinking fountains	X			
Available to all inmates in Type II and III facilities (excluding special use cells) and to workers in Type I facilities	X			
Shower (3.4) Available on a ratio of 1:16 01: Ratio changed to 1:20	X			
Lighting (3.6) Sufficient to permit easy reading. Night lighting is sufficient to allow good supervision. 8-86: Specifies at least 20 foot-candles at desk level and in grooming areas, with night lighting not to exceed 5 foot-candles	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Beds-Bunks (3.5) 30 inches wide and 76 inches long		X		4-stack-a-bunk in housing units 3B1 & 3B2 during the 2018-2020 inspection cycle.
Comfortable Living Environment [102(c)6] A comfortable living environment is maintained through an adequate heating and cooling system.	X			
Exercise Area -Type II, III and WA IV (2.10) At least one exercise area must contain a minimum of 900 square feet	X			
8-86: Outdoor exercise area provided	X			
8-86: Clear height of 15 feet with required surface area meeting a formula of: 80% of maximum rated inmate population and number of one-hour exercise periods per day = required surface area	X			
Program Space - Type II and III (2.11) Sufficient area and furnishings to meet the needs of the facility programs	X			
Dining Facilities (2.17) 15 square feet per inmate being fed	X			
Toilets, washbasins and showers are not in the same room or not in view of inmate dining	X			
Visiting (2.18) Sufficient visiting area	X			
Contact visits whenever possible for minimum security inmates			X	
Attorney Interviews (2.26) Provide for confidential attorney consultation	X			
Safety Equipment Storage (2.19) Adequate space is provided for storage of equipment such as fire extinguishers, SCBA, emergency lights, etc.	X			
Janitor Closet (2.20) Located in security areas lockable, containing a mop sink and storage space	X			
Storage Rooms (2.21) Sufficient space to accommodate inmate property, bedding and supplies	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Audio or Video Monitoring System -NA Type IV (2.22) Audio monitoring system capable of alerting staff in a central control point	X			
Video monitoring in corridors, main entries and/or exits and programs or activity areas	X			
Fire Detection and Alarm System [102(c)6] Automatic fire alarm system capable of alerting staff in a central control point	X			
Emergency Power (2.24) Available to provide minimal lighting, maintain communications, alarm, fire, life and security systems	X			
Provide Space for: **Barber/beauty shop(2.15)** 8-86: Limit requirement to Type II and III facilities 99: Requirement deleted	X			
Canteen (2.16) 8-86: Added for II, III & IV facilities	X			
Confidential Interview Rooms (2.25) 8-86: Added for Type II facilities			X	

BOARD OF STATE AND COMMUNITY CORRECTIONS-BIENNIAL INSPECTION
ADULT DETENTION FACILITY
LIVING AREA SPACE EVALUATION

BSCC Code: 3910

FACILITY: Robert Presley Detention Center	**TYPE:** II	**RC:** 760
FIELD REPRESENTATIVE: Michael J. Bush		**DATE:** 09/18/2019

ROOMS							**EACH ROOM**					
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
Male Intake Release (Basement) - Safety Cell does not have an anchor for the pro-straint chair.												
1-4	Safety	1980	4		1	(4)	6.2 X 7.3 X 9.2	1				
1-2	Detox	1980	2		8	(16)	14.3 X 12.0 X 9.2	1		1	1	
B106 – 110	Holding	1980	5		8	(40)	7.3 X 12.0 X 9.2	1		1	1	
Pre-Housing (across from the ICE and Classification office)												
B112	Holding	1980	1		8	(8)	7.0 X 12.0 X 9.2	1		1	1	
Notes: Bench is 16'												
B113	Holding	1980	1		9	(9)	8.0 X 12.0 X 9.2	1		1	1	
Notes: Bench is 16'												
Release												
B206 (2)	Holding	1980	1		10	(10)	8.8 X 12.0 X 8.0	1		1	1	
Notes: Bench is 16'												
B205 (1)	Holding	1980	1		9	(9)	8.5 X 14.9 X 8.0	1		1	1	
Notes: Bench is 14'												
B202 (3)	Holding	1980	1		12	(12)	9.3 X 13.0 X 10.4	1		1	1	
Notes: Bench is 18'												
B201 (4)	Holding	1980	1		14	(14)	16.0 X 13.0 X 10.0	1		1	1	
Notes: Bench is 21'												
Female Intake Release (Basement) Change room/Dress out area.												
B209	Holding	1980	1		3	(3)	13.5 X 8.5 X 8.0					1
Notes: Shower cell with 5' bench												
Pre-Release	Holding	1980	1		10	(10)	8.5 X 12.0 X 8.0	1		1	1	
Notes: Release cell with 16' bench												
B153	Detox	1980	1		3	(3)	7.7 X 10.7 X 8.0	1		1	1	
B152	Detox	1980	1		3	(3)	7.9 X 10.7 X 8.0	1		1	1	
5	Safety	1980	1		1	(1)	6.2 X 10.5 X 8.0	1				
6	Safety	1980	1		1	(1)	6.2 X 10.5 X 8.0	1				
1 & 2	Holding	1980	2		8	(16)	7.9 X 10.7 X 8.0	1		1	1	
Transportation-												
Briefing Room	old cell area 1-5	1980					8.9 X 20.0 X 9.4	1		1	1	
Notes: 33' Bench												
0-3	Holding	1980	4		(16)	(64)	8.9 X 20.0 X 9.4	1		1	1	

*T = Toilets; U = Urinals; W = Wash Basins; F = Fountains; S = Showers in unit; If "Total RC" appears in brackets ( ), it is not part of the facility's rated capacity. "+" indicates that capacity includes prorated air space from adjacent areas.

ROOMS							EACH ROOM					
	Cell	Applicable	#	EACH CELL		Total	DIMENSIONS	FIXTURES*				
Location	Type	Standards	Cells	# Beds	RC	RC	(L x W x H)	T	U	W	F	S
Restraints/5	Holding	1980	2		9	(18)	7.5 X 12.0 X 9.4	1		1	1	
4 & 5	Holding	1980	2		9	(18)	7.9 X 10.7 X 9.4	1		1	1	
Notes: 18' Bench												
6, 7, 8	Holding	1980	3		16	(48)	14.0 X 11.9 X 9.4	1		1	1	
Notes: 24' Bench												
9	Holding	1980	1		9	(9)	7.9 X 11.9 X 9.4	1		1	1	
Notes: 24' Bench												
10	Holding	1980	1		8	(8)	7.9 X 10.7 X 9.4	1		1	1	
Notes: 20' Bench												
11, 12	Holding	1980	2		12	(24)	9.5 X 13.1 X 9.4	1		1	1	
Notes: 23' Bench												
Seventh Floor Infirmary – Medical Housing It is the department's intent to double bunk all singles in this area; review next inspection cycle, MW 2007.												
1-2	Multiple	1980	2	6	6	(12)	33.5 X 33.6	1		1	1	1
Notes: 495.8 square feet, irregular cell												
7 & 8 (s)	Safety	1980	2		1	(2)	6.2 X 8.0	1				
3 & 7	Multiple	1980	2	4	4	(8)		1		1	1	1
Notes: 297 square feet, irregular cell												
727		1980					Male showers					
Notes:												
728-732, 734 & 735	Doubles	1980	7	2	2	(14)	11.9 X 9.3	1		1	1	
733	Single	1980	1	1	1	(1)	11.9 X 9.3	1		1	1	
Notes: Male Cell												
750,751, 753	Doubles	1980	3	2	3	(6)	8.6 X 11.3	1		1	1	
752	Double	1980	1	2	2	(2)	8.6 X 11.3	1		1	1	
743, 744, 746	Doubles	1980	3	2	2	(6)	10.5 X 11.0					
745	Double	1980	1	2	2	(2)	10.5 X 11.0					
Notes: Ad-Seg cells												
757	Multiple	1980	1	4	4	(4)	14.5 X 21.3	1		1	1	1
Notes: cell with shower												
1-3	Holding	1980	3	1	1	(3)	7.0 X 6.0 X 8.7	1		1	1	
Notes: 6' Bench												
Psych2 768		1980					10.5 X 10.8					
Notes: Office Space												
Psych2 769		1980					8.3 X 10.8					
Notes: Office Space												
770		1980					11.0 X 16.2					
General Housing – Level 2 (Administrative Segregation)												
2A1	Double	1994	12	2	2	24	6.0 X 12.5	1		1	1	

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ROOMS							EACH ROOM					
	Cell	Applicable	#	EACH CELL		Total	DIMENSIONS	FIXTURES*				
Location	Type	Standards	Cells	# Beds	RC	RC	(L x W x H)	T	U	W	F	S
2A1	Double	1994	2	2	2	4	9.5 X 12.5	1		1	1	
2A2	Double	1994	16	2	2	32	6.0 X 12.5	1		1	1	
2A3	Double	1994	12	2	2	24	6.0 X 12.5	1		1	1	
2A3	Double	1994	2	2	2	4	9.5 X 12.5	1		1	1	
NOTE: "3 bunks" in cell 2A1, 2, 43, & 44. 3rd bunks are never used and are not part of the RC.												
Level 3												
3A1	Double	1994	12	2	2	24	6.0 X 12.5	1		1	1	
3A1	Double	1994	2	2	2	4	9.5 X 12.5	1		1	1	2
3A2	Double	1994	8	2	2	16	6.0 X 12.0	1		1	1	
3A2	Double	1994	8	2	2	16	6.0 X 12.0	1		1	1	2
3A3	Double	1994	12	2	2	24	6.0 X 12.0	1		1	1	
3A3	Double	1994	2	2	2	4	9.5 X 12.0	1		1	1	2
3B1	Double	1994	18	2	2	36	6.0 X 12.0	1		1	1	
3B1	Double	1994	2	2	2	4	9.5 X 12.0	1		1	1	2
3B2	Double	1994	18	2	2	36	6.0 X 12.0	1		1	1	
3B2	Double	1994	2	2	2	4	9.5 X 12.0	1		1	1	2
Level 4												
4A1	Double	1994	12	2	2	24	6.0 X 12.5	1		1	1	
4A1	Double	1994	2	2	2	4	9.5 X 12.5	1		1	1	2
4A2	Double	1994	8	2	2	16	6.0 X 12.0	1		1	1	
4A2	Double	1994	8	2	2	16	6.0 X 12.0	1		1	1	2
4A3	Double	1994	12	2	2	24	6.0 X 12.0	1		1	1	
4A3	Double	1994	2	2	2	4	9.5 X 12.0	1		1	1	2
4B1	Double	1994	18	2	2	36	6.0 X 12.0	1		1	1	
4B1	Double	1994	2	2	2	4	9.5 X 12.0	1		1	1	2
4B2	Double	1994	18	2	2	36	6.0 X 12.0	1		1	1	
4B2	Double	1994	2	2	2	4	9.5 X 12.0	1		1	1	2
Level 5												
5A1	Double	1994	12	2	2	24	6.0 X 12.5	1		1	1	
5A1	Double	1994	2	2	2	4	9.5 X 12.5	1		1	1	2
5A2	Double	1994	8	2	2	16	6.0 X 12.0	1		1	1	
5A2	Double	1994	8	2	2	16	6.0 X 12.0	1		1	1	2
5A3	Double	1994	12	2	2	24	6.0 X 12.0	1		1	1	
5A3	Double	1994	2	2	2	4	9.5 X 12.0	1		1	1	2
5B1	Double	1994	18	2	2	36	6.0 X 12.0	1		1	1	
5B1	Double	1994	2	2	2	4	9.5 X 12.0	1		1	1	2
5B2	Double	1994	18	2	2	36	6.0 X 12.0	1		1	1	
5B2	Double	1994	2	2	2	4	9.5 X 12.0	1		1	1	2
Level 6												
6A1	Double	1994	12	2	2	24	6.0 X 12.5	1		1	1	

*T = Toilets; U = Urinals; W = Wash Basins; F = Fountains; S = Showers in unit; If "Total RC" appears in brackets ( ), it is not part of the facility's rated capacity. "+" indicates that capacity includes prorated air space from adjacent areas.

ROOMS							EACH ROOM					
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
6A1	Double	1994	2	2	2	4	9.5 X 12.5	1		1	1	2
6A2	Double	1994	8	2	2	16	6.0 X 12.0	1		1	1	
6A2	Double	1994	8	2	2	16	6.0 X 12.0	1		1	1	2
6A3	Double	1994	12	2	2	24	6.0 X 12.0	1		1	1	
6A3	Double	1994	2	2	2	4	9.5 X 12.0	1		1	1	2
6B1	Single	1994	18	2	2	36	6.0 X 12.0	1		1	1	
6B1	Double	1994	2	2	2	4	9.5 X 12.0	1		1	1	2
6B2	Single	1994	18	2	2	36	6.0 X 12.0	1		1	1	
6B2	Double	1994	2	2	2	4	9.5 X 12.0	1		1	1	2

Note: Number of double cells limited in each pod by lack of dayroom space. All other physical plant requirements in place. Level 4A State inmates; Level 4B inmate workers; Level 6 for female housing. BRC Total for Level 3 through 6: 142 X 4 (levels 3 – 6) = 568 BRC + 60 (level 2) = 628 BRC

Double buked singles cells in 6A2 – 02/07/2017 (MJB)

*T = Toilets; U = Urinals; W = Wash Basins; F = Fountains; S = Showers in unit; If "Total RC" appears in brackets ( ), it is not part of the facility's rated capacity. "+" indicates that capacity includes prorated air space from adjacent areas.

ADULT TYPE I, II, III AND IV FACILITIES
PHYSICAL PLANT EVALUATION
Board of State and Community Corrections

APPLICABLE TITLE 24 REGULATIONS: 6/94; 2/99; 2001; 2005

BSCC Code: 3920

FACILITY NAME: Larry D. Smith Correctional Center					**FACILITY TYPE:** II
APPLICABLE REGULATIONS (Check All That Apply):	**6/94: X**	**2/99:**	**2001:** X	**2005:** X	**OTHER:** 1963, 1980
FIELD REPRESENTATIVE: Michael J. Bush					**DATE:** 09/20/2019

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Reception and Booking (2.1) Contains a weapons locker, designed as outlined in these regulations.	X			
Contains a cell or room for confinement pending booking	X			Four holding cells are located in the intake/release area.
Contains a detoxification cell, where applicable 01: Name change to "sobering cell." 2-99: Two detoxification cells are provided if both male and female inmates are held.	X			Two sobering cells are located in the intake/release area. They were constructed under the 2001 standards. One sobering cell is located in Building 8. It was constructed under the 1994 standards.
Contains safety cell(s) (WA)	X			Two safety cells are located in the intake/release area. They were constructed under the 2001 standards.
Shower room available 2-99: Access to shower must be within the secure area	X			The inmate shower is located off of the property room.
Provides secure vault or storage for inmate valuables	X			
Telephone(s) available for inmate use (PC § 851.5)	X			
2-99: Unobstructed access to hot and cold running water	X			
Temporary Holding Cell or Room (2.2) Contains 10 square feet of floor area per inmate	X			
Holds no more than 16 inmates	X			Large Holding rated for (4)
Is not smaller than 40 square feet and has a clear ceiling height of 8 feet or more	X			Smallest Holding Cell is rated for (7)
Contains sufficient seating to accommodate all inmates	X			
Contains water closet (toilet), wash basin, and drinking fountain	X			
Provides for clear visual supervision by staff	X			
Temporary Staging Cell or Room (2.3) Holds inmates classified and segregated per Title 15 § 1050 and 1053			X	No temporary staging cell or room, remainder of the regulation is deleted.
Detoxification/Sobering Cell (2.4) 01: Name change to "sobering cell." Contains 20 square feet of floor area per inmate	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Is limited to no more than 8 inmates	X			The Rated Capacity for each sobering cell is (7)
Is no smaller than 60 square feet and has a clear ceiling height of 8 feet or more	X			145 Sq. Ft
Contains a water closet (toilet) wash basin and drinking fountain as specified by these regulations	X			
Has padded partitions located next to toilet fixtures	X			
Provides for clear visual supervision by staff	X			
Padding on floor	X			
01: A shower is accessible in the secure portion of the facility	X			Located adjacent to the inmate property room.
Safety Cell (2.5) Contains 48 square feet with one floor dimension of a least 6 feet and a clear ceiling height of 8 feet or more	X			Ceiling height is 8'6". Room dimensions are 7'X7'
Is limited to one inmate	X			
Contains a flushing ring toilet, mounted flush with the floor, with controls located outside the cell	X			
Padded floor, door and walls	X			
Equipped with a variable intensity, security light, inaccessible to the occupant	X			
Has one or more vertical view panels, not more than 4 inches wide nor less than 24 inches long, which provide a view of the entire cell	X			24"X5" wide; to be reduced to meet 4" requirement.
Has a food pass with lockable shutter no more than 4 inches high and, with between 26 and 32 inches from the bottom of the food pass to the floor	X			
01: Wall or ceiling mounted devices are inaccessible to inmate occupant.	X			
Single Occupancy Cells (2.6) Maximum capacity of one inmate	X			Disciplinary Isolation cells.
Contain a minimum of 60 square feet of floor area in Type I facilities and 70 square feet in Type II and III facilities	X			Approximately 77 Sq. Ft.
Have a minimum clear ceiling height of 8 feet and a minimum width of 6 feet	X			8' 6" ceiling height.
Contain a water closet (toilet), wash basin and drinking fountain	X			
Contain a bunk, desk and seat (Desk and seat not required in Type I facilities.)	X			
Double Occupancy Cells (2.7) Maximum capacity of two inmates	X			Building 8 has three double occupancy cells; one cell has been converted to a sobering cell.
Contain a minimum of 60 square feet of floor area in Type I facilities and 70 square feet in Type II and III facilities	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Have a minimum clear ceiling height of 8 feet and a minimum width of 6 feet	X			
Contain a water closet (toilet), wash basin and drinking fountain	X			
Contain 2 bunks, 1 desk and 1 seat (Desk and seat not required in Type I facilities.)	X			
Dormitories (2.8) *(Note: 2001 regulations reduced the double bunk requirement from 75 to 70 square feet and added provision for triple bunks. This is the "least restrictive standard." 2005 revisions added clarifying language, but did not change the calculations.)* Contain at least 50 square feet of floor area per inmate for single bed units; at least 70 square feet of floor space per inmate for double bed units; and, at least 90 square feet for triple bed units. Eight foot clear ceiling height required. *(To calculate double bunked BRC: 70 square feet divided by 2 inmates = 35 square feet + 35 square feet dayroom = 70 square feet per inmate. To calculate triple bunked BRC: 90 square feet divided by 3 inmates=30 square feet + 35 square feet dayroom=65 square feet per inmate.)*		X		Dormitory C4 had 10 inmates sleeping in stack-a-bunks.
Designed for no fewer than 4 and no more than 64 inmates	X			
Provide access to toilets separate from wash basins and drinking fountains	X			
Provide storage space for each inmate's personal items (NA Type I)	X			
Dayrooms (2.9) *(Required for inmates in Type II and III facilities (excluding "special use" cells) and inmate workers in Type I facilities.)* Contain 35 square feet of floor area per inmate, exclusive of 3 foot wide corridors in front of cells/rooms 2-99: Deleted 3 foot corridor in front of cells/rooms		X		Housing unit 14 – Dormitory G over the rated capacity.
Contain tables and seating to accommodate the maximum number of inmates allowed access at a given time. *(Note 2001 revisions added reference to access at a given time and are the least restrictive standard.)*		X		Housing unit 14 – Dormitory G
Exercise Area (2.10) Provided in Type II and III facilities. Type IV facilities must have a recreation area or provide community access to one.	X			Housing Unit 12 and 14 have designated outdoor recreation yards.
Clear height of 15 feet	X			
Has required surface area: 80 % of maximum rated inmate capacity, multiplied by 50 square feet, divided by number of one-hour exercise periods per day, equals the required surface area.	X			Rotating schedule.

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
2-99: Provides free access to a toilet, wash basin and drinking fountain	X			
Provides adequate security	X			
Program/Multipurpose Space (2.11) *(NA Type I)* There is sufficient area and furnishings to meet the needs of the facility programs. (See regulation for discussion of applicability to Type IV.)	X			Housing Area 12 and 14
Medical Examination Room (2.12) There is one suitably equipped medical exam room in every Type II or III facility designed to house 25 or more inmates. 2-99: Required in all facilities that provide on-site health care.	X			
Located within the security area and provide for privacy of inmates	X			
Not less than 100 square feet of floor space with no single dimension less than 7 feet	X			10' X 16' with 8'6" ceiling height. 2010 Expansion- exam rooms-12'6 X 8'2 X 8'4
Provide hot and cold running water 2-99: Hot and cold running water in any room where medical procedures are provided	X			
2-99: Lockable storage for medical supplies	X			Located inside medical examination room.
Pharmaceutical Storage Space (2.13) There is lockable storage space for medical supplies and pharmaceuticals (Title 15 § 1216).	X			Lockable storage space in the medical examination room.
Medical Care Housing (2.14) Applicable to Type II and III facilities where the facility program indicates special medical care housing is needed.			X	Inmates with medical issues are housed at RPDC, SWDC, or Indio Jail.
Housing is located within the security area, accessible to both male and female inmates, but not in the living area of either.			X	
Provides lockable storage area for medical instruments			X	
2-99: Negative pressure isolation rooms are designed to the community standard.			X	
Hair Care Space (2.15) Space and equipment are available. 2-99: Requirement deleted.	X			Not applicable for Housing Units 1 and 2 (constructed under the 2001 standards).
Commissary (2.16) (NA Type I) Inmates can purchase specified items.	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
There is secure storage for commissary stock. 01: Revisions limit requirement for secure storage to circumstances when commissary supplies are kept within the security perimeter.	X			
Dining Facilities (2.17) (NA Type I) There are 15 square feet and sufficient tables and seating for each inmate being fed.	X			
Dining space does not include toilets, wash basins or showers, without an appropriate visual barrier. 2-99: Visual barrier requirement deleted for wash basins	X			
Visiting Space (2.18) There is sufficient visiting area.	X			Expanded time frame to accommodate more visiting.
Safety Equipment Storage (2.19) Adequate space is provided to store equipment such as fire extinguishers, SCBA, emergency lights, etc.	X			
Janitors' Closet (2.20) A securely lockable janitor's closet provides sufficient storage for cleaning implements and supplies and is located within the security area (Type II only).	X			
A mop sink is available within the security area (Type II). It may be outside the security area in CH, TH and Types I, III & IV.	X			
Audio or Visual Monitoring (2.22) *(Prior to 2005 this was N/A for Type III and IV housing only minimum security inmates. In 2005 applicability was extended to all CH, TH, Type I, II, III and IV facilities regardless of security level.)* There is an audio monitoring system capable of alerting staff in a central control. When visual electronic surveillance is used, it is located primarily in corridors, elevators, or at points on the security perimeter such as entrances and exits. 2-99: Video monitoring option and references to electronic surveillance located primarily in corridors, elevators or points in security perimeter were deleted.	X			DVR
Laundry Facilities (2.23) Type IV facilities make provision for washing and drying personal laundry.	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Emergency Power (2.24) There is an emergency power source available and capable of providing minimal lighting in all areas and maintaining fire and life safety, security, communication and alarm systems.	X			Diesel.
Confidential Interview Rooms (2.25) There is at least one suitably furnished confidential interview room in every Type II facility designed for 25 or more inmates. 2-99: Applicable to every facility which provides on-site health care	X			Three confidential interview rooms are located in intake and receiving.
Located in the security area, accessible by both male and female inmates	X			
Provides at least 70 square feet floor area with no single dimension less than 6 feet	X			10' X 10' (100 sf).
Attorney Interview Space (2.26) *(NA Type IV)* Available and provides for confidentiality	X			Attorney visiting is located at the main building
Water Closets (Toilets)/Urinals (3.1) Provide for inmate privacy/modesty with staff being able to visually supervise; one is provided in every single and double occupancy cell and at the following ratio elsewhere: 1:10 in dormitories (changed from 1:8 in 2001); 1:8 in detoxification/sobering cells; 1:16 in holding cells; 1:20 in exercise areas; and, Accessible to dayroom occupants no specified ratio. 2-99: Accessible at no specified ratio in exercise areas See regulation for calculations of urinal substitutions.	X			
Wash basins (3.2) Provide hot and cold or tempered water; one is provided in every single and double occupancy cell and at the following ratio elsewhere: 1:10 in dormitories (changed from 1:8 in 2001); 1:8 in detoxification/sobering cells; 1:20 in exercise areas; and, Accessible to dayrooms at no specified ratio. 2-99: Accessible in exercise areas at no specified ratio See regulation for calculations of wash basin trough substitutions.	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Drinking Fountains (3.3) One is provided in every single and double occupancy cell and in dormitories. Accessible to inmates in dayrooms 2-99: One is provided in every single and double occupancy cell, holding and staging cells and detoxification cells. It must be accessible to inmates in dayrooms and exercise areas.	X			
The water outlet (bubbler) is mechanically actuated and at an angle that prevents wastewater from flowing over the outlet (bubbler). There is a mouth guard on the water outlet. 2-99: Mouth guard requirement deleted	X			
Showers (3.4) Available at a ratio of 1:20; provide hot and cold or tempered water; shower stalls/areas are designed and constructed of materials that are impervious to water and soap so that they may be easily cleaned. 2-99: Ratio changed from 1:16; specified that shower areas must provide modesty for inmates, with staff ability to supervise.	X			
Beds/Bunks (3.5) At least 30 inches wide and 76 inches long with 21 inches between pans; constructed of pan bottom type or concrete; securely fastened to the floor and/or wall in facilities higher than minimum security. 01: Must be elevated off the floor.		X		2 inmates sleeping on stack-a-bunks.
Lighting (3.6) Lighting in housing units, dayrooms and activity areas is sufficient to permit easy reading by a person with normal vision, and is not less than 20 foot-candles at desk level and in the grooming area. Night lighting is sufficient for purposes of supervision. Lighting is centrally controlled and/or occupant controlled in housing cells or rooms. Light fixtures are of secure design in areas higher than minimum security.	X			
Windows (3.7) In housing areas higher than minimum security, windows that are accessible to inmates are no greater than 5 inches in one dimension.	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Cell Padding (3.8) The floors and partition are padded in detoxification cells. In safety cells, floors, doors, walls and everything on them are padded. All padded cells are equipped with a tamper resistant fire sprinkler approved by the SFM.	X			
All padding is: approved for use by the SFM; nonporous; at least ½ inch thick; of a unitary or laminated construction; firmly bonded to all surfaces; and, without exposed seams.	X			
Mirrors/Shelves/Clothes Hooks (3.9) A mirror of a material appropriate to the level of security is provided near each wash basin.	X			Break away hooks.
Consistent with security needs, shelves and clothes hooks are provided wherever feasible. 2-99: Requirement for shelves and hooks deleted	X			
Clothes hooks are of a collapsible hook type 2-99: Requirement for hooks deleted	X			
Seating (3.10) Seating is designed to the level of security. When bench seating is used, eighteen inches of bench are provided per inmate. 2-99: In holding and staging cells, seating is securely fastened to the wall and/or floor.	X			
Table/Seat (3.11) *(NA Type I)* A table and seat is provided in single and double occupancy cells.	X			
Weapons Locker (3.12) *(NA type IV and Minimum Security Facilities)* A secure weapons locker is located outside the security perimeter of the facility and no weapons are brought into the security area. Lockers have individual compartments, locks and keys.	X			
Design Requirements (102(c)6) Design requirements as specified in Title 24, Part 1, 102(c)6 are met. (See regulation for specific requirements. Note areas of non-compliance that are applicable to the facility type and construction date in the "comments" section.)	X			

BOARD OF STATE AND COMMUNITY CORRECTIONS - BIENNIAL INSPECTION
ADULT DETENTION FACILITY
LIVING AREA SPACE EVALUATION

BSCC Code: 3920

FACILITY: Larry D. Smith Correctional Facility	**TYPE:** II	**RC:** 1458
FIELD REPRESENTATIVE: Michael J. Bush		**DATE:** 09/20/2019

ROOMS							EACH ROOM					
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
Intake – 1st New Addition												
1	Sobering	2001	1		(7)	(7)	14'6 X 10'X 8'6	1		1	1	
2	Sobering	2001	1		(7)	(7)	14'5 X 10' X 8'6	1		1	1	
1	Safety	2001	1		(1)	(1)	7 X 7 X 8'6	1				
2	Safety	2001	1		(1)	(1)	7 X 7 X 8'6	1				
3	Safety	2009	1		(1)	(1)	7'2 X 7'1" X 8'2	1				
4	Safety	2009	1		(1)	(1)	7'7 X 7'9 X 8'2	1				
1	Holding	2001	1		(7)	(7)	Approx 77 sf	1		1	1	
Notes: 12' bench space; Rated capacity is limited to 7 inmates based on 77 sf.												
2	Holding	2001	1		(7)	(7)	Approx 102 sf	1		1	1	
12' bench space; Rated capacity is limited to 7 inmates based on 77 sf.												
3	Holding	2001	1		(8)	(8)	Approx 85 sf	1		1	1	
Notes: 13'8" bench space; Rated capacity is limited to 8 inmates based on 85 sf.												
4	Holding	2001	1		(8)	(8)	Approx 85 sf	1		1	1	
Notes: 13'9" bench space; Rated capacity is limited to 8 inmates based on 85 sf.												
5	Holding	2001	1		(14)	(14)	Approx 142 sf	1		1	1	
Notes: 22' bench space; Rated capacity is limited to 14 inmates based on 142 sf.												
6	Holding	2001	1		(14)	(14)	Converted to 2 safety cells, 2013	1		1	1	
Notes: 22' bench space; Rated capacity is limited to 14 inmates based on 142 sf. Holding cell number 6 is converted to 2 safety cells (the new safety cells have been added to the LASE this cycle, 2013)												
Housing Unit 14- Male or Female housing in all units at this facility, designated housing units change with the need of the facility												
A	Dorm	2001	1	10	10	10	Approx 753 sf	1		1	1	1
Notes. Dormitory A is ADA accessible; shower, washbasin, and stool.												
B	Dorm	2001	1	10	10	10	Approx 753 sf	1		1	1	1
C	Dorm	2001	1	22	20	20	Approx 1419 sf	2		2	2	2
D	Dorm	2001	1	22	20	20	Approx 1419 sf	2		2	2	2
E	Dorm	2001	1	22	20	20	Approx 1419 sf	2		2	2	2
F	Dorm	2001	1	22	20	20	Approx 1419 sf	2		2	2	2
G	Dorm	2001	1	22	20	20	Approx 1419 sf	2		2	2	2
H	Iso	2001	1	1	1	(1)	Approx 77 sf	1		1	1	
I	Iso	2001	1	1	1	(1)	Approx 77 sf	1		1	1	
NOTE: Shower is accessible for inmates held in disciplinary isolation.												
Housing Unit 12												

*T = Toilets; U = Urinals; W = Wash Basins; F = Fountains; S = Showers in unit; If "Total RC" appears in brackets ( ), it is not part of the facility's rated capacity. "+" indicates that capacity includes prorated air space from adjacent areas.

