













Of remaining concern are uses of force involving inmates on the mental health caseload, and the application of tactics to deescalate the situation, absent an emergency. Sixty-nine percent (69%) of uses of force for the first quarter of 2018 (N=214) involved inmates on the mental health caseload. In another set of data, MDCR reported that 81% of incidents (as opposed to individual inmates) involved inmates on the mental health caseload. This data is confusing, and the Monitor recommends that the two data sources be reviewed and clarified.<sup>2</sup>

Since, and including the last compliance tour of December 2017, there have been five inmate deaths; three related to acute drug toxicity, and two in which the medical examiner's report is not complete. The introduction of highly toxic drugs, easily hidden, into jails around the country has been an on-going challenge for jail administrators. The two deaths in early December 2017 resulted in approval to purchase screening equipment for the inmate booking area. This equipment is being operationalized at this time.

### Staffing

The Director reports that the County's administration supports the staffing identified as a result of the 2018 staffing analysis. It is now up to the Board of County Commissioners to approve the budget.

While there has been notable improvement in the County's administrative response to the needs of MDCR, the Monitors suggest that priority be given to filling vacancies as fast as is practical, especially those related to the anti-violence initiatives, fire life safety, and sanitation.

### Classification

The Monitor recommended in Compliance Report # 8 "... that the County immediately contract with a subject matter expert to evaluate the current inmate classification processes, identify future needs, develop a validation plan (with and without the implementation of the new offender management system – see below), manage the collaboration in risk assessment for CHS and MDCR, assure that appropriate written directives and associated training materials are developed, and train/mentor staff."

The County is just now negotiating with a subject matter expert.

While MDCR embarked on data analyses of classification information using available software (e.g. Watson), this has not replaced the need for the input of a subject matter expert. The data presented to the Monitor is interesting and points to the

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<sup>2</sup> The first set of data is from the violence report for the first quarter of 2018; the second set of data is from the response to resistance incidents self-audit for the first quarter of 2018.

need for further review and recommendations. As noted in other compliance reports, the Monitor is concerned that the level of violence in the facilities might be related to the effectiveness of the classification system. The recent addition of inmate disciplinary information into reclassifications, and the plan to add gang affiliation are improvements.

Most all of the strategies/countermeasures to address violence involve classification. The language of the Settlement Agreement regarding classification (SA III.A.1. (2)) provides that the Monitor annually reviews the classification system to determine if the system accomplishes the “. . . goal of housing inmates based on level of risk and supervisory needs.” The Monitor remains unable to determine this based on currently available data.

### Investigative Capacities and Protection from Harm

In Compliance Report # 8, the Monitor recommended a thorough review of the processes, staffing, and supervision of internal investigations in MDCR – those involving allegations of staff misconduct, excessive uses of force, and inmate violence/critical misconduct.<sup>3</sup> The Director and the Deputy Mayor reviewed the Monitor’s recommendations and are re-implementing the gang unit, and exploring assignment of cross-certified staff in MDCR to conduct investigations, relieving the police department of the responsibilities. The initiatives are not yet implemented, and the Monitor will review the efforts again during the next compliance tour. As noted in this report, in the first quarter of 2018, 43% of the reasons for inmate/inmate assaults was undetermined. As 48% of uses of force are used to break up inmate/inmate altercations, accurately investigating the reasons for these assaults is of important to the level of violence.

### Inmate Grievance Process

Following compliance tour # 8, MDCR and CHS established a grievance task force to review the grievance processes and develop an action plan. This work resulted in changes to the process, including the placing of grievance boxes in all inmate housing units, and better coordination with CHS.

The Medical and Mental Health Monitors have assessed the companion paragraphs in the Consent Agreement to be in partial compliance; hence as it is the same grievance process, the relevant section in the SA is in partial compliance. The Medical and Mental Health Monitors are encouraged by the progress, but find that the strategies are too new to evaluate in terms of impact, and need the County to demonstrate sustainability of the new initiatives.

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<sup>3</sup> Settlement Agreement, III. A. 5. e.

### Violence Countermeasures

As noted above, MDCR has engaged in aggressive data driven strategies to address violence. This work is proceeding expeditiously; but not yielding the desired results. The Monitor suggested to MDCR that the work be sequenced, as the accomplishment of the goals is really influenced by what work is completed when. For example, a significant finding in the analysis is that the inmate disciplinary process requires attention. Other elements of the action plan are proceeding, but it may be that until the disciplinary issues are solved that other actions will not find success. Adoption of direct supervision philosophies as a strategy to address violence also require alignment with these initiatives with current operations, for example, how inmate housing units are managed, and the role and responsibilities of officers and their authority better defined.

### Offender Management System

As noted in all previous compliance reports, MDCR is the eight largest local jail system in the United States and is working with an information system that is woefully outdated and inadequate. The County's plan to agree that the inmate telephone vendor would provide a management system, free of charge, if the telephone contract was approved for inmate telephones has not proven successful. Almost four years later, the vendor is in default of their commitment and the County/MDCR must start over with identifying a new vendor. This *significant* delay impacts all areas of operation. Related to compliance with the Settlement Agreement, it is especially important for classification. MDCR has done a credible job of piecing together various software options to provide data.

### Obtaining and Sustaining Compliance

A compliance coordinator was hired in early 2017 to oversee and coordinate the work related gaining compliance with both the Settlement Agreement and Consent Agreement. She resigned from the position in February 2018. This position remains vacant, with the Chief of the division designated as responsible for the compliance-related work, along with her other duties. The Monitor urges the County to expeditiously fill the position. The Monitor's view is that the results of this tour are reflective of the need for this additional laser-like focus on assistance with, production of, and review of compliance-related materials.

### Collaboration with CHS

The Monitors remain convinced that the leadership of CHS and MDCR are equally committed to collaboration and mutual problem-solving. This message and actions have been slow to seep throughout both organizations. The newly named Corporate CHS director brings a wealth of experience and leadership to the position.

## Fire and Life Safety

These provisions of the Settlement Agreement remain in compliance. The suggestions of the sub-Monitor are that MDCR do more *analysis* of the source logs and data. Only maintaining logs without review and corrective actions, as needed, is not productive.

## Self-Audits and Critical Self-Analysis

In anticipation of Compliance Tour #9, MDCR provided deliverables to the Monitor based on a self-audit schedule agreed to in January 2018. As noted above, MDCR provided self-audits of critical paragraphs of the Settlement Agreement. The purpose of these audits are to demonstrate not only compliance with the Settlement Agreement, but adherence to MDCR's own policies and procedures and sustainability. These audits and reviews included:

- Improvements in data collection (III.D.1.2.)
- Countermeasure (III.A.5.c. (11) (14))
- Early warning system (III.A.6.a.b.)
- Classification (III.A.1.a.(2))
- Rounds conducted by staff; logs; and welfare checks (III.A.1.a. (3)(4) (6) (7))
- Shakedowns (III.A.1.a.(8))
- Training for staff transferred and those working in special management units (III. A. a. (9) (10))
- Staffing for medical escorts (III.A.2.b.)
- Chemical control, security equipment (III.A.5.c. (13))
- Early warning system (III.A.6.)
- Inmate grievances (III.C.)
- Outcomes of staff discipline related to allegations of inappropriate or excessive uses of form (III.A.6.a.)
- Fire drills and related staff training (III.B.4.)
- Supervision of chemicals and inmate and staff training (III.B.5.)

MDCR is commended for production of this work. As an initial effort, the work is credible, and identified areas that need improvement which most likely would not have been found without the audits. When MDCR found deficiencies, they were so reported. In most cases, where deficiencies were identified, action plans were developed. As the process evolves, the audits will be more accurate, and the scope of the action plans broadened.

The deficiencies identified in many of the County's self-audits impacted the findings of compliance in this report. The County argues in its response to changes in compliance noted in draft report #9 that the County's self-audits should not be considered by the Monitor: (1) because the methodology of the audits was flawed; and/or (2) the findings were incorrect; and/or (3) the audits are not included in the measures of compliance, and therefore not "required". The Monitor's findings and reasons are identified in the relevant paragraphs. Generally, the Monitor rejects the position that just, because the audits were

not part of the measures of compliance, they should not be considered in determining compliance. If the County wished to object to the production of the specific self-audits identified in Compliance Report # 8, it should have done so in January, 2018. The goal of producing these self-audits was for the County to begin to demonstrate that they had the capacity for self-monitoring, leading to compliance, and sustainability of compliance.

Sufficient time has not passed between the production of the action plans and the compliance tour to assess the success of the activities. This is the self-analyses and critical review of operations that will sustain compliance with the provisions of the Settlement Agreement and accepted correctional practices. The Monitor will follow-up prior to the next compliance tour.

The Monitor suggested that the Compliance and Inspection Bureau develop and publish a schedule for audits; and this has been done. The Monitor will notify MDCR of the audits she would like to see prior to the next compliance tour, to avoid duplication of work. Additionally, the Monitor suggests that as the process is implemented: (1) a format be developed for the audit reports; (2) assignment of sufficient leadership review of the final drafts to pose other questions and/or suggest other recommendations; and (3) that as many management staff be involved as reasonable to inculcate this approach (e.g. self-critical analysis) through the organization. Only through implementing such this process will the organization sustain the improvements.

There are four paragraphs in the Settlement Agreement which collectively speak to the issues of data collection, analysis, corrective actions, compliance and sustainability. These are:

III. A. a. (11) - MDCR shall continue its efforts to reduce inmate-on-inmate violence in each Jail facility annually after the Effective Date. If reductions in violence do not occur in any given year, the County shall demonstrate that its systems for minimizing inmate-on-inmate violence are operating effectively.

III. A. 5.c. (12) - Every 180 days, MDCR shall evaluate use of force reviews for quality, trends and appropriate corrective action, including the quality of the reports, in accordance with MDCR's use of force policy.

III. D. 2. - 2. Bi-annual Reports

a. Starting within 180 days of the Effective Date, MDCR will provide to the United States and the Monitor bi-annual reports regarding the following:

- (1) Total number of inmate disciplinary reports
- (2) Safety and supervision efforts. The report will include:
  - i. a listing of maximum security inmates who continue to be housed in dormitory settings;
  - ii. a listing of all dangerous contraband seized, including the type of contraband, date of seizure, location and shift of seizure; and
  - iii. a listing of inmates transferred to another housing unit because of disciplinary action or misconduct.

- (3) Staffing levels. The report will include:
    - i. a listing of each post and position needed at the Jail;
    - ii. the number of hours needed for each post and position at the Jail;
    - iii. a listing of correctional staff hired to oversee the Jail;
    - iv. a listing of correctional staff working overtime; and
    - v. a listing of supervisors working overtime.
  - (4) Reportable incidents. The report will include:
    - i. a brief summary of all reportable incidents, by type and date;
    - ii. data on inmates-on-inmate violence and a brief summary of whether there is an increase or decrease in violence;
    - iii. a brief summary of whether inmates involved in violent incidents were properly classified and placed in proper housing;
    - iv. number of reported incidents of sexual abuse, the investigating entity, and the outcome of the investigation;
    - v. a description of all suicides and in-custody deaths, including the date, name of inmate, and housing unit;
    - vi. number of inmate grievances screened for allegations of misconduct and a summary of staff response; and
    - vii. number of grievances referred to IA for investigation.
- b. The County will analyze these reports and take appropriate corrective action within the following quarter, including changes to policy, training, and accountability measures.

IV. B. - The County shall develop and implement written Quality Improvement policies and procedures adequate to identify and address serious deficiencies in protection from harm and fire and life safety to assess and ensure compliance with the terms of this Agreement on an ongoing basis.

At this time, two of the paragraphs are assessed in compliance (III.A.5.c. (11)-(12), and the other paragraphs are assessed in partial compliance.

The Monitor closely reviewed the MDCR's self-audits, referenced above, the pre-tour and post-tour documentation, and referred to meetings held during the on-site compliance tour.<sup>4</sup> While it is absolutely acceptable to continually assess strategies and provide mid-course corrections, there is no sustainable successful findings to MDCR's work to this point. As noted in the documents reviewed, many audits/reports were provided just prior to, or on-site during the compliance tour or just after the tour (revised reports). While this new information is appreciated by the Monitor as an indication of MDCR's attention, it has few

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<sup>4</sup> The documents reviewed, included, but were not limited to: PowerPoint presentation regarding Response to Resistance (RTR) and Battery on Inmate (BOI) Reduction Initiative, MDCR Court Corrections Provision SA III.A.1.a (11) Updated July 5, 2018, MDCR Inmate Violence Countermeasures Implementation Matrix – Updated 7/4/18, Quarterly Review of Response to Resistance Reports, Updated July 5, 2018, MDCR Course Corrections, 7/9/18, Quality Improvement Procedures and Protection from Harm, dated June 8, 2018, Inmate Classification System Analysis and Refinement (presentation and notebook) dated July 7, 2018.

sustainable outcomes, at this point. In fact, many of the elements of the action plans have dates through the end of 2018.

The work that MDCR needs to conclude, include, but is not limited to:

- Complete the review of the underlying causes of inmate/inmate violence, including a full and complete assessment of the effectiveness of the current inmate classification system.
- Improve investigations of inmate/inmate violence in order to determine, to the best of the investigator's abilities, the circumstances contributing to the violence.
- As noted above, sequence the countermeasures to provide a more realistic plan to address violence. (For example, addressing the deficiencies in the inmate disciplinary system as an underlying cause of inmate actions, recognizing until that matter is addressed, results of the application of other strategies may not yield reliable information.)
- Produce action plans with increased accountability and the production of underlying data to support conclusions/outcomes.
- Provision/scheduling of employee training related to the reduction strategies. For example, the Compliance Report has included recommendations for direct supervision training for staff for several years, which is not fully underway at this time.
- Implement improved investigations, training of investigators, and inclusion of gang-related data.
- Implement the Quality Improvement Procedures and Protection from Harm, dated June 8, 2018, including schedules for auditing. Committees, meetings, and other collaborations are important, but do not replace the data collection and analysis needed to support the Quality Improvement program.
- As noted in this, and previous Compliance Reports, address the quality and substance of quarterly, biannual and annual reporting, focusing on the data that is relevant to leadership decision making and corrective actions. Analyze the data, discuss the implications, develop findings and recommendations, and prepare and implement corrective action plans.

MDCR has, in the Monitor's view, the capacity to reach compliance on these important areas, but needs a clear assessment of current operations and organization, and implementation of any changes based on the leadership's review of this assessment.

### **Link Between Consent Agreement and Settlement Agreement**

The County, in their response to the draft reports, now and in the past, objects to the Monitors' assessing compliance of paragraphs in the Settlement Agreement based on the findings of companion/related paragraphs in the Consent Agreement. For example, if the inmate grievance-related requirements of the CA are found in partial compliance, then the Monitor reviewing compliance with the provisions of the SA finds grievance-related paragraphs in partial compliance. The rationale for this approach is that: the County is the

defendant, not individually MDCR and CHS; these are single processes, not separate processes (for example, MDCR and CHS share the grievance process); and, finally, gaining and sustaining compliance requires successful collaboration between MDCR and CHS.

### **Next Steps**

MDCR's priorities include developing and implementing strategies that reduce inmate/inmate violence and uses of force. Hiring a full-time compliance coordinator, with sufficient authority to coordinate work is essential. Sequencing the corrective actions is important to achievement of goals. Production of self-critical audits/reviews will assure that MDCR itself identifies non-compliance matters for their own policies, and takes corrective actions. This approach, involving managers, will help assure that this becomes part of the internal culture of the organization.

**9<sup>th</sup> Compliance Tour - Settlement Agreement - Summary of Compliance  
Tour the Week of July 9, 2018<sup>1</sup>**

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes/Requirements for Next Tour:
<b>Safety and Supervision</b>				
III.A.1.a. (1)	x			<ol style="list-style-type: none"> <li>1. Complete internal audit, quality compliance/improvement directive.</li> <li>2. Develop an audit schedule, format, and review process for drafts.</li> <li>3. Assure that corrective action plans are developed, as needed, for findings in the audits.</li> <li>4. Assure that audits are completed per MDCR policy, and not for the "DOJ monitors" – which, if referenced at all should be correctly labeled as Independent Monitors.</li> </ol>
III.A.1.a. (2)		x		<ol style="list-style-type: none"> <li>1. As the offender management system vendor is selected and implemented, revise the processes for validation. Assure that staff are trained, and that there is significant leadership review and oversight of the findings and action plans, if needed.</li> <li>2. As noted in Compliance Report number 8, by the next tour, provide the required annual update, including findings, recommendations, and if needed, a corrective action plan.</li> </ol>
III.A.1.a. (3)		x		<ol style="list-style-type: none"> <li>1. Implement the corrective action plan and provide the findings prior to the next on-site compliance tour.</li> <li>2. Engage in better editing of the findings of the audits, and conclusions to align with the data.</li> </ol>
III.A.1.a. (4)	x			<ol style="list-style-type: none"> <li>1. Re-audit findings in terms of compliance with MDCR policies on this matter.</li> </ol>
III.A.1.a. (5)	x			<ol style="list-style-type: none"> <li>1. Assure that recommendations from TAAP regarding cameras (repairs, relocation, new) are considered by MDCR leadership and acted on as deemed appropriate. Assure there is documentation regarding decisions.</li> <li>2. MDCR should evaluate/audit the timeliness of repairs for cameras located in critical areas (e.g. IRB, mental health unit.)</li> </ol>
III.A.1.a. (6)		x		See III.A.1.a.(3)
III.A.1.a. (7)		x		See III.A.1.a.(3)
III.A.1.a. (8)		x		<ol style="list-style-type: none"> <li>1. For the audit dated June 7, 2018, complete the work (rather than just plan to conduct the work), develop measurable corrective actions, as needed, implement before the next tour.</li> </ol>

<sup>1</sup> See also Attachment A for the history of compliance for each paragraph.