ROOMS							EACH ROOM					
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
A	Dorm	2001	1	22	20	20	Approx 1419 sf	2		2	2	2
B	Dorm	2001	1	22	20	20	Approx 1419 sf	2		2	2	2
C	Dorm	2001	1	22	20	20	Approx 1419 sf	2		2	2	2
D	Dorm	2001	1	22	20	20	Approx 1419 sf	2		2	2	2
E	Dorm	2001	1	22	20	20	Approx 1419 sf	2		2	2	2
F	Dorm	2001	1	10	10	10	Approx 753 sf	1		1	1	1
G	Dorm	2001	1	10	10	10	Approx 753 sf	1		1	1	1
NOTE: Dormitory G is ADA accessible; shower, washbasin, and seat.												
Original Facility												
Housing-Male or Female Units												
1	Dorm	1980	2	32	32	64		8		8	1	4
2	Dorm	1980	2	32	32	64		8		8	1	4
3	Dorm	1980	2	32	32	64		8		8	1	4
4	Dorm	1980	2	32	32	64		8		8	1	4
NOTE: Sentenced inmates are housed in these dorms.												
Housing-Male or Female Units												
5	Dorm	1980	2	32	32	64		8		8	1	4
NOTE: Each of these dorms measure 31.0 ft. x 114 ft.												
6	Dorm	1980	1	32	32	32		4		4	1	2
7	Dorm	1980	1	32	32	32		4		4	1	2
Doubles and Dorm Housing												
8A	Double	1994	4	2	2	8		1		1	1	
Converted-law library	Former Detox	1998						1		1	1	
B,C,D	Dorm	1994	3	16	12	36		2		2	1	
NOTE: Sufficient square footage cells and dayroom. One cell and shower handicap accessible. One Shower												
Bldg 9												
A,B,C,D	Dorm	1994	4	16	12	48		2		2	1	
NOTE: One shower. Four pods per building; each pod has 926 square feet. Applied 1994 Standards.												
Bldg 10												
A,B,C,D	Dorm	1994	4	16	12	48		2		2	1	
NOTE: One shower - Each pod has 926 square feet. Applied 1994 Standards												
Bldg 11												
A,B,C,D	Dorm	1994	4	16	12	48		2		2	1	
NOTE: Each pod has 936 square feet. One shower												
NOTES: 5-foot urinal. These dorms are now used for program space and measure 2,062 sq. ft. x 10 ft. (Barracks #12 & #14 were rated for 42 each.												
Current RSAT Housing Units												
19	Dayroom	1963					23.0 x 50.0	4	3	5	1	3
NOTE: #15 is used as dayroom for #16.												
19	Dorm	1963	1	32	32	32	23.0 x 50.0	4	3	5	1	3

*T = Toilets; U = Urinals; W = Wash Basins; F = Fountains; S = Showers in unit; If "Total RC" appears in brackets ( ), it is not part of the facility's rated capacity. "+" indicates that capacity includes prorated air space from adjacent areas.

ROOMS							EACH ROOM					
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
Female												
18	Dorm	1963	1	32	32	32	23.0 x 50.0	4	3	5	1	3
18	Dayroom	1963	1				23.0 x 50.0	4	3	5	1	3
NOTE: Sun porch prorated in dayroom for all dorms.												
NOTE: Each pod has 936 square feet. One shower												
(b) 08 A & B (over capacity) and (b) 09A – Dayroom Space												

ROOMS							EACH ROOM					
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
2nd New Addition 8/2010-Support Lower Floor, Transportation –under 2005 Title 24 Regulations												
1 & 2	Holding	2005	2		(12)	(24)	15’4” X 8’4 X 8	1		1	1	
3-5	Holding	2005	3		(14)	(42)	15’3” X 9’4 X 8	1		1	1	
6-ADA	Holding	2005	1		(16)	(16)	Irregular-approx 160 sft	1		1	1	
7-11	Holding	2005	5		(14)	(70)	15’3 X 9’4X 8	1				
12	Holding	2005	1		(12)	(12)	15’4 X 8’3 X 8	1		1	1	
Note: 2- benches in each cell approx 22 ft in total except cell 6. Cell 6 has 22ft of bench space exceeding space for 16 inmates / ceiling height is 8’6 but clear ceiling height is 8 ft-Security ceiling double panel (welded metal).												
13	Holding	2005	1		(11)	(11)	15’4 X 7’2 X 8	1		1	1	
14	Holding	2005	1		(13)	(13)	15’4 X 8’5 X 8	1		1	1	
15-17	Holding	2005	3		(12)	(36)	15’4 X 8’3 X 8	1		1	1	
18-20	Holding	2005	3		(13)	(39)	15’4 X 8’5 X 8	1		1	1	
Notes: 2-13 ft benches in all cells.												

New 2010 Smith Expansion Housing Unit 15 Upper and Lower Floor

Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
15-A	Double	2005	16	2	32	32	11’5 X 6’2 X 8’4	1		1	1	2
15-B	Double	2005	16	2	32	32	11’5 X 6’2 X 8’4	1		1	1	2
15-C	Double	2005	16	2	32	32	11’5 X 6’2 X 8’4	1		1	1	2
15-D	Double	2005	16	2	32	32	11’5 X 6’2 X 8’4	1		1	1	2
15-E	Double	2005	16	2	32	32	11’5 X 6’2 X 8’4	1		1	1	2
15-F	Double	2005	16	2	32	32	11’5 X 6’2 X 8’4	1		1	1	2
Notes: Bottom shower is ADA accessible.												
Ad-Seg, L-Floor	Single	2005	2	2	2	2	11’5 X 9’ X 8’4	2		2	2	1
One (1) shower on each floor-2 showers total for each pod. One cell in each 16 cell pod (15, 16, 17) is an ADA cell that is 98 square feet												
New 2010 Housing Unit 16 Upper and Lower												
16-A	Double	2005	16	2	32	32	11’5 X 6’2 X 8’4	1		1	1	2
16-B	Double	2005	16		32	32	11’5 X 6’2 X 8’4	1		1	1	2
16-C	Double	2005	16	2	32	32	11’5 X 6’2 X 8’4	1		1	1	2

*T = Toilets; U = Urinals; W = Wash Basins; F = Fountains; S = Showers in unit; If "Total RC" appears in brackets ( ), it is not part of the facility's rated capacity. "+" indicates that capacity includes prorated air space from adjacent areas.

ROOMS							EACH ROOM					
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
16-D	Double	2005	16	2	32	32	11'5 X 6'2 X 8'4	1		1	1	2
16-E	Double	2005	16	2	32	32	11'5 X 6'2 X 8'4	1		1	1	2
16-F	Double	2005	16	2	32	32	11'5 X 6'2 X 8'4	1		1	1	2
Ad-Seg, L-Floor	Single	2005	2	2	2	2	11'5 X 9 X 8'4	1		1	1	1
Notes: One (1) shower on each floor-ADA shower bottom floor												
New 2010 Housing Unit 17 Upper and Lower												
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
17-A	Double	2005	16	32	32	32	11'5 X 6'2 X 8'4	1		1	1	2
17-B	Double	2005	16	32	32	32	11'5 X 6'2 X 8'4	1		1	1	2
17-C	Double	2005	16	32	32	32	11'5 X 6'2 X 8'4	1		1	1	2
17-D	Double	2005	16	32	32	32	11'5 X 6'2 X 8'4	1		1	1	2
17-E	Double	2005	16	32	32	32	11'5 X 6'2 X 8'4	1		1	1	2
17-F	Double	2005	16	32	32	32	11'5 X 6'2 X 8'4	1		1	1	2
Ad-Seg, L-Floor	Single	2005	2	2	2	2	11'5 X 9 X 8'4	1		1	1	1
Notes: One (1) shower on each floor- ADA shower bottom floor.												
New Medical Clinic - 2019												
1-4	H	2015	(4)		(4)	(16)	9.4 x 11.5 x 10					

*T = Toilets; U = Urinals; W = Wash Basins; F = Fountains; S = Showers in unit; If "Total RC" appears in brackets ( ), it is not part of the facility's rated capacity. "+" indicates that capacity includes prorated air space from adjacent areas.

ADULT TYPE I, II, III AND IV FACILITIES
PHYSICAL PLANT EVALUATION
Board of State and Community Corrections

Applicable Title 24 Regulations: 3/80; 8/86; 5/88; 1/91

BSCC Code: 3930

FACILITY NAME: Cois Byrd Detention Center					**FACILITY TYPE:** II
APPLICABLE REGULATIONS (Check All That Apply):	**3/80:**	**8/86:**	**5/88:** X	**1/91:**	**OTHER:** 1994
FIELD REPRESENTATIVE: Michael J. Bush					**DATE:** 09/19/2019

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Temporary Holding Cells (2.2) Contain 10 square feet of floor per inmate	X			
Limited to no more than 16 inmates	X			
No smaller than 40 square feet	X			
Contain sufficient seating to accommodate all inmates	X			
Toilet accessible	X			
Water fountain accessible	X			
Wash basin accessible	X			
Provides clear visual supervision	X			
Telephone accessible	X			
Weapons Locker (3.12) External to the security area and equipped with individual compartments, locks and keys	X			
Temporary Staging Cell or Room (2.3) 1-91: Added provision for temporary staging cells-rooms Holds inmates classified and segregated per Title 15 § 1050 and § 1053	X			
Limited to holding inmates up to 4 hours	X			
Maximum capacity of no more than 80 inmates	X			
Contains 10 square feet of floor space per inmate and has a ceiling height of at least 8 feet	X			
No smaller than 160 square feet	X			1988 Standards (no smaller than 40 sq ft)
Contains seating to accommodate all inmates	X			
Contains water closet, wash basin and drinking fountain	X			
Provides unobstructed visual supervision of inmates by staff	X			
Detoxification/Sobering Cells (2.4) 01: Name change to "sobering cell" Contain 20 square feet of floor per inmate	X			
Limited to no more than 8 inmates	X			
No smaller than 60 square feet	X			
Contain toilet	X			
Contain washbasin	X			
Contain drinking fountain	X			
Partitions or handrails located next to toilet fixture to provide support	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Provide easy, unobstructed visual observation	X			
Padding on the floor	X			
Shower-Delousing Room (3.4) Available in reception/booking	X			
Secure Vault or Storage Space (2.1) Available for inmate valuables	X			
Telephone (2.1) Available for inmate use per Penal Code § 851.5	X			
Safety Cells (2.5) Contain 48 square feet with one floor dimension at least 6 feet and ceiling height of at least 8 feet	X			Light fixture 7' 6" Compliance Granted.
Limited to no more than one inmate	X			
Contain flush ring toilet with controls located outside the cell	X			
Padded floor, door and walls	X			
Equipped with variable intensity, security light, inaccessible to occupant	X			
Vertical view panel not more than 4 inches wide and at least 24 inches long, in or adjacent to the door	X			
Provide a food pass with lockable shutter no more than 4 inches high and located at least 30 inches above the floor	X			
Single Occupancy Cells (2.6) Maximum capacity of one inmate	X			Application of 1994 Standards.
Contain a minimum of 60 square feet of floor area in Type I facilities and 70 square feet in Type II and III facilities	X			
Have a minimum ceiling height of 8 feet	X			
Contain toilet, washbasin and drinking fountain	X			
Contain a bunk, desk and seat (Desk and seat not required in Type I in later, less restrictive 1986 standards)	X			
Multiple Occupancy Cells (8227) 8-86: Deleted provision for multiple occupancy cells Contain 35 square feet per person			X	
Limited to no more than 8 inmates			X	
No smaller than 100 square feet			X	
Minimum ceiling height of 8 feet			X	
Water closet separate from washbasin and drinking fountain			X	
Sufficient bunks to accommodate each occupant			X	
Provide storage space for each occupant's personal items			X	
Multiple Occupancy Rooms (8229) 8-86: Deleted provision for multiple occupancy rooms Limited to housing persons in Type III and IV facilities and workers in Type I and II facilities			X	
Contain 50 square feet of floor area per person and a minimum of 8 feet ceiling height			X	

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Limited to no more than 16 persons			X	
Access to toilets separate from washbasins (ratio 1:8) and drinking fountains			X	
Provide storage space for each occupant's personal items			X	
Double Occupancy Cells (2.7) 5-88: Added provision for double occupancy cells Maximum capacity of two inmates	X			Pod E, F, & G built under the 1994 Standards
Contain a minimum of 60 square feet of floor space in Type I facilities and 70 square feet in Type II and III facilities	X			
Have a minimum ceiling height of 8 feet and one floor dimension at least 6 feet	X			
Contain toilet, washbasin and drinking fountain	X			
Contain 2 bunks, 1 desk and seat (Desk and seat not required in Type I facilities)	X			
Dormitories (2.8) 8-86: Provision for dormitories added Contain 50 square feet of floor area per inmate and a minimum of 8 feet ceiling height	X			
Be designed for no fewer than 8 and no more than 64 inmates	X			
Facilities having a total rated capacity of 80 inmates or less, may design dormitories for no fewer than 4 inmates	X			
Access to toilets separate from washbasins (ratio 1:8) and drinking fountains 01: Ratio changed to 1:10	X			
Provide storage space for each inmates' personal items	X			
Dayrooms (2.9) 8-86: Added requirement for 3 foot wide corridors in front of cells-rooms 99: Corridor requirement deleted			X	
35 square feet of floor area per inmate	X			
Contain tables and seating to accommodate the maximum number of inmates served	X			Table space and seating has been increased from 60 to 64 in Pod D and C.(Determine Pod location)
Access to toilets, washbasins and drinking fountains	X			
Available to all inmates in Type II and III facilities (excluding special use cells) and to workers in Type I facilities	X			
Shower (3.4) Available on a ratio of 1:16 01: Ratio changed to 1:20	X			
Lighting (3.6) Sufficient to permit easy reading. Night lighting is sufficient to allow good supervision. 8-86: Specifies at least 20 foot-candles at desk level and in grooming areas, with night lighting not to exceed 5 foot-candles	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Beds-Bunks (3.5) 30 inches wide and 76 inches long	X			
Comfortable Living Environment [102(c)6] A comfortable living environment is maintained through an adequate heating and cooling system.	X			
Exercise Area -Type II, III and WA IV (2.10) At least one exercise area must contain a minimum of 900 square feet	X			
8-86: Outdoor exercise area provided	X			
8-86: Clear height of 15 feet with required surface area meeting a formula of: 80% of maximum rated inmate population and number of one-hour exercise periods per day = required surface area	X			
Program Space - Type II and III (2.11) Sufficient area and furnishings to meet the needs of the facility programs	X			
Dining Facilities (2.17) 15 square feet per inmate being fed	X			
Toilets, washbasins and showers are not in the same room or not in view of inmate dining	X			
Visiting (2.18) Sufficient visiting area	X			
Contact visits whenever possible for minimum security inmates			X	
Attorney Interviews (2.26) Provide for confidential attorney consultation	X			
Safety Equipment Storage (2.19) Adequate space is provided for storage of equipment such as fire extinguishers, SCBA, emergency lights, etc.	X			
Janitor Closet (2.20) Located in security areas lockable, containing a mop sink and storage space	X			
Storage Rooms (2.21) Sufficient space to accommodate inmate property, bedding and supplies	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Audio or Video Monitoring System -NA Type IV (2.22) Audio monitoring system capable of alerting staff in a central control	X			
Video monitoring in corridors, main entries and/or exits and programs or activity areas	X			
Fire Detection and Alarm System [102(c)6] Automatic fire alarm system capable of alerting staff in a central control point	X			
Emergency Power (2.24) Available to provide minimal lighting, maintain communications, alarm, fire, life and security systems	X			
Provide Space for: **Barber/beauty shop(2.15)** 8-86: Limit requirement to Type II and III facilities 99: Requirement deleted	X			
Canteen (2.16) 8-86: Added for II, III & IV facilities	X			
Confidential Interview Rooms (2.25) 8-86: Added for Type II facilities	X			

STATE CORRECTIONS STANDARDS AUTHORITY - BIENNIAL INSPECTION
ADULT DETENTION FACILITY
LIVING AREA SPACE EVALUATION

BSCC Code: 3930

FACILITY: Cois Byrd Detention Center	**TYPE:** II	**BRC:** 1142
FIELD REPRESENTATIVE: Michael J. Bush		**DATE:** 09/19/2019

ROOMS							EACH ROOM					
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
Receiving Area												
A-1008	Detox 1	1988	1		(1)	(1)	15.0 X 11.0 X 8.0	1		1	1	
A-1010	Detox 2	1988	1		(8)	(8)	16.5 X 10.0 X 8.0	1		1	1	
A-1064-#4	Detox	1988	1		(4)	(4)	10.0 X 8.5 X 8.0	1		1	1	
A-1065-#3	Detox	1988	1		(4)	(4)	10.0 X 8.5 X 8.0	1		1	1	
A-1004-#1	Safety	1988	1		(1)	(1)	8.0 X 6.0 X 8.0	1				
A-1005-#2	Safety	1988	1		(1)	(1)	8.0 X 6.0 X 8.0	1				
A-1062-#4	Safety	1988	1		(1)	(1)	10.0 X 6.0 X 8.0	1				
A-1063-#3	Safety	1988	1		(1)	(1)	10.0 X 6.0 X 8.0	1				
Intake medical Screen												
A1018	Medical Offices	1988	1				15.0 X 10.0 X 8.0					
A-1066 (F)	S/A	1988	1				15.0 X 10.0 X 8.0					
Notes: Hot and cold running water.												
1013-Cell-1	Holding	1988	1		(6)	(6)	120.0 X 18.0 X 8.0	1		1	1	
1014-Cell-2	Holding	1988	1		(6)	(6)	120.0 X 18.0 X 8.0	1		1	1	
1015-Cell 3	Holding	1988	1		(6)	(6)	120.0 X 18.0 X 8.0	1		1	1	
1016-Cell-4	Holding	1988	1		(6)	(6)	120.0 X 18.0 X 8.0	1		1	1	
1017-Cell-5	Holding	1988	1		(8)	(8)	120.0 X 18.0 X 8.0	1		1	1	
Notes: Handicap accessible.												
1019-Cell-6	Holding	1988	1		(6)	(6)	10.0 X 6.5 X 8.0	1		1	1	
1020-Cell-7	Holding	1988	1		(8)	(8)	10.0 X 8.5 X 8.0	1		1	1	
1028-Cell-8	Holding	1988	1		(8)	(8)	10.0 X 9.0 X 8.0	1		1	1	
1029-Cell-9	Holding	1988	1		(16)	(16)	17.5 X 10.6 X 8.0	1		1	1	
1041-Cell-10	R-Holding	1988	1		(4)	(4)	8.7 X 6.0 X 8.0	1		1	1	
1042-Cell-9	R-Holding	1988	1		(4)	(4)	9.8 X 8.8 X 8.0	1		1	1	
1068-Cell-3	R-Holding	1988	1		(6)	(6)	10.0 X 6.7 X 8.0	1		1	1	
1069-Cell-2	R-Holding	1988	1		(6)	(6)	10.0 X 6.5 X 8.0	1		1	1	
1070-Cell-1	R-Holding	1988	1		(9)	(9)	10.3 X 10.0 X 8.0	1		1	1	
1072-Cell-12	R-Hold	1988	1		(3)	(3)	8.3 X 8.0 X 8.0	1		1	1	

*T = Toilets; U = Urinals; W = Wash Basins; F = Fountains; S = Showers in unit; If "Total RC" appears in brackets ( ), it is not part of the facility's rated capacity. "+" indicates that capacity includes prorated air space from adjacent areas.

ROOMS							EACH ROOM					
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
1073-Cell-11	R-Holding	1988	1		(3)	(3)	14.0 X 8.0 X 8.0	1		1	1	
All Cell numbers reviewed during the 2008-2010 inspection cycle to clarify location, MW2009												

Transportation Area												
1090-Cell-7	Holding	1988	1		(8)	(8)	11.0 X 8.0 X 8.0	1		1	1	
1091-Cell-6	Holding	1988	1		(16)	(16)	16.5 X 10.0 X 8.0	1		1	1	
1092-Cell-5	Holding	1988	1		(8)	(8)	10.5 X 8.5 8.0	1		1	1	
1093-Cell-4	Holding	1988	1		(8)	(8)	10.5 X 8.5 8.0	1		1	1	
1094-Cell-3	Holding	1988	1		(8)	(8)	10.5 X 8.5 8.0	1		1	1	
1095-Cell-2	Holding	1988	1		(8)	(8)	10.5 X 8.5 8.0	1		1	1	
1096-Cell-1	Holding	1988	1		(8)	(8)	10.5 X 8.5 8.0	1		1	1	
1102-Cell-8	Holding	1988	1		(16)	(16)	20.3 X 8.3 X 8.0	1		1	1	
1103-Cell-9	Holding	1988	1		(16)	(16)	20.3 X 8.3 X 8.0	1		1	1	
1104-Cell-10	Holding	1988	1		(16)	(16)	20.3 X 8.3 X 8.0	1		1	1	
1105-Cell-11	Holding	1988	1		(16)	(16)	20.3 X 8.3 X 8.0	1		1	1	
1106-Cell-12	Holding	1988	1		(16)	(16)	20.3 X 8.3 X 8.0	1		1	1	
1107-Cell-13	Holding	1988	1		(16)	(16)	20.3 X 8.3 X 8.0	1		1	1	
Pod B-Ad-Seg. Each Pod has its own yard.												
Ground Level												
Day 1	Double	1988	16	2	2	32	12.5 X 6.0 X 8.0	1		1	1	2
Mezzanine Level												
Day 1	Double	1988	16	2	2	32	12.5 X 6.0 X 8.0	1		1	1	2
Ground Level												
Day 2	Single	1988	8	2	2	16	12.5 X 6.0 X 8.0	1		1	1	
Mezzanine Level												
Day 2	Single	1988	8	2	2	16	12.5 X 6.0 X 8.0	1		1	1	
Notes: Day 2 housing for Ad Seg.												
Ground Level												
Day 3	Single	1988	8	2	2	16	12.5 X 6.0 X 8.0	1		1	1	
Mezzanine Level												
Day 3	Single	1988	8	2	2	16	12.5 X 6.0 X 8.0	1		1	1	
Notes: Day 3 housing for Ad Seg.												
Ground Level												
Day 4	Double	1988	16	2	2	32	12.5 X 6.0 X 8.0	1		1	1	2
Mezzanine Level												
Day 4	Double	1988	16	2	2	32	12.5 X 6.0 X 8.0	1		1	1	2
Pod C												
Ground Level												
Day 1	Double	1988	16	2	2	32	12.5 X 6.0 X 8.0	1		1	1	2

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Mezzanine Level												
Day 1	Double	1988	16	2	2	32	12.5 X 6.0 X 8.0	1		1	1	2
Ground Level												
Day 2	Single	1988	8	2	2	16	12.5 X 6.0 X 8.0	1		1	1	1
Mezzanine Level												
Day 2	Single	1988	8	2	2	16	12.5 X 6.0 X 8.0	1		1	1	1
Notes: Day 2 housing for Ad Seg.												
Ground Level												
Day 3	Double	1988	8	2	2	16	12.5 X 6.0 X 8.0	1		1	1	1
Mezzanine Level												
Day 3	Double	1988	8	2	2	16	12.5 X 6.0 X 8.0	1		1	1	1
Ground Level												
Day 4	Dorm	1988	1	40	40	40	See Notes	4		4	4	2
Mezzanine Level												
Day 4	Dorm	1988	1	24	24	24	See Notes	4		4	4	2
Notes: Dayroom and Dorms have a total square footage of 5,067.												
Pod D – open dayrooms												
Ground Level												
Day 1	Double	1988	16	2	2	32	12.5 X 6.0 X 8.0	1		1	1	2
Mezzanine Level												
Day 1	Double	1988	16	2	2	32	12.5 X 6.0 X 8.0	1		1	1	2
Ground Level												
Day 2	Double	1988	8	2	2	16	12.5 X 6.0 X 8.0	1		1	1	1
Mezzanine Level												
Day 2	Double	1988	8	2	2	16	12.5 X 6.0 X 8.0	1		1	1	1
Ground Level												
Day 3	Double	1988	8	2	2	16	12.5 X 6.0 X 8.0	1		1	1	1
Mezzanine Level												
Day 3	Double	1988	8	2	2	16	12.5 X 6.0 X 8.0	1		1	1	1
Ground Level												
Day 4	Dorm	1988	1	40	40	40	See Notes	4		4	4	2
Mezzanine Level												
Day 4	Dorm	1988	1	24	24	24	See Notes	4		4	4	2
Notes: Dayroom and Dorms have a total square footage of 5,067.												
Pod E-												
Disc. cells	Double	1994	(2)	(1)	(1)	(2)	6'1 X 12.8 X 8	1		1	1	
NOTE: Located in hallway of the Pod												
Ground Level												
Day 1	Double	1994	16	2	2	32	12.10 X 6.1 X 8.5	1		1	1	2
Mezzanine Level												
Day 1	Double	1994	16	2	2	32	12.10 X 6.1 X 8.5	1		1	1	2
Notes: Day 2 has 8 tables with 64 seats.												
Ground Level												
Day 2	Double	1994	8	2	2	16	12.10 X 6.1 X 8.5	1		1	1	

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Mezzanine Level												
Day 2	Double	1994	8	2	2	16	12.10 X 6.1 X 8.5	1		1	1	
Notes: Day 2 has 4 tables with 32 seats												
Ground Level												
Day 3	Double	1994	7	2	2	14	12.10 X 6.10 X 8.5	1		1	1	
Mezzanine Level												
Day 3	Double	1994	7	2	2	14	12.10 X 6.10 X 8.5	1		1	1	
Notes: Day 3 has a handicapped shower and the 7 ground level rooms are designated as ADA cells. Day 3 has 3 tables with 8 seats and 1 table with 4 seats.												
Ground Level												
Day 4	Double	1994	15	2	2	30	12.10 X 6.1 X 8.5	1		1	1	2
Mezzanine Level												
Day 4	Double	1994	16	2	2	32	12.10 X 6.1 X 8.5	1		1	1	2
Notes: The (16) VOIG cells are located in Day 4 and are # 63, 65, 67, 69, 71, 73, 75, 77, 79, 81, 83, 85, 87, 89, 91, and 93. Double bunking of single cells completed in November 2003.												
POD F												
Ground Level												
Day 1	Double	1994	16	2	2	32	12.10 X 6.1 X 8.5	1		1	1	2
Mezzanine Level												
Day 1	Double	1994	16	2	2	32	12.10 X 6.1 X 8.5	1		1	1	2
Notes: Day 1 has 8 tables and 64 seats.												
Ground Level												
Day 2	Double	1994	8	2	2	16	12.10 X 6.1 X 8.5	1		1	1	
Mezzanine Level												
Day 2	Double	1994	8	2	2	16	12.10 X 6.1 X 8.5	1		1	1	
Notes: Day 2 has 4 tables and 32 seats.												
Ground Level												
Day 3	Double	1994	8	2	2	16	12.10 X 6.1 X 8.5	1		1	1	
Mezzanine Level												
Day 3	Double	1994	8	2	2	16	12.10 X 6.1 X 8.5	1		1	1	
Notes: Day 3 has 4 tables and 32 seats.												
Ground Level												
Day 4	Double	1994	16	2	2	32	12.10 X 6.1 X 8.5	1		1	1	2
Mezzanine Level												
Day 4	Double	1994	16	2	2	32	12.10 X 6.1 X 8.5	1		1	1	2
Notes: Day 4 has 8 tables and 64 seats.												
POD G												
Ground Level												
Day 1	Double	1994	16	2	2	32	12.10 X 6.1 X 8.5	1		1	1	2
Mezzanine Level												
Day 1	Double	1994	16	2	2	32	12.10 X 6.1 X 8.5	1		1	1	2
Notes: Day 1 has 8 tables and 64 seats.												
Ground Level												
Day 2	Double	1994	7	2	2	14	12.9 X 6.11 X 8.5	1		1	1	