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes/Requirements for Next Tour:
				2. Develop better data reporting as to recoveries and the number of shakedowns as well as how the information is reported and analyzed. 3. Audit the specific provisions of this paragraph and/or otherwise demonstrate compliance (i-iv) 1. Provide an update of the outcome of the action plan dated July 5, 2018.
III.A.1.a. (9)	x			1. Re-do the audit for all of 2018 prior to the next tour. 2. Provide the results/outcomes of the action plan (may be included as part of the audit.) 3. Given the findings regarding current CPR certifications of employees (Consent Agreement III. C. 8. d.), MDCR should audit this training as well.
III.A.1.a. (10)	x			Provide an update of the action plan dated June 5, 2018 prior to the next on-site compliance tour.
III.A.1.a. (11)		x		1. As a suggestion, continue to refine the Quarterly/Annual violence reports to eliminate charts and rather use narratives; and especially eliminate the charts where there is no data reported (e.g. zero or a low number of events). The narrative analyses of the data provides the foundation for the findings and recommendations; the charts and graphs perhaps can be relocated to an appendix. This will streamline/shorten the report, and allow focus on the most critical findings. The analysis should consider avoiding comparisons of per incident rate (for example uses of force per 1,000 bookings, or uses of force per 1,000 inmates) as this bases for comparison has no foundation in terms of relevance except as a measure of prevalence. The use of the analyses should be reviewed for relevance – for example Figure 149 – in terms of what it displays and the usefulness to developing countermeasures and plans of action. There are pages and pages of charts, with no descriptions, findings, or notes regarding the relevance and potential use of the data. 2. The use of performance indicators to determine good performance, for example Figures 150a and 150b are questionable. How the performance measure was selected, and the relevance is unexplained. As noted elsewhere in this report, while targets/benchmarks may be desirable, the objective needs to be have a factual or data-driven anchor. The Monitor has made this observation before, and no further information has been provided as to the data or behavioral anchors called performance objectives. For example, in figure 150a – the performance measure appears to be 225 inmate/inmate incidents as somehow an acceptable number. This requires an explanation. If for example, MDCR reaches a reported 220 inmate/inmate incidents per quarter, is that then the acceptable, “good”, level for the agency? MDCR continues to note it checks with

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes/Requirements for Next Tour:
				<p>other larger jails to determine their numbers of incidents in MDCR's efforts to determine benchmarks. While perhaps interesting, the use of data from other jails is extremely problematic as there are no uniform national (or even state) definitions of incidents and/or behaviors, no uniform policies governing self-reporting, no assessment of the validity of the reporting in other jails, nor how other jails train and/or audit their reporting.</p> <ol style="list-style-type: none"> <li>3. Continue to refine measures; insure that implementation of critical factors, such as the inmate disciplinary system, be finalized. It is not possible to evaluate options until the "package" of reform has been put into place.</li> <li>4. The continued level of violence suggests that the classification system is not working. This has not yet been analyzed. This work should be undertaken as soon as possible. While a full validation study is ultimately the goal, interim review of how classification contributes to safety needs to be done. While MDCR continues to document a very low "mis-classification" of inmates, the methodology is not provided. Further, the level of disorder in the facilities seems to suggest that classification most likely is a contributing factor.</li> <li>5. Refine the countermeasure initiatives. The use of reports without explanation, analysis or findings is not helpful.</li> <li>6. Assure that staffing of critical areas to support violence reduction is a priority for the County.</li> <li>7. Continue to decrease the finding of "undetermined" for the reason for inmate/inmate violence; the same recommendations as included in the last compliance report.</li> </ol>
<b>Security Staffing</b>				
III.A.2. a.	x			<ol style="list-style-type: none"> <li>1. Assure that the County's human resources bureaucracy handles requests with a level of urgency, especially for positions related to violence reduction (e.g. counselors) and clinic and infirmary cleanliness (maintenance workers.)</li> <li>2. MDCR may include calendar year 2018 data to document how long it takes from the time of a resignation until an individual is hired, as documentation of this collaboration.</li> </ol>
III.A.2. b.		x		<ol style="list-style-type: none"> <li>1. Conduct a complete audit as to how data is collected, analyzed, and the development of a meaningful action plan.</li> <li>2. Prior to the next compliance tour, the County should identify the accurate data, and if necessary provide a corrective action plan.</li> </ol>
III.A.2.c.	x			
III.A.2.d.	x			See III.A.2.a. See also CA III.C.7.

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes/Requirements for Next Tour:
<b>Sexual Misconduct</b>				
III. A.3.	x			<ol style="list-style-type: none"> <li>1. The County is encouraged to conduct annual reviews of on-going PREA compliance in anticipation for the next formal audit; including implementation of recommendations as contained in the self-audit dated April 26, 2018. Monitor will follow-up at the next tour.</li> <li>2. Review/document the MDPD's SVU's collaboration with CHS' mental health providers, pursuant to the Director's memo of May 23, 2018. Monitor will follow-up at the next tour.</li> <li>3. Prior to the next tour, MDCR should review the management of transgender inmates; provide any findings and, in necessary, provide plans of action.</li> </ol>
<b>Incident and Referrals</b>				
III. A.4 a.	x			1. See recommendations in III.A.1.a. (1)
III.A.4. b.	x			
III.A.4.c.	x			1. Assure the request for proposal and subsequent award processes insure that relevant paragraphs of both the Settlement Agreement and Consent Agreement, including interfaces with Cerner and other CHS data system, are required as part of any new system.
III.A.4.d.		x		<ol style="list-style-type: none"> <li>1. Provide a more complete audit of findings, specifically how many staff may need training remediation and the length of time, and number of training sessions which have used outdated materials and lesson plans.</li> <li>2. Prepare a corrective action plan that includes due dates, responsible parties, and how success is measured.</li> </ol> See also CA provision III. B. 3. b. and c.
III.A.4.e.	x			1. Prior to the next on-site tour, MDCR is requested to conduct an audit of this provision. See recommendation for III.A.4.f.
III.A.4.f.	x			<ol style="list-style-type: none"> <li>1. Consider conducting a more complete audit of findings, specifically how many staff may need training remediation and the length of time, and number of training sessions which have used outdated materials and lesson plans.</li> <li>2. Prior to the next tour, report on the results of the corrective action plan (July 3, 2018).</li> </ol>
<b>Use of Force</b>				
III.A. 5 a.(1) (2) (3)	x			<ol style="list-style-type: none"> <li>1. Develop facility-specific plans to address the increases in uses of force (and inmate/inmate violence)</li> <li>2. Provide training to all staff working with inmates (all levels) on the mental health caseload.</li> </ol>

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes/Requirements for Next Tour:
				<ol style="list-style-type: none"> <li>1. Continue re-envisioning Metro West to its original direct supervision design; develop that plan as well as what skills and strategies can be expanded.</li> <li>2. New Recommendation – Assure that “de-escalation techniques” are not limited to verbal commands in non-emergency situations.</li> </ol>
III.A.5. b. (1), i., ii, iii, iv, v, vi (2)	x			<ol style="list-style-type: none"> <li>1. Prior to the next tour, provide an update on the elements of improved internal investigative capacity at MDCR based on the April 1, 2018 memorandum; including any corrective actions or revised plans.</li> </ol>
III.A. 5. c. (1)	x			No recommendations at this time other than to consider the TAAP findings when MDCR conducts the annual evaluation of the policy.
III.A. 5. c. (2)		x		<ol style="list-style-type: none"> <li>1. Prior to the next tour, provide an update on the elements of improved internal investigative capacity at MDCR based on the April 1, 2018; including any corrective actions or revised plans.</li> </ol>
III.A. 5. c. (3)	x			<ol style="list-style-type: none"> <li>1. Provide updated training for facility leadership to improve reviews prior to the next tour.</li> </ol>
III.A. 5. c. (4)		x		See III.A.5.c. (3)
III.A. 5. c. (5)	x			<ol style="list-style-type: none"> <li>1. Review the process to assure compliance with this paragraph. If the policy needs amendment, do so; if the training is an issue; provide training. Provide update prior to the next compliance tour..</li> </ol>
III.A. 5. c. (6)	x			<ol style="list-style-type: none"> <li>1. Develop relevant lesson plans, testing mechanisms, and provide documentation of training prior to the next tour.</li> <li>2. Provide a training/re-training plan for CHS and, if necessary, MDCR staff.</li> <li>3. Assess the outcomes of audit Tool # 30 for additional training needs</li> </ol> See CA III.B.3.b.
III.A. 5. c. (7)	x			
III.A. 5. c. (8)	x			<ol style="list-style-type: none"> <li>1. Repeat/update the audit for the last six months of 2018 and develop a corrective action plan, if indicated.</li> <li>2. Include data in the audit, rather than language such as “a large percentage”; which cannot be measured in terms of progress.</li> </ol>
III.A. 5. c. (9)	x			
III.A. 5. c. (10)	x			See CA III.B.3.b.

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes/Requirements for Next Tour:
III.A. 5. c. (11)	x			<ol style="list-style-type: none"> <li>1. Update and revise the action plan to include how success is measured. There seems to be more attention to the physical plant than to the knowledge and skills of staff working in the mental health units particularly. The report should also assess the injuries that are a result of the underlying inmate/inmate altercation (as appropriate) versus the injury related to a use a force by MDCR.</li> <li>2. Involve CHS' behavior health staff in the initiative.</li> <li>3. De-escalation is more than just verbal commands. Review, revise and update training materials.</li> </ol>
III.A. 5. c. (12)	x			
III.A. 5. c. (13)	x			<ol style="list-style-type: none"> <li>1. Repeat/update the audit for the last six months of 2018.</li> <li>2. Report on the corrective action prior to the next tour (can be part of the audit).</li> <li>3. Be sure to date all audit reports.</li> </ol>
III.A. 5. c. (14)	x			
III.A.5. d. (1) (2) (3) (4)	x			<ol style="list-style-type: none"> <li>1. Provide the outcome of the 2018 testing prior the next compliance tour; provide the schedule for the annual testing for 2019 prior to the next tour.</li> </ol>
III.A.5. e. (1) (2)	x			<ol style="list-style-type: none"> <li>1. Assure that newly designated/assigned investigators receive training; provide documentation prior to the next compliance tour.</li> </ol>
<b>Early Warning System (EWS)</b>				
III.A.6. a. (1) (2) (3) (4) (5)		x		<ol style="list-style-type: none"> <li>1. Prior to the next compliance tour, provision of: <ol style="list-style-type: none"> <li>a. Evidence (minutes, etc.) of how the information is used by leadership to make changes, (3) above;</li> <li>b. Regarding (5) ii and iii above – computation of the data, or an explanation of why it is not provided; or another alternative;</li> <li>c. Provision of the additional information noted by MDCR in the provision of documentation for this tour – that being a field audit has been scheduled to assess the effectiveness of the trainings that were conducted on the EWIS System back in May 2018. A make-up training is also occurring July 20, 2018, for those that were not available for the May trainings, this training will also include the Chiefs.</li> <li>d. MDCR will provide a revised policy/procedure (draft is acceptable);</li> <li>e. The recommendations for change to the program since moving it to the Regulatory and Compliance Division, and if those recommendations were implemented (action plans acceptable);</li> <li>f. Any benchmarks or measurable objectives established for the EIS;</li> <li>g. The training lesson plan(s) for facility based staff in EIS;</li> <li>h. The schedule for training; and</li> </ol> </li> </ol>

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes/Requirements for Next Tour:
				i. Data indicating if changes to the process are achieving benchmarks or measurable objectives.
III.A.6.b.	x			See recommendations III.A.6. a.
III.A.6.c.		x		1. Prior to the next tour, identify the elements that indicate that the EWS is successful, and produce a report assessing its effectiveness.
<b>Fire and Life Safety</b>				
III.B.1.	x			
III.B.2.	x			
III.B.3.	x			
III.B.4.	x			
III.B. 5.	x			1. Ensure all inventory forms for chemicals are clear on what is being counted i.e. ounces, bottles, cases, cans etc.
III.B.6	x			
<b>Inmate Grievances</b>				
III.C. 1.,2.,3.,4.,5.,6.		x		1. Implement action plan of Grievance Committee; update findings prior to the next on-site compliance tour. See also III.A.3.a.(4) and III.D. 1.b.
<b>Audits and Continuous Improvements</b>				
III.D.1. a. b.	x			1. Update the reporting to match requirements of this paragraph. 2. Establish self-monitoring to address inmates' constitutional rights or the risk of constitutional violations. MDCR, as noted above, is encouraged to self-monitor and to take corrective action to ensure compliance with constitutional mandates in addition to the review and assessment of technical provisions of the Agreement.
III.D. 2. a. b.		x		1. See recommendations for III.D.1.a.b.
<b>Compliance and Quality Improvement</b>				
IV. A.	x			1. See previous recommendations about amending (editing/shortening) the quarterly and annual reports to include relevant data, analyses, and action plans, as necessary.
IV. B.		x		1. Assess the quarterly and annual reports for utility to the County. Determine how the data is used in decision-making, and amend accordingly. Assess the human resources used in this work compared to the return on investment. 2. Coordinate this assessment with CHS' data keeping and QA/QI processes. Determine what data can be jointly collected, analyzed, and how plans of action/countermeasures are developed, implemented and assessed for effectiveness. 3. See recommendations for III.D.1.a.b.

Subsection of Settlement Agreement	Compliance	Partial Compliance	Non-Compliance	Comments/Notes/Requirements for Next Tour:
IV. C.	x			
IV. D.	x			

## Compliance Report - Settlement Agreement Findings – Tour July 9 - 11, 2018

### III. A. PROTECTION FROM HARM

Consistent with constitutional standards, the County's Jail facilities shall provide inmates with a reasonably safe and secure environment to ensure that they are protected from harm. The County shall ensure that inmates are not subjected to unnecessary or excessive force by the County's Jail facilities' staff and are protected from violence by other inmates. The County's Jail facilities' efforts to achieve this constitutionally required protection from harm will include the following remedial measures regarding: (1) Safety and Supervision; (2) Security Staffing; (3) Sexual Misconduct; (4) Incidents and Referrals (5) Use of Force by Staff; and (6) Early Warning System.

Paragraph	III. A. 1. Safety and Supervision: a. MDCR will take all reasonable measures to ensure that inmates are not subjected to harm or the risk of harm. While some danger is inherent in a jail setting, MDCR shall implement appropriate measures to minimize these risks, including: (1) Maintain implemented security and control-related policies, procedures, and practices that will ensure a reasonably safe and secure environment for all inmates and staff, in accordance with constitutional standards.			
Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16	Partial Compliance: 3/28/14, 7/19/13, 10/24/14, 1/8/16	Non-Compliance:	Other: Per MDCR not reviewed in 5/15
Unresolved/partially resolved issues from previous tour:				
<i>Measures of Compliance:</i>	<u>Protection from Harm:</u> 1. Manual of security and control-related policies, procedures, written directives and practices, consistent with Constitutional standards and contents of the Settlement Agreement. 2. Internal audits. 3. Documentation of annual review(s). 4. Schedule of review for policies, procedures, practices.			
Steps taken by the County to Implement this paragraph:	MDCR has implemented security and control-related policies and procedures, however, MDCR's own audits reveal significant deficiencies.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR's own audits demonstrate that there is a gap between policy/procedures and operational practices. MDCR is commended for conducting these audits, and identifying the deficiencies. Repeats of audits are requested in this compliance report.			
Monitor's Recommendations:	1. Complete internal audit, quality compliance/improvement directive. 2. Develop an audit schedule, format, and review process for drafts. 3. Assure that corrective action plans are developed, as needed, for findings in the audits. 4. Assure that audits are completed per MDCR policy, and not for the "DOJ monitors" – which, if referenced at all should be correctly labeled as Independent Monitors.			

Paragraph	III. A. 1. Safety and Supervision: (2) Within 90 days of the Effective Date, conduct an inmate bed and classification analysis to ensure the Jail has adequate beds for maximum security and disciplinary segregation inmates. Within 90 days thereafter, MDCR will implement a plan to address the results of the analysis. The Monitor will conduct an annual review to determine whether MDCR's objective classification system continues to accomplish the goal of housing inmates based on level of risk and supervision needs.			
Compliance Status:	Compliance:	Partial Compliance: 7/11/18, 12/7/17, 3/3/17, 10/24/14, 7/29/16, 7/11/18	Non-Compliance: 3/28/14, 7/19/13	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:	See below.			
<i>Measures of Compliance:</i>	<u>Protection from Harm:</u> 1. Completion of a bed and classification analysis. 2. Post-study housing plan. 3. Annual report by Monitor of the objective classification system and housing plan. 4. Data provided by MDCR regarding outcomes/impact of classification system.			
Steps taken by the County to Implement this paragraph:	<p>The County's vendor for the offender management system has not fulfilled their commitments, and has advised the County that they, the vendor, GTL, will bear the costs of whatever vendor the County selects to develop a system. The GTL contract for a Jail Management System was signed on July 11, 2014. This would also be the official start date for work on this system. There were negotiations with Miami-Dade County for this system (scope of work included in the contract) that started in March 2014. The go live date in the contract was July 2016.</p> <p>This has put MDCR behind at least five years, and directly impacted the ability to collect and analyze data need to validate the classification system.</p> <p>To address this provision, the County has provided a memorandum dated April 2 with a snap shot of classification on March 31<sup>st</sup>. The report provided several recommendations, but there is no indication if these recommendations were considered or implemented. Also provided were a housing plan as of March 31<sup>st</sup>, and bed classification analysis and risk analysis of maximum security inmates, for the period July 1 – September 30, 2017.</p> <p>The County's position is that a validation study is outside the language of the Agreement, and that the materials provided are sufficient. The validation study recommendation and the County's understanding of the need for this work has been included in every compliance report – even if the Monitor concurred with the County's position, the element of the requirement is not met at this time -that being: inmate safety and the relationship to classification and housing. See below – the Monitor's determination.</p>			
Monitor's analysis of conditions to assess compliance, verification of	The materials provided, with the exception of the April 2 <sup>nd</sup> summary, do not include findings or recommendations. The Monitors have long expressed concern about the level of violence and how that might be related to the classification			

<p>the County’s representations, and the factual basis for finding(s)</p>	<p>system. Other than noting if inmates were properly classified at the time of incidents, there has been no evidence produced that the underlying system resulting in those classifications are valid. This is a continuous security risk.</p> <p>MDCR provided a presentation on July 10<sup>th</sup> demonstrating the use of “Watson” analytics and the classification data, including correlations. In the absence of the gang information, the data might not be as helpful as it will be in the future. While the presentation indicated relevant work on the issue of whether the system keeps inmates and staff safe, the Monitor’s take-away was that more analyses are needed, as well as preliminary working hypothesis developed.</p> <p>The County has indicted after Compliance Report #8 that it would retain a subject matter expert to assist to review the system and engage in subsequent validation. The contract to engage the expert was not executed prior to this on-site tour.</p> <p>The Monitor notes it is, based on the language of this paragraph, the Monitor’s responsibility to determine if the system accomplishes the goal of keeping inmates safe. At this time, the Monitor determines that there is insufficient information/data to make this determine, in spite of eight reports with recommendations. The level of inmate/inmate assaults, the absence of a meaningful gang assessment of arrestees/inmates, the County’s commitment to hire a subject matter expert to assist with validation are all indicators of the recognition by all parties of this important work. The Monitor also notes, that while the work to date is seminal, the absence of meaningful analysis of the findings, and lack of specific action plans makes the information, at this point, interesting, but not informing operations.</p> <p>Therefore, the finding relative to this paragraph is partial compliance, not based on whether a validation study is completed or not, but the Monitor’s inability to make a determination of whether the classification system houses inmates based on legitimate risk and supervision needs.</p>
<p>Monitor’s Recommendations:</p>	<ol style="list-style-type: none"> <li>1. As the offender management system vendor is selected and implemented, revise the processes to assist with validation.</li> <li>2. Assure that classification staff are trained, and that there is significant leadership review and oversight of the findings and action plans, if needed.</li> <li>3. As noted in Compliance Report 8, by the next tour, provide the required annual update, including findings, recommendations, and if needed, a corrective action plan.</li> </ol>

Paragraph	III. A. 1. Safety and Supervision: (3) Develop and implement a policy requiring correctional officers to conduct documented rounds, at irregular intervals, inside each housing unit, to ensure periodic supervision and safety. In the alternative, MDCR may provide direct supervision of inmates by posting a correctional officer inside the day room area of a housing unit to conduct surveillance.			
Compliance Status:	Compliance: 12/7/17, 3/3/17, 7/29/16, 10/24/14	Partial Compliance: 7/11/18, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16.
Unresolved/partially resolved issues from previous tour:	None			
<i>Measures of Compliance:</i>	<u>Protection from Harm:</u> 1. Policies and procedures requiring conduct of rounds. 2. Review of housing unit logs. 3. Review of staffing in housing units through observation and logs. 4. Interviews with inmates, employees.			
Steps taken by the County to Implement this paragraph:	<p>MDCR conducted an audit of the provisions of this and III.A.1. (4), reviewing documents for the period October – December 2017. The audit is dated May 4, 2018. The findings of the audit indicated general compliance with policy provisions at Metro West, with concerns identified missing 11% of 30 minute checks in safety cells; for PTDC, 81% of 60 minute checks conducted, and 63% of checks for safety cells documented; and for TGK, significant areas of non-compliance – 20% of checks undocumented for the juvenile units; 44% of 15-minute checks in mental health units non-compliant, 25% of 60 minute checks noncompliance for the general population; 26% of checks for safety cells non-compliant, and 69% of supervisory checks (2 per shift) not documented.</p> <p>Analysis by MDCR of the information includes concerns about wi-fi reception related to the tablets and battery life used to document checks, not raised until the audit. The issue about the tablets is also raised for TGK.</p> <p>Based on discussion of the findings during the on-site tour, MDCR produced an updated audit and audit plan dated July 19, 2018. MDCR concluded that the audit results submitted to the Monitor were “misleading”, and note that MDCR will be implementing corrective action and conduct another audit.</p>			
Monitor’s analysis of conditions to assess compliance, verification of the County’s representations, and the factual basis for finding(s)	<p>The audit is a good first step toward self-critical analysis of MDCR’s policies and procedures related to inmate supervision/safety.</p> <p>The Monitor is concerned that the findings of the May 4<sup>th</sup> audit, documenting non-compliance with this paragraph, upon discussion, were then found to be inaccurate and misleading, with an action plan developed (July 19, 2018).</p> <p>The County’s maintains that the audits conducted pursuant to demonstrating sustainability of compliance with this paragraph were not “required” as a measure of compliance, and as such should not be used to determine the current compliance rating. The County now states that the results of their audits were “overinflated”, and so informed the Monitor. This is true; the Monitors was informed. The Monitor finds this argument is not compelling given that the County could have reviewed, amended or edited the findings prior to providing to the Monitor.</p>			

	<p>The Monitor is impressed by the fact that MDCR acknowledges that the audit was incorrect, but the confusion on this matter results in a finding of partial compliance with this paragraph. The Monitor asked for supplemental documentation about when issues with wi-fi and battery life of tablets used at TGK had been previously documented, as a measure of leadership knowledge and action. No additional information was provided by MDCR. The Monitor noted, however, that one of the morbidity and mortality reviews of a death at TGK included information about the tablets.</p> <p>Nonetheless these were reports provided by the County, and stand as documentation. After five years of compliance initiatives, the County is aware of the significance of materials provided to the Monitor and should appropriately review submissions for accuracy. The need for a full-time compliance manager is thus demonstrated.</p> <p>See also CA III. C. 6. a. (1)</p>
<p>Monitor's Recommendations:</p>	<ol style="list-style-type: none"> <li>1. Implement the corrective action plan and provide the findings prior to the next on-site compliance tour.</li> <li>2. Engage in better editing of the findings of the audits, and conclusions to align with the data.</li> </ol>

Paragraph	III. A. 1. Safety and Supervision: (4) Document all security rounds on forms or logs that do not contain pre-printed rounding times. Video surveillance may be used to supplement, but not replace, rounds by correctional officers.			
Compliance Status:	Compliance: : 7/11/18, 12/10/17, 3/3/17, 7/29/16, 5/15/15	Partial Compliance 10/24/14, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 1/16.
Unresolved/partially resolved issues from previous tour:				
<i>Measures of Compliance:</i>	<u>Protection from Harm:</u> 1. Policies and procedures on reporting and logging. 2. Policy on use of video surveillance. 3. Review of staffing in housing units through observation and logs. 4. Interviews with inmates, employees, examination of logs.			
Steps taken by the County to Implement this paragraph:	See SA III.A.1.a. (3)			
Monitor’s analysis of conditions to assess compliance, verification of the County’s representations, and the factual basis for finding(s)	See also III.A.1.a. (3) The May 4, 2018 audit identified that incorrect forms were used for supervisory accountability. No findings were made regarding whether pre-printed times were contained in the “red books”. No findings were made regarding compliance or not with the provisions of DSOP 11-020.  The County’s maintains that the audits conducted pursuant to demonstrating sustainability of compliance with this paragraph were not “required” as a measure of compliance, and as such should not be used to determine the current compliance rating.  The compliance with this paragraph will remain in compliance; pending a re-audit. The fact that the incorrect forms were used, is an important finding going to the heart of enforcement of current policy, supervisory oversight, and sustainability.			
Monitor’s Recommendations:	1. Re-audit findings in terms of compliance with MDCR policies on this matter.			

Paragraph	<p>III. A. 1. Safety and Supervision:</p> <p>(5) MDCR shall document an objective risk analysis of maximum security inmates before placing them in housing units that do not have direct supervision or video monitoring, which shows that these inmates have no greater risk of violence toward inmates than medium security inmates. MDCR shall continue to increase the use of overhead video surveillance and recording cameras to provide adequate coverage and video monitoring throughout all Jail facilities to include:</p> <ul style="list-style-type: none"> <li>i. PTDC – 24 safety cells, by July 1, 2013</li> <li>ii. PTDC – 10B disciplinary wing, by December 31, 2013; kitchen, by Jan. 31, 2014;</li> <li>iii. Women’s Detention Center – kitchen, by Sept. 30, 2014;</li> <li>iv. Training and Treatment Center - all inmate housing units and kitchen, by Apr. 30, 2014;</li> <li>v. Turner Guilford Knight Correctional Center – kitchen; future intake center; by May 31, 2014; and</li> <li>vi. Metro West Detention Center – throughout all areas; by Aug. 31, 2014.</li> </ul>			
Compliance Status:	Compliance: 7/11/18, 12/10/17, 3/3/17, 7/29/16, 10/24/14	Partial Compliance: 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16.
Unresolved/partially resolved issues from previous tour:				
<i>Measures of Compliance:</i>	<p><u>Protection from Harm:</u></p> <ol style="list-style-type: none"> <li>1. Re-classification screening documentation for inmates moved to maximum security housing that does not have direct supervision or video monitoring.</li> <li>2. Plan to increase video surveillance and recording capacity; implementation dates; contracts; evidence of completion on required dates; plan of action if dates specified in the Settlement Agreement for completion not met.</li> </ol>			
Steps taken by the County to Implement this paragraph:	Various TAAP reports note that the location and number of cameras should be reconsidered based on the findings of the review. There is no information as to the outcome of those recommendations.			
Monitor’s analysis of conditions to assess compliance, verification of the County’s representations, and the factual basis for finding(s)	The Monitor requested evidence of camera repairs and was provided with a Facilities Management Bureau Electronic Tech Work Order for the first quarter of 2018. As these repairs are done in-house, a listing was provided.			
Monitor’s Recommendations:	<ol style="list-style-type: none"> <li>1. Assure that recommendations from TAAP regarding cameras (repairs, relocation, new) are considered by MDCR leadership and acted on as deemed appropriate. Assure there is documentation regarding decisions.</li> <li>2. MDCR should evaluate/audit the timeliness of repairs for cameras located in critical areas (e.g. IRB, mental health unit.)</li> </ol>			

Paragraph	III. A. 1. Safety and Supervision: (6) In addition to continuing to implement documented half-hour welfare checks pursuant to the “Inmate Administrative and Disciplinary Confinement” policy (DSOP 12.002), for the PTDC safety cells, MDCR shall implement an automated welfare check system by July 1, 2013. MDCR shall ensure that correctional supervisors periodically review system downloads and take appropriate action with officers who fail to complete required checks.			
Compliance Status:	Compliance: 12/10/17, 3/3/17, 7/29/16, 10/24/14, 3/28/14	Partial Compliance: 7/11/18, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
<i>Measures of Compliance:</i>	<u>Protection from Harm:</u> 1. Policies and procedures governing welfare checks. 2. Implementation of an automated welfare check system in PTDC by 7/1/13. 3. Policies and procedures regarding management of data generated from automated welfare check system, including re-training and corrective action. 4. Review of incidents from housing units in which automated welfare check system is deployed.			
Steps taken by the County to Implement this paragraph:	See SA III.A.1.a. (3)			
Monitor’s analysis of conditions to assess compliance, verification of the County’s representations, and the factual basis for finding(s)	See also III.A.1.a. (3)  The County’s maintains that the audits conducted pursuant to demonstrating sustainability of compliance with this paragraph were not “required” as a measure of compliance, and as such should not be used to determine the current compliance rating. MDCR determined, subsequent to providing the audit to the Monitor that the results were “incorrect” and “overinflated” apparently based on the method of compiling data from the automated system. MDCR produced an action plan, and the Monitor was advised of these issues; which is true. The County notes that the audit is not included in the measures of compliance, and therefore should not be considered when compliance is determined.  Nonetheless these were reports provided by the County, and stand as documentation. After five years of compliance initiatives, the County is aware of the significance of materials provided to the Monitor and should appropriately review submissions for accuracy. The need for a full-time compliance manager is thus demonstrated.			
Monitor’s Recommendations:	See III.A.1.a. (3)			

Paragraph	III. A. 1. Safety and Supervision: (7) Security supervisors shall conduct daily rounds on each shift in the inmate housing units, and document the results of their rounds.			
Compliance Status:	Compliance: 12/10/17, 3/3/17, 7/29/16, 10/24/14	Partial Compliance: 7/11/18, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:	NA			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding daily supervisory rounds in inmate housing units on all shifts. 2. Examination of logs/documentation. 3. Inmate interviews. 4. Corrective actions for any supervisory findings from rounds (examples of), if any.			
Steps taken by the County to Implement this paragraph:	See SA III.A.1.a. (3)			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See also III.A.1.a. (3)  The County's maintains that the audits conducted pursuant to demonstrating sustainability of compliance with this paragraph were not "required" as a measure of compliance, and as such should not be used to determine the current compliance rating. The County now states that the results of their audits were "overinflated", and so informed the Monitor. This is true; the Monitors was informed.  Nonetheless these were reports provided by the County, and stand as documentation. After five years of compliance initiatives, the County is aware of the significance of materials provided to the Monitor and should appropriately review submissions for accuracy. The need for a full-time compliance manager is thus demonstrated.			
Monitor's Recommendations:	See III.A.1.a. (3)			

Paragraph	III. A. 1. Safety and Supervision: (8) MDCR shall maintain a policy ensuring that security staff conduct sufficient searches of cells to ensure that inmates do not have access to dangerous contraband, including at least the following: i. Random daily visual inspections of four to six cells per housing area or cellblock; ii. Random daily inspections of common areas of the housing units; iii. Regular daily searches of intake cells; and iv. Periodic large scale searches of entire housing units.			
Compliance Status:	Compliance: 12/10/17, 3/3/17, 7/29/16, 1/8/16	Partial Compliance: 7/11/18, 10/24/14	Non-Compliance: 3/28/14, 7/19/13	Other: Per MDCR not reviewed in 5/15.
Unresolved/partially resolved issues from previous tour:				
<i>Measures of Compliance:</i>	<u>Protection from Harm:</u> 1. Policies and procedures regarding staff searches of inmate cells and living areas, meeting language in this Settlement Agreement. 2. Shakedown logs/records. 3. Operational plans for large scale searches; and post search evaluations/management reviews. 4. Reports provided by MDCR regarding contraband and shakedowns.			
Steps taken by the County to Implement this paragraph:	<p>MDCR conducted an audit of the provisions of this paragraph and DSOPs 11-045 and 14-001. This audit reviewed and evaluated shakedowns from the three facilities for the period January 1 – March 31, 2018. The audit report is dated June 7, 2018. This audit was conducted against the backdrop of inmate deaths potentially related to contraband, and the issues presented in the last compliance tour for both the SA and CA regarding excess medication and medical administration.</p> <p>The findings of the audit address the issue of excessive medication, reporting of seizure of contraband, and the frequency of shakedowns. The “preliminary observations and conclusions” include: needed improvements in data reviews regarding excessive medication, more staff training, staff meetings and spot inspections are needed; the use of liquid and floating medication to minimize medication hoarding; improvements in incident reporting and related inmate disciplinary reports; and acknowledgement of an increase in the number of shakedowns in TGK and PTDC, attributed to additional staffing made available to conduct the shakedowns.</p> <p>MDCR provided an updated action plan, dated July 5, 2018, which includes a self-assessment of the root cause of the contraband (7/27/18), the establishment of performance objectives, and the development of a process to track performance.</p> <p>The County maintains that since an audit was not part of the measures of compliance, the results should be disregarded when determining compliance. Nonetheless these were reports provided by the County, and stand as documentation. The County’s line of reasoning is illogical and inconsistent with the agreement that the County be in compliance for 18 months after an initial findings of compliance. Whether documentation of sustained compliance is produced by the</p>			

	<p>County, or assessed through primary or secondary data by the Monitor is irrelevant. If the County had an objection to producing audits following pursuant to Compliance Report #8, the time to object would have been at that time.</p>
<p>Monitor’s analysis of conditions to assess compliance, verification of the County’s representations, and the factual basis for finding(s)</p>	<ul style="list-style-type: none"> <li>• There is no finding about the frequency of shakedowns in MW.</li> <li>• It is unclear in Figure 1, if no contraband was found, what is the data that is reported? Additionally, the Monitor finds it exceedingly unlikely that shakedowns find no contraband, unless the inmates or staff are anticipating the shakedown. The data in Figure 1 appears to miss recoveries and shakedowns and is confusing. The statement that the disparity of what is found in shakedowns “ . . . indicate[s] inconsistent business practices, documentation guidelines, or management expectations.” Is unclear as to the meaning, and the ability to draw any conclusions supported by data.</li> <li>• 22% of the recovering should have been found by or controlled by the staff – bed sheets , pillow cases, towels, blankets, pilots and mattresses. The same might be found for the 7% of recoveries regarding perishable food – something also that should be the routine work of officers to discover.</li> <li>• The conclusion that MW has more recoveries due to the open design that allows inmates to “hide” contraband is illogical, in the Monitor’s opinion based on subject matter expertise, review of reporting, and observation. There is no data to support this statement. In fact, in open dorms, the contraband should be easier to see if staff are routinely walking the unit, as contrasted to the cell configurations of PTDC. The conclusion regarding PTDC supports the Monitor’s review.</li> <li>• Removing the unexplained data of “no contraband found” reveals that excessive medication accounted for 11% of the recoveries; and this is after MDCR and CHS initiated improvements in medication administration in 2017.</li> <li>• The actions taken lack documentation, data, or the ability to evaluate initiatives. There are no dates regarding the actions, and no indication of how success will be measured.</li> <li>• The corrective action plan (Appendix 4) notes that performance objectives will be developed in the future. Given the urgency of this matter, the Monitor anticipated that this work would have been accomplished in a tighter time frame, and looks forward to reviewing the next set of reports from MDCR.</li> <li>• Figure 1 does not identify serious contraband recovered, such as tobacco or illegal drugs.</li> <li>• The category of “other” in Figure 1 accounts for 15% of recoveries. The category needs further definition if the data is to be useful in assessing the problem and developing a corrective action plan.</li> <li>• There is no analysis regarding the recoveries of excessive medication.</li> </ul> <p>The Monitor’s conclusion is that the work to analyze contraband and develop effective strategies was intended to be done by this tour; not pushed to the next tour.</p> <p>This analysis only peripherally addresses the collaboration with CHS regarding excessive medication, and provides to cogent plan, with measures.</p> <p>The analysis did not include the specifics of the requirements of this paragraph. To accomplish this analysis, the Monitor reviewed shakedown logs provided for the facilities to October 2017 – April 2018 to assess: random daily visual inspections of four to six cells per housing area or cellblock; random daily inspections of common areas of the housing units; regular daily searches of intake cells; and periodic large scale searches of entire housing units.</p>