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Mezzanine Level												
Day 2	Double	1994	7	2	2	14	12.9 X 6.11 X 8.5	1		1	1	
Notes: Day 2 has a handicap shower and the 7 ground level rooms are designated as ADA cells. Day 2 has 3 tables with 8 seats and 1 table with 4 seats.												
Ground Level												
Day 3	Double	1994	8	2	2	16	12.10 X 6.1 X 8.5	1		1	1	
Mezzanine Level												
Day 3	Double	1994	8	2	2	16	12.10 X 6.1 X 8.5	1		1	1	
Notes: Day 3 has 4 tables and 32 seats.												
Ground Level												
Day 4	Double	1994	16	2	2	32	12.11 X 6.2 X 8.5	1		1	1	2
Mezzanine Level												
Day 4	Double	1994	16	2	2	32	12.11 X 6.2 X 8.5	1		1	1	2
Notes: Day 4 has 8 tables and 64 seats.												
INFIRMARY												
A-2054	Holding	1988	1		(6)	(6)	10.3 X 9.5 X 8.0	1		1	1	
A-2055	Holding	1988	1		(5)	(5)	10.5 X 9.5 X 8.0	1		1	1	
2079-Cell 10	Holding	1988	1		(5)	(5)	10.5 X 9.5 X 8.0	1		1	1	
2080-Cell 9	Ward	1988	1	4	(4)	(4)	22.3 X 15.5 X 8.0	1		1	1	1
2081-Cell 8	Single	1988	1	1	(1)	(1)	15.5 X 8.5 X 8.0	1		1	1	
2082-Cell 7	Single	1988	1	1	(1)	(1)	15.5 X 8.5 X 8.0	1		1	1	1
2083-Cell 6	Single	1988	1	1	(1)	(1)	15.5 X 9.0 X 8.0	1		1	1	1
2084-Cell 5	Mental	1988	1	1	(1)	(1)	15.5 X 8.7 X 8.0	1		1	1	1
2085-Cell 4	Mental	1988	1	1	(1)	(1)	15.5 X 8.5 X 8.0	1		1	1	1
2086-Cell 3	Mental	1988	1	1	(1)	(1)	15.5 X 9.0 X 8.0	1		1	1	1
2087-Cell 2	Mental	1988	1	1	(1)	(1)	15.5 X 11.6 X 8.0	1		1	1	1
2088-Cell 1	Mental	1988	1	1	(1)	(1)	15.5 X 11.6 X 8.0	1		1	1	1
A-2069	Exam	1988	1	2	(2)	(2)	9.8 X 12.0 X 8.0					
Court Holding – Custody												
Cell 1	Holding	1999	1		(2)	(2)	9'9" x 6'8" x 8'3"	1		1	1	
Note: Seating Capacity 48"												
Cell 2	Holding	1999	1		(1)	(1)	8' x 10' x 8'3"	1		1	1	
Note: Seating Capacity 28"												
Cell 3	Holding	1999	1		(2)	(2)	8'1" x 6'8" x 8'3"	1		1	1	
Note: Seating Capacity 53"												
Cell 4	Holding	1999	1		(1)	(1)	10' x 6'8" x 8'3"	1		1	1	
Note: Seating Capacity 28"												
Cell 5	Holding	1999	1		(16)	(16)	15'5" x 15'1" x 8'3"	1		1	1	
Note: Seating Capacity 351"												
Cell 6	Holding	1999	1		(16)	(16)	21'9" x 13'6" x 8'3"	1		1	1	
Note: Seating Capacity 336"												
Cell 7	Holding	1999	1		(16)	(16)	19'6" x 11'4" x 8'3"	1		1	1	
Note: Seating Capacity 317"												
Cell 8	Holding	1999	1		(16)	(16)	19'1" x 11'4" x 8'3"	1		1	1	

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Note: Seating Capacity 321”												
Cell 9	Holding	1999	1		(7)	(7)	17’7” x 13’ x 8’3”	1		1	1	
Note: Seating Capacity 135’												
Cell 10	Holding	1999	1		(15)	(15)	13” x 12’6” x 8’3”	1		1	1	
Note: Seating Capacity 286”												
Cell 11	Holding	1999	1		(8)	(8)	16’3” x 6’8” x 8’3”	1		1	1	
Note: Seating Capacity 148”												
Cell 12	Holding	1999	1		(8)	(8)	15’11” x 8’ x 8’3”	1		1	1	
Note: Seating Capacity 156”												
Cell 13	Holding	1999	1		(9)	(9)	15’3” x 8’8” x 8’3”	1		1	1	
Note: Seating Capacity 177”												
Cell 14	Holding	1999	1		(3)	(3)	7’5” x 12’3” x 8’3”	1		1	1	
Note: Seating Capacity 68”												
Cell 15	Holding	1999	1		(2)	(2)	8’4” x 6’8” x 8’3”	1		1	1	
Note: Seating Capacity 40”												
Cell 16	Holding	1999	1		(2)	(2)	7’4” x 6’8” x 8’3”	1		1	1	
Note: Seating Capacity 40”												
Cell 17	Holding	1999	1		(3)	(3)	7’4” X 9’11” X 8’3”	1		1	1	
Note: Seating Capacity 80”												
Cell 18	Holding	1999	1		(9)	(9)	11’4” X 11’4” X 8’3”	1		1	1	
Note: Seating Capacity 174”												
Cell 19	Holding	1999	1		(1)	(1)	10’3” X 9’ X 8’3”	1		1	1	
Note: Seating Capacity 18”												

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ADULT TYPE I, II, III AND IV FACILITIES
PHYSICAL PLANT EVALUATION
Board of State and Community Corrections

APPLICABLE TITLE 24 REGULATIONS: 6/94; 2/99; 2001

BSCC Code: 3940

FACILITY NAME: Blythe Jail				**FACILITY TYPE:** II
APPLICABLE REGULATIONS (Check All That Apply):	**6/94: X**	**2/99:**	**2001:** X	**OTHER:** 1963
FIELD REPRESENTATIVE: Michael J. Bush				**DATE:** 09/19/2019

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Reception and Booking (2.1) Contains a weapons locker, designed as outlined in these regulations.	X			
Contains a cell or room for confinement pending booking	X			
Contains a detoxification cell, where applicable 01: Name change to "sobering cell." 2-99: Two detoxification cells are provided if both male and female inmates are held.	X			
Contains safety cell(s) (WA)			X	
Shower room available 2-99: Access to shower must be within the secure area	X			
Provides secure vault or storage for inmate valuables	X			
Telephone(s) available for inmate use (PC § 851.5)	X			
2-99: Unobstructed access to hot and cold running water	X			
Temporary Holding Cell or Room (2.2) Contains 10 square feet of floor area per inmate			X	One pre-booking holding; not rated. Remainder of the regulation was removed
Temporary Staging Cell or Room (2.3) Holds inmates classified and segregated per Title 15 § 1050 and 1053			X	No cell of this type, remainder of regulation was removed
Detoxification/Sobering Cell (2.4) 01: Name change to "sobering cell." Contains 20 square feet of floor area per inmate	X			One cell under 1963 Standards and the other is under the 1994 Standards.
Is limited to no more than 8 inmates	X			
Is no smaller than 60 square feet and has a clear ceiling height of 8 feet or more	X			
Contains a water closet (toilet) wash basin and drinking fountain as specified by these regulations	X			
Has padded partitions located next to toilet fixtures	X			
Provides for clear visual supervision by staff	X			
Padding on floor	X			
Safety Cell (2.5) Contains 48 square feet with one floor dimension of a least 6 feet and a clear ceiling height of 8 feet or more			X	No safety cell, remainder of regulation deleted

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Single Occupancy Cells (2.6) Maximum capacity of one inmate		X		Two inmates were occupying single cell D-1 – D-3. 3 single cells in old portion of jail (1963 Standards), the remainder of single cells are under the 1994 Standards.
Contain a minimum of 60 square feet of floor area in Type I facilities and 70 square feet in Type II and III facilities	X			
Have a minimum clear ceiling height of 8 feet and a minimum width of 6 feet	X			
Contain a water closet (toilet), washbasin and drinking fountain	X			
Contain a bunk, desk and seat (Desk and seat not required in Type I facilities.)	X			
Multiple Occupancy Cells (8227) 8-86: Deleted provision for multiple occupancy cells Contain 35 square feet per person		X		Housing unit E exceeded the rated capacity.
Limited to no more than 8 inmates	X			
No smaller than 100 square feet	X			
Minimum ceiling height of 8 feet	X			
Water closet separate from washbasin and drinking fountain	X			
Sufficient bunks to accommodate each occupant	X			
Provide storage space for each occupant's personal items	X			
Double Occupancy Cells (2.7) Maximum capacity of two inmates	X			New addition is under the 1994 Standards
Contain a minimum of 60 square feet of floor area in Type I facilities and 70 square feet in Type II and III facilities	X			
Have a minimum clear ceiling height of 8 feet and a minimum width of 6 feet	X			
Contain a water closet (toilet), washbasin and drinking fountain	X			
Contain 2 bunks, 1 desk and 1 seat (Desk and seat not required in Type I facilities.)	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Dormitories (2.8) *(Note: 2001 regulations reduced the double bunk requirement from 75 to 70 square feet and added provision for triple bunks. This is the "least restrictive standard.")* Contain at least 50 square feet of floor area per inmate for single bed units; at least 70 square feet of floor space per inmate for double bed units; and, at least 90 square feet for triple bed units. Eight foot clear ceiling height required. *(To calculate double bunked BRC: 70 square feet divided by 2 inmates = 35 square feet + 35 square feet dayroom = 70 square feet per inmate. To calculate triple bunked BRC: 90 square feet divided by 3 inmates=30 square feet + 35 square feet dayroom=65 square feet per inmate.)*		X		Dormitory "A" continues to exceed the rated capacity.
Designed for no fewer than 4 and no more than 64 inmates	X			
Provide access to toilets separate from washbasins and drinking fountains	X			
Provide storage space for each inmate's personal items (NA Type I)	X			
Dayrooms (2.9) Required for inmates in Type II and III facilities - excluding "special use" cells - and inmate workers in Type I facilities)	X			
Contain 35 square feet of floor area per inmate, exclusive of 3 foot wide corridors in front of cells/rooms 2-99: Deleted 3 foot corridor in front of cells/rooms		X		Although Dormitory "A" was remodeled and the capacity was lowered to 44, the Rated Capacity is 24; does not meet this standard. It's important to note that the remodel definitely improved conditions in the housing area and the ability to supervise the inmates has increased tremendously.
Contain tables and seating to accommodate the maximum number of inmates allowed access at a given time. *(Note 2001 revisions added reference to access at a given time and are the least restrictive standard.)*		X		
Exercise Area (2.10) Provided in Type II and III facilities. Type IV facilities must have a recreation area or provide community access to one.	X			
Clear height of 15 feet	X			
Has required surface area: 80% of maximum rated inmate capacity, multiplied by 50 square feet, divided by number of one-hour exercise periods per day, equals the required surface area.	X			
2-99: Provides free access to a toilet, washbasin and drinking fountain	X			
Provides adequate security	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Program/Multipurpose Space (2.11) (NA Type I) There is sufficient area and furnishings to meet the needs of the facility programs. (See regulation for discussion of applicability to Type IV.)	X			
Medical Examination Room (2.12) There is one suitably equipped medical exam room in every Type II or III facility designed to house 25 or more inmates. 2-99: Required in all facilities that provide on-site health care.	X			
Located within the security area and provide for privacy of inmates	X			
Not less than 100 square feet of floor space with no single dimension less than 7 feet		X		
Provide hot and cold running water 2-99: Hot and cold running water in any room where medical procedures are provided			X	
2-99: Lockable storage for medical supplies	X			
Pharmaceutical Storage Space (2.13) There is lockable storage space for medical supplies and pharmaceuticals (Title 15 § 1216).	X			
Medical Care Housing (2.14) Applicable to Type II and III facilities where the facility program indicates special medical care housing is needed.			X	Inmates with medical housing needs are transferred to the Indio Jail or Robert Presley Detention Center.
Housing is located within the security area, accessible to both male and female inmates, but not in the living area of either.			X	
Provides lockable storage area for medical instruments			X	
2-99: Negative pressure isolation rooms are designed to the community standard.			X	
Hair Care Space (2.15) Space and equipment are available. 2-99: Requirement deleted.			X	
Commissary (2.16) (NA Type I) Inmates can purchase specified items.	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
There is secure storage for commissary stock. 01: Revisions limit requirement for secure storage to circumstances when commissary supplies are kept within the security perimeter.	X			
Dining Facilities (2.17) (NA Type I) There are 15 square feet and sufficient tables and seating for each inmate being fed.	X			
Dining space does not include toilets, washbasins or showers, without an appropriate visual barrier. 2-99: Visual barrier requirement deleted for washbasins	X			
Visiting Space (2.18) There is sufficient visiting area.	X			
Safety Equipment Storage (2.19) Adequate space is provided to store equipment such as fire extinguishers, SCBA, emergency lights, etc.	X			
Janitors' Closet (2.20) A securely lockable janitors' closet provides sufficient storage for cleaning implements and supplies and is located within the security area (Type II only).	X			
A mop sink is available within the security area (Type II). It may be outside the security area in CH, TH and, Types I, III & IV.	X			
Audio or Visual Monitoring (2.22) (NA Type III and IV housing only minimum security inmates) There is an audio monitoring system capable of alerting staff in a central control. When visual electronic surveillance is used, it is located primarily in corridors, elevators, or at points on the security perimeter such as entrances and exits. 2-99: Video monitoring option deleted.	X			
Laundry Facilities (2.23) Type IV facilities make provision for washing and drying personal laundry.	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Emergency Power (2.24) There is an emergency power source available and capable of providing minimal lighting in all areas and maintaining fire and life safety, security, communication and alarm systems.	X			
Confidential Interview Rooms (2.25) There is at least one suitably furnished confidential interview room in every Type II facility designed for 25 or more inmates. 2-99: Applicable to every facility which provides on-site health care	X			
Located in the security area, accessible by both male and female inmates	X			
Provides at least 70 square feet floor area with no single dimension less than 6 feet	X			
Attorney Interview Space (2.26) (NA Type IV) Available and provides for confidentiality	X			
Water Closets (Toilets)/Urinals (3.1) Provide for inmate privacy/modesty with staff being able to visually supervise; one is provided in every single and double occupancy cell and at the following ratio elsewhere: 1:10 in dormitories (changed from 1:8 in 2001); 1:8 in detoxification/sobering cells; 1:16 in holding cells; 1:20 in exercise areas; and, Accessible to dayroom occupants no specified ratio. 2-99: Accessible at no specified ratio in exercise areas See regulation for calculations of urinal substitutions.	X			
Washbasins (3.2) Provide hot and cold or tempered water; one is provided in every single and double occupancy cell and at the following ratio elsewhere: 1:10 in dormitories (changed from 1:8 in 2001); 1:8 in detoxification/sobering cells; 1:20 in exercise areas; and, Accessible to dayrooms at no specified ratio. 2-99: Accessible in exercise areas at no specified ratio See regulation for calculations of washbasin trough substitutions.	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Drinking Fountains (3.3) One is provided in every single and double occupancy cell and in dormitories. Accessible to inmates in dayrooms 2-99: One is provided in every single and double occupancy cell, holding and staging cells and detoxification cells. It must be accessible to inmates in dayrooms and exercise areas.	X			
The water outlet (bubbler) is mechanically actuated and at an angle that prevents wastewater from flowing over the outlet (bubbler). There is a mouth guard on the water outlet. 2-99: Mouth guard requirement deleted	X			
Showers (3.4) Available at a ratio of 1:20; provide hot and cold or tempered water; shower stalls/areas are designed and constructed of materials that are impervious to water and soap so that they may be easily cleaned. 2-99: Ratio changed from 1:16; specified that shower areas must provide modesty for inmates, with staff ability to supervise.	X			
Beds/Bunks (3.5) At least 30 inches wide and 76 inches long with 21 inches between pans; constructed of pan bottom type or concrete; securely fastened to the floor and/or wall in facilities higher than minimum security. 01: Must be elevated off the floor.	X			
Lighting (3.6) Lighting in housing units, dayrooms and activity areas is sufficient to permit easy reading by a person with normal vision, and is not less than 20 foot-candles at desk level and in the grooming area. Night lighting is sufficient for purposes of supervision. Lighting is centrally controlled and/or occupant controlled in housing cells or rooms. Light fixtures are of secure design in areas higher than minimum security.	X			
Windows (3.7) In housing areas higher than minimum security, windows that are accessible to inmates are no greater than 5 inches in one dimension.			X	

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Cell Padding (3.8) The floors and partition are padded in detoxification cells. In safety cells, floors, doors, walls and everything on them are padded. All padded cells are equipped with a tamper resistant fire sprinkler approved by the SFM.	X			
All padding is: approved for use by the SFM; nonporous; at least ½ inch thick; of a unitary or laminated construction; firmly bonded to all surfaces; and, without exposed seams.	X			
Mirrors/Shelves/Clothes Hooks (3.9) A mirror of a material appropriate to the level of security is provided near each washbasin.	X			
Consistent with security needs, shelves and clothes hooks are provided wherever feasible. 2-99: Requirement for shelves and hooks deleted	X			
Clothes hooks are of a collapsible hook type 2-99: Requirement for hooks deleted	X			
Seating (3.10) Seating is designed to the level of security. When bench seating is used, eighteen inches of bench are provided per inmate. 2-99: In holding and staging cells, seating is securely fastened to the wall and/or floor.	X			
Table/Seat (3.11) (NA Type I) A table and seat is provided in single and double occupancy cells.	X			
Weapons Locker (3.12) (NA type IV and Minimum Security Facilities) A secure weapons locker is located outside the security perimeter of the facility and no weapons are brought into the security area. Lockers have individual compartments, locks and keys.	X			
Design Requirements (102(c)6) Design requirements as specified in Title 24, Part 1, 102(c)6 are met. (See regulation for specific requirements. Note areas of non-compliance that are applicable to the facility type and construction date in the "comments" section.)	X			

BOARD OF STATE AND COMMUNITY CORRECTION - BIENNIAL INSPECTION
ADULT DETENTION FACILITY
LIVING AREA SPACE EVALUATION

BSCC Code: 3940

FACILITY: Blythe Jail	**TYPE:** II	**RC:** 79
FIELD REPRESENTATIVE: Michael J. Bush		**DATE:** 09/19/2019

ROOMS							EACH ROOM					
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
Station	Holding	1963	1		(0)	(0)	5.0 x 4.0					
	Detox	1994	1		(3)	(3)	6.8 x 10	1		1	1	
	Detox	1963	1		(7)	(7)	8.0 x 13.5 x 10.0	1		1	1	
NOTES: Holding cell is not rated. New detox cell in place. Both detox cells are padded.												
"E" (Male)	Multiple	1963	2	6	2	4	10.0 x 12.8 x 10.0	2		2	2	2
"B" (Inmate Workers)	Dorm	1963	1	9	6	6	12.0 x 10.0 x 10.0	1		1	1	1
NOTES: As the door is normally left open, the cell has adequate space. Tank E does not have enough square footage per bunk (70 square ft) to meet a dormitory requirement in order to increase rated capacity.												
D 1-3	Single	1963	3	2	1	3	6.8 x 10.0 x 10.0	4		4	4	
C 1-3	Multiple	1963	3	8	7	22	10.5 x 18.8 x 10.0	5	1	5	5	2
	Dayroom						23.0 x 21.0 x 10.0					
NOTE: Single cells in this area are reduced by one. One cell had the bunk removed and the floor padded to convert to a detox cell. Multiple cell rated for 22 inmates; Housing 24.												
"A" Sentenced	Dorm	1963	1	44	24	24	38.5 x 33.5 x 10.0	4	2	3	3	3
NOTES: Recommend replacement of old wash basins. This dorm is over RC, 1/09; MW.												
New Addition – VOIG – 1998												
NEW ADDITION												
"F" 1-6	Double	1994	6	2	2	12	7.2 x 10.8	1		1	1	
"F" 7,8,9	Single	1994	3	2	2	6	7.2 x 10.8	1		1	1	
"F" 10	Single	1994	1	2	1	1	12.5 x 9	1		1	1	
NOTE: #10 cell is handicap accessible. 2 showers												
Dayroom – Sufficient for 16 inmates. Tanks – seating not in place – Next on-site. Review audio monitoring system, locks and furnished cells. 1,100 square feet.												

*T = Toilets; U = Urinals; W = Wash Basins; F = Fountains; S = Showers in unit; If "Total RC" appears in brackets ( ), it is not part of the facility's rated capacity. "+" indicates that capacity includes prorated air space from adjacent areas.

ADULT TYPE I, II, III AND IV FACILITIES
PHYSICAL PLANT EVALUATION
Board of State and Community corrections

Applicable Title 24 Regulations: 3/80; 8/86; 5/88; 1/91

BSCC Code: 3960

FACILITY NAME: Indio Jail					**FACILITY TYPE:** II
APPLICABLE REGULATIONS (Check All That Apply):	**3/80:** X	**8/86:**	**5/88:**	**1/91:**	**OTHER:** 1963
FIELD REPRESENTATIVE: Michael J. Bush					**DATE:** 09/23/2019

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Temporary Holding Cells (2.2) Contain 10 square feet of floor per inmate	X			
Limited to no more than 16 inmates	X			
No smaller than 40 square feet	X			
Contain sufficient seating to accommodate all inmates	X			
Toilet accessible	X			
Water fountain accessible	X			
Wash basin accessible	X			
Provides clear visual supervision	X			
Telephone accessible	X			
Weapons Locker (3.12) External to the security area and equipped with individual compartments, locks and keys	X			
Temporary Staging Cell or Room (2.3) 1-91: Added provision for temporary staging cells-rooms. Holds inmates classified and segregated per Title 15 § 1050 and § 1053			X	No cell of this type, remainder of the regulation has been removed.
Detoxification/Sobering Cells (2.4) 01: Name change to "sobering cell" Contain 20 square feet of floor per inmate	X			
Limited to no more than 8 inmates	X			
No smaller than 60 square feet	X			
Contain toilet	X			
Contain washbasin	X			
Contain drinking fountain	X			
Partitions or handrails located next to toilet fixture to provide support	X			
Provide easy, unobstructed visual observation	X			
Padding on the floor	X			
Shower-Delousing Room (3.4) Available in reception/booking	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Secure Vault or Storage Space (2.1) Available for inmate valuables	X			
Telephone (2.1) Available for inmate use per Penal Code § 851.5	X			
Safety Cells (2.5) Contain 48 square feet with one floor dimension at least 6 feet and ceiling height of at least 8 feet	X			
Limited to no more than one inmate	X			
Contain flush ring toilet with controls located outside the cell	X			
Padded floor, door and walls	X			
Equipped with variable intensity, security light, inaccessible to occupant	X			
Vertical view panel not more than 4 inches wide and at least 24 inches long, in or adjacent to the door	X			
Provide a food pass with lockable shutter no more than 4 inches high and located at least 30 inches above the floor	X			
Single Occupancy Cells (2.6) Maximum capacity of one inmate	X			
Contain a minimum of 60 square feet of floor area in Type I facilities and 70 square feet in Type II and III facilities	X			
Have a minimum ceiling height of 8 feet	X			
Contain toilet, washbasin and drinking fountain	X			
Contain a bunk, desk and seat (Desk and seat not required in Type I in later, less restrictive 1986 standards)	X			
Multiple Occupancy Cells (8227) 8-86: Deleted provision for multiple occupancy cells Contain 35 square feet per person			X	No cell of this type, remainder of the regulation has been removed.
Multiple Occupancy Rooms (8229) 8-86: Deleted provision for multiple occupancy rooms Limited to housing persons in Type III and IV facilities and workers in Type I and II facilities	X			
Contain 50 square feet of floor area per person and a minimum of 8 feet ceiling height	X			
Limited to no more than 16 persons	X			
Access to toilets separate from washbasins (ratio 1:8) and drinking fountains	X			
Provide storage space for each occupant's personal items	X			
Double Occupancy Cells (2.7) 5-88: Added provision for double occupancy cells Maximum capacity of two inmates			X	No cell of this type, remainder of the regulation has been removed
Dormitories (2.8) 8-86: Provision for dormitories added Contain 50 square feet of floor area per inmate and a minimum of 8 feet ceiling height		X		Continue to exceed rated capacity.

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Be designed for no fewer than 8 and no more than 64 inmates	X			
Facilities having a total rated capacity of 80 inmates or less, may design dormitories for no fewer than 4 inmates			X	
Access to toilets separate from washbasins (ratio 1:8) and drinking fountains 01: Ratio changed to 1:10		X		
Provide storage space for each inmate's personal items	X			
Dayrooms (2.9) 8-86: Added requirement for 3 foot wide corridors in front of cells-rooms 99: Corridor requirement deleted	X			
35 square feet of floor area per inmate		X		Continue to exceed rated capacity
Contain tables and seating to accommodate the maximum number of inmates served		X		Continue to exceed rated capacity
Access to toilets, washbasins and drinking fountains		X		Continue to exceed rated capacity
Available to all inmates in Type II and III facilities (excluding special use cells) and to workers in Type I facilities	X			
Shower (3.4) Available on a ratio of 1:16 01: Ratio changed to 1:20		X		Continue to exceed rated capacity
Lighting (3.6) Sufficient to permit easy reading. Night lighting is sufficient to allow good supervision. 8-86: Specifies at least 20 foot-candles at desk level and in grooming areas, with night lighting not to exceed 5 foot-candles	X			
Beds-Bunks (3.5) 30 inches wide and 76 inches long		X		Floor sleeper (portable beds) during the 2016-2018 inspection cycle.
Comfortable Living Environment [102(c)6] A comfortable living environment is maintained through an adequate heating and cooling system.	X			
Exercise Area -Type II, III and WA IV (2.10) At least one exercise area must contain a minimum of 900 square feet	X			
8-86: Outdoor exercise area provided	X			
8-86: Clear height of 15 feet with required surface area meeting a formula of: 80% of maximum rated inmate population and number of one-hour exercise periods per day = required surface area	X			
Program Space - Type II and III (2.11) Sufficient area and furnishings to meet the needs of the facility programs	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Dining Facilities (2.17) 15 square feet per inmate being fed	X			
Toilets, washbasins and showers are not in the same room or not in view of inmate dining	X			
Visiting (2.18) Sufficient visiting area	X			
Contact visits whenever possible for minimum security inmates	X			
Attorney Interviews (2.26) Provide for confidential attorney consultation	X			
Safety Equipment Storage (2.19) Adequate space is provided for storage of equipment such as fire extinguishers, SCBA, emergency lights, etc.	X			
Janitor Closet (2.20) Located in security areas lockable, containing a mop sink and storage space	X			
Storage Rooms (2.21) Sufficient space to accommodate inmate property, bedding and supplies	X			
Audio or Video Monitoring System -NA Type IV (2.22) Audio monitoring system capable of alerting staff in a central control	X			
Video monitoring in corridors, main entries and/or exits and programs or activity areas	X			
Fire Detection and Alarm System [102(c)6] Automatic fire alarm system capable of alerting staff in a central control point	X			
Emergency Power (2.24) Available to provide minimal lighting, maintain communications, alarm, fire, life and security systems	X			
Provide Space for: **Barber/beauty shop(2.15)** 8-86: Limit requirement to Type II and III facilities 99: Requirement deleted			X	
Canteen (2.16) 8-86: Added for II, III & IV facilities	X			
Confidential Interview Rooms (2.25) 8-86: Added for Type II facilities			X	

BOAD OF STATE AND COMMUNITY CORRECTIONS - BIENNIAL INSPECTION
ADULT DETENTION FACILITY
LIVING AREA SPACE EVALUATION

BSCC Code: 3960

FACILITY: Indio Jail	**TYPE:** II	**RC:** 238
FIELD REPRESENTATIVE: Michael J. Bush		**DATE:** 09/23/2019

ROOMS							EACH ROOM					
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
Old Court Holding Cells												
1	Holding	1963	1		(2)	(2)	9.5 X 4.0	1		1	1	
2	Holding	1963	1		(5)	(5)	14.0 X 4.0	1		1	1	
3	Holding	1963	1		(5)	(5)	13.0 X 4.0	1		1	1	
4	Holding	1963	1		(3)	(3)	9.5 X 4.0	1		1	1	
Addition to Intake:												
1	Holding	1982	1		(6)	(6)		1		1	1	
2	Holding	1982	1		(6)	(6)		1		1	1	
3	Holding	1982	1		(8)	(8)		1		1	1	
1	Safety	1982	1		(1)	(1)	6.0 X 8.0					
2	Safety	1982	1		(1)	(1)	6.0 X 8.0					
Male	Sobering	1982	1		(7)	(7)		1		1	1	
Female	Sobering	1982	1		(5)	(5)		1		1	1	
Medical Observation:												
1 - 4	Double	1982	4	4	(2)	(8)	15.0 X 7.5	1		1	1	
5	Double	1982	1	2	(2)	(2)	11.3 X 10.4	1		1	1	1
Main Corridor:												
Note: New shower added off of Main Corridor, male or female housing depending on need												
Tank 1	Multiple	1963	3	8	8	24+	15.5 X 60.0 X 11.2	5		5	5	2
Tank 2	Multiple	1963	3	8	8	24+	15.5 X 60.0 X 11.2	5		5	5	2
Tank 4	Multiple	1963	3	8	8	24+	15.5 X 60.0 X 11.2	5		5	5	2
Tank 5	Multiple	1963	3	8	8	24+	15.5 X 60.0 X 11.2	5		5	5	2
Tank 3	Dorm	1963	1	21	16	16+	20.0 X 30.0 X 11.2	2		2	2	1
6, 11, 12	Multiple	1963	3	21	10	30	28.0 X 23.4 X 11.2	3		3	3	1
7	Multiple	1963	1	21	10	10	28.0 X 23.4 X 11.2	3		3	3	1
10	Multiple	1963	1	16	10	10	28.0 X 23.4 X 11.2	2		3	3	1
8 (female overflow)	Multiple	1982	1	3	2	2	8.1 X 13.4 X 11.2	1		1	1	1
9	Multiple	1982	1	4	4	4	11.4 X 18.0 X 11.2	1		1	1	1
13	Dorm	1963	1	26	16	16+	27.5 X 29.5 X 11.2	2		2	2	1
14	Dorm	1963	1	26	16	16	22.5 X 29.5 X 11.2	2		2	2	1
15 (females)	Dorm	1963	1	26	16	16	22.5 X 29.5 X 11.2	2		2	2	1

*T = Toilets; U = Urinals; W = Wash Basins; F = Fountains; S = Showers in unit; If "Total RC" appears in brackets ( ), it is not part of the facility's rated capacity. "+" indicates that capacity includes prorated air space from adjacent areas.