	<p>The logs provide an overview of searches of housing units, but do not include, for example, intake cells. There is no information about daily visual inspections of four to six cells per housing areas or cellblock, etc.</p> <p>The Monitor requested after the last compliance tour that an analysis of searches of cells/shakedowns; action plans related to seizures/findings be provided before the next tour. MDCR provided the same audit, as noted above, for the documentation. This audit does not address the issues, particularly the specifics of this paragraph.</p>
<p>Monitor's Recommendations:</p>	<ol style="list-style-type: none"> <li>1. For the audit dated June 7, 2018 , complete the work (rather than just plan to conduct the work), develop measurable corrective actions, as needed, implement before the next tour.</li> <li>2. Develop better data reporting as to recoveries and the number of shakedowns as well as how the information is reported and analyzed.</li> <li>3. Audit the specific provisions of this paragraph and/or otherwise demonstrate compliance (i-iv)</li> <li>4. Provide an update of the outcome of the action plan dated July 5, 2018.</li> </ol>

Paragraph	III. A. 1. Safety and Supervision: (9) MDCR shall require correctional officers who are transferred from one facility to a facility in another division to attend training on facility-specific safety and security standard operating procedures within 30 days of assignment.			
Compliance Status:	Compliance: 7/11/18, 12/10/17, 3/3/17, 7/29/16, 1/8/16	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15.
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding training for officers who transfer from one division to another. 2. Facility specific operational procedures/written directives. 3. Lesson plans on facility-specific safety and security. 4. Proof of attendance within 30 days of assignment. 5. Demonstration of knowledge gained (e.g. pre-and post-tests) 6. Examples of remedial training, if any.			
Steps taken by the County to Implement this paragraph:	MDCR conducted an audit regarding the provisions of this paragraph for the period October 2017 thru December 2017, dated May 29, 2018. The audit found that 85% of staff received required training within 30 days of assignment. In 11% of those instances the Training Bureau did not receive the transfer orders, thus triggering training. An action plan was provided.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	This paragraph will remain in compliance; and the results of the action plan will be assessed during the next compliance tour.			
Monitor's Recommendations:	1. Re-do/update the audit for all of 2018 prior to the next tour. 2. Provide the results/outcomes of the action plan (may be included as part of the audit.) 3. Given the findings regarding current CPR certifications of employees (Consent Agreement III. C. 8. d.), MDCR should audit this training as well.			

Paragraph	III. A. 1. Safety and Supervision: (10) Correctional officers assigned to special management units, including disciplinary segregation and protective custody, shall receive eight hours of specialized training for working on that unit on at least an annual basis.			
Protection from harm: Compliance Status:	Compliance: 7/11/18, 12/10/17, 3/3/17	Partial Compliance: 10/24/14, 3/28/14, 7/19/13, 7/29/16	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:	Training for staff who are assigned to work with inmates on the (non-acute) mental health caseload.			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding training of staff assigned to special management units. 2. Lesson plans for the 8 hours of training. 3. Evidence training was held annually; evidence those working in the units attended. 4. Documentation of knowledge gained (e.g., pre-and post-tests) 5. Remedial training, if any.			
Steps taken by the County to Implement this paragraph:	MDCR conducted a review, dated May 28, 2018, of the provisions of this paragraph for calendar year 2017. The distinction is made between officers assigned to housing units designated as special management, disciplinary segregation and protective custody; and officers assigned to PTDC where there are areas in the building with specialize cells; but not specialized units. In the case of PTDC, MDCR works to assure that 30% of the staff assigned to that facility have specialized training, as the officers may work in a variety of posts, and are available in the building on each shift.  MDCR provided an action plan dated June 4, 2018 in which the Training Bureau will create a tracker to note officers' assignments and assure training is provided as required for all facilities.  Among the action items is to obtain a training management system.			
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Segregation cells at PTDC are on several floors (3,4,5,6); training is provided to assure that there are a sufficient number of trained staff on each shift, even though MDCR maintains this is not a special management unit.  MDCR will improve tracking to assure that the training requirements are met in Metro West and TGK.			
Monitors' Recommendations:	1. Provide an update of the action plan dated June 5, 2018 prior to the next on-site compliance tour.			

Paragraph	III. A. 1. Safety and Supervision: (11) MDCR shall continue its efforts to reduce inmate-on-inmate violence in each Jail facility annually after the Effective Date. If reductions in violence do not occur in any given year, the County shall demonstrate that its systems for minimizing inmate-on-inmate violence are operating effectively.			
Compliance Status:	Compliance: 3/3/17	Partial Compliance: 7/11/18, 12/7/17; 10/24/14; 3/28/14, 7/19/13, 7/29/16	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
<i>Measures of Compliance:</i>	<ol style="list-style-type: none"> <li>1. Operational plan to reduce/address inmate-on-inmate violence, including definitions of what constitutes inmate-on-inmate violence;</li> <li>2. Data regarding inmate-on-inmate violence, by year.</li> <li>3. If violence increases from one reporting year to the next, documentation of the MDCR's evaluation of the current operational plan and proposed changes, improvements.</li> </ol>			
Steps taken by the County to Implement this paragraph:	<p>MDCR's violence report for the first quarter of 2018 indicates that the number of inmate/inmate batteries was 1,237 in 2017 (1,159 in 2014, 1066 in 2015 and 1,111 in 2016). This is plotted against a decrease in the average inmate population. To the extent the information was determined for the first quarter of 2018, the reasons for the assaults were undetermined (43.11%). This is critical as MDCR notes that 48% of their uses of force are attributed to stopping inmate fights.</p> <p>MDCR's Inmate Violence Report for the last quarter of 2017 noted the following: uses of force rose from 445 reported incidents in 2014 to 712 incidents in 2017; the use of force involving inmates on the acute mental health caseload represented approximately 11% of total uses of force; and the number of inmate/inmate batteries rose from a reported 1,159 in 2014 to 1,237 in 2017. In the analysis of the causes of the inmate/inmate assaults for 2017, the largest category is "undetermined" – 42%, providing virtually no basis for assessment and plans of action. The report also highlights inmates who are transferred to prevent fights (no description of how this is determined is provided) or inmates transferred due to aggressive/disruptive behaviors.</p> <p>MDCR provided a report on countermeasures/corrective action plans to reduce inmate violence, dated June 11, 2018. MDCR also provided an update on implementation of countermeasures dated July 4, 2018; and the course corrections for the inmate violence reduction initiative dated July 5, 2018.</p> <p>The County notes in response to this draft compliance report that "MDCR has recently identified relevant data metrics and has developed a new Quarterly Report . . ." The Monitor has been consistently supportive of the County efforts to drill down into the information and produce useful data.</p> <p>The work continues, but the results of the work do not reach compliance with this paragraph. The Monitor looks forward to discussing the intricacies of data reporting and management in a jail setting. The questions posed to the Monitor in the County's response to the draft can be addressed in a forum other than this one. For example, in the absence of any evidence-based standard for acceptable violence in a jail, the County posts the question of what the</p>			

	<p>Monitor would use to “deem the number of inmate-on-inmate fight [sic] within MDCR facilities as excessive or even at a higher rate than that of jails of similar size”? The Monitor looks forward to that conversation and debate; including progress on the issues noted below. The Monitor has never set a number or standard for what constitutes a safe environment, but the data produced by MDCR indicates that inmates are not uniformly safe, and the trends are upward.</p>
<p>Monitor’s analysis of conditions to assess compliance, verification of the County’s representations, and the factual basis for finding(s)</p>	<p>If the cause of inmate fights cannot be determined, effective countermeasures are unlikely to be developed.</p> <p>The Monitor provides these recommendations.</p> <ul style="list-style-type: none"> <li>• All the data provided will be more relevant if it were plotted against the average daily population as well as the classification of inmates involved. This is the one rate of occurrence that would be significant (see recommendations, below).</li> <li>• The quarterly reports do not have summaries of relevant, important data.</li> <li>• While the data regarding transferring of inmates to attempt to avoid fights, the very core issue there – appropriateness/accuracy of classification is not reviewed. Additionally, while avoiding fights is a worthy goal, the moving of inmates also does not assess the quality of staff supervision of inmates, nor the type of housing (e.g. direct supervision/linear indirect). There are no recommendations regarding how the data can inform decisions and ensure inmate/staff safety.</li> <li>• The data regarding uses of force involving inmates on the mental health caseload needs to be aligned with that reported by the facilities in their self-audit reports.</li> <li>• The June 11<sup>th</sup> report regarding countermeasures and corrective actions appears to repeat earlier findings.</li> <li>• Continuing to measure progress in targeted and non-targeted housing units without addressing and fixing core issues leads to frustration among all involved, and is not sufficiently holistic in the approach. The conclusions about the effectiveness in reducing violence do not appear to be statistically significant and/or sufficiently analyzed and explained. Although promising, the implementation of the entire range of fixes needs to be implemented before conclusions can be drawn with any certainty of sustainability.</li> <li>• MDCR acknowledges that the countermeasures have not yielded the results of sustainable lower rates of uses of force and inmate/inmate assaults. This may be due to not addressing core/root causes such as classification, housing options, providing incentives and disincentives to promote inmate behaviors, assurance of adequate staffing in critical areas, training and supervision of staff, and appropriate provision of mental health services.</li> <li>• MDCR’s important work continues at this time.</li> </ul>
<p>Monitor’s Recommendations:</p>	<ol style="list-style-type: none"> <li>1. As a suggestion, continue to refine the Quarterly/Annual violence reports to eliminate charts and rather use narratives; and especially eliminate the charts where there is no data reported (e.g. zero or a low number of events). The narrative analyses of the data provides the foundation for the findings and recommendations; the charts and graphs perhaps can be relocated to an appendix. This will streamline/shorten the report, and allow focus on the most critical findings. The analysis should consider avoiding comparisons of per incident rate (for example uses of force per 1,000 bookings, or uses of force per 1,000 inmates) as this bases for comparison has no foundation in terms of relevance except as a measure of prevalence. The use of the analyses should be reviewed for relevance – for example Figure 149 – in terms of what it displays and the usefulness to developing countermeasures and plans of action. There are pages and pages of charts, with no descriptions, findings, or notes regarding the relevance and potential use of the data.</li> </ol>

	<ol style="list-style-type: none"> <li>2. The use of performance indicators to determine good performance, for example Figures 150a and 150b are questionable. How the performance measure was selected and the relevance is unexplained. As noted elsewhere in this report, while targets/benchmarks may be desirable, the objective needs to be have a factual or data-driven anchor. The Monitor has made this observation before, and no further information has been provided as to the data or behavioral anchors called performance objectives. For example, in figure 150a – the performance measure appears to be 225 inmate/inmate incidents as somehow an acceptable number. This requires an explanation. If for example, MDCR reaches a reported 220 inmate/inmate incidents per quarter, is that then the acceptable, “good”, level for the agency? MDCR continues to note it checks with other larger jails to determine their numbers of incidents in MDCR’s efforts to determine benchmarks. While perhaps interesting, the use of data from other jails is extremely problematic as there are no uniform national (or even state) definitions of incidents and/or behaviors, no uniform policies governing self-reporting, no assessment of the validity of the reporting in other jails, nor how other jails train and/or audit their reporting.</li> <li>3. Continue to refine measures; insure that implementation of critical factors, such as the inmate disciplinary system, be finalized. It is not possible to evaluate options until the “package” of reform has been put into place.</li> <li>4. The continued level of violence suggests that the classification system is not working. This has not yet been analyzed. This work should be undertaken as soon as possible. While a full validation study is ultimately the goal, interim review of how classification contributes to safety needs to be done. While MDCR continues to document a very low “mis-classification” of inmates, the methodology is not provided. Further, the level of disorder in the facilities seems to suggest that classification most likely is a contributing factor.</li> <li>5. Refine the countermeasure initiatives. The use of reports without explanation, analysis or findings is not helpful.</li> <li>6. Assure that staffing of critical areas to support violence reduction is a priority for the County.</li> <li>7. Continue to decrease the finding of “undetermined” for the reason for inmate/inmate violence; the same recommendations as included in the last compliance report.</li> </ol>
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III. **A. 2. Security Staffing**

Correctional staffing and supervision must be sufficient to adequately supervise incidents of inmate violence, including sexual violence, fulfill the terms of this Agreement, and allow for the safe operation of the Jail, consistent with constitutional standards. MDCR shall achieve adequate correctional officer staffing in the following manner:

Compliance Status:	Compliance: 7/11/18, 12/10/17, 3/3/17, 7/29/16, 5/15/15	Partial Compliance: 10/24/14, 3/28/14	Non-Compliance: Not yet due (11/27/13)	Other: Per MDCR not reviewed in 1/16.
Unresolved/partially resolved issues from previous tour:				
Steps taken by the County to Implement this paragraph:	MDCR has updated the staffing plan; the Mayor has indicated his support for funding the staffing as required.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR conducts very good staffing analyses, and adjusts the findings as needed. The County's human resources bureaucracy <b>needs to be responsive to the needs to fill positions, including civilian positions.</b> At the time of the last tour, the Monitor noted that counselors were needed to help implement the violence reduction program at MW, yet those positions were not filled for four months. The last report also needed the critical need for cleanliness in the clinics and infirmaries (custodial workers); and those civilian positions have just been filled.			
Monitor's Recommendations:	<ol style="list-style-type: none"> <li>1. Assure that the County's human resources bureaucracy handles requests with a level of urgency, especially for positions related to violence reduction (e.g. counselors) and clinic and infirmary cleanliness (maintenance workers.)</li> <li>2. MDCR may include calendar year 2018 data to document how long it takes from the time of a resignation until an individual is hired, as documentation of this collaboration.</li> </ol>			

<p>Paragraph <u>Coordinate with Drs. Johnson and Greifinger</u></p>	<p>III. A. 2. Security Staffing: b. MDCR shall ensure that the staffing plan includes staffing an adequate number of correctional officers at all times to escort inmates to and from medical and mental health care units.</p>			
<p>Protection from Harm: Compliance Status:</p>	<p>Compliance: 12/7/17, 3/3/17, 5/15/15</p>	<p>Partial Compliance: 7/11/18, 10/24/14, 3/28/14, 7/29/16</p>	<p>Non-Compliance: 7/19/13</p>	<p>Other: Per MDCR not reviewed in 1/16</p>
<p>Unresolved/partially resolved issues from previous tour:</p>				
<p><i>Measures of Compliance:</i></p>	<p><u>Protection from Harm:</u></p> <ol style="list-style-type: none"> <li>1. Staffing plan; staffing for escorts in each facility.</li> <li>2. Policies and procedure for officer escorts to and from medical and mental health care units.</li> <li>3. Overtime records, if any.</li> <li>4. Consultation with Drs. Johnson and Greifinger; interview with medical and mental health personnel</li> <li>5. Review of patient scheduling deficiencies (e.g. cancelled, rescheduled appointments).</li> </ol> <p><u>Medical Care:</u></p> <ul style="list-style-type: none"> <li>• Audit Step a: (Inspection) This compliance measure will be assessed by exception, i.e. any credible reports of lack of staff from CHS, MDCR and/or inmates to escort inmates to and from the medical health care appointments.</li> </ul> <p><u>Mental Health:</u></p> <ol style="list-style-type: none"> <li>1. Staffing plan; staffing for escorts in each facility.</li> <li>2. Policies and procedure for officer escorts to and from medical and mental health care units.</li> <li>3. Overtime records, if any.</li> <li>4. Consultation with Drs. Johnson and Greifinger; interview with medical and mental health personnel</li> <li>5. Review of patient scheduling deficiencies (e.g. cancelled, rescheduled appointments).</li> </ol>			
<p>Steps taken by the County to Implement this paragraph</p>	<p>MDCR conducted an audit of the provisions of this paragraph, dated May 22, 2018, using data provided by Corrections Health Services for January – March 2018. The audit cited a substantial discrepancy in the numbers reported by CHS (38) and MDCR (1,056). During the on-site compliance tour, the parties noted that this data was not correct, and would be corrected. The issue appeared to be a data-input issue.</p> <p>In CHS’ documentation production for the materials due under Summary Action Plan 4 (7/16/18), CHS noted that more staff had been hired since the last on-site compliance tour for the purpose of following-up on any clinic no-shows. If no-shows are identified, CHS immediately notifies the facility administrator. For April , CHS reported a total of 239 clinic no-shows (51 for PTDC, 135 for Metro West, and 53 for TGK). The reasons for the no-shows provided in this snap shot were:</p> <ul style="list-style-type: none"> <li>○ 27% patient refusal</li> <li>○ 42% clinic overbooking/overscheduling</li> <li>○ 4% patient transfer</li> <li>○ .04% no movement officer</li> <li>○ 25% undetermined</li> <li>○ .8% clinic lockdown or movement delay</li> </ul>			

	<p>The data provided by CHS is incomplete – and with 25% of the reasons as underdetermined, the data remains questionable.</p> <p>An additional 7 working days was provided to CHS/MDCR to update this information; and on July 24<sup>th</sup> additional clarification was provided, citing the need to train CHS staff on how to enter information into the data system regarding “no shows” related to no officer being available. The additional information also noted that a directive was put in place requiring CHS to notify the shift commander if there are any concerns by CHS that relate to staffing.</p>
<p>Monitors’ analysis of conditions to assess compliance, verification of the County’s representations, and the factual basis for finding(s)</p>	<p>As there are conflicts in the data, and late-submitted data and information, acknowledged by the County, the Monitor finds that this provision is in partial compliance. Prior to the next compliance tour, the County should identify the accurate data, and if necessary provide a corrective action plan.</p> <p>The County’s maintains that the audits conducted pursuant to demonstrating sustainability of compliance with this paragraph were not “required” as a measure of compliance, and as such should not be used to determine the current compliance rating.</p> <p>Nonetheless these were reports provided by the County, and stand as documentation. After five years of compliance initiatives, the County is aware of the significance of materials provided to the Monitor and should appropriately review submissions for accuracy. The need for a full-time compliance manager is thus demonstrated.</p> <p>There is no other way to report on this paragraph at this time except for partial compliance.</p>
<p>Monitors’ Recommendations:</p>	<ol style="list-style-type: none"> <li>1. Conduct a complete audit as to how data is collected, analyzed, and the development of a meaningful action plan.</li> <li>2. Prior to the next compliance tour, the County should identify the accurate data, and if necessary provide a corrective action plan.</li> </ol>

Paragraph	III. A. 2. Security Staffing: c. MDCR shall staff the facility based on full consideration of the staffing plan and analysis, together with any recommended revisions by the Monitor. The parties shall agree upon the timetable for the hiring of any additional staff.			
Compliance Status:	Compliance: 7/11/18, 12/10/17, 3/3/17, 7/29/16, 5/15/15,	Partial Compliance: 10/24/14; 3/28/14	Non-Compliance: Not yet due 11/27/13	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Completed staffing plan; discussion of recommendations by the monitor, if any. 2. Determination of the need for more hiring, if any. 3. Hiring plan, if needed, with timetable. 4. Results of hiring, if needed.			
Steps taken by the County to Implement this paragraph:	Staffing plan completed and updated; Director states that Mayor supports additional staffing request.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)				
Monitor's Recommendations:	No further recommendations. The hiring will be assessed at the next tour.			