ROOMS							EACH ROOM					
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
16	Dorm	1963	1	12	8	(8)	22.5 X 29.5 X 11.2	1		1	1	1
17	Multiple	1982	5	2	2	(10)	10.4 X 11.3 X 11.2	1		1	1	1
18 Ad Seg	Single	1982	7	2	2	14		1		1	1	
19 DI	Single	1992	4	1	(1)	(4)		1		1	1	
Note: Overall dimension is 95 square feet; Unit 19 is designated as disciplinary isolation. Cells 1 and 2 are converted to negative pressure; however, the cells are still used for disciplinary isolation.												
Ct. Holding in the Indio Jail												
H1 -5	Holding	1992	5		(16)	(16)	See Note	2		2	2	
Note: Overall dimension is 176 square feet.												
H6	Holding	1992	1		(15)	(15)	See Note	2		2	2	
Note: Overall dimension is 179 square feet.												
H7	Holding	1992	1		(11)	(11)	See Note	2		2	2	
Note: Overall dimension is 103 square feet.												
H8	Holding	1992	1		(11)	(11)	See Note	2		2	2	
Note: Overall dimension is 90 square feet.												
H9	Holding	1992	1		(6)	(6)	See Note	2		2	2	
Note: Overall dimension is 72 square feet.												
H10	Holding	1992	1		(5)	(5)	See Note	2		2	2	
H11 - 12	Holding	1992	2		(11)	(22)	See Note	2		2	2	
Note: Overall dimension is 109 square feet.												

Note: Overall dimension is 95 square feet. Rated capacity modified from 237 to 240 due to adding error of cells and beds, 2007MW. Number of cells and beds were reviewed this cycle, therefore the rated capacity has been adjusted, there are actually 10 medical beds in Tank 17 (we had listed 2 beds in 17), therefore overall we reduced the RC to 238 3/2013 MW.

*T = Toilets; U = Urinals; W = Wash Basins; F = Fountains; S = Showers in unit; If "Total RC" appears in brackets ( ), it is not part of the facility's rated capacity. "+" indicates that capacity includes prorated air space from adjacent areas.

COURT HOLDING FACILITIES

Board of State and Community Corrections

PROCEDURES[1]

FACILITY NAME: Hall of Justice	Type: CH	**BSCC** #3916	DATE: 09/18/2019
FACILITY NAME: Southwest Justice Center	Type: CH	**BSCC** #3935	DATE: 09/19/2019
FACILITY NAME: Southwest Juvenile Center	Type: CH	**BSCC** #3937	DATE: 09/19/2019
FACILITY NAME: Family Law Court	Type: CH	**BSCC** #3950	DATE: 09/18/2019
FACILITY NAME: Larson justice Center	Type: CH	**BSCC** #3970	DATE: 09/24/2019
FACILITY NAME: Banning Court	Type: CH	**BSCC** #3974	DATE: 09/20/2019
FACILITY NAME: Blyth Court	Type: CH	**BSCC** #3975	DATE: 09/25/2019
FIELD REPRESENTATIVE: Michael J. Bush			

TITLE 15 SECTION	YES	NO	N/A	P/P REFERENCE – COMMENTS
1024 COURT HOLDING AND TEMPORARY HOLDING FACILITY TRAINING Custodial personnel who supervise inmates in, and supervisors of, a Court Holding or Temporary Holding facility shall complete 8 hours of specialized training. Such training shall include, but not be limited to: (a) applicable minimum jail standards; (b) jail operations liability; (c) inmate segregation; (d) emergency procedures and planning, fire and life safety; and, (e) suicide prevention. *Each agency shall determine if additional training is needed based upon, but not limited to, the complexity of the facility, the number of inmates, the employees' level of experience and training, and other relevant factors*	X	☐	☐	CSM 601.05 CDPM 503.06 Correctional deputies are responsible for inmates attending court proceedings. Deputies will deliver inmates via elevator to the receiving bailiff. Inmates will go directly into the courtroom. There are holding cells adjacent to the courtroom. They are only used for inmates to use the restroom or when there is a break during the proceedings. Inmates are only held for max 15-20 min.
Such training shall be completed as soon as practical, but in any event not more than six months after the date of assigned responsibility, or the effective date of this regulation. Successful completion of Core training or supplemental Core training, pursuant to Section 1020, Corrections Officer Core Course, may be substituted for the initial eight hours of training.	X	☐	☐	
Eight hours of refresher training shall be completed once every two years. Successful completion of the requirements in Section 1025, Continuing Professional Training may be substituted for the eight hour refresher.	X	☐	☐	

[1] This document is intended for use as a tool during the inspection process; this worksheet may not contain each Title 15 regulation that is required. Additionally, many regulations on this worksheet are SUMMARIES of the regulation; the text on this worksheet may not contain the entire text of the actual regulation. Please refer to the complete California Code of Regulations, Title 15, Minimum Standards for Local Facilities, Division 1, Chapter 1, Subchapter 4 for the complete list and text of regulations.

TITLE 15 SECTION	YES	NO	N/A	P/P REFERENCE – COMMENTS
1027 NUMBER OF PERSONNEL A sufficient number of personnel shall be employed in each local detention facility to ensure the implementation and operation of the programs and activities required by these regulations.	X	☐	☐	CDPM 501.20
Whenever there is an inmate in custody, there shall be at least one employee on duty at all times in a local detention facility or in the building which houses a local detention facility who shall be immediately available and accessible to inmates in the event of an emergency.	X	☐	☐	CDPM 601.22 Section 2.0
Such an employee shall not have any other duties which would conflict with the supervision and care of inmates in the event of an emergency.	X	☐	☐	
Whenever one or more female inmates are in custody, there shall be at least one female employee who shall be immediately available and accessible to such females. *Note: Reference PC§ 4021.*	X	☐	☐	
To determine if there is a sufficient number of personnel for a specific facility, the facility administrator shall prepare and retain a staffing plan indicating the personnel assigned in the facility and their duties. Such a staffing plan shall be reviewed by the Board staff at the time of their biennial inspection. The results of such a review and recommendations shall be reported to the local jurisdiction having fiscal responsibility for the facility.	X	☐	☐	
1027.5 SAFETY CHECKS Safety checks shall be conducted at least hourly through direct visual observation of all inmates. There shall be no more than a 60 minute lapse between safety checks.	X	☐	☐	C601.22, requires visual checks of all occupied holding cells every hour.
There shall be a written plan that includes the documentation of routine safety checks.	X	☐	☐	Except for Banning and Southwest Juvenile court, Inmates are held in the court holding cells for a very limited amount of time (less than 60 minutes), not long enough to log an hourly check. BSCC reviewed Banning and Southwest Juvenile court observation logs. each facility revealed compliance with regulation standard.
1028 FIRE AND LIFE SAFETY STAFF Whenever there is an inmate in custody, there shall be at least one person on duty at all times who meets the training standards established by the BSCC for general fire and life safety. (Penal Code section 6030[e])	X	☐	☐	CDPM 505.05 Section 4.0 Each CH Facility has a Fire Life and Safety Manual on site.
The facility manager shall ensure that there is at least one person on duty who trained in fire and life safety procedures that relate specifically to the facility.	X	☐	☐	

TITLE 15 SECTION	YES	NO	N/A	P/P REFERENCE – COMMENTS
1029 POLICY AND PROCEDURES MANUAL [2] Facility administrator(s) shall develop and publish a manual of policy and procedures for the facility. The policy and procedures manual shall address all applicable Title 15 and Title 24 regulations and shall be comprehensively reviewed and updated at least every two years. Such a manual shall be made available to all employees. *The policies and procedures required in subsections (a)(6) and (a)(7) may be placed in a separate manual to ensure confidentiality. Subsections d does not apply and has been deleted.*	X	☐	☐	Court Services Policy/Procedures Manual (CSM) Riverside Sheriff's Department Manual (RSDM) Corrections Division Policy Manual (CDPM)
(a) The manual shall provide for, but not be limited to, the following: (1) Table of organization, including channels of communications.	X	☐	☐	RSDM
(2) Inspections and operations reviews by the facility administrator/manager.	X	☐	☐	CDPM 502.04 Facility Inspections
(3) Policy on the use of force.	X	☐	☐	CSM 601.37 Non-Compliant Inmates
(4) Policy on the use of restraint equipment, including the restraint of pregnant inmates as referenced in Penal Code Section 3407.	X	☐	☐	CSM 601.28 Restraints 601.12 Custodial Situations and Prisoner Transport
(6) Security and control including physical counts of inmates, searches of the facility and inmates, contraband control, and key control. Each facility administrator shall, at least annually, review, evaluate, and make a record of security measures. The review and evaluation shall include internal and external security measures of the facility including security measures specific to prevention of sexual abuse and sexual harassment.	X	☐	☐	CSM 601.06 Duties 1.0 CSM 601.12 Custodial Situations CSM 601.06 Duties
(7) Emergency procedures include:	X	☐	☐	CSM 601.28 1.0 Escape
(A) fire suppression preplan as required by section 1032 of these regulations;	X	☐	☐	CDPM 502.04 Facility Inspections
(B) escape, disturbances, and the taking of hostages;	X	☐	☐	CSM 601.28 1.0 Escape CSM 601.07 General Procedures CSM 601.17 Hostage Situations
(C) mass arrests;	X	☐	☐	CSM 601.07 General Procedures
(D) natural disasters;	X	☐	☐	CSM 601.15 Earthquake
(E) periodic testing of emergency equipment; and,	X	☐	☐	CSM 601.06 Duties 5.0
(F) storage, issue, and use of weapons, ammunition, chemical agents, and related security devices.	X	☐	☐	

[2] Procedures related to security and emergency response may be in a separate manual to ensure confidentiality by limiting general access.

TITLE 15 SECTION	YES	NO	N/A	P/P REFERENCE – COMMENTS
(8) Suicide Prevention.	X	☐	☐	CDPM 508.15 Suicide Prevention Program
(9) Segregation of Inmates.	X	☐	☐	CDPM 504.02 Admin. Segregation
(10) Zero tolerance in the prevention of sexual abuse and sexual harassment.	X	☐	☐	501.24 Sexual Assault 507.11 Orientation 508.10 Medical Screening/Medical Release
(11) Policy and procedure to detect, prevent, and respond to retaliation against any staff or inmate after reporting any abuse.	X	☐	☐	
(b) The policies and procedures required in subsections (a)(6) and (a)(7) may be placed in a separate manual to ensure confidentiality.	X	☐	☐	
(c) The manual for court holding facilities shall include all of the procedures listed in subsection (a), except number (5) (*which has been deleted)*.	X	☐	☐	
(e) The manual for Temporary Holding, Court Holding, Type I, II, III, and IV facilities shall provide for, but not be limited to, the following:	X	☐	☐	
(1) multiple internal ways for inmates to privately report sexual abuse and sexual harassment, retaliation by other inmates or staff for reporting sexual abuse and sexual harassment, and staff neglect or violation of responsibilities that may have contributed to such incidents,	X	☐	☐	
(2) a method for uninvolved inmates, family, community members, and other interested third-parties to report sexual abuse or sexual harassment. The method for reporting shall be publicly posted at the facility.	X	☐	☐	
1030 SUICIDE PREVENTION PROGRAM The facility shall have a comprehensive written suicide prevention program developed by the facility administrator, in conjunction with the health authority and mental health director, to identify, monitor, and provide treatment to those inmates who present a suicide risk. The program shall include the following:	X	☐	☐	CDPM 508.15 Suicide Prevention Program
(a) Suicide prevention training for all staff that have direct contact with inmates.	X	☐	☐	
(b) Intake screening for suicide risk immediately upon intake and prior to housing assignment.	X	☐	☐	
(c) Provisions facilitating communication among arresting/transporting officers, facility staff, medical and mental health personnel in relation to suicide risk.	X	☐	☐	
(d) Housing recommendations for inmates at risk of suicide.	X	☐	☐	
(e) Supervision depending on level of suicide risk.	X	☐	☐	
(f) Suicide attempt and suicide intervention policies and procedures.	X	☐	☐	
(g) Provisions for reporting suicides and suicides attempts.	X	☐	☐	
(h) Multi-disciplinary administrative review of suicides and attempted suicides as defined by the facility administrator.	X	☐	☐	

TITLE 15 SECTION	YES	NO	N/A	P/P REFERENCE – COMMENTS
1032 FIRE SUPPRESSION PREPLANNING Pursuant to Penal Code Section 6031.1(b), the facility administrator shall consult with the local fire department having jurisdiction over the facility, with the State Fire Marshal, or both, in developing a plan for fire suppression which shall include, but not be limited to:	X	☐	☐	CSM 601.16 Fire
(a) a fire suppression pre-plan developed with the local fire department to be included as part of the policy and procedures manual (Title 15, California Code of Regulations Section 1029);	X	☐	☐	
(b) regular fire prevention inspections by facility staff on a monthly basis with two year retention of the inspection record;	X	☐	☐	Logs maintained with the Fire, Life and Safety Manual.
(c) fire prevention inspections as required by Health and Safety Code Section 13146.1(a) and (b) which requires inspections at least once every two years;	X	☐	☐	All have been inspected with no issues except.
(d) an evacuation plan; and,	X	☐	☐	
(e) a plan for the emergency housing of inmates in the case of fire.	X	☐	☐	In FLS Manual
1044 INCIDENT REPORTS Each facility administrator shall develop written policies and procedures for the maintenance of written records and reporting of all incidents which result in physical harm, or serious threat of physical harm, to an employee or inmate of a detention facility or other person.	X	☐	☐	CSM 601.22 Documentation Section 3.2 601.22 Section 1.0 Activity Log
Such records shall include the names of the persons involved, a description of the incident, the actions taken, and the date and time of the occurrence.	X	☐	☐	
Such a written record shall be prepared by the staff assigned to investigate the incident and submitted to the facility manager or his/her designee.	X	☐	☐	CSM 601.22 Section 3.2.2
1046 DEATH IN CUSTODY (a) Death in Custody Reviews for Adults and Minors. The facility administrator, in cooperation with the health administrator, shall develop written policy and procedures to ensure that there is an initial review of every in-custody death within 30 days. The review team shall include the facility administrator and/or the facility manager, the health administrator, the responsible physician and other health care and supervision staff who are relevant to the incident.	X	☐	☐	CSM 601.36 Death in Custody
Deaths shall be reviewed to determine the appropriateness of clinical care; whether changes to policies, procedures, or practices are warranted; and to identify issues that require further study.	X	☐	☐	
(b) Death of a Minor In any case in which a minor dies while detained in a jail, lockup, or court holding facility:	X	☐	☐	CDPM 510.10 Death in Custody
(1) The administrator of the facility shall provide to the Board a copy of the report submitted to the Attorney General under Government Code Section 12525. A copy of the report shall be submitted within 10 calendar days after the death.	X	☐	☐	

TITLE 15 SECTION	YES	NO	N/A	P/P REFERENCE – COMMENTS
(2) Upon receipt of a report of death of a minor from the administrator, the Board may within 30 calendar days inspect and evaluate the jail, lockup, or court holding facility pursuant to the provisions of this subchapter. Any inquiry made by the Board shall be limited to the standards and requirements set forth in these regulations.	X	☐	☐	
1050 CLASSIFICATION PLAN (b) Each administrator of a court holding facility shall establish and implement a written plan designed to provide for the safety of staff and inmates held at the facility. The plan shall include receiving and transmitting of information regarding inmates who represent unusual risk or hazard while confined at the facility, and the segregation of such inmates to the extent possible within the limits of the court holding facility.	X	☐	☐	CSM 601.12 Custody Situations Questions included in booking paperwork. Remands are typically transported directly to the jail facility where classification occurs.
(c) In deciding whether to assign an inmate to a housing area for male or female inmates, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the inmate's health and safety, and whether the placement would present management or security problems. An inmate's own views with respect to his or her own safety shall be given serious consideration.	X	☐	☐	
1051 COMMUNICABLE DISEASES The facility administrator, in cooperation with the responsible physician, shall develop written policies and procedures specifying those symptoms that require segregation of an inmate until a medical evaluation is completed	X	☐	☐	CSD 601.12 Medical Releases for Booking Section 5.0
At the time of intake into the facility, an inquiry shall be made of the person being booked as to whether or not he/she has or has had any communicable diseases, such as tuberculosis or has observable symptoms of tuberculosis or any other communicable diseases, or other special medical problem identified by the health authority. The response shall be noted on the booking form and/or screening device.	X	☐	☐	
1052 MENTALLY DISORDERED INMATES The facility administrator, in cooperation with the responsible physician, shall develop written policies and procedures to identify and evaluate all mentally disordered inmates, and may include telehealth.	X	☐	☐	CSD 601.12 Medical Releases for Booking Section 5.0 The practice is direct transport to the jail. Remands are typically direct transports to the jail facility where classification occurs.
If an evaluation from medical or mental health staff is not readily available, an inmate shall be considered mentally disordered for the purpose of this section if he or she appears to be a danger to himself/herself or others or if he/she appears gravely disabled. An evaluation from medical or mental health staff shall be secured within 24 hours of identification or at the next daily sick call, whichever is earliest.	X	☐	☐	
Segregation may be used if necessary to protect the safety of the inmate or others.	X	☐	☐	

TITLE 15 SECTION	YES	NO	N/A	P/P REFERENCE – COMMENTS
1053 ADMINISTRATIVE SEGREGATION Except in Type IV facilities, each facility administrator shall develop written policies and procedures which provide for the administrative segregation of inmates who are determined to be prone to: promote activity or behavior that is criminal in nature or disruptive to facility operations; demonstrate influence over other inmates, including influence to promote or direct action or behavior that is criminal in nature or disruptive to the safety and security of other inmates or facility staff, as well as to the safe operation of the facility; escape; assault, attempted assault, or participation in a conspiracy to assault or harm other inmates or facility staff; or likely to need protection from other inmates, if such administrative segregation is determined to be necessary in order to obtain the objective of protecting the welfare of inmates and staff.	X	☐	☐	CSM 601.08 Ad-Seg inmates are typically directly transported to and from the jail facility.
Administrative segregation shall consist of separate and secure housing but shall not involve any other deprivation of privileges than is necessary to obtain the objective of protecting the inmates and staff.	X	☐	☐	
1057 DEVELOPMENTALLY DISABLED INMATES The facility administrator, in cooperation with the responsible physician, shall develop written policies and procedures for the identification and evaluation, appropriate classification and housing, protection, and nondiscrimination of all developmentally disabled inmates.	X	☐	☐	CSD 601.12 Medical Releases for Booking
The health authority or designee shall contact the regional center on any inmate suspected or confirmed to be developmentally disabled for the purposes of diagnosis and/or treatment within 24 hours of such determination, excluding holidays and weekends.	X	☐	☐	
1058 USE OF RESTRAINT DEVICES The facility administrator, in cooperation with the responsible physician, shall develop written policies and procedures for the use of restraint devices and may delegate authority to place an inmate in restraints to a responsible health care staff. In addition to the areas specifically outlined in this regulation, at a minimum, the policy shall address the following areas: acceptable restraint devices; signs or symptoms which should result in immediate medical/mental health referral; availability of cardiopulmonary resuscitation equipment; protective housing of restrained persons; provision for hydration and sanitation needs; and exercising of extremities.	X	☐	☐	CSM 601.12 CSM 601.28 Long term restraints are not used in the Court Holding Facility, the department practice is that inmates who need behavioral restraints are direct transports to and from court and the court holding cells are not used for this type of inmate. Remainder of regulation removed.
1058.5 RESTRAINTS AND PREGNANT INMATES The facility administrator, in cooperation with the responsible physician, shall develop written policies and procedures for the use of restraint devices on pregnant inmates. In accordance with Penal Code 3407 the policy shall include reference to the following:	X	☐	☐	508.19

TITLE 15 SECTION	YES	NO	N/A	P/P REFERENCE – COMMENTS
(1) An inmate known to be pregnant or in recovery after delivery shall not be restrained by the use of leg irons, waist chains, or handcuffs behind the body.	X	☐	☐	508.19 (2.1)
(2) A pregnant inmate in labor, during delivery, or in recovery after delivery, shall not be restrained by the wrists, ankles, or both, unless deemed necessary for the safety and security of the inmate, the staff, or the public.	X	☐	☐	
(3) Restraints shall be removed when a professional who is currently responsible for the medical care of a pregnant inmate during a medical emergency, labor, delivery, or recovery after delivery determines that the removal of restraints is medically necessary.	X	☐	☐	50/.19 (2.1)
(4) Upon confirmation of an inmate's pregnancy, she shall be advised, orally or in writing, of the standards and policies governing pregnant inmates.	X	☐	☐	50/.19 (2.1)
1068 ACCESS TO COURTS The facility administrator shall develop written policies and procedures to ensure inmates have access to the court and to legal counsel. Such access shall consist of:	X	☐	☐	CDPM 504.35
(a) unlimited mail as provided in Section 1063 of these regulations, and,	X	☐	☐	
(b) confidential consultation with attorneys.	X	☐	☐	
DETENTION OF MINORS				
Are minors held in this facility? If yes, the following sections, including those summarized in Title 15, Article 10, apply (Minors in Court Holding Facilities.)	☐	☐	X	510.10 Youth attending court proceedings at the new Southwest Juvenile Court are supervised by probation staff.
1122.5 PREGNANT MINORS (a) The health administrator, in cooperation with the facility administrator, shall develop written policies and procedures pertaining to pregnant minors that address the requirements in Title 15, Section 1417.	☐	☐	X	
(b) The facility administrator, in cooperation with the responsible physician, shall develop written policies and procedures for the use of restraint devices on pregnant minors. The policy shall address requirements of Penal Code 3407. Policy shall include reference to the following:	☐	☐	X	
(1) A minor known to be pregnant or in recovery after delivery shall not be restrained by the use of leg irons, waist chains, or handcuffs behind the body.	☐	☐	X	
(2) A pregnant minor in labor, during delivery, or in recovery after delivery, shall not be restrained by the wrists, ankles, or both, unless deemed necessary for the safety and security of the minor, the staff, or the public.	☐	☐	X	
(3) Restraints shall be removed when a professional who is currently responsible for the medical care of a pregnant minor during a medical emergency, labor, delivery, or recovery after delivery determines that the removal of restraints is medically necessary.	☐	☐	X	

TITLE 15 SECTION	YES	NO	N/A	P/P REFERENCE – COMMENTS
(4) Upon confirmation of a minor's pregnancy, she shall be advised, orally or in writing, of the standards and policies governing pregnant minors.	☐	☐	X	
1161 CONDITIONS OF DETENTION Court holding facilities shall be designed to provide the following:			X	
(a) Separation of minors from adults in accordance with Section 208 of the Welfare and Institutions Code.	☐	☐	X	
(b) Segregation of minors in accordance with an established classification plan.	☐	☐	X	
(c) Secure non-public access, movement within and egress. If the same entrance/exit is used by both minors and adults, movements shall be scheduled in such a manner that there is no opportunity for contact.	☐	☐	X	
An existing court holding facility built in accordance with construction standards at the time of construction shall be considered as being in compliance with this article unless the condition of the structure is determined by the appropriate authority to be dangerous to life, health, or welfare of minors. Upon notification of noncompliance with this section, the facility administrator shall develop and submit a plan for corrective action to the Corrections Standards Authority within 90 days.	☐	☐	X	
1162 SUPERVISION OF MINORS A sufficient number of personnel shall be employed in each facility to permit unscheduled safety checks of all minors at least twice every 30 minutes, and to ensure the implementation and operation of the activities required by these regulations. There shall be a written plan that includes the documentation of safety checks.	☐	☐	X	
1163 CLASSIFICATION The administrator of a court holding facility shall establish and implement a written plan designed to provide for the safety of staff and minors held at the facility. The plan shall include receiving and transmitting of information regarding minors who represent a risk or hazard to self or others while confined at the facility, and the segregation of such minors to the extent possible within the limits of the court holding facility, and for the separation of minors from any adult inmate(s) as required by Section 208 of the Welfare and Institutions Code.	☐	☐	X	
1047 SERIOUS ILLNESS OR INJURY OF A MINOR IN AN ADULT DETENTION FACILITY The facility administrator shall develop policy and procedures for notification of the court of jurisdiction and the parent, guardian, or person standing in loco parentis, in the event of a suicide attempt, serious illness, injury or death of a minor in custody.	☐	☐	X	

ADULT COURT AND TEMPORARY HOLDING FACILITIES
PHYSICAL PLANT EVALUATION
Board of State and Community corrections
Applicable Title 24 Regulations: 6/94; 2/99; 2001

BSCC Code: 3916

FACILITY NAME: Hall of Justice– Court Holding				**FACILITY TYPE:** CH
APPLICABLE REGULATIONS (Check All That Apply):	**6/94:** x	**2/99:**	**2001:**	**OTHER:**
FIELD REPRESENTATIVE: Michael J. Bush				**DATE:** 09/19/2019

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Reception and Booking (2.1) Contains a weapons locker, designed as outlined in these regulations.			X	
Contains a cell or room for confinement pending booking			X	
Contains a detoxification cell (WA in TH; NA in CH) 01: Name changed to "sobering cell." 2-99: Two detoxification cells are provided if both male and female inmates are held.			X	
Contains safety cell(s) (WA in TH; NA in CH)			X	
Shower room available 2-99: Access to shower must be within the secure area			X	
Provides secure vault or storage for inmate valuables			X	
Telephone(s) available for inmate use (PC § 851.5)			X	
2-99: Unobstructed access to hot and cold running water			X	
Temporary Holding Cell or Room (2.2) Contains 10 square feet of floor area per inmate	X			
Holds no more than 16 inmates	X			
Is not smaller than 40 square feet and has a clear ceiling height of 8 feet or more	X			
Contains sufficient seating to accommodate all inmates	X			
Contains water closet (toilet), washbasin, and drinking fountain	X			
Provides for clear visual supervision by staff	X			
A bunk is provided if inmates are held 12 hours or more			X	
Temporary Staging Cell or Room (2.3) Holds inmates classified and segregated per Title 15 § 1050 and 1053			X	No cells of this type, remainder of the regulation is removed.
Detoxification/Sobering Cell (2.4) 01: Name change to "sobering cell" Contains 20 square feet of floor area per inmate			X	No cell of this type, remainder of the regulation is deleted.
Safety Cell (2.5) Contains 48 square feet with one floor dimension of a least 6 feet and a clear ceiling height of 8 feet or more			X	No cell of this type, remainder of the regulation is deleted.
Safety Equipment Storage (2.19) Adequate space is provided to store equipment such as fire extinguishers, SCBA, emergency lights, etc.	X			Located on the first floor.