Paragraph	III. A. 2. Security Staffing: d. Every 180 days after completion of the first staffing analysis, MDCR shall conduct and provide to DOJ and the Monitor staffing analyses examining whether the level of staffing recommended by the initial staffing analysis and plan continues to be adequate to implement the requirements of this Agreement. If the level of staffing is inadequate, the parties shall re-evaluate and agree upon the timetable for the hiring of any additional staff.		
Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16, 1/8/16	Partial Compliance:	<u>Not Yet Due:</u> 5/15/15 10/24/14; 3/28/14
Unresolved/partially resolved issues from previous tour:			
<i>Measures of Compliance:</i>	<ol style="list-style-type: none"> <li>1. Report from MDCR comparing if recommended staffing is adequate to implement the requirements of this agreement.</li> <li>2. Review of overtime costs; vacancies and vacancy trends.</li> <li>3. Re-evaluation of hiring and hiring timetable, if needed.</li> <li>4. Review/comment by the monitor of report in III.A.2.a., above.</li> </ol>		
Steps taken by the County to Implement this paragraph:	Completed and provided		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)			
Monitor's Recommendations:	Nothing further at this time.		

**III.A.3. Sexual Misconduct**

<p>Paragraph <u>Coordinate with Drs. Johnson and Greifinger</u></p>	<p>III. A. 3. Sexual Misconduct MDCR will develop and implement policies, protocols, trainings, and audits consistent with the requirements of the Prison Rape Elimination Act of 2003, 42 U.S.C. § 15601, et seq., and its implementing regulations, including those related to the prevention, detection, reporting, investigation, data collection of sexual abuse, including inmate-on-inmate and staff-on-inmate sexual abuse, sexual harassment, and sexual touching.</p>		
<p>Protection from Harm: Compliance Status:</p>	<p>Compliance: 7/11/18, 10/24/14,</p>	<p>Partial Compliance: 12/7/17, 3/3/17, 7/29/16, 1/8/16, 3/28/14, 7/19/13</p>	<p>Non-Compliance: MDCR did not request review during tour of 5/15; compliance was reviewed due to identifying issues of conflict with the PREA audit.</p>
<p>Unresolved/partially resolved issues from previous tour:</p>			
<p><i>Measures of Compliance:</i></p>	<p><u>Protection from Harm:</u>                      1. PREA policies and procedures                      2. Self-audit (separate action plan to be based on MDCR’s self-audit) [see <a href="http://static.nicic.gov/Library/026880.pdf">http://static.nicic.gov/Library/026880.pdf</a> ]                      3. Implementation of plans of action, etc., including audit results based on self-audit.</p>		
<p>Steps taken by the County to Implement this paragraph:</p>	<p>MDCR resolved all issues with the formal PREA audits of all facilities. MDCR conducted a self-assessment of PREA compliance, April 26, 2018.</p>		
<p>Monitors’ analysis of conditions to assess compliance, verification of the County’s representations, and the factual basis for finding(s)</p>	<p>This paragraph is found in compliance as all MDCR facilities have been audited per the requirements of the PREA standards, and passed these audits. These audits will now take place every three years.</p> <p>The Monitor will not review PREA compliance going forward; unless an incident(s) is identified by the SA and/or CA monitors indicates that the County is not in compliance with PREA standards. This must be a systemic issue rather than a single incident.                      MDCR posted their audits on their website as required by the PREA standards:  <a href="http://www.miamidade.gov/corrections/library/2017-08-29-prea-audit-report.pdf">http://www.miamidade.gov/corrections/library/2017-08-29-prea-audit-report.pdf</a></p> <p>Monitors were advised that there needs to be attention to the management of/communications with transgender inmates; and MDCR was also informed. They are reviewing the concerns. This is not sufficient information to find this paragraph in anything but compliance. The Monitors will follow-up on this matter in the next audit.</p>		
<p>Monitors’ Recommendations:</p>	<ol style="list-style-type: none"> <li>1. The County is encouraged to conduct annual reviews of on-going PREA compliance in anticipation for the next formal audit; including implementation of recommendations as contained in the self-audit dated April 26, 2018. Monitor will follow-up at the next tour.</li> <li>2. Review/document the MDPD’s SVU’s collaboration with CHS’ mental health providers, pursuant to the Director’s memo of May 23, 2018. Monitor will follow-up at the next tour.</li> <li>3. Prior to the next tour, MDCR should review the management of transgender inmates; provide any findings and, in necessary, provide plans of action.</li> </ol>		

**III. A. 4. Incidents and Referrals**

Paragraph	4. Incidents and Referrals a. MDCR shall ensure that appropriate managers have knowledge of critical incidents in the Jail to act in a timely manner to prevent additional harm to inmates or take other corrective action. At a minimum, MDCR shall document all reportable incidents by the end of each shift, but no later than 24 hours after the incident. These incidents should include inmate fights, rule violations, inmate injuries, suicide attempts, cell extractions, medical emergencies, contraband, destruction of property, escapes and escape attempts, and fires.			
Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16, 10/24/14	Partial Compliance: 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:	None at this time			
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding notifications to managers regarding critical incidents; actions required. 2. Policies and procedures regarding reportable incidents. 3. Documentation of notification managers; checklists/incident reports. 4. Review of incident reports. 5. Review of critical incidents. 6. Interview with supervisory and management staff.			
Steps taken by the County to Implement this paragraph:				
Monitor’s analysis of conditions to assess compliance, verification of the County’s representations, and the factual basis for finding(s)	MDCR is in compliance with this paragraph by documenting the incidents.  MDCR needs to develop a format and processes for critical incident reviews. The reviews of critical incident provided did not contain findings and/or recommendations. Two of the reviews had a section entitled “additional considerations” which were somewhere between findings and recommendations.  It is essential that the organization develop self-critical review of serious incidents, including findings and recommendations (and action plans as needed).			
Monitor’s Recommendations:	1. See recommendations in III.A.1.a. (1)			

Paragraph	4. Incidents and Referrals b. Staff shall report all suicides and other deaths immediately, but no later than one hour after the incident, to a supervisor, Internal Affairs ("IA"), and medical and mental health staff.			
Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16, 10/24/14	Partial Compliance:	Non-Compliance: 3/28/14, 7/19/14	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding notifications for critical incidents, including suicides and deaths. 2. Documentation of notification checklists/documentation. 3. Review of incident reports/investigations.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Documentation evidenced compliance.			
Monitor's Recommendations:	No recommendations at this time.			

Paragraph	<p>4. Incidents and Referrals</p> <p>c. MDCR shall employ a system to track, analyze for trends, and take corrective action regarding all reportable incidents. The system should include at least the following information:</p> <ol style="list-style-type: none"> <li>1. unique tracking number;</li> <li>2. inmate(s) name;</li> <li>3. housing classification;</li> <li>4. date and time;</li> <li>5. type of incident;</li> <li>6. any injuries to staff or inmate;</li> <li>7. any medical care;</li> <li>8. primary and secondary staff involved;</li> <li>9. reviewing supervisor;</li> <li>10. any external reviews and results;</li> <li>11. corrective action taken; and</li> <li>12. administrative sign-off.</li> </ol>		
Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16, 1/8/16	Partial Compliance: 5/15/15; 10/24/14; 3/28/14	Non-Compliance: 7/19/13
Unresolved/partially resolved issues from previous tour:			
<i>Measures of Compliance:</i>	<p><u>Protection from Harm:</u></p> <ol style="list-style-type: none"> <li>1. Policies and procedures to track, analyze data, develop corrective action plans, as needed for all reportable incidents.</li> <li>2. Definition of reportable incidents.</li> <li>3. Review of reports, analysis, corrective action plans.</li> <li>4. Review of elements in database.</li> <li>5. Review of incident reports</li> <li>6. Review of any external reviews/results.</li> <li>7. Review of corrective action plan, if any.</li> <li>8. Review of data/reports generated from the information in the system.</li> </ol>		
Steps taken by the County to Implement this paragraph:	The current information system captures this information.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	<p>The County's plan to have the current inmate telephone vendor include in their contract the new offender management system has not come to fruition. The vendor has indicated to the Director that it, GTL, will pay for the costs associated with a vendor of the County's choice to develop the system. This has essentially put MDCR a few more years away from implementation of a system needed for an agency of this size and complexity.</p> <p>Nonetheless, the current jail management system supports the requirements of this paragraph.</p>		

Monitor's Recommendations:	1. Assure the request for proposal and subsequent award processes insure that relevant paragraphs of both the Settlement Agreement and Consent Agreement, including interfaces with Cerner and other CHS data system, are required as part of any new system.
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<p><u>Paragraph</u>  <u>Coordinate with Dr. Johnson</u>  <u>See Also Consent III.A.3.(4)</u></p>	<p>4. Incidents and Referrals  d. MDCR shall develop and implement a policy to screen incident reports, use of force reports, and inmate grievances for allegations of staff misconduct and refer an incident or allegation for investigation if it meets established policy criteria.</p>			
<p>Protection from Harm: Compliance Status:</p>	<p>Compliance: 3/3/17, 7/29/16, 5/15/15</p>	<p>Partial Compliance: 7/11/18, 12/7/17, 10/24/14</p>	<p>Non-Compliance: 3/28/14, 7/19/13 (not yet due)</p>	<p>Other: Per MDCR not reviewed in 1/16</p>
<p>Unresolved/partially resolved issues from previous tour:</p>				
<p><u>Measures of Compliance:</u></p>	<p><u>Protection from Harm:</u></p> <ol style="list-style-type: none"> <li>1. Policies and procedures regarding incident reports, including criteria for screening for critical incidents (see also III.A.3);</li> <li>2. Documentation of referrals of grievances for investigations; outcomes.</li> <li>3. Corrective actions for incidents not referred as required.</li> <li>4. Review of medical and mental health policies and procedures regarding referrals/notifications of inmate injuries that might be result from staff misconduct, use of excessive force, inmate/inmate sexual assault, etc.</li> <li>5. Medical and mental health policies and procedure regarding review of medical grievances to screen for critical incidents.</li> <li>6. Documentation of referrals to investigators by medical and/or mental health staff, if any.</li> <li>7. Assure that companion CHS policies are in place, and medical providers are trained at recognizing signs and symptoms of use of force, use of excessive force, and inmate/inmate assault and sexual assault.</li> </ol> <p><u>Mental Health:</u></p> <ol style="list-style-type: none"> <li>1. Policies and procedures regarding incident reports, including criteria for screening for critical incidents (see also III.A.3);</li> <li>2. Documentation of referrals of grievances for investigations; outcomes.</li> <li>3. Corrective actions for incidents not referred as required.</li> <li>4. Review of medical and mental health policies and procedures regarding referrals/notifications of inmate injuries that might be result from staff misconduct, use of excessive force, inmate/inmate sexual assault, etc.</li> <li>5. Medical and mental health policies and procedure regarding review of medical grievances to screen for critical incidents.</li> <li>6. Documentation of referrals to investigators by medical and/or mental health staff, if any.</li> </ol>			
<p>Steps taken by the County to Implement this paragraph:</p>	<p>MDCR and CHS have established a grievance committee working to improve all processes. The Medical/MH Monitors report partial compliance with this provision of the CA; hence it is in partial compliance for the Settlement Agreement.</p> <p>In its review of this draft compliance report, the County renews its objection that there should be no link between compliance in the Settlement Agreement and Compliance in the Consent Agreement.</p>			
<p>Monitors' analysis of conditions to assess compliance, verification of</p>	<p><u>Protection from harm:</u>  <b>NOTE that Consent III. A.3.(4) is in partial compliance.</b>  See also recommendations contained in III. C. Inmate Grievances</p>			

<p>the County’s representations, and the factual basis for finding(s)</p>	<p><u>Mental Health:</u>                  There is evidence that responses are being provided to inmates on the mental health caseload who file grievances. There is a disproportionately low number of grievances submitted from this population indicating attention/advocacy is needed for this population. Additionally, the responses are not sufficiently in-depth in terms of problem solving rather than justifying the actions taken or not taken.</p>
<p>Monitors’ Recommendations:</p>	<p><u>Protection from Harm/Mental Health:</u></p> <ol style="list-style-type: none"> <li>1. MDCR coordinate with CHS to assure all inmates’ medical care includes visual screening for these incidents.</li> <li>2. Assure that MDCR’s inspectional processes assesses this requirement.</li> <li>3. Provide any self-audit of this provision prior to the Monitors next tour, including any evidence of specific inmate grievances referred based on the requirements of this paragraph.</li> </ol>

Paragraph	4. Incidents and Referrals e. Correctional staff shall receive formal pre-service and biennial in-service training on proper incident reporting policies and procedures.			
Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16	Partial Compliance: 10/24/14; 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
<i>Measures of Compliance:</i>	<u>Protection from Harm:</u> 1. Policies and procedures regarding training on preparing incident reports; and notification criteria for critical incidents. 2. Lesson plans; pre-service and in-service. 3. Training schedule and attendance rosters. 4. Documentation of knowledge gained (e.g. pre-and post-tests) 5. Evidence of remedial training, if needed. 6. Review of incident reports.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Audit findings regarding other training required by the SA and CA revealed deficiencies. A recommendations is included with paragraph III.A.4.f. for MDCR to consider an audit of the entire training function.			
Monitor's Recommendations:	1. Prior to the next on-site tour, MDCR is requested to conduct an audit of this provision. See recommendations for III.A.4.f.			

Paragraph	4. Incidents and Referrals f. MDCR shall continue to train all corrections officers to immediately inform a member of the Qualified Medical Staff when a serious medical need of an inmate arises.		
Protection from Harm: Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 1/8/16	Partial Compliance: 7/29/16, 5/15/15, 10/24/14, 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
<i>Measures of Compliance:</i>	<ol style="list-style-type: none"> <li>1. Policies and procedures regarding training for notifications for Medical Care and mental health emergencies.</li> <li>2. Lesson plans; training schedule.</li> <li>3. Documentation of knowledge gained (e.g. pre-and post-tests)</li> <li>4. Evidence of remedial training, if needed.</li> <li>5. Review of incidents in which medical/mental health issues reported and not reported.</li> <li>6. Minutes of meetings between security and medical/mental health.</li> </ol>		
Steps taken by the County to Implement this paragraph:	<p>MDCR conducted an audit of the provisions of this paragraph, dated May 9, 2018. The audit concluded that the training materials were not being updated when new policies and related written directives were implemented, and that test questions had not been revised since the unspecified date of the lesson plan. The audit does not address how many staff may not have received the updated/correct training, whether these individuals will be identified, and some remediation undertaken.</p> <p>An action plan was prepared, and updated July 3, 2018.</p>		
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	<p>The MDCR audit found that the training lesson plans, the core of the required training, tests, and related materials were not timely updated. An action plan was prepared, but it lack dates when the work will be done, who is responsible for the work, and changes to internal procedures in the training bureau that will assure on-going compliance. The audit does not address how long this situation has continued – e.g. since 2017 or 2016, etc. therefore the scope of the needed remedies cannot be determined.</p> <p>With this finding for this training topic, it raises questions regarding the other training lesson plans, related materials, and the quality of the training program. Perhaps, MDCR should undertake an audit of all training.</p> <p>This paragraph will remain in compliance, but the results of the corrective action plan will be reviewed prior to the next on-site compliance tour.</p>		
Monitor's Recommendations:	<ol style="list-style-type: none"> <li>1. Consider conducting a more complete audit of findings, specifically how many staff may need training remediation and the length of time, and number of training sessions which have used outdated materials and lesson plans.</li> <li>2. Prior to the next tour, report on the results of the corrective action plan (July 3, 2018).</li> </ol>		

**III. A. 5. Use of Force by Staff**

Paragraph	<p>III. A. 5. Use of Force by Staff</p> <p>a. Policies and Procedures</p> <p>(1) MDCR shall sustain implementation of the “Response to Resistance” policy, adopted October 2009. In accordance with constitutional requirements, the policy shall delineate the use of force continuum and permissible and impermissible uses of force, as well as emphasize the importance of de-escalation and non-force responses to resistance. The Monitor shall provide ongoing assistance and annual evaluation regarding whether the amount and content of use of force training achieves the goal of reducing excessive use of force. The Monitor will review not only training curricula but also relevant data from MDCR’s bi-annual reports.</p> <p>(2) MDCR shall revise the “Decontamination of Persons” policy section to include mandatory documentation of the actual decontamination time in the response to resistance reports.</p> <p>(3) The Jail shall ensure that each Facility Supervisor/Bureau Commander reviews all MDCR incidents reports relating to response to resistance incidents. The Facility Supervisor/Bureau Commander will not rely on the Facility’s Executive Officer’s review.</p>		
Compliance Status:	Compliance: 7/11/18, 3/3/17	Partial Compliance: 12/7/17, 7/29/16, 1/8/16, 5/15/15, 10/24/14, 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
<i>Measures of Compliance:</i>	<p><u>Protection from Harm:</u></p> <ol style="list-style-type: none"> <li>1. Policies and procedures regarding use of force, response to resistance, including reporting and review protocols.</li> <li>2. Monitor’s annual evaluation of relevant data, including whether the amount and content of use of force training achieves the goal of reducing use of excessive force; review of bi-annual reports from MDCR.</li> <li>3. Policies and procedures regarding decontamination; corresponding medical policies/procedures.</li> <li>4. Policies and procedures on review of incident reports (see also III.A.4.a, III.A. 4.b.) by Facility Supervisor/Bureau Commander.</li> <li>5. Review of reports; data.</li> </ol>		
Steps taken by the County to Implement this paragraph:	<p>MDCR continues to examine the causes and countermeasures for the uses of force and inmate/inmate violence. The MDCR inmate violence report for the first quarter of 2018 reports that the uses of force have increased from 445 in 2014 to 712 in 2017, with fewer inmates in custody. MDCR reports that 48% of the uses of force in this quarter were to stop inmate fighting, although the cause of the fight in 43% of the instances was undetermined. Thus the need to address the causes (via investigations and other proactive measures) of inmate/inmate altercations is a necessary first step to addressing uses of force.</p> <p>MDCR has suggested an amendment to the definition of a use of force excluding instances where staff simply pull inmates apart without using any force and where no injuries result to staff or the inmate. Such an event would be reported as an inmate/inmate altercation. MDCR’s survey of other jails indicates that are varying definitions; and there is no national definition.</p>		

<p>Monitor’s analysis of conditions to assess compliance, verification of the County’s representations, and the factual basis for finding(s)</p>	<p>The Monitor assesses this paragraph in compliance at this time as there is no evidence of excessive uses of force, or any pattern of excessive uses of force.. However, there are too many uses of force, for which the underlying causes have not been identified.</p> <p>The Monitor suggests that de-escalation training be a priority. MDCR noted that there is a report done by staff when a fight is avoided due to de-escalation; but it was not provided to the Monitor.</p>
<p>Monitor’s Recommendations:</p>	<p>1. New Recommendation – Assure that “de-escalation techniques” are not limited to verbal commands in non-emergency situations.</p>

<p>Paragraph <u>See Consent Agreement III.B.3.c.</u></p>	<p>III. A. 5. Use of Force by Staff                      b. Use of Restraints                      (1) MDCR shall revise the “Recognizing and Supervising Mentally Ill Inmates” policy regarding restraints (DSOP 12-005) to include the following minimum requirements:                      i. other than restraints for transport only, mechanical or injectable restraints of inmates with mental illness may only be used after written approval order by a Qualified Health Professional, absent exigent circumstances.                      ii. four-point restraints or restraint chairs may be used only as a last resort and in response to an emergency to protect the inmate or others from imminent serious harm, and only after the Jail attempts or rules out less-intrusive and non-physical interventions.                      iii. the form of restraint selected shall be the least restrictive level necessary to contain the emerging crisis/dangerous behavior.                      iv. MDCR shall protect inmates from injury during the restraint application and use. Staff shall use the least physical force necessary to control and protect the inmate.                      v. restraints shall never be used as punishment or for the convenience of staff. Threatening inmates with restraint or seclusion is prohibited.                      vi. any standing order for an inmate’s restraint is prohibited.                      (2) MDCR shall revise its policy regarding restraint monitoring to ensure that restraints are used for the minimum amount of time clinically necessary, restrained inmates are under 15 minute in-person visual observation by trained custodial staff. For any custody-ordered restraints, Qualified Medical Staff are notified immediately in order to review the health record for any contraindications or accommodations required and to initiate health monitoring.</p>			
<p>Protection from Harm: Compliance Status:</p>	<p>Compliance: 7/11/18, 3/3/17, 7/29/16</p>	<p>Partial Compliance: 12/7/17, 5/15/15, 10/24/14, 3/28/14, 7/19/14</p>	<p>Non-Compliance:</p>	<p>Other: Per MDCR not reviewed in 1/16</p>
<p>Unresolved/partially resolved issues from previous tour:</p>				
<p><i>Measures of Compliance:</i></p>	<ol style="list-style-type: none"> <li>1. Policies and procedures regarding recognizing and supervising inmates with mental illness; use of restraints; monitoring those in restraints and elements of this paragraph of the Settlement Agreement.</li> <li>2. Corresponding medical and mental health policies/procedures. Consistency between the directives of security and medical/mental health.</li> <li>3. Minutes of meetings between security and medical/mental health in which these topics are reviewed/discussed; or other documentation of collaboration, and problem-solving.</li> <li>4. Review of uses of restraints; required logs.</li> <li>5. Identification of employees requiring training.</li> <li>6. Review of use of seclusion.</li> <li>7. Lesson plans and schedule for training.</li> <li>8. Maintenance of data regarding uses of force involving inmates on the mental health caseload, by facility.</li> </ol>			
<p>Steps taken by the County to Implement this paragraph:</p>	<p>In its review of this draft compliance report, the County renews its objection that there should be no link between compliance in the Settlement Agreement and Compliance in the Consent Agreement.</p>			

<p>Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)</p>	<p>The Mental Health Monitor has found CHS and MDCR to be in compliance with the companion standard in the CA. Therefore this paragraph in the SA is now in compliance. See CA III. B. c. (1-3) which is now in compliance.</p>
<p>Monitors' Recommendations:</p>	<ol style="list-style-type: none"> <li>1. Provide training to all staff working with all levels of inmates on the mental health caseload. Consider conducting an audit of the training to assure that staff have the tools, other than verbal commands, to deescalate in non-emergency situations.</li> <li>2. Continue to document discussions in MAC and mini-MAC meetings.</li> </ol>

Paragraph	III. A. 5. Use of Force by Staff c. Use of Force Reports (1) MDCR shall develop and implement a policy to ensure that staff adequately and promptly report all uses of force within 24 hours of the force.		
Compliance Status this tour:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16, 10/24/14, 3/28/14	Partial Compliance:	Non-Compliance: July 2013, not reviewed 5/11/15
Unresolved/partially resolved issues from previous tour:	NA		
Measures of Compliance:	<u>Protection from Harm:</u> a. Policies and procedures regarding reporting of uses of force; definitions; reporting formats; time requirements. b. Review of incident reports. c. Review of investigations into uses of force. d. Review of remedial/corrective actions, if any.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Remains in compliance with policy.		
Monitor's Recommendations:	No recommendations at this time other than to consider the TAAP findings when MDCR conducts the annual evaluation of the policy. This should include developing corrective action plans, as necessary. For the next tour, the Monitor will be asking to see any such action plans, based on TAAP recommendations and/or leadership decisions as to which TAAP recommendations to pursue.		

Paragraph	<p>III.A. 5.c.                  (2) MDCR shall ensure that use of force reports:</p> <ul style="list-style-type: none"> <li>i. are written in specific terms and in narrative form to capture the details of the incident in accordance with its policies;</li> <li>ii. describe, in factual terms, the type and amount of force used and precise actions taken in a particular incident, avoiding use of vague or conclusory descriptions for describing force;</li> <li>iii. contain an accurate account of the events leading to the use of force incident;</li> <li>iv. include a description of any weapon or instrument(s) of restraint used, and the manner in which it was used;</li> <li>v. are accompanied with any inmate disciplinary report that prompted the use of force incident;</li> <li>vi. state the nature and extent of injuries sustained both by the inmate and staff member</li> <li>vii. contain the date and time any medical attention was actually provided;</li> <li>viii. include inmate account of the incident; and</li> <li>ix. note whether a use of force was videotaped, and if not, explain why it was not videotaped.</li> </ul>			
Protection from Harm: Compliance Status:	Compliance: 3/3/17	Partial Compliance: 7/11/18, 12/17/17, 7/29/16, 1/8/16, 10/24/14, 3/28/14	Non-Compliance: 7/19/13	Other: Other: Not reviewed per MDCR 5/15
Unresolved/partially resolved issues from previous tour:				
<i>Measures of Compliance:</i>	<p><u>Protection from Harm:</u></p> <ol style="list-style-type: none"> <li>1. Policies and procedures regarding use of force reports; specifications for reporting.</li> <li>2. Review of incident reports.</li> <li>3. Review of investigations.</li> <li>4. Review of inmate disciplinary reports.</li> <li>5. Review of lesson plans.</li> <li>6. Review of Medical Care/mental health records regarding injuries, including any required off-site hospitalizations.</li> <li>7. Review of sample of staff workers' compensation claim relating to uses of force, inmate/inmate altercations.</li> <li>8. Remedial, corrective action if necessary.</li> <li>9. Review of digitally recorded incidents.</li> <li>10. Review of MDCR Inmate Violence Report</li> </ol>			
Steps taken by the County to Implement this paragraph:	<p>MDCR has worked to update investigative practices in response to gathering victim/inmate statements. A memorandum dated April 1, 2018 notes these proposed improvements: policy revision to include investigators attempts to gather statements, resolve any inconsistencies, including adding training for these investigators; add more aggressive oversight of investigations into uses of force from SIAB; reinstitute internal surveillance of security threat groups in collaboration with MDPD, evaluation of the feasibility of dual-certified corrections officers and assign to facilities to provide for more timely reviews, enhance quality of investigations, and develop corrections specific expertise; and standardize critical incident reviews. The goal is to assign three investigators, one assigned to each facility, by July 2018.</p> <p>MDCR's report on violence for the first quarter reports that the reasons for the assaults were undetermined (43.11%). This is relevant as MDCR reports that 48% of "uses of force" are related to stopping up inmate fights. Having such large</p>			

	<p>number of undetermined causes is problematic to establishing an effective countermeasure, and related to the lack of focus on interviews with combatants.</p> <p>The County notes in their review of this draft report that they are making efforts to gain witness statements; and cite their strategies to improve the outcomes of “undetermined” altercations; therefore asking for substantial compliance. As noted below, these witness statements are critical to improving outcomes, and have been referenced in previous compliance reports.</p>
<p>Monitors’ analysis of conditions to assess compliance, verification of the County’s representations, and the factual basis for finding(s)</p>	<p>The proposal of April 1<sup>st</sup> are excellent first steps; and the Monitor awaits an update, and timelines for implementation.</p> <p>The Monitor’s review of use of force reports indicates efforts are improving to obtain witness and victim statements; and improvements are still needed. TAAP did a good job of flagging inmate statements that were not accurately summarized by the facility-investigators and returned for clarification.</p> <p>As the implementation of changes to address the issue of victim/witness statements remain outstanding, this provision will remain in partial compliance. The recommendations to address this matter have been included in previous reports, but not until after Compliance Tour # 8 were they addressed in any substantive way. The work to date, is commendable, but as the credible witness interviews and statements are crucial to developing strategies to address violence, substantial compliance is not noted at this time.</p> <p>The County reports that in the near future one investigator in each facility will be assigned to follow-up.</p>
<p>Monitors’ Recommendations:</p>	<ol style="list-style-type: none"> <li>1. Prior to the next tour, provide an update on the elements of improved internal investigative capacity/human resources at MDCR based on the April 1, 2018 memorandum; including any corrective actions or revised plans.</li> </ol>

Paragraph	III. A. 5.c. (3) MDCR shall require initial administrative review by the facility supervisor of use of force reports within three business days of submission. The Shift Commander/Shift Supervisor or designee shall ensure that prior to completion of his/her shift, the incident report package is completed and submitted to the Facility Supervisor/Bureau Commander or designee.			
Compliance Status:	Compliance: 7/11/18, 12/10/17, 3/3/17, 7/29/16, 5/15/15	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 1/16
Unresolved/partially resolved issues from previous tour:				
<i>Measures of Compliance:</i>	<u>Protection from Harm:</u> 1. Policies and procedures regarding use of force reports; supervisory review of reports; time deadlines. 2. Review of incident reports; review of a sample of use of force incident report packages for each facility. 3. Review of investigations. 4. Remedial, corrective action if necessary 5. Lesson plans regarding supervisory review of use of force reports.			
Steps taken by the County to Implement this paragraph:	There was a change in the process since the last tour, in which the facility supervisor's [commander] review of the use of force are contained in the reporting format, rather than requiring a separate memorandum.			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Monitor's review of use of force packages reveals that the commanders' reviews are not always identifiable, or they reviews fail to confirm or agree with findings and recommendations of those who have thus far reviewed the reports.  As this is a new process, continuing compliance is noted above; but upon review of two quarters of reports for the next tour, the facility supervisors' reviews need to be more substantial, reflecting both the comments made by others, and any additional recommendations.			
Monitor's Recommendations:	1. Provide updated training for facility leadership to improve reviews prior to the next tour.			

Paragraph	III. A. 5.c. (4) The Facility Supervisor/Bureau Commander or his/her designee shall submit the MDCR Incident Report (with required attachments) and a copy of the Response to Resistance Summary (memorandum) to his/her Division Chief within 14 calendar days. If the MDCR Incident Report and the Response to Resistance Summary (memorandum) are not submitted within 14 calendar days, the respective Facility Supervisor/Bureau Commander or designee shall provide a memorandum to his/her Division Chief explaining the reason(s) for the delay.			
Compliance Status:	Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16, 10/24/14	Partial Compliance: 7/19/13	Non-Compliance:	Other: Per MDCR not reviewed in 5/15, 1/16
Unresolved/partially resolved issues from previous tour:				
Measures of Compliance:	<u>Protection from Harm:</u> 1. Policies and procedures regarding use of force reports; supervisory review of reports; time deadlines. 2. Review of MDCR Incident Report and Response to Resistance Summary, as specified above. 3. Review of memoranda with exceptions. 4. Review of investigations. 5. Remedial, corrective action if necessary 6. Review of post orders; job descriptions for Facility supervisor/Bureau Commander.			
Steps taken by the County to Implement this paragraph:				
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See the comments/findings in SA III.A.5.c. (3)			
Monitor's Recommendations:	See SA III.A.5.c. (3)			

<p>Paragraph See Consent Agreement III. B. 3</p>	<p>III. A. 5.c. (5) The Division Chief shall review use of force reports, to include a review of medical documentation of inmate injuries, indicating possible excessive or inappropriate uses of force, within seven business days of submission, excluding weekends. The Division Chief shall forward all original correspondences within seven business days of submission, excluding weekends to Security and Internal Affairs Bureau.</p>			
<p>Protection from Harm: Compliance Status:</p>	<p>Compliance: 7/11/18, 12/7/17, 3/3/17, 7/29/16, 10/24/14, 3/28/14</p>	<p>Partial Compliance: 7/19/13</p>	<p>Non-Compliance:</p>	<p>Other: Per MDCR not reviewed in 5/15, 1/16</p>
<p>Unresolved/partially resolved issues from previous tour:</p>				
<p><i>Measures of Compliance:</i></p>	<p><u>Protection from Harm:</u>                      1. Policies and procedures regarding use of force reports; review of reports; time deadlines.                      2. Review of incident reports.                      3. Review of Division Chiefs' reports                      4. Referrals to IAB.                      5. Review of inmate medical records.                      6. Review of investigations.                      7. Remedial, corrective action if necessary.                      8. Review of post orders/job descriptions of Division Chief.</p>			
<p>Steps taken by the County to Implement this paragraph:</p>	<p>See III.A.5.c.3.</p>			
<p>Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)</p>	<p>The revised use of force reporting process moves the facility and division commander's report to the form, rather than in a cover memorandum. The Monitor's review of use of force packages for the last quarter of 2017 did not identify the facility commander's response in some of the reports; especially concerning when the sergeant or lieutenant found issues in the use of force and/or the reporting. MDCR's observation was that if the leadership/management staff agreed with the observations of their subordinate staff, they didn't write anything further.  MDCR should assure that the findings/recommendations of the facility commander are reported/identified.</p>			
<p>Monitors' Recommendations:</p>	<p>1. Review the process to assure compliance with this paragraph. If the policy needs amendment, do so; if the training is an issue; provide training. Provide update prior to the next compliance tour.</p>			

<p>Paragraph See Consent Agreement III. B. 3. b.</p>	<p>III. A. 5.c. (6) MDCR shall maintain its criteria to identify use of force incidents that warrant a referral to IA for investigation. These criteria should include documented or known injuries that are extensive or serious; injuries of suspicious nature (including black eyes, injuries to the mouth, injuries to the genitals, etc.); injuries that require treatment at outside hospitals; staff misconduct; complaints by the inmate or someone reporting on his/her behalf, and occasions when use of force reports are inconsistent, conflicting, or suspicious.</p>			
<p>Protection from Harm: Compliance Status:</p>	<p>Compliance: 7/11/18, 3/3/17, 7/29/16, 5/15/15</p>	<p>Partial Compliance: 12/7/17, 10/24/14</p>	<p>Non-Compliance: 7/19/13</p>	<p>Other: Per MDCR not reviewed in 1/16</p>
<p>Unresolved/partially resolved issues from previous tour:</p>	<p>Assure that CHS staff are trained per CA III.B.3. c.</p>			
<p><i>Measures of Compliance:</i></p>	<p><u>Protection from Harm:</u>                      1. Policies and procedures regarding criteria for referrals to IAB for use of force investigations.                      2. Review of reports.                      3. Review of medical and mental health policies and procedures for referrals regarding injuries consistent with excessive use of force, and other related critical incidents.                      4. Documentation of referrals from medical/mental health to IAB.                      5. Minutes of meeting between security and medical/mental health in which these topics are discussed/reviewed.                      6. Treatment of inmates at outside hospitals.                      7. PREA policies, data.                      8. Review of investigations.                      9. Review of remedial or corrective action plans, if any.</p>			
<p>Steps taken by the County to Implement this paragraph:</p>	<p>MDCR and CHS conducted a review, dated June 1, 2018. The review found that MDCR provided CHS staff with orientation training, including 37 new CHS staff from 1/1/18 – 5/3/18. The review identified that a formal lesson plan was never developed for this training, which will be developed by October 31, 2018.</p> <p>CHS provided, in their most recent submission (7/16/18) in response to Summary Action Plan 4, information about their training. In this submission, CHS produced “curriculum” – which is really Power Points to train staff. This material does not address the injuries noted in this paragraph. Further, audit tool # 30 provides data about conformance with CHS/MDCR policies.</p> <p>In its review of this draft compliance report, the County renews its objection that there should be no link between <u>compliance in the Settlement Agreement and Compliance in the Consent Agreement.</u></p>			
<p>Monitors’ analysis of conditions to assess compliance, verification of the County’s representations, and the factual basis for finding(s)</p>	<p>To their credit, MDCR and CHS have identified that training for CHS staff, the front line of identifying possible sexual abuse and excessive uses of force, although provided, was never finalized in terms of a lesson plan. The County provided the outline of a web-based training for CHS which includes important information, dated May 8, 2018, however, it needs to be adapted for a jail setting.</p> <p>CA III.B.3.b. is in compliance.</p>			



















































































































































































































































































































