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Janitors' Closet (2.20) Lockable, containing a mop sink and storage space 01: Mop sink may be separate from janitors' closet	X			
Audio or Visual Monitoring (2.22) There is an audio monitoring system capable of alerting staff in a central control. When visual electronic surveillance is used, it is located primarily in corridors, elevators, or at points on the security perimeter such as entrances and exits. 2-99: Video monitoring option deleted.	X			
Emergency Power (2.24) There is an emergency power source available and capable of providing minimal lighting in all areas and maintaining fire and life safety, security, communication and alarm systems.	X			
Attorney Interview Space (2.26) Available and provides for confidentiality	X			
Water Closets (Toilets)/Urinals (3.1) Provide for inmate privacy/modesty with staff being able to visually supervise; provided at a ratio of 1:16 in holding and staging cells. See regulation for calculations of urinal substitutions.	X			
Washbasins (3.2) Provide hot and cold or tempered water; provided at a ratio of 1:16 in holding and staging cells. See regulation for calculations of washbasin trough substitutions.	X			
Drinking Fountains (3.3) 2-99: Available in each temporary holding, staging and sobering cell.	X			
Water outlet (bubbler) is mechanically actuated and at an angle that prevents wastewater from flowing over the outlet (bubbler); there is a mouth guard on the water outlet (bubbler). 2-99: Mouth guard requirement deleted	X			
Showers (3.4) (NA in CH) Available in the security area; provide hot and cold or tempered water; shower stalls/areas are designed and constructed of materials that are impervious to water and soap so that they may be easily cleaned.			X	

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Beds/Bunks (3.5) (NA in CH; applicable in TH if inmates are held longer than 12 hours) At least 30 inches wide and 76 inches long with 21 inches between pans; constructed of pan bottom type or concrete; securely fastened to the floor and/or wall in facilities higher than minimum security. 01: Must be elevated off the floor.			X	
Lighting (3.6) Lighting is sufficient to permit easy reading by a person with normal vision, night lighting is sufficient for purposes of supervision. Lighting is centrally controlled and/or occupant controlled in housing cells or rooms. Light fixtures are of secure design.	X			
Windows (3.7) Windows that are accessible to inmates are no greater than 5 inches in one dimension.			X	
Cell Padding (3.8) The floors and partition are padded in detoxification cells. In safety cells, floors, doors, walls and everything on them are padded. All padded cells are equipped with a tamper resistant fire sprinkler approved by the SFM.			X	
All padding is: approved for use by the SFM; nonporous; at least ½ inch thick; of a unitary or laminated construction; firmly bonded to all surfaces; and, without exposed seams.			X	
Seating (3.10) Seating is designed to the level of security. When bench seating is used, eighteen inches of bench are provided per inmate. 2-99: In holding and staging cells, seating is securely fastened to the wall and/or floor.	X			
Weapons Locker (3.12) (NA type IV and Minimum Security Facilities) A secure weapons locker is located outside the security perimeter of the facility and no weapons are brought into the security area. Lockers have individual compartments, locks and keys.	X			Outside of each courtroom.
Design Requirements (102(c)6) Design requirements as specified in Title 24, Part 1, 102(c)6 are met. (See regulation for specific requirements. Note areas of non-compliance that are applicable to the facility type and construction date in the "comments" section.)	X			

BOARD OF STATE AND COMMUNITY CORRECTIONS - BIENNIAL INSPECTION
ADULT DETENTION FACILITY
LIVING AREA SPACE EVALUATION

BSCC Code: 3916

FACILITY: Hall of Justice Court Holding	**TYPE:** CH	**RC:** 0
FIELD REPRESENTATIVE: Michael J. Bush		**DATE:** 09/19/2019

ROOMS							**EACH ROOM**					
Location	Cell Type	Applicable Standards	# Cells	EACH CELL		Total RC	DIMENSIONS (L x W x H)	FIXTURES*				
				# Beds	RC			T	U	W	F	S
Hall of Justice Court Room Holding Cells												
Southside 2-6 floors	Holding	1988	10		(7)	(70)	5.10 X 15.0 X 8.7	1		1	1	
Notes: Holding cells for courtroom 2 - 5; Two cells per floor (2nd, 3rd, 4th and 5th).												
Northside 3-6 floors	Holding	1988	8		(5)	(40)	5.10 X 8.9.0 X 8.7	1		1	1	
Notes: 2 cells on each floor, address 4100 main Street												

*T = Toilets; U = Urinals; W = Wash Basins; F = Fountains; S = Showers in unit; If "Total RC" appears in brackets ( ), it is not part of the facility's rated capacity. "+" indicates that capacity includes prorated air space from adjacent areas.

ADULT COURT AND TEMPORARY HOLDING FACILITIES
PHYSICAL PLANT EVALUATION
Corrections Standards Authority

Applicable Title 24 Regulations: 6/94; 2/99; 2001

CSA Code: 3935

FACILITY NAME: Southwest Justice Center – Court Holding				**FACILITY TYPE:** CH
APPLICABLE REGULATIONS (Check All That Apply):	**6/94:**	**2/99:** X	**2001:**	**OTHER:**
FIELD REPRESENTATIVE: Michel J. Bush				**DATE:** 09/19/2019

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Reception and Booking (2.1) Contains a weapons locker, designed as outlined in these regulations.			X	
Contains a cell or room for confinement pending booking			X	
Contains a detoxification cell (WA in TH; NA in CH) 01: Name changed to "sobering cell." 2-99: Two detoxification cells are provided if both male and female inmates are held.			X	
Contains safety cell(s) (WA in TH; NA in CH)			X	
Shower room available 2-99: Access to shower must be within the secure area			X	
Provides secure vault or storage for inmate valuables			X	
Telephone(s) available for inmate use (PC § 851.5)			X	
2-99: Unobstructed access to hot and cold running water			X	
Temporary Holding Cell or Room (2.2) Contains 10 square feet of floor area per inmate	X			
Holds no more than 16 inmates	X			
Is not smaller than 40 square feet and has a clear ceiling height of 8 feet or more	X			
Contains sufficient seating to accommodate all inmates	X			
Contains water closet (toilet), washbasin, and drinking fountain	X			
Provides for clear visual supervision by staff	X			
A bunk is provided if inmates are held 12 hours or more			X	
Temporary Staging Cell or Room (2.3) Holds inmates classified and segregated per Title 15 § 1050 and 1053			X	Staging cells are located at the jail.
Holds inmates for four hours or less			X	
Limited to holding no more than 80 inmates			X	
Contains 10 square feet of floor area per inmate and has a clear ceiling height of 8 feet or more.			X	
Is at least 160 square feet			X	
Contains sufficient seating to accommodate all inmates			X	
Contains water closets (toilets), wash basins and drinking fountains as specified by these regulations			X	

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Provides for clear visual supervision by staff			X	
Detoxification/Sobering Cell (2.4) 01: Name change to "sobering cell" Contains 20 square feet of floor area per inmate			X	
Is limited to no more than 8 inmates			X	
Is no smaller than 60 square feet and has a clear ceiling height of 8 feet or more			X	
Contains a water closet (toilet) wash basin and drinking fountain as specified by these regulations			X	
Has padded partitions located next to toilet fixtures			X	
Provides for clear visual supervision by staff			X	
Padding on floor			X	
Safety Cell (2.5) Contains 48 square feet with one floor dimension of a least 6 feet and a clear ceiling height of 8 feet or more			X	
Is limited to one inmate			X	
Contains a flushing ring toilet, mounted flush with the floor, with controls located outside the cell			X	
Padded floor, door and walls			X	
Equipped with a variable intensity, security light, inaccessible to the occupant			X	
Has one or more vertical view panels, not more than 4 inches wide nor less than 24 inches long, which provide a view of the entire cell			X	
Has a food pass with lockable shutter no more than 4 inches high and, with between 26 and 32 inches from the bottom of the food pass to the floor			X	
Safety Equipment Storage (2.19) Adequate space is provided to store equipment such as fire extinguishers, SCBA, emergency lights, etc.	X			Located on the first floor.
Janitors' Closet (2.20) Lockable, containing a mop sink and storage space 01: Mop sink may be separate from janitors' closet	X			Located on the second floor.
Audio or Visual Monitoring (2.22) There is an audio monitoring system capable of alerting staff in a central control. When visual electronic surveillance is used, it is located primarily in corridors, elevators, or at points on the security perimeter such as entrances and exits. 2-99: Video monitoring option deleted.	X			
Emergency Power (2.24) There is an emergency power source available and capable of providing minimal lighting in all areas and maintaining fire and life safety, security, communication and alarm systems.	X			Lower level holding cells have call buttons in each cell. Holding cells on the upper levels are voice activated.

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Attorney Interview Space (2.26) Available and provides for confidentiality	X			
Water Closets (Toilets)/Urinals (3.1) Provide for inmate privacy/modesty with staff being able to visually supervise; provided at a ratio of 1:16 in holding and staging cells. See regulation for calculations of urinal substitutions.	X			
Washbasins (3.2) Provide hot and cold or tempered water; provided at a ratio of 1:16 in holding and staging cells. See regulation for calculations of washbasin trough substitutions.	X			
Drinking Fountains (3.3) 2-99: Available in each temporary holding, staging and sobering cell.	X			
Water outlet (bubbler) is mechanically actuated and at an angle that prevents wastewater from flowing over the outlet (bubbler); there is a mouth guard on the water outlet (bubbler). 2-99: Mouth guard requirement deleted	X			
Showers (3.4) (NA in CH) Available in the security area; provide hot and cold or tempered water; shower stalls/areas are designed and constructed of materials that are impervious to water and soap so that they may be easily cleaned.			✓	
Beds/Bunks (3.5) (NA in CH; applicable in TH if inmates are held longer than 12 hours) At least 30 inches wide and 76 inches long with 21 inches between pans; constructed of pan bottom type or concrete; securely fastened to the floor and/or wall in facilities higher than minimum security. 01: Must be elevated off the floor.			X	
Lighting (3.6) Lighting is sufficient to permit easy reading by a person with normal vision, night lighting is sufficient for purposes of supervision. Lighting is centrally controlled and/or occupant controlled in housing cells or rooms. Light fixtures are of secure design.	X			
Windows (3.7) Windows that are accessible to inmates are no greater than 5 inches in one dimension.			X	

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Cell Padding (3.8) The floors and partition are padded in detoxification cells. In safety cells, floors, doors, walls and everything on them is padded. All padded cells are equipped with a tamper resistant fire sprinkler approved by the SFM.			X	
All padding is: approved for use by the SFM; nonporous; at least ½ inch thick; of a unitary or laminated construction; firmly bonded to all surfaces; and, without exposed seams.			X	
Seating (3.10) Seating is designed to the level of security. When bench seating is used, eighteen inches of bench are provided per inmate. 2-99: In holding and staging cells, seating is securely fastened to the wall and/or floor.	X			
Weapons Locker (3.12) (NA type IV and Minimum Security Facilities) A secure weapons locker is located outside the security perimeter of the facility and no weapons are brought into the security area. Lockers have individual compartments, locks and keys.	X			Weapons locker is located near the jail entrances and in the sally port between holding cells and the courtroom.
Design Requirements (102(c)6) Design requirements as specified in Title 24, Part 1, 102(c)6 are met. (See regulation for specific requirements. Note areas of non-compliance that are applicable to the facility type and construction date in the "comments" section.)	X			

BOARD OF STATE AND COMMUNITY CORRECTIONS– BIENNIAL INSPECTION
ADULT DETENTION FACILITY
LIVING AREA SPACE EVALUATION

BSCC Code: 3935

FACILITY: Southwest Justice Center Court Holding	**TYPE:** CH	**RC:** 0
FIELD REPRESENTATIVE: Michael J. Bush		**DATE:** 09/19/2019

ROOMS							EACH ROOM					
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
Court Holding First Floor – Courts – 2 courtrooms are on each floor that utilize the holding cells.												
Cell 1A	Holding	1999	1		(4)	(4)	6’4” x 13’8” x 8’3”	1		1	1	
Note: Seating Capacity 77”												
Cell 1B	Holding	1999	1		(4)	(4)	6’4” x 13’8” x 8’3”	1		1	1	
Note: Seating Capacity 77”												
Cell 1C	Holding	1999	1		(4)	(4)	6’4” x 12’ x 8’3”	1		1	1	
Note: Seating Capacity 77”												
Cell 1D	Holding	1999	1		(5)	(5)	8’8” x 11’2” x 8’3”	1		1	1	
Note: Seating Capacity 104”												
Cell 1E	Holding	1999	1		(2)	(2)	6’8” x 6’3” x 8’3”	1		1	1	
Note: Seating Capacity 38”												
Cell 1F	Holding	1999	1		(2)	(2)	7’5” x 6’1” x 8’3”	1		1	1	
Note: Seating Capacity 39”												
Court Holding – Second Floor – Courts												
Cell 2A	Holding	1999	1		(4)	(4)	6’4” x 13’8” x 8’3”	1		1	1	
Note: Seating Capacity 77”												
Cell 2B	Holding	1999	1		(4)	(4)	6’4” x 13’8” x 8’3”	1		1	1	
Note: Seating Capacity 77”												
Cell 2C	Holding	1999	1		(4)	(4)	6’4” x 11’2” x 8’3”	1		1	1	
Note: Seating Capacity 77”. Typically where juveniles are held (supervised by probation), this area is completely separate from the adult prisoners.												
Cell 2D	Holding	1999	1		(2)	(2)	9’2” x 6’4” x 8’3”	1		1	1	
Note: Seating Capacity 38”												
Cell 2E	Holding	1999	1		(2)	(2)	6’8” x 6’4” x 8’3”	1		1	1	
Note: Seating Capacity 38”												
Cell 2F	Holding	1999	1		(2)	(2)	7’5” x 6’1” x 8’3”	1		1	1	
Note: Seating Capacity 38”												
Court Holding Third Floor – Courts												
Cell 3A	Holding	1999	1		(4)	(4)	6’4” x 13’8” x 8’3”	1		1	1	
Note: Seating Capacity 77”												
Cell 3B	Holding	1999	1		(4)	(4)	6’4” x 13’8” x8’3”	1		1	1	
Note: Seating Capacity 77”												

Note: It is recommended that the cells are reviewed (grills) to ensure the openings do not pose a safety threat.

*T = Toilets; U = Urinals; W = Wash Basins; F = Fountains; S = Showers in unit; If "Total RC" appears in brackets ( ), it is not part of the facility's rated capacity. "+" indicates that capacity includes prorated air space from adjacent areas.

ROOMS							EACH ROOM					
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
Cell 3C	Holding	1999	1		(4)	(4)	6'4" x 12' x 8'3"	1		1	1	
Note: Seating Capacity 78"												
Cell 3D	Holding	1999	1		(5)	(5)	8'8" x 11'2" x 8'3"	1		1	1	
Note: Seating Capacity 104"												
Cell 3E	Holding	1999	1		(2)	(2)	6'8" x 6'3" x 8'3"	1		1	1	
Note: Seating Capacity 38"												
Cell 3F	Holding	1999	1		(2)	(2)	7'4" x 6'2" x 8'3"	1		1	1	
Note: Seating Capacity 42"												

The court holding cells are rarely used. Typically inmates are held in the jury box. The Court Holding cells are clean and well maintained, 1/2009;MW.

*T = Toilets; U = Urinals; W = Wash Basins; F = Fountains; S = Showers in unit; If "Total RC" appears in brackets ( ), it is not part of the facility's rated capacity. "+" indicates that capacity includes prorated air space from adjacent areas.

ADULT COURT AND TEMPORARY HOLDING FACILITIES
PHYSICAL PLANT EVALUATION
BOARD OF STATE AND COMMUNITY CORRECTIONS

Applicable Title 24 Regulations: 6/94; 2/99; 2001; 2005;2008;2010

BSCC Code: 3937

FACILITY NAME: Southwest Juvenile CH				**FACILITY TYPE:** CH		
APPLICABLE REGULATIONS (Check All That Apply):	**6/94:**	**2/99:**	**2001:**	**2005:**	**2008:**	**2010: X**
FIELD REPRESENTATIVE: Michael J. Bush				**DATE:** 09/19/2019		

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Reception and Booking (2.1) Contains a weapons locker, designed as outlined in these regulations.	X			
Contains a cell or room for confinement pending booking	X			
Contains a detoxification cell (WA in TH; NA in CH) 01: Name changed to "sobering cell." 2-99: Two detoxification cells are provided if both male and female inmates are held.			X	
Contains safety cell(s) (WA in TH; NA in CH)			X	
Shower room available 2-99: Access to shower must be within the secure area			X	
Provides secure vault or storage for inmate valuables	X			
Telephone(s) available for inmate use (PC § 851.5)	X			
2-99: Unobstructed access to hot and cold running water	X			
Temporary Holding Cell or Room (2.2) Contains 10 square feet of floor area per inmate	X			2 – Adults 2 – Juveniles
Holds no more than 16 inmates	X			
Is not smaller than 40 square feet and has a clear ceiling height of 8 feet or more	X			
Contains sufficient seating to accommodate all inmates	X			
Contains water closet (toilet), washbasin, and drinking fountain	X			
Provides for clear visual supervision by staff	X			
A bunk is provided if inmates are held 12 hours or more			X	
Temporary Staging Cell or Room (2.3) Holds inmates classified and segregated per Title 15 § 1050 and 1053			X	
Safety Equipment Storage (2.19) Adequate space is provided to store equipment such as fire extinguishers, SCBA, emergency lights, etc.	X			
Janitors' Closet (2.20) Lockable, containing a mop sink and storage space 01: Mop sink may be separate from janitors' closet	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Audio or Visual Monitoring (2.22) There is an audio monitoring system capable of alerting staff in a central control. When visual electronic surveillance is use, it is located primarily in corridors, elevators, or at points on the security perimeter such as entrances and exits. 2-99: Video monitoring option deleted. 10: Deleted language referring to central control point. 10: Terminate at a location where staff can respond immediately.	X			
Emergency Power (2.24) There is an emergency power source available and capable of providing minimal lighting in all areas and maintaining fire and life safety, security, communication and alarm systems.	X			
Attorney Interview Space (2.26) Available and provides for confidentiality	X			
Water Closets (Toilets)/Urinals (3.1) Provide for inmate privacy/modesty with staff being able to visual supervise; provided at a ratio of 1:16 in holding and staging cells. See regulation for calculations of urinal substitutions.	X			
Washbasins (3.2) Provide hot and cold or tempered water; provided at a ratio of 1:16 in holding and staging cells. See regulation for calculations of washbasin trough substitutions.	X			
Drinking Fountains (3.3) 2-99: Available in each temporary holding, staging and sobering cell.	X			
Water outlet (bubbler) is mechanically actuated and at an angle that prevents wastewater from flowing over the outlet (bubbler); there is a mouth guard on the water outlet (bubbler). 2-99: Mouth guard requirement deleted	X			
Lighting (3.6) Lighting is sufficient to permit easy reading by a person with normal vision, night lighting is sufficient for purposes of supervision. Lighting is centrally controlled and/or occupant controlled in housing cells or rooms. Light fixtures are of secure design.	X			
Windows (3.7) Windows that are accessible to inmates are no greater than 5 inches in on dimension.	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Seating (3.10) Seating is designed to the level of security. When bench seating is used, eighteen inches of bench are provided per inmate. 2-99: In holding and staging cells, seating is securely fastened to the wall and/or floor.				
Weapons Locker (3.12) A secure weapons locker is located outside the security perimeter of the facility and no weapons are brought into the security area. Lockers have individual compartments, locks and keys.	X			
Design Requirements (102(c)6) Design requirements as specified in Title 24, Part 1, 102(c)6 are met. (See regulation for specific requirements. Noteareas of non-compliance that are applicable to the facility type and construction date in the "comments" section.)	x			

ADULT DETENTION FACILITY
LIVING AREA SPACE EVALUATION
Board of State and Community Corrections

BSCC Code: 3937

FACILITY: Southwest Juvenile CH	**TYPE:** CHJ	**RC:**
FIELD REPRESENTATIVE: Michael J. Bush		**DATE** 09/19/2019

ROOMS							EACH ROOM					
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
Adult												
1 & 2	H	2010	2		(4)	(8)	7.5 x 11.4 x 10	1		1	1	
Bench Space – 89”…… Irregular Cell (-4’.2” sq ft)												
Juvenile												
1 & 2	H	2010			(4)	(8)	7.5 x 11.4 x 10	1		1	1	
Bench Space – 89” Irregular Cell (-4’.2” sq ft)												

*T = Toilets; U = Urinals; W = Wash Basins; F = Fountains; S = Showers in unit. If "Total RC" appears in brackets ( ), it is not part of the facility's rated capacity. "+" indicates that capacity includes prorated air space from adjacent areas.

ADULT COURT AND TEMPORARY HOLDING FACILITIES
PHYSICAL PLANT EVALUATION
Board of State and Community Corrections

Applicable Title 24 Regulations: 6/94; 2/99; 2001

BSCC Code: 3950

FACILITY NAME: Family Law Courts				**FACILITY TYPE:** CH
APPLICABLE REGULATIONS (Check All That Apply):	**6/94:** X	**2/99:**	**2001:**	**OTHER:**
FIELD REPRESENTATIVE: Michael J. Bush				**DATE:** 09/18/2019

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Reception and Booking (2.1) Contains a weapons locker, designed as outlined in these regulations.			X	No reception of booking, remainder of the regulation has been deleted.
Temporary Holding Cell or Room (2.2) Contains 10 square feet of floor area per inmate	X			
Holds no more than 16 inmates	X			
Is not smaller than 40 square feet and has a clear ceiling height of 8 feet or more	X			
Contains sufficient seating to accommodate all inmates	X			
Contains water closet (toilet), washbasin, and drinking fountain		X		No drinking fountain
Provides for clear visual supervision by staff	X			
A bunk is provided if inmates are held 12 hours or more			X	
Temporary Staging Cell or Room (2.3) Holds inmates classified and segregated per Title 15 § 1050 and 1053			X	No cell of this type, remainder of regulation has been removed.
Detoxification/Sobering Cell (2.4) 01: Name change to "sobering cell" Contains 20 square feet of floor area per inmate			X	No cell of this type, remainder of the regulation has been removed.
Safety Cell (2.5) Contains 48 square feet with one floor dimension of a least 6 feet and a clear ceiling height of 8 feet or more			X	No cell of this type, remainder of the regulations has been removed.
Safety Equipment Storage (2.19) Adequate space is provided to store equipment such as fire extinguishers, SCBA, emergency lights, etc.	X			
Janitors' Closet (2.20) Lockable, containing a mop sink and storage space 01: Mop sink may be separate from janitors' closet	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Audio or Visual Monitoring (2.22) There is an audio monitoring system capable of alerting staff in a central control. When visual electronic surveillance is used, it is located primarily in corridors, elevators, or at points on the security perimeter such as entrances and exits. 2-99: Video monitoring option deleted.	X			
Emergency Power (2.24) There is an emergency power source available and capable of providing minimal lighting in all areas and maintaining fire and life safety, security, communication and alarm systems.	X			
Attorney Interview Space (2.26) Available and provides for confidentiality	X			
Water Closets (Toilets)/Urinals (3.1) Provide for inmate privacy/modesty with staff being able to visually supervise; provided at a ratio of 1:16 in holding and staging cells. See regulation for calculations of urinal substitutions.	X			
Washbasins (3.2) Provide hot and cold or tempered water; provided at a ratio of 1:16 in holding and staging cells. See regulation for calculations of washbasin trough substitutions.	X			
Drinking Fountains (3.3) 2-99: Available in each temporary holding, staging and sobering cell.	X			
Water outlet (bubbler) is mechanically actuated and at an angle that prevents wastewater from flowing over the outlet (bubbler); there is a mouth guard on the water outlet (bubbler). 2-99: Mouth guard requirement deleted	X			
Showers (3.4) (NA in CH) Available in the security area; provide hot and cold or tempered water; shower stalls/areas are designed and constructed of materials that are impervious to water and soap so that they may be easily cleaned.			X	

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Beds/Bunks (3.5) (NA in CH; applicable in TH if inmates are held longer than 12 hours) At least 30 inches wide and 76 inches long with 21 inches between pans; constructed of pan bottom type or concrete; securely fastened to the floor and/or wall in facilities higher than minimum security. 01: Must be elevated off the floor.			X	
Lighting (3.6) Lighting is sufficient to permit easy reading by a person with normal vision, night lighting is sufficient for purposes of supervision. Lighting is centrally controlled and/or occupant controlled in housing cells or rooms. Light fixtures are of secure design.	X			
Windows (3.7) Windows that are accessible to inmates are no greater than 5 inches in one dimension.	X			
Cell Padding (3.8) The floors and partition are padded in detoxification cells. In safety cells, floors, doors, walls and everything on them is padded. All padded cells are equipped with a tamper resistant fire sprinkler approved by the SFM.			X	
All padding is: approved for use by the SFM; nonporous; at least ½ inch thick; of a unitary or laminated construction; firmly bonded to all surfaces; and, without exposed seams.			X	
Mirrors/Shelves/Clothes Hooks (3.9) A mirror of a material appropriate to the level of security is provided near each washbasin.	X			
Consistent with security needs, shelves and clothes hooks are provided wherever feasible. 2-99: Requirement for shelves and hooks deleted			X	
Clothes hooks are of a collapsible hook type 2-99: Requirement for hooks deleted			X	

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Seating (3.10) Seating is designed to the level of security. When bench seating is used, eighteen inches of bench are provided per inmate. 2-99: In holding and staging cells, seating is securely fastened to the wall and/or floor.	X			
Weapons Locker (3.12) (NA type IV and Minimum Security Facilities) A secure weapons locker is located outside the security perimeter of the facility and no weapons are brought into the security area. Lockers have individual compartments, locks and keys.	X			
Design Requirements (102(c)6) Design requirements as specified in Title 24, Part 1, 102(c)6 are met. (See regulation for specific requirements. Note areas of non-compliance that are applicable to the facility type and construction date in the "comments" section.)	X			

BOARD OF STATE AND COMMUNITY CORRECTIONS- BIENNIAL INSPECTION
ADULT DETENTION FACILITY
LIVING AREA SPACE EVALUATION

BSCC Code: 3950

FACILITY: Family Law Courts	**TYPE:** CH	**RC:** 0
FIELD REPRESENTATIVE: Michael J. Bush		**DATE:** 09/18/2019

ROOMS							EACH ROOM					
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
	Holding	1994	1		(4)	(4)	7' X 9'10" X 9'8"	1		1		
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL BRC	Total BRC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
	Holding	1994	1		(2)	(2)	7' X 9'10" X 9'8"	1		1		

Notes: Bench is 4' long in holding cell (2), RC is limited to (2). Bench in cell (1) is approximately 6’ long, RC is increased to 4.

Holding cells are not used daily…

*T = Toilets; U = Urinals; W = Wash Basins; F = Fountains; S = Showers in unit; If "Total RC" appears in brackets ( ), it is not part of the facility's rated capacity. "+" indicates that capacity includes prorated air space from adjacent areas.

ADULT COURT AND TEMPORARY HOLDING FACILITIES
PHYSICAL PLANT EVALUATION
Board of State and Community Corrections

Applicable Title 24 Regulations: 6/94; 2/99; 2001

BSCC Code: 3970

FACILITY NAME: Larson Justice Center				**FACILITY TYPE:** CH
APPLICABLE REGULATIONS (Check All That Apply):	**6/94:** X	**2/99:**	**2001:**	**OTHER:**
FIELD REPRESENTATIVE: Michael J. Bush				**DATE:** 09/23/2019

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Reception and Booking (2.1) Contains a weapons locker, designed as outlined in these regulations.			X	No reception or booking, remainder of the regulations has been removed.
Temporary Holding Cell or Room (2.2) Contains 10 square feet of floor area per inmate	X			
Holds no more than 16 inmates	X			
Is not smaller than 40 square feet and has a clear ceiling height of 8 feet or more	X			
Contains sufficient seating to accommodate all inmates	X			
Contains water closet (toilet), washbasin, and drinking fountain	X			
Provides for clear visual supervision by staff	X			
A bunk is provided if inmates are held 12 hours or more			X	
Temporary Staging Cell or Room (2.3) Holds inmates classified and segregated per Title 15 § 1050 and 1053			X	No cell of this type, remainder of the regulation has been removed.
Detoxification/Sobering Cell (2.4) 01: Name changed to "sobering cell" Contains 20 square feet of floor area per inmate			X	No cell of this type, remainder of the regulation has been removed.
Safety Equipment Storage (2.19) Adequate space is provided to store equipment such as fire extinguishers, SCBA, emergency lights, etc.	X			
Janitors' Closet (2.20) Lockable, containing a mop sink and storage space 01: Mop sink may be separate from janitors' closet	X			
Audio or Visual Monitoring (2.22) There is an audio monitoring system capable of alerting staff in a central control. When visual electronic surveillance is used, it is located primarily in corridors, elevators, or at points on the security perimeter such as entrances and exits. 2-99: Video monitoring option deleted.	X			Security camera; no audio monitoring.