<p>Paragraph Author: Johnson</p>	<p>III.D.2.a. (3) Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi-annual reports regarding the following: All health care delivered by the Jail to inmates to address serious medical concerns. The report will include: i. All suicide-related incidents. The report will include: ii. all suicides; iii. all serious suicide attempts; iv. list of inmates placed on suicide monitoring at all levels, including the duration of monitoring and property allowed (mattress, clothes, footwear); v. all restraint use related to a suicide attempt or precautionary measure; and vi. information on whether inmates were seen within four days after discharge from suicide monitoring.</p>		
<p>Mental Health: Compliance Status:</p>	<p>Compliance:</p>	<p>Partial Compliance: 1/16; 3/3/2017; 12/7/17; 7/18</p>	<p>Non-Compliance: 10/14 (NR); 5/15 (NR); 7/29/16</p>
<p>Measures of Compliance:</p>	<p><b>Mental Health:</b></p> <ul style="list-style-type: none"> <li>The Mental Health Monitor receives bi-annual reports of health care delivered to inmates <b>including the volume of and reason</b> for episodic clinic visits, follow-up/chronic care clinic visits, ER transfers, and hospitalizations.</li> <li>Bi-annual reports are being submitted in a timely manner <b>and to include accurate data supportive of its conclusions.</b></li> </ul>		
<p>Steps taken by the County to Implement this paragraph:</p>	<p>The Bi-annual report was provided</p>		
<p>Monitor’s analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County’s representations, and the factual basis for finding(s):</p>	<p>See comments from III.D.2.a.</p>		
<p>Monitor’s Recommendations:</p>	<p>See recommendations from III.D.2.a.</p>		

<p>Paragraph Author: Johnson</p>	<p>III.D.2.a. (4) Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi-annual reports regarding the following: Inmate counseling services. The report and review shall include: (4) inmates who are on the mental health caseload, classified by levels of care; (5) inmates who report having participated in general mental health/therapy counseling and group schedules, <u>as well as any waitlists for groups</u>; (6) inmates receiving one-to-one counseling with a psychologist, as well as any <b>waitlists for such counseling</b>; and (7) <u>inmates receiving one-to-one counseling with a psychiatrist</u>, as well as any <b>waitlists for such counseling</b>.</p>		
<p>Mental Health: Compliance Status:</p>	<p>Compliance:</p>	<p>Partial Compliance: 3/3/2017; 12/7/17; 7/18</p>	<p>Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16; 7/29/16</p>
<p><i>Measures of Compliance:</i></p>	<p><u>Mental Health:</u></p> <ul style="list-style-type: none"> <li>• The Mental Health Monitor receives bi-annual reports of health care delivered to inmates including the volume of and reason for episodic clinic visits, evidence of timely follow-up/chronic care clinic visits, group therapy and individual therapy.</li> <li>• Bi-annual reports are being submitted in a timely manner and to include accurate data supportive of its conclusions.</li> </ul>		
<p>Steps taken by the County to Implement this paragraph:</p>	<p>The Bi-annual report was produced.</p>		
<p>Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):</p>	<p>See comments from III.D.2.a.</p>		
<p>Monitor's Recommendations:</p>	<p>See recommendations from III.D.2.a.</p>		

<p>Paragraph Author: Johnson</p>	<p>III.D.2.a. (5) Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi-annual reports regarding the following: The report will include: (8) Total number of inmate disciplinary reports, the number of reports that involved inmates with mental illness, and whether Qualified Mental Health Professionals participated in the disciplinary action.</p>		
<p>Mental Health: Compliance Status:</p>	<p>Compliance:</p>	<p>Partial Compliance: 1/16; 3/3/2017; 12/7/17; 7/18</p>	<p>Non-Compliance: 10/14 (NR); 5/15 (NR); 7/29/16</p>
<p><i>Measures of Compliance:</i></p>	<ul style="list-style-type: none"> <li>• The Mental Health Monitor receives bi-annual reports of health care delivered regarding inmates involved in disciplinary reports at each level of care, the date of any hearing that may have resulted as a result of the disciplinary hearing, whether a QMHP participated in the disciplinary action, and the outcome.</li> <li>• Bi-annual reports are being submitted in a timely manner and to include accurate data supportive of its conclusions.</li> </ul>		
<p>Steps taken by the County to Implement this paragraph:</p>	<p>The County submitted a Biannual report.</p>		
<p>Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):</p>	<p>See comments from III.D.2.a.</p>		
<p>Monitor's Recommendations:</p>	<p>See recommendations from III.D.2.a.</p>		

<p>Paragraph Authors: Greifinger and Johnson</p>	<p>III.D.2.a.(6) Starting within six months of the Effective Date, the County and CHS will provide to the United States and the Monitor bi-annual reports regarding the following: ... [6] Reportable incidents. The report will include: i. a brief summary of all reportable incidents, by type and date; ii. [Joint audit with MH] a description of all suicides and in-custody deaths, including the date, name of inmate, and housing unit; and iii. number of grievances referred to IA for investigation.</p>		
<p>Medical Care: Compliance Status:</p>	<p>Compliance: 1/16</p>	<p>Partial Compliance: 7/29/16; 3/3/2017; 12/7/17; 7/18</p>	<p>Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR)</p>
<p>Mental Health Care: Compliance Status:</p>	<p>Compliance:</p>	<p>Partial Compliance: 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18</p>	<p>Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR)</p>
<p>Measures of Compliance:</p>	<p><u>Medical Care:</u> Inspection  <u>Mental Health Care:</u> 1. Review of bi-annual reports 2. Review of incident reports 3. Review of inmate deaths, including those which died following transfer from MDCR to Jackson Healthcare</p>		
<p>Steps taken by the County to Implement this paragraph:</p>	<p><u>Medical and Mental Health Care:</u> Reports are provided.  <u>Mental Health Care:</u></p>		
<p>Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):</p>	<p><u>Medical and Mental Health Care:</u> The bi-annual report contains only one of the required elements: inmate deaths. All other elements are missing. See comments from III.D.2.a</p>		
<p>Monitors' Recommendations:</p>	<p><u>Medical and MH Care:</u> Provide a report responsive to all the requirements of this provision. The Monitors recommend, however, that these elements be incorporated into the broader quality improvement program as captured in a comprehensive Mortality and Morbidity Detection and Prevention policy. Indeed, such information as the number of injuries, for example, is information that the County will want to collect and monitor (i.e. report) more often than every 6 months. Further, it will want to augment these raw numbers with analysis of the cause and preventability of these injuries as well as efforts to reduce them.</p>		

Paragraph Authors: Greifinger and Johnson	III.D.2.b. (See also III.D.1.c.) The County and CHS shall develop and implement corrective action plans within 60 days of each quarterly review, including changes to policy and changes to and additional training.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/29/16; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16, 3/3/17
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/14; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR); 1/16; 7/29/16; 3/3/2017
<i>Measures of Compliance:</i>	<u>Medical Care:</u> Duplicate III.D.1.c.  <u>Mental Health Care:</u> Review of Quarterly Reviews Review of corrective action plans Review of implementation of CAP Review of policy and procedure, as applicable		
Steps taken by the County to Implement this paragraph:	<u>Medical Care:</u> Same as comments in III.D.1.c.  <u>Mental Health Care:</u> Same as comments in III.D.1.c.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<u>Medical and Mental Health Care:</u> Same as comments in III.D.1.c.		
Monitors' Recommendations:	<u>Medical and Mental Health Care:</u> Same as recommendations in III.D.1.c.		

**IV. COMPLIANCE AND QUALITY IMPROVEMENT**

Paragraph Authors: Greifinger and Johnson	IV.A Within 180 days of the Effective Date, the County and CHS shall revise and develop policies, procedures, protocols, training curricula, and practices to ensure that they are consistent with, incorporate, address, and implement all provisions of this Agreement. The County and CHS shall revise and develop, as necessary, other written documents such as screening tools, logs, handbooks, manuals, and forms, to effectuate the provisions of this Agreement. The County and CHS shall send any newly adopted and revised policies and procedures to the Monitor and the United States for review and approval as they are promulgated. The County and CHS shall provide initial and in-service training to all Jail staff in direct contact with inmates, with respect to newly implemented or revised policies and procedures. The County and CHS shall document employee review and training in policies and procedures.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/14; 7/29/16; 3/3/2017; 12/7/17; 7/18	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR); 1/16
<i>Measures of Compliance:</i>	<u>Medical and Mental Health Care:</u> To be determined		
Steps taken by the County to Implement this paragraph:	<u>Medical and Mental Health Care:</u> This is an over-arching provision; a number of other provisions fall under its umbrella, some of which are compliant or partially compliant. For example, the County has been sending new policies and procedures to the Monitors and has developed some operational documents to implement the Consent Agreement.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<u>Medical and Mental Health Care:</u> See above. Many policies have only recently been approved.		
Monitor's Recommendations:	<u>Medical and MH Care:</u> See various recommendations throughout this report.		

Paragraph Authors: Greifinger and Johnson	IV. B The County and CHS shall develop and implement written Quality Improvement policies and procedures adequately to identify and address serious deficiencies in medical care, mental health care, and suicide prevention to assess and ensure compliance with the terms of this Agreement on an ongoing basis.		
Compliance Status:	Compliance: 7/18	Partial Compliance: 7/13; 7/29/16;	Non-Compliance: 3/14 (NR); 10/14 (NR); 5/15 (NR); 1/16 (NR); 3/3/2017; 12/7/17
Mental Health Care: Compliance Status:	Compliance: 7/18	Partial Compliance: 7/13; 3/14; 7/29/16;	Non-Compliance: 10/14 (NR); 5/15 (NR); 1/16 (NR); 3/3/2017; 12/7/17
<i>Measures of Compliance:</i>	<p><u>Medical Care:</u> Inspection of policies and procedures.</p> <p><u>Mental Health Care:</u> 1. Review of policies and procedures.</p>		
Steps taken by the County to Implement this paragraph:	<p><u>Medical Care:</u> The County performs a limited number of the activities required under provisions III.D.1.b. and III.D.1.c. that overlap with this provision. For example, they do conduct regular quality improvement meetings. The peer review process has been revised in a constructive manner.</p> <p><u>Mental Health Care:</u> CHS has scheduled QI and MHRC meetings with minutes that reflect some of the requirements of this provision, and, As above in Medical Care comments.</p>		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<p><u>Medical Care:</u> Vastly improved quality management processes.</p> <p><u>Mental Health Care:</u> QI review continues to improve.</p>		
Monitors' Recommendations:	<p><u>Medical Care and Mental Health Care:</u> Please see the comments in provision III. A. 7. a.</p>		

Paragraph Authors: Greifinger and Johnson	IV. C. and D. On an annual basis, the County and CHS shall review all policies and procedures for any changes needed to fully implement the terms of this Agreement and submit to the Monitor and the United States for review any changed policies and procedures.		
Medical Care Compliance Status:	Compliance: 1/16; 7/29/16; 3/3/2017; 12/7/17; 7/18	Partial Compliance: 7/29/16	Non-Compliance: 7/13 (NR); 3/14 (NR); 10/14 (NR); 5/15 (NR)
Mental Health Compliance Status:	Compliance: 3/3/2017; 12/7/17; 7/18	Partial Compliance: 3/14; 1/16; 7/29/16	Non-Compliance: 7/13 (NR); 10/14 (NR); 5/15 (NR)
<i>Measures of Compliance:</i>	<u>Medical Care:</u> <ul style="list-style-type: none"> <li>Annual review of policies and procedures for any needed changes.</li> </ul> <u>Mental Health Care:</u> <ol style="list-style-type: none"> <li>Review of policies and procedures</li> <li>Review of implementation of policies and procedures, as noted in Medical Care</li> <li>Review of committee meeting minutes and/ or documentation reflecting annual review of policies and updates, as needed.</li> </ol>		
Steps taken by the County to Implement this paragraph:	<u>Medical Care:</u> The County is actively reviewing policies, most of which are the subject of provisions within the CA. <u>Mental Health Care:</u> CHS policy updates policies with the monitors on an ongoing basis.		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<u>Medical Care:</u> Policy review is ongoing. <u>Mental Health Care:</u> Policy review is an ongoing process.		
Monitor's Recommendations:	No additional recommendations at this time.		

## Settlement Agreement Status

August 22, 2018

Appendix A - Settlement Agreement									
Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17	Jul-18
<b>Safety and Supervision</b>									
III.A.1.a. (1)	pc	pc	pc	nr	pc	c	c	c	c
III.A.1.a. (2)	nc	nc	pc	nr	nr	pc	pc	pc	pc
III.A.1.a. (3)	pc	pc	c	nr	nr	c	c	c	pc
III.A.1.a. (4)	pc	pc	pc	c	nr	c	c	c	c
III.A.1.a. (5)	pc	pc	c	nr	nr	c	c	c	c
III.A.1.a. (6)	pc	c	c	nr	nr	c	c	c	pc
III.A.1.a. (7)	pc	pc	c	nr	nr	c	c	c	pc
III.A.1.a. (8)	nc	nc	pc	nr	c	c	c	c	pc
III.A.1.a. (9)	pc	pc	pc	nr	c	c	c	c	c
III.A.1.a. (10)	pc	pc	pc	nr	nr	pc	c	c	c
III.A.1.a. (11)	pc	pc	pc	nr	nr	pc	c	pc	pc
<b>Security Staffing</b>									
III.A.2. a.	not due	pc	pc	c	nr	c	c	c	c
III.A.2. b.	nc	pc	pc	c	nr	pc	c	c	pc
III.A.2.c.	not due	pc	pc	c	nr	c	c	c	c
III.A.2.d.	not audited	not due	nc	not due	c	c	c	c	c
<b>Sexual Misconduct</b>									
III. A.3.	pc	pc	c	nr	pc	pc	pc	pc	c
<b>Incidents and Referrals</b>									
III. A.4 a.	pc	pc	c	nr	nr	c	c	c	c
III.A.4. b.	nc	nc	c	nr	nr	c	c	c	c
III.A.4.c.	nc	pc	pc	nr	c	c	c	c	c
III.A.4.d.	not due	nc	pc	c	nr	c	c	pc	pc
III.A.4.e.	pc	pc	pc	nr	nr	p	c	c	c
III.A.4.f.	pc	pc	pc	pc	c	pc	c	c	c

## Settlement Agreement Status

August 22, 2018

Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17	Jul-18
<b>Use of Force by Staff</b>									
III.A. 5 a.(1) (2) (3)	pc	pc	pc	pc	pc	pc	c	pc	c
III.A.5. b.(1), i., ii, iii, iv, v, vi (2)	pc	pc	pc	pc	nr	c	c	pc	c
III.A. 5. c. (1)	nc	c	pc	nr	nr	c	c	c	c
III.A. 5. c. (2)	nc	pc	pc	nr	pc	pc	c	pc	pc
III.A. 5. c. (3)	pc	pc	pc	c	nr	c	c	c	c
III.A. 5. c. (4)	pc	not audited	c	nr	nr	c	c	c	c
III.A. 5. c. (5)	pc	c	c	nr	nr	c	c	c	c
III.A. 5. c. (6)	nc	not audited	pc	c	nr	c	c	pc	c
III.A. 5. c. (7)	pc	c	c	nr	nr	c	c	c	c
III.A. 5. c. (8)	nc	nc	c	nr	c	c	c	c	c
III.A. 5. c. (9)	nc	nc	pc	pc	c	c	c	c	c
III.A. 5. c. (10)	pc	c	c	c	nr	c	c	nc	c
III.A. 5. c. (11)	nc	nc	nc	pc	nr	pc	pc	pc	c
III.A. 5. c. (12)	nc	nc	nc	pc	nr	pc	c	pc	c
III.A. 5. c. (13)	nc	c	c	nr	nr	c	c	c	c
III.A. 5. c. (14)	nc	nc	nc	pc	nr	pc	c	pc	c
III.A.5. d. (1) (2) (3) (4)	pc	pc	pc	nr	nr	pc	c	pc	c
III.A.5. e. (1) (2)	nc	pc	pc	nr	nr	pc	c	pc	c
<b>Early Warning System</b>									
III.A.6. a. (1) (2) (3) (4) (5)	nc	nc	pc	nr	c	pc	c	c	pc
III.A.6.b.	nc	nc	not due	pc	c	pc	c	c	c
III.A.6.c.	nc	nc	no	pc	c	pc	c	pc	pc

## Settlement Agreement Status

August 22, 2018

Section	Jul-17	May-17	Oct-17	May-17	Jan-17	Jul-17	Mar-17	Dec-17	Jul-18
<b>Fire and Life Safety</b>									
III.B.1.	pc	pc	pc	nr	nr	pc	c	c	c
III.B.2.	c	c	c	nr	nr	pc	c	c	c
III.B.3.	pc	pc	pc	nr	nr	pc	c	c	c
III.B.4.	pc	pc	pc	pc	pc	pc	c	c	c
III.B.5.	nc	pc	pc	nr	nr	pc	c	c	c
III.B.6	nc	nc	nc	pc	nr	pc	c	c	c
<b>Inmate Grievances</b>									
III.C. 1.,2.,3.,4.,5.,6.	pc	pc	pc	c	nr	c	c	pc	pc
<b>Audits and Continuous Improvements</b>									
PFH III.D.1. a. b.	nc	nc	pc	nr	nr	pc	c	pc	c
FLS III.D.1. a. b.	nc	nc	pc	nr	nr	pc	c	c	c
PFH III.D. 2.a. b.	not due	nc	pc	pc	pc	pc	c	pc	pc
<b>Compliance and Quality Improvement</b>									
PFH IV. A.	not due	nc	pc	nr	nr	pc	c	c	c
FLS IV. A.	not due	not audited	pc	nr	pc	pc	c	c	c
PFH IV. B.	nc	nc	pc	nr	nr	pc	c	pc	pc
FLS IV.B.	nc	nc	pc	nr	nr	pc	c	c	c
PFH IV.C.	not due	nc	pc	nr	c	c	c	c	c
FLS IV. C.	not due	nc	pc	nr	pc	c	c	c	c
PFH IV. D.	pc	pc	c	nr	nr	c	c	c	c
FLS IV. D.	pc	pc	pc	nr	pc	c	c	c	c
Legend:	PFH - Protection from Harm								
nc = noncompliance	FLS - Fire Life Safety								
pc = partial compliance									
c = compliance									
nr = not reviewed									

## Appendix B Consent Agreement

June 2018

## Consent Agreement C= Compliance; PC=Partial Compliance; NC=Non-Compliance; NR=Not Reviewed

Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17	Jun-18
A. Medical and Mental Health Care									
1. Intake Acreeing									
III.A.1.a.	Med-PC MH-PC	Med- NR MH- NR	Med-PC MH-PC	Med- PC MH- C	Med-PC MH-PC	Med-PC MH-PC	Med-PC MH-PC	Med-PC MH-PC	Med-C MHC
III. A. 1. b.	MH- PC	MH- PC	MH- PC	MH- PC	MH- PC	MH- PC	MH- C	MH- C	MH- PC
III. A. 1. c.	MH- NC	MH- NC	MH- NC	MH- PC	MH- NC	MH- NC	MH- PC	MH- PC	MH- PC
III.A.1.d.	Med- C MH-PC	Med- NR MH- NR	Med- NC MH- NC	Med- C MH- PC	Med- C MH- NC	Med- PC MH- NC	Med- PC MH- PC	Med- C MH- C	Med- C MH- C
III.A.1.e.	Med- NR MH- NR	Med- NR MH- NR	Med- NC MH- PC	Med- C MH- PC	Med- PC MH- PC	Med-PC MH-PC	Med- PC MH- PC	Med- PC MH- PC	Med- C MH- PC
III.A.1.f.	Med- PC MH- PC	Med- NR MH- NR	Med- PC MH- PC	Med- PC MH- PC	Med- PC MH- PC	Med- PC MH- PC	Med- PC MH- PC	Med- C MH- C	Med- C MH- C
III.A.1.g.	Med- NR MH- NR	Med- NR MH- NR	Med- PC MH- PC	Med- PC MH- PC	Med- PC MH- PC	Med- PC MH- PC	Med- NC MH- PC	Med- C MH- C	Med- C MH- C
2. Health Assessments									
III. A. 2. a.	Med- NR	Med- NR	Med- NR	Med- NR	Med- NR	Med- NR	Med- NC	Med- NC	Med-PC
III. A. 2. b.	MH- NR	MH- PC	MH- NR	MH- NR	MH- NR	MH- NC	MH- NC	MH- PC	MH- C
III. A. 2. c.	Not Yet Due	MH- PC	MH- NR	MH- NR	MH- NR	MH- NC	MH- PC	MH- PC	MH- C
III. A. 2. d.	Not Yet Due	MH- PC	MH- NR	MH- NR	MH- NR	MH- PC	MH- NC	MH- PC	MH- PC
III.A.2.e.	MH- NR	MH- NR	MH- NR	MH- NR	MH- NR	MH- C	MH- NC	MH- NC	Med- PC
III.A.2.f. (See (IIIA1a) and C. (IIIA2e))	Med- PC MH- PC	Med- NR MH- NR	Med- NR MH- NR	Med- NR MH- NR	Med- PC MH- PC	Med- PC MH- PC	Med- NC MH- PC	Med-PC MH-PC	Med- PC MH-PC
III.A.2.g.	Med- NR MH- NR	Med- NR MH- NR	Med- NR MH- NR	Med- NR MH- NR	Med- NR MH- NR	Med- NC MH- NC	Med- NC MH- NC	Med-C MH-PC	Med-C MH- C
3. Access to Medical and Mental Health Care									
III.A.3.a.(1)	Med- C MH- PC	Med- NR MH- NR	Med- C MH- C	Med- NR MH- NR	Med- NR MH- NR	Med- C MH- C	Med- C MH- C	Med- C MH- C	Med- C MH- C
III.A.3.a.(2)	Med- NR MH- PC	Med- NR MH- NR	Med- C MH- NR	Med- NR MH- NR	Med- NR MH- NR	Med- C MH- NR	Med- C MH- NC	Med- C MH- PC	Med- C MH- C

## Appendix B Consent Agreement

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Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17	Jun-18
III.A.3.a.(3)	Med - PC MH - PC	Med- NR MH - NR	Med - C MH - C	Med- NR MH - NR	Med- NR MH - NR	Med - C MHC	Med - C MH - C	Med - C MH - C	Med - C MH - C
III.A.3.a.(4)	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC
III.A.3.b.	Med - PC MH - PC	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH - NC	Med - NC MH - NC	Med - NC MH - NC	Med - PC MH - PC
<b>4. Medication Administration and Management</b>									
III.A.4.a.	Med - PC MH - PC	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med - NC MH - PC	Med - PC MH - PC	Med - PC MH - PC
III.A.4.b(1)	Not Yet Due	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- NC	Med - PC MH - NC	Med - C MH - C	Med - C MH - C
III.A.4.b(2)	Not Yet Due	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - NC MH- NC	Med - NC MH - NC	Med - NC MH - PC	Med - PC MH - PC
III. A. 4. c.	MH - PC	MH- NR	MH- NR	MH- NR	MH- NR	MH - NC	MH- PC	MH- PC	MH - C
III. A. 4. d.	MH - PC	MH- NR	MH- NR	MH- NR	MH- NR	MH - NC	MH- NC	MH- PC	MH- PC
IIIA.4.e.	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH - NC	Med - NC MH - PC	Med - NC MH - PC	Med - PC MH - PC
III.A.4.f. (See (III.A.4.a.)	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med - NC MH - PC	Med - C MH - C	Med - C MH - C
<b>5. Record Keeping</b>									
III.A.5.a.	Med - PC MH - NC	Med - NR MH- PC	Med - PC MH- PC	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med-PC MH - PC	Med - PC MH - PC	Med - C MH - PC
III.A.5 b.	MH - NC	MH - PC	MH - PC	MH - NR	MH - NR	MH- PC	MH - NC	MH - PC	MH - PC
III.A.5.c.(See III.A.5.a.)	Med - PC MH- PC	Med- NR MH - NR	Med-PC MH - PC	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med-PC MH - PC	Med - PC MH - PC	Med - C MH - C
III.A.5.d.	Med - PC MH- PC	Med - NR MH- NR	Med-PC MH - PC	Med- NR MH - NR	Med- NR MH - NR	Med - PC MH- PC	Med-PC MH - PC	Med - PC MH - PC	Med - PC MH - PC

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<b>6. Discharge Planning</b>									
III.A.6.a.(1)	Med - NR MH- PC	Med - NR MH- NC	Med - PC MH - PC	Med- NR MH - NR	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - NC MH - PC
III.A.6.a.(2)	Med - NR MH - PC	Med - NR MH - NC	Med - PC MH - PC	Med- NR MH - NR	Med - NC MH - PC	Med - PC MH - PC	Med - NC MH - PC	Med - NC MH - PC	Med - NC MH - PC
III.A.6.a.(3)	Med - NR MH- PC	Med - NR MH - NC	Med - PC MH - PC	Med- NR MH - NR	Med-PC MH -PC	Med- NR MH - NR	Med - NC MH - PC	Med - PC MH - PC	Med - PC MH - PC
<b>7. Mortality and Morbidity Reviews</b>									
III.A.7.a.	Med - PC MH - PC	Med - NR MH - PC	Med - NR MH- NR	Med - NR MH- NR	Med - PC MH - NC	Med - PC MH - PC	Med - NC MH - NC	Med - PC MH - PC	Med - C MH - C
III.A.7.b.	Med - NR MH - NC	Med - NR MH - PC	Med - NR MH- NR	Med - NR MH- NR	Med - NC MH - NC	Med - PC MH- NC	Med - NC MH - NC	Med - NC MH - NC	Med - C MH - C
III.A.7.c.	Med - NR MH - NC	Med - NR MH - NC	Med - NR MH- NR	Med - NR MH- NR	Med - NC MH - NC	Med - PC MH - NC	Med - NC MH - NC	Med - NC MH - NC	Med - PC MH - PC
<b>B. Medical Care</b>									
<b>1. Acute Care and Detoxification</b>									
III.B.1.a.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - NC	Med - PC
III.B.1.b. (See (III.B.1.a.)	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - PC	Med - PC	Med - PC
III.B.1.c.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - C	Med - C
<b>2. Chronic Care</b>									
III.B.2.a.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - PC	Med - PC
III.B.2.b. (See (III.B.2	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - PC	Med - PC
<b>3. Use of Force Care</b>									
III.B.3.a.	Med - NR MH- NR	Med - NR MH- NR	Med - NC MH - NC	Med - NR MH- NR	Med - NR MH - NC	Med - C MH - NC	Med-C MH-PC	Med - PC MH-PC	Med - C MH - C
III.B.3.b.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - PC	Med - C
III.B.3.c. (1) (2) (3)	Med - NR	Med - NR	Med - PC	Med - NR	Med - NR	Med - NC	Med - NC	Med - PC	Med - C

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C. Mental Health Care and Suicide Prevention									
1. Referral Process and Access to Care									
III. C. 1. a. (1) (2) (3)		MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 1. b.	MH - PC	MH - NR	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - C
2. Mental Health Treatment									
III. C. 2. a.	MH - PC	MH - NC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 2. b.	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 2. c.	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC	MH - C
III. C. 2. d.	MH - PC	MH - PC	MH - PC	MH - NR	MH - NC	MH - PC	MH - PC	MH - C	MH - C
III. C. 2. e. (1) (2)	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 2. f.	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 2. g.	MH - NC	MH - NR	MH - NR	MH - NR	MH - NR	MH - NC	MH - C	MH - C	MH - C
III. C. 2. g. (1)	MH - NC	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - C	MH - PC	MH - C
III. C. 2. g. (2)	MH - NC	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - PC	MH - C	MH - C
III. C. 2. g. (3)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - C	MH - C
III. C. 2. g. (4)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - C	MH - C	MH - C
III. C. 2. h.	MH - PC		MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - PC	MH - PC
III. C. 2. i.	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - C	MH - C
III. C. 2. j.	MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 2. k.	MH - NR	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC	MH - PC	MH - PC
3. Suicide Assessment and Prevention									
III. C. 3. a. (1) (2) (3) (4) (5)	MH - PC	MH - PC	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 3. b.	MH - PC	MH - NC	MH - NR	MH - NR	MH - PC	MH - NC	MH - NC	MH - PC	MH - PC
III. C. 3. c.	MH - PC	MH - PC	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC	MH - PC	MH - PC
III. C. 3. d.	MH - PC	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - C
III. C. 3. e.	MH - PC	MH - NC	MH - NR	MH - NR	MH - NC	MH - PC	MH - NC	MH - PC	MH - PC
III. C. 3. f.	MH - PC	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - C
III. C. 3. g.	Med - NR MH - NC	Med - NR MH - NC	Med - NR MH - NR	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - C MH - PC	Med - PC MH - PC	Med - C MH - C
III. C. 3. h.	MH - NR	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC	MH - PC	MH - PC

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4. Review of Disciplinary Measures									
III. C. 4. a. (1) (2) and	MH - PC	MH - NC	MH - NR	MH - NR	MH - PC	MH - PC	MH - C	MH - PC	MH - PC
5. Mental Health Care Housing									
III. C. 5. a.	MH - NC	MH - NC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - C
III. C. 5. b.	MH - NC	MH - NC	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC	MH - NC	MH - PC
III. C. 5. c.	MH - NC	MH - NC	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - PC	MH - PC
III. C. 5. d.	MH - NR	MH - PC	MH - PC	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 5. e.	MH - PC	MH - NC	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC	MH - C
6. Custodial Segregation									
III. C. 6. a. (1a)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 6. a. (1b)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 6. a. (2)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 6. a. (3)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 6. a. (4) i	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - NC	MH - NC	MH - PC	MH - PC
III. C. 6. a. (4) ii	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - NC	MH - NC	MH - NC	MH - NC
III. C. 6. a. (5)	MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - PC	MH - PC
III. C. 6. a. (6)	MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - NC	MH - NC
III. C. 6. a. (7)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - NC	MH - NC
III. C. 6. a. (8)	MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - NC	MH - NC
III. C. 6. a. (9)	MH - C	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 6. a.(10)	Med - NC	Med - NR	Med - NR	Med - NR	Med - PC	Med - PC	Med - NC	Med - PC	Med - C
	MH - PC	MH - NC	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - PC	MH - PC
III. C. 6. a. (11)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - NC	MH - NC
7. Staffing and Training									
III. C. 7. a.	MH - PC	MH - PC	MH - NR	MH - NR	MH - C	MH - C	MH - C	MH - C	MH - C
III. C. 7. b.	MH - NR	MH - PC	MH - NR	MH - NR	MH - C	MH - C	MH - C	MH - C	MH - C
III. C. 7. c.	MH - NC	MH - PC	MH - NR	MH - NR	MH - C	MH - C	MH - C	MH - C	MH - C
III. C. 7. d.	MH - NR	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - C
III. C. 7. e.	MH - PC	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - C	MH - C	MH - C
III. C. 7. f.	MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - C	MH - C	MH - C
III. C. 7. g. (1)(2)(3)	MH - NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - C	MH - C	MH - C
III. C. 7. h.	MH - PC	MH - PC	MH - NR	MH - NR	MH - NC	MH - PC	MH - NC	MH - PC	MH - PC

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<b>8. Suicide Prevention Training</b>									
III. C. 8. a. (1-9)	MH - NC	MH - NC	MH - PC	MH - NR	MH - NC	MH - NC	MH - PC	MH - C	MH - C
III. C. 8. b.	MH - NC	MH - NC	MH - PC	MH - NR	MH - NC	MH - NC	MH - PC	MH - C	MH - C
III. C. 8. c.	MH - NC	MH - NC	MH - PC	MH - NR	MH - NC	MH - NC	MH - C	MH - C	MH - C
III. C. 8. d.	MH - NC	MH - NC	MH - PC	MH - NR	MH - PC	MH - PC	MH - C	MH - C	MH - PC
<b>9. Risk Management</b>									
III. C. 9. a.	MH - NR	MH - PC	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 9. b. (1)(2)(3)(4)	MH - NR	MH - PC	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC	MH - PC
III. C. 9. c. (1)(2)(3)(4)(5)	MH - NR	MH - PC	MH - NR	MH - NR	MH - NC	MH - NC	MH - PC	MH - PC	MH - C
III. C. 9. d. (1)(2)(3)(4)(5)(6)	MH - NR	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC
<b>D. Audits an Continuous Improvement</b>									
<b>1. Self Audits</b>									
III. D. 1. b.	Med - NR MH-PC	Med - NR MH-PC	Med - NR MH- NR	Med - NR MH- NR	Med - PC MH - NC	Med - PC MH - PC	Med - NC MH - NC	Med - NC MH - NC	Med - PC MH - PC
III. D. 1. c.	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NC MH- NC	Med - PC MH - NC	Med - NC MH - NC	Med - PC MH - PC	Med - PC MH - PC
<b>2. Bi-annual Reports</b>									
III. D. 2 .a. (1)(2)	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med -NC MH - NC	Med - PC MH - NC	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC
III. D. 2. a. (3)			MH - NR	MH - NR	MH - PC	MH - NC	MH - PC	MH - PC	MH - PC
III. D. 2. a. (4)			MH - NR	MH - NR	MH - NC	MH - NC	MH - PC	MH - PC	MH - PC
III. D. 2. a. (5)			MH - NR	MH - NR	MH - PC	MH - NC	MH - PC	MH - PC	MH - PC
III. D. 2. a.(6)	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - C MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC	Med - PC MH - PC
III. D. 2. b.(See III. D. 1. c.)	Med - NR MH- NR	Med - NR MH- PC	Med - NR MH- NR	Med - NR MH- NR	Med - NC MH - NC	Med - PC MH - NC	Med - NC MH - NC	Med - PC MH - PC	Med - PC MH - PC

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IV. Compliance and quality Improvement									
IV. A	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - PC MH- NC	Med - PC MH- PC	Med - PC MH- PC	Med - PC MH- PC	Med - PC MH- PC
IV. B	Med - PC MH -PC	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - NR MH- NR	Med - PC MH- PC	Med - NC MH- NC	Med - NC MH- NC	Med - C MH - C
IV. C	Med - NR MH- NR	Med - NF MH -PC	Med - NR MH- NR	Med - NR MH- NR	Med-PC MH-PC	Med - PC MH- PC	Med - C MH - C	Med - C MH - C	Med - C MH - C
IV. D	Med - NR MH- NR	Med - NF MH -PC	Med - NR MH- NR	Med - NR MH- NR	Med-PC MH-PC	Med - PC MH- PC	Med - C MH - C	Med - C MH - C	Med - C MH - C

Yellow = Collaboration - Medical (Med) and Mental Health (MH)

Purple = Collaboration with Protection from Harm

Orange = Medical Only

Green = Mental Health Only