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Emergency Power (2.24) There is an emergency power source available and capable of providing minimal lighting in all areas and maintaining fire and life safety, security, communication and alarm systems.	X			
Attorney Interview Space (2.26) Available and provides for confidentiality	X			
Water Closets (Toilets)/Urinals (3.1) Provide for inmate privacy/modesty with staff being able to visually supervise; provided at a ratio of 1:16 in holding and staging cells. See regulation for calculations of urinal substitutions.	X			
Washbasins (3.2) Provide hot and cold or tempered water; provided at a ratio of 1:16 in holding and staging cells. See regulation for calculations of washbasin trough substitutions.	X			
Drinking Fountains (3.3) 2-99: Available in each temporary holding, staging and sobering cell.	X			
Water outlet (bubbler) is mechanically actuated and at an angle that prevents wastewater from flowing over the outlet (bubbler); there is a mouth guard on the water outlet (bubbler). 2-99: Mouth guard requirement deleted	X			
Showers (3.4) (NA in CH) Available in the security area; provide hot and cold or tempered water; shower stalls/areas are designed and constructed of materials that are impervious to water and soap so that they may be easily cleaned.			X	
Beds/Bunks (3.5) (NA in CH; applicable in TH if inmates are held longer than 12 hours) At least 30 inches wide and 76 inches long with 21 inches between pans; constructed of pan bottom type or concrete; securely fastened to the floor and/or wall in facilities higher than minimum security. 01: Must be elevated off the floor.			X	

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Lighting (3.6) Lighting is sufficient to permit easy reading by a person with normal vision, night lighting is sufficient for purposes of supervision. Lighting is centrally controlled and/or occupant controlled in housing cells or rooms. Light fixtures are of secure design.	X			
Windows (3.7) Windows that are accessible to inmates are no greater than 5 inches in one dimension.	X			
Cell Padding (3.8) The floors and partition are padded in detoxification cells. In safety cells, floors, doors, walls and everything on them is padded. All padded cells are equipped with a tamper resistant fire sprinkler approved by the SFM.			X	
All padding is: approved for use by the SFM; nonporous; at least ½ inch thick; of a unitary or laminated construction; firmly bonded to all surfaces; and, without exposed seams.			X	
Seating (3.10) Seating is designed to the level of security. When bench seating is used, eighteen inches of bench are provided per inmate. 2-99: In holding and staging cells, seating is securely fastened to the wall and/or floor.	X			
Weapons Locker (3.12) (NA type IV and Minimum Security Facilities) A secure weapons locker is located outside the security perimeter of the facility and no weapons are brought into the security area. Lockers have individual compartments, locks and keys.	X			
Design Requirements (102(c)6) Design requirements as specified in Title 24, Part 1, 102(c)6 are met. (See regulation for specific requirements. Note areas of non-compliance that are applicable to the facility type and construction date in the "comments" section.)	X			

BOARD OF STATE AND COMMUNITY CORRECTIONS – BIENNIAL INSPECTION
ADULT DETENTION FACILITY
LIVING AREA SPACE EVALUATION

BSCC Code: 3970

FACILITY: Larson Justice Center	**TYPE:** CH	**RC:** 0
FIELD REPRESENTATIVE: Michael J. Bush		**DATE:** 09/23/2019

ROOMS							EACH ROOM					
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
2E	Holding	1994	1	0	(8)	(8)	8' x 10'6"	1		1	1	
Note: Rated for 8. Typically used for Family Court Proceedings; MW 2007												
2F	Holding	1994	1	0	(8)	(8)	8' x 10'6"	1		1	1	
Note: Rated for 8.												
2G	Holding	1994	1	0	(8)	(8)	8' x 10'6"	1		1	1	
Note: Three benches rated for 8, now being used for Family law Ct. MW 1/2009												
2H	Holding	1994	1	0	(8)	(8)	8' x 10'6"	1		1	1	
Note: Three benches rated for 8.												
2J	Holding	1994	1	0	(9)	(9)	8' x 14'	1		1	1	
Note: 7'6" and 6' benches.												
2K	Holding	1994	1	0	(9)	(9)	8' x 14'	1		1	1	
Note: 7'6" and 6' benches												
3M	Holding	1994	1	0	(8)	(8)	8' x 10'6"	1		1	1	
Note: Rated for 8.												
3N	Holding	1994	1	0	(8)	(8)	8' x 10'6"	1		1	1	
Note: Rated for 8.												
3P	Holding	1994	1	0	(8)	(8)	8' x 10'6"	1		1	1	
Note: Rated for 8.												
3R	Holding	1994	1	0	(8)	(8)	8' x 10'6"	1		1	1	
Note: Rated for 8.												
3S	Holding	1994	1	0	(9)	(9)	8' x 12'	1		1	1	
Note: Rated for 9.												
3T	Holding	1994	1	0	(9)	(9)	8' x 12'	1		1	1	
Note: Rated for 9.												
The Court Holding cells are typically empty because the inmates are held in the jury box of the court room.												

*T = Toilets; U = Urinals; W = Wash Basins; F = Fountains; S = Showers in unit; If "Total RC" appears in brackets ( ), it is not part of the facility's rated capacity. "+" indicates that capacity includes prorated air space from adjacent areas.

ADULT COURT AND TEMPORARY HOLDING FACILITIES
PHYSICAL PLANT EVALUATION
Board of State and Community Corrections

Applicable Title 24 Regulations: 6/94; 2/99; 2001; 2005; 2008

BSCC Code: 3974

FACILITY NAME: Banning Court House					**FACILITY TYPE:** CHJ
APPLICABLE REGULATIONS (Check All That Apply):	**6/94:**	**2/99:**	**2001:**	**2005:**	**2008:** X
FIELD REPRESENTATIVE: Michael J. Bush					**DATE:** 09/20/2019

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Reception and Booking (2.1) Contains a weapons locker, designed as outlined in these regulations.	X			
Contains a cell or room for confinement pending booking			X	
Contains a detoxification cell (WA in TH; NA in CH) 01: Name changed to "sobering cell." 2-99: Two detoxification cells are provided if both male and female inmates are held.			X	
Contains safety cell(s) (WA in TH; NA in CH)			X	
Shower room available 2-99: Access to shower must be within the secure area			X	
Provides secure vault or storage for inmate valuables	X			
Telephone(s) available for inmate use (PC § 851.5)	X			
2-99: Unobstructed access to hot and cold running water	X			
Temporary Holding Cell or Room (2.2) Contains 10 square feet of floor area per inmate	X			
Holds no more than 16 inmates	X			
Is not smaller than 40 square feet and has a clear ceiling height of 8 feet or more	X			
Contains sufficient seating to accommodate all inmates	X			
Contains water closet (toilet), washbasin, and drinking fountain	X			
Provides for clear visual supervision by staff	X			
A bunk is provided if inmates are held 12 hours or more	X			
Temporary Staging Cell or Room (2.3) Holds inmates classified and segregated per Title 15 § 1050 and 1053			X	
Safety Equipment Storage (2.19) Adequate space is provided to store equipment such as fire extinguishers, SCBA, emergency lights, etc.	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Janitors' Closet (2.20) Lockable, containing a mop sink and storage space 01: Mop sink may be separate from janitors' closet	X			
Audio or Visual Monitoring (2.22) There is an audio monitoring system capable of alerting staff in a central control. When visual electronic surveillance is use, it is located primarily in corridors, elevators, or at points on the security perimeter such as entrances and exits. 2-99: Video monitoring option deleted.	X			
Emergency Power (2.24) There is an emergency power source available and capable of providing minimal lighting in all areas and maintaining fire and life safety, security, communication and alarm systems.				
Attorney Interview Space (2.26) Available and provides for confidentiality	X			
Water Closets (Toilets)/Urinals (3.1) Provide for inmate privacy/modesty with staff being able to visual supervise; provided at a ratio of 1:16 in holding and staging cells. See regulation for calculations of urinal substitutions.	X			
Washbasins (3.2) Provide hot and cold or tempered water; provided at a ratio of 1:16 in holding and staging cells. See regulation for calculations of washbasin trough substitutions.	X			
Drinking Fountains (3.3) 2-99: Available in each temporary holding, staging and sobering cell.	X			
Water outlet (bubbler) is mechanically actuated and at an angle that prevents wastewater from flowing over the outlet (bubbler); there is a mouth guard on the water outlet (bubbler). 2-99: Mouth guard requirement deleted	X			
Lighting (3.6) Lighting is sufficient to permit easy reading by a person with normal vision, night lighting is sufficient for purposes of supervision. Lighting is centrally controlled and/or occupant controlled in housing cells or rooms. Light fixtures are of secure design.	X			

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Windows (3.7) Windows that are accessible to inmates are no greater than 5 inches in on dimension.	X			
Seating (3.10) Seating is designed to the level of security. When bench seating is used, eighteen inches of bench are provided per inmate. 2-99: In holding and staging cells, seating is securely fastened to the wall and/or floor.	X			
Weapons Locker (3.12) A secure weapons locker is located outside the security perimeter of the facility and no weapons are brought into the security area. Lockers have individual compartments, locks and keys.	X			
Design Requirements (102(c)6) Design requirements as specified in Title 24, Part 1, 102(c)6 are met. (See regulation for specific requirements. Note areas of non-compliance that are applicable to the facility type and construction date in the "comments" section.)	X			

ADULT DETENTION FACILITY
LIVING AREA SPACE EVALUATION
Board of State and Community Corrections

BSCC Code: 3974

FACILITY: Banning Courthouse	**TYPE:** CHJ	**RC:** 0
FIELD REPRESENTATIVE: Michael J. Bush		**DATE:** 09/20/2019

ROOMS							EACH ROOM					
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
Basement												
1-4	Holding	2008	4		(4)	(16)	55 sq. ft	1		1	1	
Bench Space – all 8 cells are a mirror image, cells 1-4 have 88 inches of bench space and 9ft. ceiling height. RC is limited due to bench space available.												
5-8	Holding	2008	4		(6)	(24)	85 sq. ft.	1		1	1	
Bench Space – cells 5-8 have 120 inches of bench space (two benches in each cell) and 9 ft/ ceiling height. RC is limited due to bench space available.												
9-10	Holding	2008	2		(6)	(12)	7.5 x 14.6 x 9	1		1	1	
Bench Space – cells 9 and 10 have 120 inches of bench space (two benches in each cell). RC is limited due to bench space available.												
Juvenile												
1-2	Holding	2008	2		(4)	(8)	7.9 x 6 x 9	1		1	1	
Bench Space – 72 inches of bench space. RC is limited due to bench space available.												
3-4	Holding	2008	2		(4)	(8)	7.5 x 9.5 x 9	1		1	1	
Bench Space – 88 inches of bench space. RC is limited due to bench space available.												
Notes: 2 attorney visiting rooms available.												
First Floor												
1	Holding	2008	1		(2)	(2)	8.1 x 7.10 x 9	1		1	1	
Bench Space – 53 inches of bench space.												
2	Holding	2008	1		(5)	(5)	8.1 x 7.10 x 9	1		1	1	
Bench Space – 98 inches of bench space.												
Second Floor												

*T = Toilets; U = Urinals; W = Wash Basins; F = Fountains; S = Showers in unit. If "Total RC" appears in brackets ( ), it is not part of the facility's rated capacity. "+" indicates that capacity includes prorated air space from adjacent areas.

ROOMS							EACH ROOM					
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
Between Courtrooms 310 and 320												
1	Holding	2008	1		(5)	(5)	8.2 x 7.10 x 9	1		1	1	
Bench Space- cell 1 has 98 inches of bench space.												
2	Holding	2008	1		(2)	(2)	8.1 x 7.9 x 9	1		1	1	
Bench Space - 53 inches of bench space. RC is limited based on bench space available.												
Between Courtrooms 330 and 340												
3	Holding	2008	1		(5)	(5)	8.2 x 7.10 x 9	1		1	1	
Bench Space- 98 inches of bench space.												
4	Holding	2008	1		(2)	(2)	8.1 x 7.9 x 9	1		1	1	
Bench Space - 53 inches of bench space. RC is limited based on bench space available.												
Notes**:**												

*T = Toilets; U = Urinals; W = Wash Basins; F = Fountains; S = Showers in unit. If "Total RC" appears in brackets ( ), it is not part of the facility's rated capacity. "+" indicates that capacity includes prorated air space from adjacent areas.

ADULT COURT AND TEMPORARY HOLDING FACILITIES
PHYSICAL PLANT EVALUATION
Board of State and Community Corrections

Applicable Title 24 Regulations: 6/94; 2/99; 2001

BSCC Code: 3975

FACILITY NAME: Blythe Court				**FACILITY TYPE:** CH
APPLICABLE REGULATIONS (Check All That Apply):	**6/94:** X	**2/99:**	**2001:**	**OTHER:**
FIELD REPRESENTATIVE: Michael J. Bush				**DATE:** 09/24/2019

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Reception and Booking (2.1) Contains a weapons locker, designed as outlined in these regulations.			X	No reception, remainder of regulation has been removed.
Temporary Holding Cell or Room (2.2) Contains 10 square feet of floor area per inmate	X			
Holds no more than 16 inmates	X			
Is not smaller than 40 square feet and has a clear ceiling height of 8 feet or more	X			
Contains sufficient seating to accommodate all inmates	X			
Contains water closet (toilet), washbasin, and drinking fountain	X			
Provides for clear visual supervision by staff	X			
A bunk is provided if inmates are held 12 hours or more	X			
Temporary Staging Cell or Room (2.3) Holds inmates classified and segregated per Title 15 § 1050 and 1053			X	Remainder of this regulation is deleted.
Detoxification/Sobering Cell (2.4) 01: Name change to "sobering cell" Contains 20 square feet of floor area per inmate			X	Remainder of this regulation is deleted.
Safety Cell (2.5) Contains 48 square feet with one floor dimension of a least 6 feet and a clear ceiling height of 8 feet or more			X	Remainder of this regulation is deleted.
Safety Equipment Storage (2.19) Adequate space is provided to store equipment such as fire extinguishers, SCBA, emergency lights, etc.			X	
Janitors' Closet (2.20) Lockable, containing a mop sink and storage space 01: Mop sink may be separate from janitors' closet			X	

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Audio or Visual Monitoring (2.22) There is an audio monitoring system capable of alerting staff in a central control. When visual electronic surveillance is used, it is located primarily in corridors, elevators, or at points on the security perimeter such as entrances and exits. 2-99: Video monitoring option deleted.	X			Cells have cameras.
Emergency Power (2.24) There is an emergency power source available and capable of providing minimal lighting in all areas and maintaining fire and life safety, security, communication and alarm systems.	X			Battery back up
Attorney Interview Space (2.26) Available and provides for confidentiality	X			Law library is used; adjacent to holding cell #2.
Water Closets (Toilets)/Urinals (3.1) Provide for inmate privacy/modesty with staff being able to visually supervise; provided at a ratio of 1:16 in holding and staging cells. See regulation for calculations of urinal substitutions.	X			
Washbasins (3.2) Provide hot and cold or tempered water; provided at a ratio of 1:16 in holding and staging cells. See regulation for calculations of washbasin trough substitutions.	X			
Drinking Fountains (3.3) 2-99: Available in each temporary holding, staging and sobering cell.	X			
Water outlet (bubbler) is mechanically actuated and at an angle that prevents wastewater from flowing over the outlet (bubbler); there is a mouth guard on the water outlet (bubbler). 2-99: Mouth guard requirement deleted	X			
Showers (3.4) (NA in CH) Available in the security area; provide hot and cold or tempered water; shower stalls/areas are designed and constructed of materials that are impervious to water and soap so that they may be easily cleaned.			X	

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Beds/Bunks (3.5) (NA in CH; applicable in TH if inmates are held longer than 12 hours) At least 30 inches wide and 76 inches long with 21 inches between pans; constructed of pan bottom type or concrete; securely fastened to the floor and/or wall in facilities higher than minimum security. 01: Must be elevated off the floor.			X	
Lighting (3.6) Lighting is sufficient to permit easy reading by a person with normal vision, night lighting is sufficient for purposes of supervision. Lighting is centrally controlled and/or occupant controlled in housing cells or rooms. Light fixtures are of secure design.	X			
Windows (3.7) Windows that are accessible to inmates are no greater than 5 inches in one dimension.			X	
Cell Padding (3.8) The floors and partition are padded in detoxification cells. In safety cells, floors, doors, walls and everything on them is padded. All padded cells are equipped with a tamper resistant fire sprinkler approved by the SFM.			X	
All padding is: approved for use by the SFM; nonporous; at least ½ inch thick; of a unitary or laminated construction; firmly bonded to all surfaces; and, without exposed seams.				
Mirrors/Shelves/Clothes Hooks (3.9) A mirror of a material appropriate to the level of security is provided near each washbasin.			X	
Consistent with security needs, shelves and clothes hooks are provided wherever feasible. 2-99: Requirement for shelves and hooks deleted			X	
Clothes hooks are of a collapsible hook type 2-99: Requirement for hooks deleted			X	

TITLE 24 SECTION	YES	NO	N/A	COMMENTS
Seating (3.10) Seating is designed to the level of security. When bench seating is used, eighteen inches of bench are provided per inmate. 2-99: In holding and staging cells, seating is securely fastened to the wall and/or floor.	X			
Weapons Locker (3.12) (NA type IV and Minimum Security Facilities) A secure weapons locker is located outside the security perimeter of the facility and no weapons are brought into the security area. Lockers have individual compartments, locks and keys.	X			
Design Requirements (102(c)6) Design requirements as specified in Title 24, Part 1, 102(c)6 are met. (See regulation for specific requirements. Note areas of non-compliance that are applicable to the facility type and construction date in the "comments" section.)	X			

BOARD OF STATE AND COMMUNITY CORRECTIONS - BIENNIAL INSPECTION
ADULT DETENTION FACILITY
LIVING AREA SPACE EVALUATION

BSCC Code: 3975

FACILITY: Blythe Court	**TYPE:** CH	**RC** (6)
FIELD REPRESENTATIVE: Michael J. Bush		**DATE:** 09/24/2019

ROOMS							EACH ROOM					
Location	Cell Type	Applicable Standards	# Cells	EACH CELL # Beds	EACH CELL RC	Total RC	DIMENSIONS (L x W x H)	FIXTURES* T	U	W	F	S
1	Holding	1994	1	0	(4)	(4)	11.5 x 8.0	1		1	1	
NOTE: 81” of Bench												
2	Holding	1994	1	0	(2)	(2)	8.0 x 7.0	1		1	1	
NOTE: 41” of Bench												
Interview room is available in law library adjacent to cell #2.												

*T = Toilets; U = Urinals; W = Wash Basins; F = Fountains; S = Showers in unit; If "Total RC" appears in brackets ( ), it is not part of the facility's rated capacity. "+" indicates that capacity includes prorated air space from adjacent areas.

EXHIBIT P

Grey v. Riverside
Tour of Indio Jail, Southwest Detention Facility, and Robert Presley Detention Center, February 7-9, 2017

On February 7-9, attorney Sara Norman and litigation assistant Sarah Hopkins toured Indio, Southwest, and Presley jails. We spoke to several dozen prisoners in each jail, both individually in confidential interviews and in brief group interviews. We spoke to custody, medical and mental health staff and administrators at all the jails as well. We reviewed health care records for numerous patients. We are grateful for the courtesy and openness of the staff we met and the readiness with which our questions were answered and multiple jails processes explained. We would like to thank in particular Lt. Hal Reed, for his tireless help and thoughtful work as health care liaison, and Chief Deputy Sheriff Cheryl Evans, for her attention and engagement regarding the many issues discussed.

This report is not an overview or a comprehensive set of findings. Instead, it is a discussion and memorialization of several observations and concerns, with requests for follow-up from the County or the Court Experts as appropriate.

Indio Jail

Privacy at intake screening (Remedial Plan I.A.2, I.D.1): Patients coming into Indio Jail are screened by an RN in a sort of sally port located between the parking lot and the jail. The space looked clean and quiet, but we were told that the arresting officer is always present in that space along with the RN and patient during the screening. While we understand that space is a problem at the Indio facility, the presence of the arresting officer violates the Remedial Plan requirement that the "intake screening shall take place in a setting the ensures confidentiality of communications between nurses and individual inmates." We had some conversations during the tour about whether a work-around might be possible, such as enhanced mental health screening shortly after the booking process, once inside the jail building.

Clinical space (Remedial Plan I.B.8, I.D.1, II.E.1): The clinic space in Indio Jail continues to be inadequate. Patients are seen for RN sick call face to face with the nurse and seated just inside a door to a busy hallway, with the deputy in the hallway outside. This might be compliant so long as the deputy remains out of earshot and the door is closed enough to provide privacy from passersby; we did not see an actual sick call to make that determination. However, on the other side of the RN is a work space with many other staff members seated at their desks, in full sight and earshot of the examination.

Similarly, the provider sick call and examination space is at the far end of the same room, around a corner. Although a curtain can be drawn, according to Nurse Practitioner Samson it is drawn for only about half of the appointments. Even if it is drawn, there is no sound separation from a roomful of people. Although those people are

presumably health care staff, these are not confidential settings and it is not an appropriate work environment.

Medication administration (Remedial Plan I.C): We spoke to [redacted] [redacted] who reported that a facility nurse mistakenly gave him [redacted] [redacted] psychiatric medications at pill call instead of the Sudafed he had been prescribed for his cold. He said he told the nurse that she had dispensed an unusual amount of pills for him, and she responded, "You're [redacted], aren't you?" He said he swallowed the pills, went back to his bunk, and "knocked out" before the nurse realized her mistake. His medical record shows that on 10/3/16 he was issued a potent dose of schizophrenia medication instead of Sudafed. He was transferred to a medical tank for observation. SOAP notes starting at 10/4/16 track his care in the medical tank. We were relieved to hear from Mr. [redacted] that he emerged relatively unharmed from this incident (though we do not know how this medication interruption affected [redacted] psychiatric condition, if at all). We recommend that the facility implement a system to mitigate medication mix-ups and prevent any resultant harm to patients. If such a system exists, we recommend that facility supervisors ensure that medical staff remain fully aware of its implementation.

Transportation for specialty care (Remedial Plan II.B): Many prisoners related the process for traveling to the Riverside University Medical Center (RUMC) to receive specialty care. Their accounts were all the same: they leave Indio at 4 a.m. in a bus to Presley. From there, they wait in a holding cell for a van to RUMC. After the appointments are over, they are taken in a van back to Presley, then a bus to Smith Correctional Facility, then a bus to Indio Jail. They arrived back at the jail at 7 p.m. During this entire time -- 15 hours -- they are shackled. All described pain from such a long span of time in shackles. Several described severe anxiety over traveling on the buses and vans without seat belts and without the ability to brace themselves as the vehicles turned or braked. (With the shackles, they have "T Rex arms," as one person put it.) The process they describe is an extremely arduous one, particularly for some of the sickest patients. It appears to pose an unnecessary barrier to care. We ask that the County explore direct transportation for the small Indio population who need specialty care in order to remove this barrier.

Medical and mental health consequences of Housing Units 13-15 (Remedial Plan I.G): We are concerned about prisoners spending long periods of time in the extremely crowded and close quarters of Housing Unit 15 and other similar units at Indio (Units 13 and 14). These housing units consist of a small dayroom with a shower on the other side of a small divider. The cells are just behind the dayroom. The dayroom is off a dark hallway which is behind a locked door separating it from the mail jail corridors; there is no fresh air. We saw more than 20 people crowded into the dayroom, which is their entire living space while they are awake. Some of them spend months or years in this environment, with no work or organized programming to occupy their time. The ventilation is minimal and the shower frequently in use.

One prisoner described how difficult and dangerous it is to experience withdrawal from opiate addiction in those extremely close quarters, with frequent vomiting and uncontrolled bowel movements. Other prisoners described the experience of being in a small, unventilated space where often two or more people are going through withdrawal. People universally described it as extremely unhygienic, unsafe, and stressful, with the lack of movement or programming compounded by the inescapable sights, sounds, and smells of people in extreme distress.

We ask that the Court Experts review these conditions to determine whether they are consistent with basic medical and mental health needs of prisoners, particularly those with mental illness and those experiencing withdrawal.

Robert Presley Detention Center

Assistive devices in holding cells (Remedial Plan IV.2, IV.3, IV.5): The transportation sergeant told us that his understanding is that prisoners were not allowed to have canes and walkers with them in the holding cells in the transportation hub, and that those devices were automatically removed and kept outside the cells. He appeared to be extremely competent and knowledgeable, giving us the impression that he had not received training in the Remedial Plan requirement that "[a]n inmate who arrives at the jail with an assistive device shall be allowed to retain the device, or shall be provided with a jail-issued equivalent device, so long as it does not constitute an immediate risk of bodily harm or threaten the security of the facility based on an individualized assessment, unless a jail physician documents that the device is not medically necessary or reasonable to allow equal access to jail programs, services, or activities." If a cane or walker is outside a holding cell, it is not "retained" by the prisoner.

We discussed this problem on the tour. One measure mentioned to address the problem was to have doctors more clearly indicate which prisoners needed assistive devices at all times as opposed to distance walking. As I noted on the tour, I urge you to avoid this distinction, which is unnecessarily confusing and sets up different rules for different people. It is also hard for providers to apply.

Accommodations for disabled prisoners in holding cells (Remedial Plan IV.2): We spoke to several disabled prisoners on the seventh floor who agreed that when they are waiting in the holding cells to go out to court or to specialty appointments, often for many hours, their hands are kept shackled. Even when they request for their hands to be freed to allow them to use the toilet or to eat, they said that they are often refused. One prisoner in a wheelchair described a deputy's response to his request to have his hands freed: the deputy released only one hand and told him to make it work. He told us that he fell in attempting to maneuver himself onto the toilet. Prisoners with mobility impairments who use wheelchairs and walkers must have the use of their hands to safely transfer themselves to and from the toilet and perform other basic needs.

Medication administration (Remedial Plan I.C.1): We spoke to [redacted] [redacted] at Indio, who said that Presley medical providers had belatedly

administered his post-operative medications. He said he was discharged from Moreno Valley Hospital on 1/3/17 after undergoing jaw surgery. He said he was transferred to Presley, where he suffered intense pain for a number of days without his prescribed painkillers, antibiotics, or liquid diet. His medical record bears this out. His post-operative orders from 1/3/17 state that his surgeon prescribed a six-week liquid diet, antibiotics (clindamycin and Keflex), and pain medication (hydrocodone). The record states the Keflex was administered seven days late (on 1/10/17); the clindamycin two days late (1/5/17); the hydrocodone four days late (1/7/17); and the liquid diet two days late (1/5/17). This is an obvious violation of the Remedial Plan's requirement that the County "ensure that prescribed medications are provided at therapeutically appropriate times as determined by the ordering physician," and raises a general concern about the facility's ability to implement treatment plans as ordered by outside specialists.

Confidentiality of medical encounters on second floor (Remedial Plan I.B.8, I.D.1, II.E.1): We heard from one prisoner on the second floor (administrative segregation) who reported that it is common practice for nursing staff to take patients' vital signs prior to provider appointments on the tier, in front of their cells. He said that it had happened to him and he heard that it had happened to others. If this is the case, it is obviously a concern as a violation of these patients' confidentiality.

Mental health treatment space (Remedial Plan III.C): This is clearly inadequate at Presley. We heard about the plans to convert more rooms on the seventh floor for mental health treatment, which will be very welcome. In the interim, it seemed that more space might be available with better communication and direction between mental health and custody staff. For example, one of our escorts quickly enabled a confidential attorney interview with a seventh floor prisoner by bringing him down to the program room on another floor. Such measures, if made readily available to mental health staff, could enhance current capabilities.

EXHIBIT Q

Grey v. Riverside

Plaintiffs' tour of Indio Jail, Smith Correctional Facility, Cois Byrd Correctional Facility, and Robert Presley Detention Center, December 2019

On December 2-5, 2019, attorneys Sara Norman and Shira Tevah toured the Indio Jail, Smith Correctional Facility, Cois Byrd Correctional Facility, and Robert Presley Detention Center. We spoke to a dozen or more people housed in each jail, both people we requested to see and people whose names we picked randomly from lists of patients with disabilities and medical and mental health diagnoses. We reviewed health care records for numerous patients. We also talked to custody, medical and behavioral health staff and administrators, and had a meeting with Chief Deputy Sheriff Edward Delgado; Deborah Johnson, RUHS Behavioral Health Assistant Director for Programs; Brian Betz, Behavioral Health Administrator for Detention Health Services; Mike Mesisca, Chief Medical Officer, Correctional Health; Correctional Health Care Administrator Bonnie Carl; and others on the executive team.

As I have said before, I continue to be grateful for the open discussions and collaborative approach from the Sheriff's Department and behavioral health and medical leadership, as well as the courtesy and commitment we encountered from staff at the individual jails. Lieutenant Hyland's organizational skills and the professionalism he brings to his job as health care liaison were impressive.

This report is intended to document general policy and systemic issues that we raised on the tour. It is not intended as an overview or a comprehensive set of findings – those reviews are left to the Court experts -- but to memorialize concerns for ongoing discussion and to suggest measures to move more effectively towards compliance.

1. ADA and disability access

(a) Accessible housing

The seventh floor of RPDC, which houses many of the people in the system with the most significant mobility impairments, is not wheelchair accessible. I have raised this point repeatedly over several years of reports. For example, after my July 2018 tour, I wrote:

> Presley is not wheelchair accessible. The modifications for people with mobility impairments who use wheelchairs or other devices, on the seventh floor and in the holding cells for court or outside transportation, are clearly not up to the relevant standards, set forth in the Department of Justice ADA Accessibility Guidelines (ADAAG). People with disabilities on this tour, as on past tours, reported serious access problems, as described in more detail below. It is time for the County to do a thorough review of the facilities on the seventh floor and in the holding facilities,

with expert help, to determine what physical plant changes and what policy solutions are needed.

I was extremely disappointed to see that nothing at all has been done to the seventh floor in the years that I have been raising these concerns. People are being harmed by these problems: for example, [REDACTED], in Dorm 1, said he is paralyzed on the left side and fell while attempting to use the shower in the dorm (which has a high lip and is completely inaccessible). He said that deputies had to lift him off the floor. He said he has not been offered the use of the accessible hallway shower and had not taken a shower since. [REDACTED] said that when he has asked deputies to use the hallway shower, they respond, "isn't there one in the dayroom?" People generally said that either the hallway shower was not available because of deputies' reluctance to bring people out to use it, or people had no idea that there was an alternative to the inaccessible dorm showers. This situation is unacceptable – accessible facilities to shower, toilet, and program generally must be readily accessible to and usable by people with disabilities. Every time I go to the seventh floor, I hear of many clear ADA violations – the County must take responsibility for fixing this chronic problem.

I have concerns about other housing for people with mobility impairments, such as A Pod at Cois Byrd. Any accessibility review should include that location as well.

We had a good discussion at the debrief about these concerns and the urgency with which the County must take remedial steps. There is undoubtedly expertise in other County departments on ADA accessibility requirements. Also, as I mentioned at the meeting, several other county sheriffs' departments have used the ADA Coordinator Training Certification Program (https://www.adacoordinator.org/page/Training) to help their ADA staff learn some of the basics about compliance. I know little about the certification program and do not personally endorse it, but I know that people from Santa Clara (Sergeant Jared Marandino) and San Bernardino (Sergeant Brad Shaver) have attended the trainings and found them helpful. Sergeant Marandino in particular has developed an impressive range of expertise in architectural accessibility.

In addition to the architectural concerns, we heard of a few problems from disabled people who are or were improperly housed. [REDACTED] in Building 12 at Smith Correctional Facility, uses a walker. He said he was scheduled for surgery for serious hip problems when he was arrested. He was booked on November 14 in Indio, and reported that he told staff about his hip problems but was nonetheless housed in an upper tier at Smith for two days until he refused to climb the stairs. He said he was put in the recreation yard for 12 hours and then the program room, where he spent the night with no bed and only a blanket to sleep on, until he was rehoused accessibly the next day. He also said it took two weeks to get a shower chair after it was prescribed for him. [REDACTED] RPDC 3A, has crutches for a broken leg that occurred

while he was on work release. Despite having crutches, he said he is housed on an upper tier (bottom bunk) and does not get any cuffing accommodations, although he is not able to use the crutches while cuffed with waist chains.

(b) Assistive devices

I was very glad to hear of the policy change to allow people to keep assistive devices during transfers and in holding cells. It is a welcome step forward. Unfortunately it is not fully implemented: we continue to get numerous reports from the people we interview from the Special Needs list that they are not always provided their assistive devices or allowed to keep them on transfers.

- [redacted], in Cois Byrd E Pod, uses a cane. When he walked up to meet me for the interview on this tour, the deputy with him matter-of-factly took his cane from him. When I protested, the deputy said he would keep it ready for Mr. [redacted] when he was done. Mr. [redacted] said that when he goes out to court, it is sometimes removed from him and sometimes he is allowed to keep it; they nearly always take it when he goes to RPDC.
- [redacted] Cois Byrd A Pod, uses a cane. He said it is sometimes taken away from him in the holding cells at Cois Byrd and RPDC when he goes out to court, but sometimes he is allowed to keep it. He needs it – he has had a stroke and one leg drags; he said he has fallen without his cane.
- [redacted] also in A Pod, uses a wheelchair when he goes to court. He reported that he is made to leave it outside the holding cell at Cois Byrd when he goes out to court (the last time was in late November). He said he can't use the toilet in the holding cell because of the lack of grab bars and the removal of his wheelchair, so he tries to stop eating and drinking early in the evening the night before so he won't have to. He said that another person once had an accident on the bus and deputies ridiculed him.
- [redacted] Cois Byrd E Pod, said his cane is usually taken from him in the holding cell, although he is sometimes allowed to keep it.
- [redacted] Cois Byrd F Pod, uses a walker and cane. He reported that the holding cells while going to court are "first come first served" for sitting down, have only one bench, and he has had to sit or lie down on the floor and needed several men to help him stand up. He reported that he spent three days in a holding cell while coming back from the hospital when he first entered the jail, and his walker was removed from him. He reported that when he goes to court, his cane is taken from him when he gets on the bus and he is without it all day. He also reported that deputies have yelled at him for getting into the van too slowly because of his mobility impairment.

- [REDACTED] Smith Building 1, reported that he has a wheelchair prescribed for trips to court, the hospital, and the jail clinic but when he goes to outside medical appointments, he is only allowed to use it to get to the bus—staff do not bring it with him. As a result, he has to walk a great deal, which causes him pain.
- [REDACTED] in RPDC 5A, reported that he was supposed to have a cane for his multiple sclerosis, and the special needs list listed him as having one. He said he went to the Riverside University Medical Center when he was arrested and was given a cane there, but then he did not have it when he got to the jail. He reported that he has asked for it multiple times to use when he goes to court but has not seen it. He reported that his leg locks up every few days and puts him at risk of falling.

2. Intake holding cells

We continue to hear accounts from people with disabilities or specialized health care needs who are required to spend multiple nights in harsh conditions in holding cells:

- [REDACTED], Smith Building 14, reported he was held in a holding cell for four days at RPDC when he was booked on September 13; he said he slept on the floor and on benches. He said there were no sheets, blankets, grooming supplies, or showers, and the number of people in the tank varied between seven and 15. He told us he was taken from there to court and then to Smith, where his cane was taken from him in the holding cell.
- [REDACTED] reported that he spent more than three days in a holding cell in intake at RPDC starting around September 30, from Monday mid-day to Thursday at 11 p.m., while waiting for housing assignment. He said he was going through heroin withdrawal and there were 16-20 people in the holding cell, with one toilet and one sink. He thought several others in the cell were also going through withdrawal. He reports he spent another four days in intake one month later after he was rehoused at RPDC, and this time there were about 15 people in the cell. He said that three weeks later he spent three days in a holding cell again after he was again rehoused. At that point, he estimates there were about 12 people in the holding cell with him.
- [REDACTED] reported he spent three days in a holding cell in Cois Byrd following surgery on his foot for a staph infection at the Riverside University Medical Center. He said he had an open wound but no dressing change, medications, or facilities to clean the wound for that entire time. He said there were usually 10-11 other people in the cell with him, and he was not removed from the cell despite multiple complaints until an RN found him, got him rehoused, and provided treatment.

- [redacted] RPDC 7th floor, said he has three separate times spent three consecutive nights in holding cells at RPDC without blankets following hospital stays. He said that this experience led him to refuse his last hospital trip.
- [redacted] RPDC 7th floor, said that he spent three days in intake at RPDC before being housed on the seventh floor, in a placement that had been empty and available the entire time (according to his dorm-mates).

I do not understand why anyone would have to spend the night in an intake cell after booking unless they arrived late in the evening and staff were not able to secure a placement until the following morning. But more than one night is unacceptable, particularly for the special needs patients described in the numerous examples in this and past reports. In particular, Mr. [redacted]'s and Mr. [redacted]'s accounts should be investigated, because as we have discussed several times on these tours, the hospital and jail must communicate directly regarding immediate housing for patients who return following medical procedures.

As a basic public health measure, the Sheriff's Department should keep a supply of blankets and toiletry items to allow anyone experiencing an overnight stay in a holding cell to have some degree of comfort and sanitation, particularly where there are multiple people in close quarters. Medical staff should also screen those in the holding cells overnight to remove people who are suffering withdrawal or have significant medical conditions requiring treatment, and to ensure people have any assistive devices they are prescribed.

3. Confidentiality

We continue to see significant problems with confidentiality for health care encounters. The County has installed cuff bars in medical exam rooms in many places, but the use of restraints in medical appointments raises more concerns than it addresses. For one thing, people widely reported that even when they are cuffed to the bar or to their wheelchairs or waist chains, the exam room door remains open and deputies and other patients outside can hear their private medical communications. This was the case for nursing appointments on the housing units at Smith (reported by [redacted] 12; [redacted] 12; and [redacted] 14; among others). Similarly, at Cois Byrd, some people reported that they are cuffed to the cuff bar, one person said the cuff bar is used sometimes, and another person said he is sometimes cuffed to his wheelchair instead, but all said that the door is always open for medical appointments. Some reported that deputies are situated in the open doorway and others said they are sometimes across the hall.

The main problem with restraints in health care appointments is that they interfere with the clinician-patient relationship and the kind of communication that is essential for adequate care. As a result, they should only be used during a health care encounter if there is an individualized safety concern about that particular patient. The problem with installing cuff bars in all exam rooms is that they become the default option, when in fact it should be the reverse – they should be used only in those cases where there is a demonstrated need. Judging from our patient interviews, the cuff bars are currently being used without regard to their purported purpose, which is to allow staff security from assaultive patients while also ensuring confidentiality.

Dr. Gage, in his September 2019 report, reported confidentiality problems with behavioral health encounters, particularly with excessive use of cell-front contacts, but also with custody presence for routine contacts (Report at pp. 18-19). He also described a policy that calls for cuffing patients to program tables for behavioral health clinical appointments even if they are not ordinarily cuffed for groups or medical appointments (p. 6), which seems similar to the blanket use of the cuff bar for medical appointments described above, and which he objected to as lacking in the kind of individualized safety assessment that is called for when determining whether a patient should be restrained.

Also on the behavioral health side, we heard from [redacted], RPDC 4A, said that a doctor reviewed his medications with him at the dayroom door while dayroom was running and other people were within earshot in early September 2019. He said that he filed a grievance and the doctor subsequently saw him in an attorney booth, but a deputy was next to him during the visit, so that was not confidential either.

In positive developments, it is clear that Lieutenant Hyland and others have worked to train deputies to stand back from open doors, outside of hearing range of appointments inside. Based on patient interviews, however, this measure is not always followed. It was good to hear from patients that in the freestanding clinic at Smith, the exam room doors are closed and deputies are outside, which we also observed on the tour. (A few patients did say that in their experience, the exam room doors are sometimes left open.)

It is clear that there are problems with the physical plant of the exam facilities that render it difficult to provide confidential appointments in a secure setting: for example, the doors in some exam rooms open inwards, allowing an assaultive patient to blockade them; others lack adequate windows to allow visual supervision;[1] and Dr. Gage described

[1] The newly constructed pre-screening room in the RPDC booking area had a door that opened out and a window, making secure and confidential interviews possible. It was

cell-front contacts due to lack of treatment space at RPDC (pp. 46-47). These problems can and are being addressed by the County. But the more elusive problem lies in the approach to addressing the issue, with blanket fear-based approaches that do not treat patient confidentiality as an important and essential aspect of health care. That attitude must be replaced by a patient-centered approach in order to achieve adequate care.

4. Behavioral health

We discussed on the tour Dr. Gage's September 2019 report; I will not repeat his findings in detail here, except to say that I share his concerns. His most serious finding was that "individual contacts and groups are far too infrequent to meet the standard of care" (p. 24). This was consistent with what we heard in our interviews: most of the behavioral health patients we talked to described a paucity of individual or group therapy (although most were satisfied with their medications): few had anything more than rare group sessions, and many had none. They were, however, uniformly positive about those behavioral health staff they did encounter. Behavioral health leadership on the tour said they plan to gather data on group participation and availability from a patient level, which sounds like a very important metric to track.

It remains unclear if the paucity of treatment is a staffing or access problem; I look forward to hearing the results of the staffing assessment, which I was told would be done in early 2020, to help determine the way forward on this central issue.

Another area of significant concern in Dr. Gage's report was the lack of safety cell stepdown procedures (p. 47) and the failure to implement one-on-one observations as an alternative (pp. 48-49). We discussed these on the tour, and I look forward to receiving the stepdown procedure policy when it is drafted.

Dr. Gage also found very spotty care in the safety cells (pp. 48-49), people kept in safety cells regularly for more than 12 hours (p. 48), and only 9 of 20 patients assessed outside the safety cell despite staff reports to the contrary (p. 48). He had similar concerns with the use of restraint chairs (pp. 50-51): while noting rare usage, which is welcome, he also found that face to face assessments were often denied for "safety reasons," which is hard to imagine when the patient is secured in a restraint chair, and inadequate nursing assessments in 10 of 10 cases reviewed. Clearly, the area of safety cells and restraints, where patients are often at their most distressed and vulnerable, are an area that requires significant work to ensure consistent, compassionate treatment.

There were several points to follow up from Dr. Gage's last report:

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disappointing to see that the window was almost completely covered with non-official paperwork (saying "God Bless America") that blocked any visual supervision.

- He found substantial compliance with behavioral health 30-day reviews of people in administrative housing because they are done, and he does not review substance (p. 38). The parties agree that he should review the substance of the 30-day reviews.
- He asked us to weigh in on whether behavioral health approval is needed for transfers of people with acuity ratings below moderately-severe (p. 45); we agreed to accept his recommendation that they are not needed. He asked for guidance on intra-facility transfers; we also agree to accept his view that no additional behavioral health input is needed if patients are transferred within a facility to a placement designated for their acuity code.

Finally, I interviewed [redacted] a deeply troubled behavioral health patient. She is currently at RPDC 6A, after moving back and forth between the DCU, safety cells, and the seventh floor. She cuts herself often and her arms were deeply distressing masses of scars. She is extremely well known to behavioral health staff and clearly presents extraordinary difficulties in a custodial setting. We had multiple reports from other women that Ms. [redacted] had cut herself and waited long periods of time, bleeding, without staff response, which Ms. [redacted] confirmed. Ms. [redacted] herself reported that at one point a sergeant in administrative segregation told her to "kill yourself already" and the entire dayroom clapped. She said she filed a grievance about this incident but had not received a response. We ask that you investigate these allegations.

5. Administrative housing and out of cell time generally

On this tour, we were told that there were 36 men and four women in administrative housing. People in administrative housing also told us that they are now present for their regular status reviews, at which time they are given some indication of what they need to do to return to general population. These are significant accomplishments, and very welcome news.

We continue to have concerns over administrative housing conditions for men and women, other placements with severely restricted out of cell time, and out of cell time generally for behavioral health patients.

(a) Administrative housing conditions

The women in administrative housing at RPDC 6A reported receiving only one hour a day out of their cells, which is sometimes closer to 45 minutes (depending on the deputy). One woman said that every few days, they get a second rotation of 45 minutes to an hour each. One woman, [redacted], said she is pro per and must use that time to speak to her investigator as well as her child and also to shower. It is not

enough out of cell time, particularly since many of the men in administrative housing now receive more.

We were told that for the men in administrative housing on the second floor of RPDC, the planned 90 minutes per day of out-of-cell time rarely happens, because staff shorten dayroom time when behavioral health staff do walk-throughs or for various other administrative reasons. We were also told that people deeply regretted the loss of behavioral health classes and workbooks since the move to the second floor.

Several women in administrative housing spoke of spending extended periods in the isolation rooms on the seventh floor, sometimes for weeks at a time. [redacted] has been housed in one of the isolation cells for 10 months. He never leaves – there is a TV and shower in the cell – except for non-contact visits twice a week. Why are the seventh floor rooms used for administrative housing when they are so severely isolating?

While we are grateful for the ongoing efforts to limit administrative housing placements and the time spent in them, we continue to maintain that one two hours out of cell time a day for extended periods of time is inadequate and places people at risk of harm to their mental health and physical well-being. We look forward to ongoing conversations in this area, and to length-of-stay data, which is essential to an analysis of the adequacy of protective measures in restricted housing.

(b) Other placements with severely restricted out of cell time

I saw some examples of severely limited out of cell time for people in non-administrative housing: [redacted], in Tank 17 in Indio, said she is in a four-person cell which she never leaves, except for two recreation sessions each week. She said it is very small, and very stressful; some women “go crazy” and kick the door repeatedly in frustration with their extremely limited movement. Similarly, people in A Pod at Cois Byrd, which is sheltered medical housing, have showers and TVs in their single-person cells and stay in them at all times except for recreation. The isolation rooms on the seventh floor in RPDC appear to be the same.

I have reviewed Title 24 Section 1231.2.9, which allows dayroom space to be “part of a single occupancy cell used for administrative segregation or a dormitory, in which case the floor area of the cell or a dormitory must be increased by the square footage required for the dayroom.” Even if the rooms used for this purpose in Riverside meet this space requirement, I am concerned that confinement in a small room for 24 hours a day, nearly every day, runs afoul of constitutional requirement for humane living conditions. (I am not talking about large dormitories that have clearly defined and open dayroom and bed areas.) I would like to discuss this matter further on the next tour, with

an understanding of how many people live in such housing and the dimensions of the cells.

(c) Out of cell time for behavioral health patients

There is a significant population of people in behavioral health housing on administrative housing status (there are even "ad seg" signs on some of the units). These people do not appear to be included in the totals for people in administrative housing (36 men and four women, as of the December tour). They appear to live in RPDC in one pod on the 5th floor and in Cois Byrd C Pod (population of 16). It appears that these patients generally get only 30-60 minutes a day out of cell unless they can come out in groups, in which case they get one hour. Very few reported attending groups regularly; those who had been to groups had no more than one or two a week (one patient at Cois Byrd reported a one-on-one "group" during which they played Uno).

Other behavioral health patients, not on ad seg status, spoke of getting out of their cells only one to three hours a day (for example, in Smith Building 16).

Dr. Gage's report of September 2019 addressed out of cell time and dayroom fragmentation, noting that data is hand-gathered and error-prone (pp. 25-35). His report raises two significant problems in this area: (a) why is there no better data of this crucial metric? and (b) women and behavioral health patients consistently receive less out of cell time than men and non-behavioral health patients (p. 28).

Dr. Gage's report pinpoints what we have generally observed, which is that dayrooms are uniformly open 8 a.m. to 11 p.m. around the system. The problem is one of fragmented opportunities for release rather than general dayroom availability. Sometimes these are unnecessary: for example, he wrote that some behavioral health units allow both tiers out to recreation yard together, so why not dayroom?

I am also concerned about Dr. Gage's reports of the very large numbers of recreation yard refusals documented on the behavioral health units, including all people for some yard times (pp. 29-35). This bears further examination, to ensure that recreation is offered in a way that encourages patients to make use of it.

6. Custody functions

It was cold outside during our December site visits, and people we talked to in all the jails were cold. Very few had sweatshirts or extra blankets; nearly everyone wore short-sleeved white t-shirts with short-sleeved canvas tops and pants. Nobody had any kind of coat or jacket, even though many people in Smith walk outside regularly, including to the clinic, and all have recreation outdoors, sometimes as early as 6 a.m. People told us they wrap themselves in their blanket or even their sheets and towels while

in their cells. One person said he wore socks on his hands to warm them until they were confiscated.

It was pouring outside during our visit to Smith, and nobody we spoke with had any kind of rain gear; we watched as people walked outside, including to the clinic, with no coat or umbrella and with only cotton socks and plastic slip-ons for their feet.

We were told varying rules at the different jails about extra blankets or sweatshirts, including that they are given out at some jails on a certain day in November (although it was December and nobody had them). There should be a clear, consistent, and humane policy that provides people with sweatshirts under normal circumstances and coats and appropriate footwear for inclement weather. The County must provide for the basic needs of the people in its custody

At Smith Correctional Facility, we got numerous reports of deputies being rude, abusive, or unprofessional: [REDACTED] Building 12, said some are respectful, especially the Wednesday-Saturday regulars, but others mock them (for example, they make fun of last names, like call him "cerote," or "piece of shit") or yell at them to "get away from the glass" when they are just looking at the commissary notices. According to Mr. [REDACTED], a few weeks ago, some people were being disruptive and refusing to bunk up; they were taken to the rec yard and made to kneel on the ground for approximately 30 minutes while a sergeant (tall, white, young, works mornings) yelled at them: "They is our house!" [REDACTED] in Building 14, said that some deputies are respectful but some curse at him. [REDACTED], said deputies in Building 16 were verbally abusive and bullying (his report was echoed by at least one other person interviewed). [REDACTED], formerly in Building 16, reported the deputies there taunted him through the intercom, including calling him "faggot." [REDACTED] in Building 1, reported that he uses a wheelchair and has collapsed spinal disks and a straightened cervical spine, as well as a torn shoulder ligament, and is in a great deal of pain. He said that he had to go to mandatory rec on a Friday or Saturday in late November or early December, and it was cold outside. His sweatshirt was draped on his walker and he asked a deputy if he could put it on, but the deputy said no and put his walker and sweatshirt away out of reach. He said he was hunched over and trembling in pain and cold, and another deputy stepped in and allowed to put on his sweatshirt.

Dr. Gage reported similar concerns at Smith, noting conflicts between behavioral health and custody staff in Building 16 (p. 25), including lack of professionalism and cooperation, retaliation, and name-calling. He also noted inadequate morning meetings with nonexistent custody involvement and only one patient discussed (in contrast with much more robust meetings at RPDC) (p. 26).

7. Miscellaneous

Copays and hearing aids: Bonnie Carl confirmed that the County will implement the new state law banning copays for health care service and requiring counties to pay for durable medical equipment such as hearing aids and glasses. She said that the need for hearing aids would be evaluated on a case by case basis, and they are considering the use of amplifiers. We disagree with the use of amplifiers (sometimes called pocket talkers or Personal Sound Amplification Products) as an alternative to hearing aids. According to the United States Food and Drug Administration, consumers should not use pocket talkers as substitutes for hearing aids because they are "not intended to compensate for impaired hearing, but rather [are] intended for non-hearing-impaired consumers to amplify sounds in the environment for a number of reasons, such as for recreational activities." The FDA defines a hearing aid as a sound-amplifying device intended to compensate for impaired hearing, and pocket talkers as devices that are not intended to make up for impaired hearing. (*See* FDA, Regulatory Requirements for Hearing Aid Devices and Personal Sound Amplification Products, February 25, 2009, at 1-2 (attached); FDA, Hearing Aids and Personal Sound Amplifiers: Know the Difference, October 20, 2009 (attached).)

We strongly believe that hearing aids should be treated as durable medical equipment, and patients with suspected hearing loss be routinely referred to audiologists for testing and, if appropriate, fitting of hearing aids.

Staffing: the Remedial Plan requires an annual assessment. I was told on the tour it would be done in the first quarter of 2020; I look forward to the results.

9. Next steps

To summarize, we ask that the following actions be taken:

- Have experts on ADA accessibility standards and the removal of architectural barriers to review all housing for people with mobility disabilities, particularly the seventh floor of RPDC and A Pod at Cois Byrd, to determine how to bring them into compliance with the ADA.
- Provide supplemental training and oversight for the policy on retention of assistive devices in holding cells (for example, have supervisors do regular unannounced spot checks to ask people in the cells if they have or need any assistive devices or accessible features (such as toilets with grab bars) that are not available to them).
- Provide clear policy direction on overnight stays in holding cells, including basic measures such as a supply of blankets and toiletry items for people experiencing an overnight stay in a holding cell and medical screenings for those in the holding cells overnight to remove people who are suffering withdrawal or have significant

medical conditions requiring treatment, and to ensure people have any assistive devices they are prescribed.

- Provide clear policy direction and supplemental training and oversight to all staff, custody and health care, regarding privacy in health care appointments.
- Behavioral health: address the concerns in Dr. Gage's report, particularly regarding paucity of treatment, safety cell and restraint processes, and out of cell time. Please also send me a copy of the Program Guide.
- Investigate Ms. [redacted]'s allegations.
- Administrative and other restricted housing: continue to work toward substantially greater out of cell time for people in administrative housing and similarly restricted settings, including through more group dayroom releases; generate data on length of stay, both average and median, to inform efforts to decrease time spent under these conditions; provide workbooks and other productive means for people to pass the time.
- Revisit system-wide policies on clothing for cold and inclement weather, particularly for people who must go outside in order to obtain health care at Smith.
- Review and address the allegations regarding behavior of some custody staff at Smith.

EXHIBIT R

Grey v. Riverside

Plaintiffs' tour of Smith Correctional Facility, Cois Byrd Correctional Facility, Robert Presley Detention Center, January 28-30, 2019

On January 28-30, 2019, attorneys Sara Norman and Shira Tevah toured the Smith Correctional Facility, Cois Byrd Correctional Facility, and Robert Presley Detention Center. We spoke to a dozen or more people housed in each jail, both people we requested to see and people whose names we picked randomly from lists of patients with disabilities and medical and mental health diagnoses. We reviewed health care records for numerous patients. We also talked to custody, medical and behavioral health staff and administrators, and had a meeting with Chief Deputy Sheriff Edward Delgado; Deborah Johnson, RUHS Behavioral Health Assistant Director for Programs; Brian Betz, Behavioral Health Administrator for Detention Health Services; CMO of the County Correctional Health Mike Mesisca; Correctional Health Care Administrator Bonnie Carl; and others on the executive team.

I am grateful, as always, for the courteous and open approach that characterizes the County's response to these visits. In particular, I deeply appreciate the clear commitment to quality care from the new leaders in the Sheriff's Department and Correctional Health, and have long valued the ongoing dedication of the Behavioral Health leaders. Line staff I encountered were uniformly helpful, and the custody health care liaisons, including Sergeant Nelson at Smith, Sergeant Conn at Byrd, and Sergeant Rivera at Presley, were all impressive. Although Lieutenant Hal Reed will be sorely missed as health care liaison, given his professionalism, thoughtfulness, and problem-solving approach, we are clearly in good hands with his replacement, Lieutenant Tom Hyland.

This report is intended to document general policy and systemic issues that we raised on the tour. It is not intended as an overview or a comprehensive set of findings – those reviews are left to the Court experts -- but to memorialize concerns for ongoing discussion and to suggest measures to move more effectively towards compliance.

1. Positive developments

There are significant signs of progress. I continue to be impressed with the integration of TechCare into the care systems for the jail, allowing health care staff far greater access to essential patient information.

There were differences in how some medical patients talked about their care. Every diabetic patient we talked to at Smith and Cois Byrd was satisfied with his or her care. This is an important sign that crucial treatment systems have been developed, given that diabetic care is difficult to manage in a correctional environment. Similarly, from

the people we talked to and the TechCare files we reviewed, it appears that medication administration and start-up times after intake are significantly better. These are anecdotal findings; I will defer to the more comprehensive, data-driven findings from the Court Experts. But I did not get comparable responses from patients two years ago, and the difference is notable and praiseworthy.

2. Intake holding cells (for booking, hospital returns, and court dates)

People with disabilities continue to describe struggles with being improperly placed in inaccessible holding cells:

- [redacted], who uses a wheelchair, said at his intake to Cois Byrd three weeks ago, he spent one and a half days in a holding cell with no grab bars on the toilet. He said he slept on a bench and was not given a blanket.
- [redacted], Byrd A Pod, said that in October 2018 he spent more than 19 hours in intake at Presley. He reported that his extra-wide wheelchair did not fit in the cell doorway, so it was taken from him. He said he was given a walker instead, and could barely use it (he had been bed-bound for seven months in the hospital). He said it was then taken away from him while he was in the cell, and when he asked for it back to use the toilet, he was refused; the deputy said "figure it out." He said he did not use the toilet the whole time.

In addition, we talked to several people who said they spent extreme lengths of time in holding cells in the intake area after being discharged from the hospital:

- [redacted], currently housed in Byrd E Pod, described two experiences at Presley in August and November 2017, in which he returned from the hospital following heart attacks and spent approximately three days each time in a holding cell filled with other people, with nowhere to lie down. He described an experience at Byrd in November 2017, in which Deputy Hartman told him to move faster. He said that he could not, given his weakened heart condition. He said the deputy slammed him into the wall and told him to raise his arms, which he couldn't do because of his recent heart surgery. He said he subsequently spent three days in his cell, unable to get up, and eventually had another heart attack and was sent back to the hospital.
- [redacted] currently housed in Smith Building 15, said he spent three days in an intake cell in Riverside, from September 24-27, 2018, on his return from the hospital after falling from an upper bunk in Byrd (despite his lower bunk chrono).

We were told of several other intake problems:

- [REDACTED], said that at Smith, the week prior to the tour, he spent two to three days in a holding cell at intake with seven or eight other people, sleeping on the floor. He said they were given blankets after the first night. He was shortly thereafter found to have staph or MRSA in his finger and sent to the emergency room. The long-term stay in extremely close quarters is clearly a public health concern, given his condition; although staff could not have known of it at the time, this situation illustrates why such practices present a risk of harm to people's health.
- [REDACTED] said that last week he spent more than 12 hours in intake at Southwest while detoxing from alcohol and meth, with no blankets or food.

Lengthy stays in these holding cells, under crowded and often unsanitary conditions, are a risk for people with disabilities and medical and mental health conditions. We had a constructive discussion on the tour about ways to ensure hospital discharges go directly to a specific placement instead of spending lengthy periods in intake; we look forward to discussing potential solutions for the other concerns.

3. Confidentiality

I was pleased to see the response to my July 2018 tour report in this area: audits and training sounds like a productive approach to change staff behavior and improve confidentiality of health care information and encounters.

We continued to hear of concerns. People in Byrd complained that medical appointments in B, E, and G Pods were not confidential, with the doors open and the patients sitting near the door, which allows the deputy outside and passersby to overhear. We understand that the doors swing in so that shutting the door might still present a safety concern, since an attacker inside could block the deputy outside from intervening. We also understand there have been recent attacks on nurses, making security a particularly charged topic at present. But the compromised confidentiality and lack of individualized decision-making must be addressed. At the very least the doors should be changed for ones that swing out, so that they can be shut and the deputy outside can maintain visual supervision through the window.

In Smith, [REDACTED] told us about an incident in which, first, a deputy announced to her in the dayroom in a loud voice that she needed to come get a shot, and, second, the same deputy was inside the room with her when she had a medical encounter and received a syphilis diagnosis. Another time, she said, a nurse talking to her at the door to her dormitory—which houses 16 women—revealed her syphilis diagnosis.

We witnessed several questionable practices on this tour: In Byrd G Pod, we were waiting for the dayroom to be cleared so we could look at a particular cell. We were standing in a group outside the health care examination room, closer to the control area than to the deputy supervising the appointment. We could clearly hear the voice of the patient sitting in the chair just inside the exam room. People were coming and going in the hallway, including other people housed in the jail, and anyone passing by would be able to hear the content of the communication.

As Smith, we were walking outside and passed a deputy with a line of people who looked like workers returning from their job. She called out two of them by name, one for diabetic line and the other by asking, "you wanted to see the nurse, right?" It would be better for people not to be singled out as needing treatment, since it might discourage patients from seeking care.

4. ADA and disability access

Accessible holding cells: I was glad to see the County's response to prior concerns about inaccessible transport and holding cells. Spot checking, regular audits, and frequent interviews with the patient population sound like important remedial steps. I look forward to discussing more specifically on the next tour the results of these efforts.

There were signs of progress on this tour. Several people we talked to said that they were sometimes or usually allowed to keep their assistive devices in holding cells and uncuffed for lunch. However, there were reports of ongoing problems: for example, [REDACTED], at Cois Byrd in early January, and [REDACTED] at Presley in October 2018, detailed lengthy stays in inaccessible holding cells (see Section 2, above). [REDACTED] who is now at Presley, said that when he went to court in Banning two weeks ago, he spent four hours in a holding cell in Smith, handcuffed the entire time. He said that the deputies refused his request to uncuff his hands so he could use the toilet.

Accessible housing: People in Cois Byrd who use wheelchairs were housed inaccessibly. [REDACTED], in G Pod is a full-time wheelchair user who can barely squeeze his wheelchair through his cell door (Dayroom 2, cell 34). His cell is smaller than the others on his row and the stool in front of the desk is fixed in place instead of swinging out the way. As a result, he does not have access to the desk. Lt. Hyland agreed he should be moved and the cell should not be designated for wheelchair users.

In A Pod, the medical unit, we saw only two cells with grab bars around the toilets: 8 and 10. They were poorly placed, however: not at right angles, and with the side bar too far from the toilet. These are not accessible placements.

[REDACTED], was transferred from Byrd to Smith on December 3, 2018, because he was going to trial nearby. However, he is a full-time wheelchair user and cannot be housed accessibly at Smith. He said he had to argue with deputies about his placement and also to prevent the removal of his wheelchair. He was sent back to Byrd the next day, as the TechCare records confirm. He should never have been sent in the first place.

At Smith, we talked to [REDACTED], who is prescribed a walker but was housed on the upper tier in Building 15. This should not be allowed to happen. (He also said he was also housed on an upper bunk at Byrd in September 2018 in violation of a chrono, and rolled off, hurting his back and requiring a trip to the hospital.)

Assistive devices: [REDACTED] in Byrd A Pod, came to Byrd from Presley around October, after being in the hospital for many months. He said he came with an extra wide wheelchair, which he needs. After a short time at Byrd, he asked to move to a walker to help him start to ambulate, and he was given one, with the wheelchair kept in the hall for distance travel. But he said that the tag indicating it was his fell off, and by mid-November it had disappeared. He said he asked for it repeatedly but was told it was missing. He came to his interview with me in a shoddy wheelchair with no footrests or sides, which is not acceptable for him – his feet were dragging and he was spilling over the edges. He said he was provided with whatever wheelchair could be found when he needed one. That is unacceptable – a wheelchair is a prescription device and if his was missing, he should have been provided a replacement that met his needs. This one was not in fact missing – Sergeant Conn found it in a matter of minutes in a supply closet.

[REDACTED], housed at Smith Building 16, who uses a walker, said that he is not allowed to have it in his cell and has fallen as a result. For example, he said he was not given it for a recent court date and fell in the corridor. He said he did not ask for it because he said he had been told in the past he could not have it and deputies "made it known" he would not get it. He is seriously mentally ill; the default should be that he has his walker and is not allowed to leave without it, instead of requiring him to speak up in a situation in which he might be passive or fearful.

As a general matter, these serious incidents will keep happening unless people are allowed to keep their assistive devices at all times as the default, and custody and medical staff accept this as the rule. I do not understand why this rule has not been adopted in Riverside. The generalized safety concerns that I have been given do not stand up, given that CDCR allows people to keep their assistive devices with them at all times unless that individual has misused the device, and has operated even maximum security yards in this way for many years.

The rule seems to extend to even apparently innocuous medical devices. [redacted], in Byrd E Pod, said he was not allowed to keep a compression pillow in 2017 when he returned to Byrd after bypass surgery; it was removed for security reasons. He said that a staff member later secretly gave him a blanket wrapped up to resemble the pillow, which he said was useful and for which he was immensely grateful.

Housing accommodations: Several people with disabilities interviewed on the 7th floor of Presley said that they sometimes have difficulty getting off their beds and coming to the door to get their medications: for example, [redacted] said that his left side is paralyzed from a stroke and he sometimes has difficulty getting up. Patients said that most nurses will not take the medications to the patients in bed, but instead require them to come to the door. They were very appreciative of the one nurse who will accommodate them in this way. It seems like a small measure to accommodate certain people whose disabilities make this effort difficult.

Why not allow people with mobility impairments on the 7th floor at Presley to have the TV remote control in their dorms? The current process requires them to flag down a passing deputy to turn the channel, which adds to the deputies' workload and can be difficult for people with mobility impairments. Sheriffs' department administrators brainstormed ways this can be accomplished at our meeting; I look forward to hearing about implementation on my next tour.

5. Staffing

The Remedial Plan requires an annual staffing review and analysis. I would like to receive documentation of this review.

I noted significant vacancies for medical staff: the assistant administrator, the UM nurse, two of four QA coordinators, two of seven MDs, two of nine NPs, three of nine senior nurses, three telemedicine nurses, and four of 13 medical records technicians. For behavioral health, the staffing looks fairly good, with only one psychiatrist at Riverside and several recreation therapist positions vacant.

6. Behavioral health

The patients we interviewed in the mental health unit at Smith (Building 16) were generally getting the medications they believed they needed, but reported a dearth of groups and very few one-on-one meetings with behavioral health staff. Many of them presented very obvious symptoms of mental illness. Those who did receive group or individualized treatment found it valuable. We were glad to hear that six clinical therapists were hired in December – that will hopefully make a big difference in providing treatment to this population.

We heard from these patients that their dayroom time is separated for the upper and lower tiers. In other words, the 16 people on the upper tier and the 16 people on the lower tier are given dayroom at separate times, which halves the available out-of-cell time for all of them. There did not appear to be a security justification for limiting all the patients in this way. If some individuals are not appropriate to come out to dayroom with the entire group, due to past behavior or clinically determined limitations, surely others can. I suggested on the tour that staff explore the use of extra dayroom time as an incentive for people who can program with everyone?

We also passed on to staff the names of several patients who seemed in significant distress and asked that they be seen: At Smith, ██████ (whom we heard about from another patient), ██████ ██████ (who subsequent to our interview had been placed in a safety cell), and ██████ ██████

7. Miscellaneous

We heard some complaints from patients that they were charged copays for medical encounters to get lab results from an HIV blood test or diabetic compression socks, which seem like they could fall under chronic care exceptions. I ask that you send copies of your policies on copay charges and any other health care charges, including any exceptions for indigent patients.

On the next tour, I would like to discuss treatment for Hepatitis C, which we discussed briefly at our final meeting. We were given an "active HCV" list but we didn't talk to anyone actually getting treatment yet.

8. Individual health care concerns

We raised the following individual concerns with staff at the facilities, but request a response as to any follow-up.

Cois Byrd Detention Center

██████, B Pod: Mr. ██████ told me that he is 74 years old and that he has dementia and was detoxing from methadone maintenance. He was not listed on the detox list we were provided. He was shaking with cold when I saw him, although I was told that he was quickly provided with a sweatshirt after I requested it. Given his age and his self-reported dementia, detoxing, and heart condition, he is medically fragile and should have been followed more closely.

██████ F Pod: I am concerned that Mr. ██████ serious injury might have been missed by a nurse, and an appointment with a provider that might have caught the problem never took place. On Saturday, January 12, 2019, Mr. ██████

injured his hand. I confirmed in TechCare that he saw a nurse, who indicated he would be seen on MD sick call the following Monday. He was never seen, and not examined until a different nurse saw him the following Saturday and immediately sent him to the hospital, where he was found to have a fracture and recommended for orthopedic evaluation as soon as possible. This case should be reviewed for possible violations of emergency protocols and follow-up care requirements.

[REDACTED] told us that he had previously entered the jail and received bridging medications right away, but upon his most recent reentry he had not received his medications for over a week. He believed he would be leaving the jail on January 26 and wanted to make sure he had a 30-day supply upon release. He also told us that during his prior release around January 17, he had been dropped off at 2 a.m. in a place he did not recognize, in the rain and without shoes.

[REDACTED] described having been interrogated by law enforcement at the Sheriff's department for approximately 40 hours, while detoxing, and without food, before being brought to the jail.

Smith Correctional Facility

[REDACTED] who was 12 weeks pregnant upon arrival at Smith, informed us that she has lupus. She said the doctor she saw at 19 weeks pregnant at Moreno Valley Hospital prescribed lupus medication (that her prior doctor had discontinued before she was arrested), but that it took 12-13 weeks after her arrest for her to receive the medication in custody. She told us that she experienced lupus flare-ups in the interim. Ms. [REDACTED] was also concerned about getting to see a rheumatologist and making sure there would not be a lapse in the lupus medication.

[REDACTED] had just arrived at the facility the day before our tour. He informed us that he takes a sleeping aid, as well as medication for anxiety, depression, and schizophrenia. He told us that he had called the police in the midst of a mental health episode or breakdown because he felt he needed help, which resulted in his arrest. He said that although he spoke to mental health staff at the jail during intake, he had not spoken to any mental health staff since then although he asked to. He let us know he has a history of self-harming behavior and he wasn't sure if he was OK.

Robert Presley Detention Center

The trays that hold health care request forms (blue slips) and grievances were empty on the second floor A side in all three dayrooms. They were also missing in one of the dayrooms on the B side of the sixth floor. We did not do a systematic review, but the fact that four of the five dayrooms we observed were missing the forms indicates a widespread problem. Staff in one unit said that people take the papers and use them for

other purposes, but the management difficulties that entails do not excuse the failure to have them readily available for people who need them for their intended purpose.

[REDACTED] was housed on the 7th floor. He said that he receives dialysis at the jail but does not have any resources to continue this care or connections to help him in the area when he is released, which he thinks will be in the third or fourth week of February. Similarly, [REDACTED] also on the 7th floor, said that he was at a nursing home when he was arrested, and uses a wheelchair due to a below-the-knee amputation on his left side (with no prosthetic) and a recent partial amputation of his right foot. He said that he cannot return to the nursing home and has no resources to find a place to live on release, which he believes will be in February or March. We were told on the tour that the case managers can help them with discharge planning, which is good to hear.

[REDACTED] a wheelchair user on the 7th floor, said that he is occasionally incontinent and it can be hard to get diapers and extra clothing from staff when he soils himself.

[REDACTED], told us that he had requested to be evaluated for his Hepatitis C seven months prior, and had never received any response to his request.

[REDACTED] informed us that she has lupus but was not receiving any treatment for it at the jail. She believed she previously received prednisone shots at the hospital when she was detained at Smith. She also described a medical emergency incident around January 27, 2019, in which she threw her back out and was unable to move, and a nurse and deputy came into her cell. After the nurse examined her and called the doctor, who prescribed muscle relaxers, Ms. [REDACTED] said the nurse came back to administer the medication, and the deputy accompanied the nurse into the cell again although both the nurse and the deputy knew at that point that Ms. [REDACTED] was immobilized by back pain.

9. Next steps

To summarize, we ask for the following actions:

1. **Intake holding cells:** We ask that the County review its practices on keeping people in holding cells during booking, processing in and out of court, and particularly for medical transfers and hospital returns, and ensure that stays are shortened and that conditions are carefully monitored. People must have accessible placements and access to their assistive devices. On the tour, we discussed ways in which hospital returns could be planned so that people spend minimal time in intake, and are moved directly into a waiting, accessible cell. I

am grateful for the creativity and problem-solving approach and look forward to hearing solutions for these patients as well as more generally.

2. **Confidentiality:** We applaud the efforts already undertaken, but more must be done with the physical plant, such as the doors in Byrd exam rooms, and to raise staff consciousness that health care appointments and communication about health-related matters should be conducted in as confidential a manner as possible.

3. **Accessible holding cells and accessible housing:** The County must determine which housing placements are accessible for which disabilities, and do a regular review to ensure people are accessibly placed (ground floor, lower bunk, wheelchair accessible cells, etc.) Lieutenant Reed already started working on a plan for this with Sergeant Nelson in Smith, to do weekly reviews. That is an excellent step. But there must also be a system to review transfers of people with disabilities before the fact, including hospital discharges, and to ensure they are being sent to open and accessible placements, and accommodated in in accessible holding cells along the way.

4. **Assistive devices:** People should be allowed to keep their assistive devices at all times as the default, and custody and medical staff should be trained accept this as the rule. Exceptions should be made only for patients who misuse their own devices.

5. **Staffing:** Please provide documentation of the annual staffing review and analysis required by the Remedial Plan.

6. **Dayroom time for mental health programs (Smith Building 16):** We ask that the County review dayroom time policies in the mental health buildings to try to give as much out-of-cell time to the population as possible, including using additional dayroom as an incentive for patients to learn to program in larger groups.

7. **Policies:** Please provide any policies on copay charges and any other health care charges, including any exceptions for indigent patients. Please also provide any Hepatitis C treatment policies or protocols.

8. **Individual concerns:** Please provide responses on the individual concerns that we raised on the tour and repeated in this report.

EXHIBIT S

CDCR Announces Plan to Further Protect Staff and Inmates from the Spread of COVID-19 in State Prisons

March 31, 2020

Plan will create increased capacity and space to help with inmate movement, physical distancing, isolation efforts

The department has taken several actions to mitigate the spread of COVID-19, including temporarily suspending the intake of new inmates, cancellation of in-person visiting, practicing physical distancing, and providing hand sanitizer across the system

SACRAMENTO – Today, the California Department of Corrections and Rehabilitation (CDCR) is amplifying actions to protect staff and inmates at the state's institutions by implementing additional measures to help mitigate the spread of COVID-19. The measures will increase both capacity and physical space at the state's prisons, which will allow the department to increase physical distancing, and assist it with isolation and quarantine efforts for suspected or positive COVID-19 cases.

CDCR's plan includes expediting the transition to parole for eligible inmates who have 60 days or less to serve on their sentences and are not currently serving time for a violent crime as defined by law, a sex offense, or domestic violence. The plan also includes making more use of the state's private and public Community Correctional Facilities, as well maximizing open spaces in the prisons, such as gymnasiums, to increase capacity and inmate movement options.

"We do not take these new measures lightly. Our first commitment at CDCR is ensuring safety – of our staff, of the incarcerated population, of others inside our institutions, and of the community at large," said CDCR Secretary Ralph Diaz. "However, in the face of a global pandemic, we must consider the risk of COVID-19 infection as a grave threat to safety, too."

These new measures build on many others already taken to reduce the risk of COVID-19 to all who work and live in the state prison system. Those measures include:

- Mandatory verbal and temperature screenings for staff before they enter any institutions and other CDCR work sites
- Suspension of intake from county jails, projected to reduce the population by 3,000 within 30 days
- Suspension of visitation; inmates will get additional free phone calls to their loved ones, made available through a partnership with inmate telephone network provider Global Tel Link (GTL)
- Suspension of access by volunteers and rehabilitative program providers
- Suspension of inmate movement, other than for critical purposes

- Measures to support increased physical distancing, including reducing the number of inmates who use common spaces at the same time
- Reinforced commitment to hygiene both institutional and personal, including greater availability of soap and hand sanitizer.

- Developed comprehensive health care guidelines based on CDC and CDPH recommendations for correctional settings, which includes procedures for infection control, assessment, testing, treatment, proper use of PPE and quarantine/isolation. Deployed educational materials for staff on the new guidelines, including posters, quick reference pocket guides, webinars and websites.
- Modified the delivery of non-emergent health care procedures such as routine dentals cleanings to redirect supplies of PPE. Created a network among all state-managed facilities to redirect PPE as needed.
- Created handouts, posters and continually updated video messaging for the population about COVID-19 and what CDCR and CCHCS is doing to respond to the virus.

As of March 30, 22 employees and four inmates have tested positive for COVID-19. For updated information, please view the department's Patient Testing Tracker.

CDCR estimates that up to 3,500 incarcerated persons would be eligible for an expedited transition to parole. The department is preparing on-site multidisciplinary teams at each institution to expedite the pre-release coordination. Review of potential expedited transition will first focus on those with less than 30 days to serve, then those with less than 60 days to serve. Returning individuals will release to state parole or local probation supervision, or will discharge, depending on their individual sentence.

CDCR will also immediately expand space in community-based parolee programs, particularly for those at risk of homelessness or housing instability. Additionally, the department has been in communication with its county partners regarding these measures and will coordinate with them to promote a successful reentry. Finally, all victim notification requirements are being met.

For updates and information on CDCR's efforts to protect staff and inmates from COVID-19, visit here. For Frequently Asked Questions on this plan, visit here.

EXHIBIT T

Sara Norman

From: Sara Norman
Sent: Tuesday, March 31, 2020 7:56 PM
To: 'Brown, Jeb'
Subject: RE: Emergency proposal for modification of the Remedial Plan

Thanks, Jeb.

I look forward to reading the response from Dr. Mesisca. But both experts' reports as well as my proposal to modify the Remedial Plan focus on reduction of population density to allow physical distancing. I do not believe that is under Dr. Mesisca's control.

Will I hear from the Sheriff's Department on population reduction and physical distancing in the jails?

--Sara

From: Brown, Jeb [mailto:JebBrown@RIVCO.ORG]
Sent: Tuesday, March 31, 2020 7:24 PM
To: Sara Norman <snorman@prisonlaw.com>
Subject: Re: Emergency proposal for modification of the Remedial Plan

Sara:

I discussed the issues with Dr. Mesisca and he is preparing a written response to Dr. Allen's proposal. He advised that we are complying with the overwhelming majority of Dr. Allen's suggestions. I hope to receive that document tonight.

By way of background, Dr. Mesisca is providing medical assistance and guidance to the Emergency Operations Center. He is also working as a doctor in our emergency room. I know that these other duties, and the other duties that all County management are dealing with in attempting to manage this crisis take away from your focus on the inmates. I only share this information as background. Your concerns, and the concerns for the inmates are not being ignored. However, they are only one facet in the complex crisis response for 2.5 million county residents.

I am confident that we will be able to satisfactorily address all of your concerns and will be able to reach a mutually agreeable solution.

I'll get our written response to you as soon as I receive it.

Thanks.

Jeb

Sent from my iPad

> On Mar 31, 2020, at 12:05, Sara Norman <snorman@prisonlaw.com> wrote:
>
> Hi Jeb,

I would very much like to handle the concerns Scott and I have both raised in a collaborative way and I still hope that we can. But
I want to be clear – I am preparing an emergency motion with the Court. At this point I see no other way to proceed, since despite repeated requests to speak to County decision-makers, I have never received any information other than the fairly vague responses on March 22, nine days ago.

Please let me know as soon as possible when I can talk to County decision-makers, when I will have substantive answers to the questions I raised on March 22, and when I can expect to hear the County's response to Scott's report and my proposal to modify the Remedial Plan.

--Sara

From: Brown, Jeb [mailto:JebBrown@RIVCO.ORG]
Sent: Tuesday, March 31, 2020 11:35 AM
To: Sara Norman <snorman@prisonlaw.com>
Subject: Re: Emergency proposal for modification of the Remedial Plan

Hi Sara. Sorry for the delay, I've been working through some administrative issues.

Let me circle back with the team here regarding Dr. Allen's proposal. Hopefully we can talk sometime either later today or tomorrow.

I'll stay in touch so we can address these important issues ASAP.

Thanks.

Sent from my iPad

> On Mar 31, 2020, at 09:10, Sara Norman <snorman@prisonlaw.com> wrote:
>
> Hi Jeb,
>
> When can we talk? Scott's report is very clear and I need to know whether the County is willing to follow his direction. The only substantive information I have received from you in response to my queries was on March 22, and my follow-up questions sent that day were never answered. Please call me this morning.
>
> --Sara
>
> ---
>
> **From:** Brown, Jeb [mailto:JebBrown@RIVCO.ORG]
> **Sent:** Monday, March 30, 2020 1:54 PM
> **To:** Sara Norman <snorman@prisonlaw.com>
> **Subject:** Re: Emergency proposal for modification of the Remedial Plan
>
> Sara:

I've received your email and have a meeting later today to discuss. I will get back to you ASAP.

Thanks.

Jeb

James E. "Jeb" Brown
Assistant County Counsel
3960 Orange Street, 5th Floor
Riverside, CA 92501
951.955.6300
jebbrown@rivco.org

Sent from my iPhone

On Mar 30, 2020, at 13:50, Sara Norman <snorman@prisonlaw.com> wrote:

CAUTION: This email originated externally from the **Riverside County** email system.
DO NOT click links or open attachments unless you recognize the sender and know the content is safe.

Dear Jeb, Scott, and Bruce:

I write to include an additional measure that I believe is essential to include in the Remedial Plan in order to maintain constitutional healthcare standards:

> The Remedial Plan must further be modified to require the County to provide, in cases of public health emergencies, ample free soap for personal use, cleaning supplies to sanitize cells and common living areas, and public health education regarding handwashing, sanitizing, and social distancing.

Thank you to all of you for reviewing this modification request. I know that these are extraordinarily difficult and demanding times for us all, but I hope that you are able to respond quickly with your positions. I very much hope that we are able to proceed with the spirit of collaboration that has been the hallmark of the remedial process to date, and that you understand that my obligation to my clients compels me to urge these measures that I believe are essential.

--Sara

From: Sara Norman [mailto:snorman@prisonlaw.com]
Sent: Saturday, March 28, 2020 6:21 PM
To: 'Brown, Jeb' <JebBrown@RIVCO.ORG>
Cc: 'Scott Allen' <Scott.Allen@medsch.ucr.edu>; 'Bruce Gage'

<gage@pugetsoundmentalhealth.com>; 'Moran, Kelly' <KMoran@RIVCO.ORG>
Subject: Emergency proposal for modification of the Remedial Plan

Dear Jeb:

I write to submit a proposed modification of the *Gray v. Riverside* Remedial Plan on an emergency basis.

The Consent Decree states that "The Remedial Plan is designed to meet the minimum level of health care necessary to fulfill Defendant's obligations under the Eighth and Fourteenth Amendments." Consent Decree ¶ 9. It further states that "Plaintiffs may seek to modify the Remedial Plan if the plan does not effectively [ensure provision of constitutional care], or a modification is necessary to ensure Plaintiff class members receive adequate healthcare under the Eighth and Fourteenth Amendment to the United States Constitution." *Id.* ¶ 11.

The coronavirus has the capacity to spread like wildfire inside correctional settings, as numerous corrections and public health experts have warned. *See* attached declarations of Dr. Marc Stern and Dr. Craig Haney, filed in *Plata/Coleman v. Newsom*, attached. Riverside County is no exception, and the ravages of the virus are poised to overwhelm the medical and mental health care delivery system capacity in the jails. In light of the pandemic, the Remedial Plan no longer can effectively meet the healthcare needs of the Plaintiff class and a modification is required to ensure they receive constitutional care.

Plaintiffs believe that the Remedial Plan must be modified to address the dangers of the coronavirus pandemic in two ways. First, every Californian was ordered by the Governor to practice social distancing in order to slow the spread of the virus and save lives. Social distancing is impossible in many of the crowded dormitories in the County's five jails. Second, many people living in the jails are elderly and have underlying medical conditions that make them particularly vulnerable to severe complications or death. The Remedial Plan must be modified to require (a) the release of enough people living in the jail to allow for social distancing in all living spaces, and (b) the release of elderly and high-risk patients to protect them from the dangers of the pandemic behind bars.

The Sheriff has the power to effect these releases. Section 8658 of the California Government Code provides specific direction to counties in the case of emergencies like today's pandemic:

> In any case in which an emergency endangering the lives of inmates of a state, county, or city penal or correctional institution has occurred or is imminent, the person in

charge of the institution may remove the inmates from the institution. He shall, if possible, remove them to a safe and convenient place and there confine them as long as may be necessary to avoid the danger, or, if that is not possible, may release them. Such person shall not be held liable, civilly or criminally, for acts performed pursuant to this section.

Pursuant to the Consent Decree, "Any party wishing to modify the plan must submit a proposed modification to the opposing party. The opposing party may request further information, request that the modification(s) be reviewed by the Court's experts, and/or request that the proposed modification(s) be subjected to the dispute resolution process described below. If the parties fail to reach agreement on the proposed modification(s), the party proposing the modification(s) may seek relief from the Court." Consent Decree, ¶ 14.

In light of the urgent nature of this situation, along with the request for a modification I am simultaneously asking that the Court experts review Plaintiffs' proposal and provide a response as soon as possible. (The Consent Decree at ¶ 13 also allows either party to request a report from the Court experts.) I further request that if Defendant disagrees with the proposal, you waive the dispute resolution process and agree to an expedited briefing schedule before the Court.

Please call me to discuss this matter as soon as possible.

--Sara

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County of Riverside California

EXHIBIT U

Sara Norman

From: Sara Norman
Sent: Wednesday, April 1, 2020 7:39 PM
To: 'Brown, Jeb'
Subject: RE: Update

Hi Jeb,

I still don't have anything. I am available any time tomorrow after 3 to discuss my proposal, the expert reports, and any plan you send. Let me know when you are available.

--Sara

-----Original Message-----
From: Brown, Jeb [mailto:JebBrown@RIVCO.ORG]
Sent: Wednesday, April 1, 2020 12:42 PM
To: Sara Norman <snorman@prisonlaw.com>
Subject: Update

Sara:

Just want to update you. Correctional Health is finalizing the response to Dr. Allen's proposal. I hope to have it later this afternoon. I'll send it to you as soon as I get it.

Once you've reviewed it we can schedule a call to discuss.

Thanks.

Jeb

James E. "Jeb" Brown
Assistant County Counsel
3960 Orange Street, 5th Floor
Riverside, CA 92501
951.955.6300
jebbrown@rivco.org

Sent from my iPhone
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County of Riverside California <http://www.countyofriverside.us/>

EXHIBIT V

Sara Norman

From: Sara Norman
Sent: Friday, April 3, 2020 11:32 AM
To: 'Brown, Jeb'
Subject: RE: Friday Update

Hi Jeb,

I'm terribly sorry for these losses and for the devastation to their families and community and to the Sheriff's Department.

Please let me know when we can talk.

Hope you are safe and well.

--Sara

-----Original Message-----
From: Brown, Jeb [mailto:JebBrown@RIVCO.ORG]
Sent: Friday, April 3, 2020 10:50 AM
To: Sara Norman <snorman@prisonlaw.com>
Subject: Friday Update

Sara:

More tragic news. Another Riverside deputy with COVID-19 passed away.

As you can imagine, RSO is focused on the families of the deputies who have passed away and those with a positive diagnosis.

As soon as I get the information from them in response to Allen's proposal, I will share it with you.

Thanks.

Jeb

James E. "Jeb" Brown
Assistant County Counsel
3960 Orange Street, 5th Floor
Riverside, CA 92501
951.955.6300
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