UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF FLORIDA

UNITED STATES OF AMERICA,

Plaintiff,

v.

MIAMI-DADE COUNTY; MIAMI-DADE COUNTY BOARD OF COUNTY COMMISSIONERS; MIAMI-DADE COUNTY PUBLIC HEALTH TRUST

Defendants,

1:13-CV- 21570 CIV
The Honorable Beth Bloom

Report No. 10 of the Independent Monitors

March 22, 2019

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This is the tenth report of the Independent Monitors regarding Miami-Dade County's and the Public Health Trust's compliance with both the Settlement Agreement (effective April 30, 2013) and the Consent Agreement (effective May 22, 2013). This report is based on the information provided by the Defendants regarding their on-going performance focused on achieving compliance with the provisions of both agreements in the six months prior to the on-site tour of the Monitors. Information gathered during the on-site is used in the assessment; and as such, the compliance reporting is not a "snap shot" of compliance, but rather the review of documentation of efforts to achieve and maintain compliance. The Introduction to the report of the Consent Agreement details the activities related to developing findings for these provisions.

Regarding the Consent Agreement, the Monitors are heartened by the efforts and outcome of the County's work to gain compliance. The Summary Action Plan (as amended) has lent not only urgency to the work, but resulted in substantial gains in compliance. The Monitors find that there are no paragraphs in non-compliance at this time. The Summary Action Plan addressed 126 paragraphs (some duplicative), and resulted in the production of more than 800 documents to guide and evaluate compliance, along with action plans. This initiative resulted in the compliance changes seen in this Report.

The County has achieved 100% with the provisions of the Settlement Agreement. This progress will be reviewed in the next on-site tour to assure sustained compliance on the important issues of use of force and inmate-on-inmate violence.

The Monitors have observed over time the change in the strength of the collaboration between MDCR and CHS. The joint problem-identification and solving is impressive.

The Monitors thank and commend the leadership of MDCR Director Daniel Junior and CHS Corporate Director Edith Wright. We also extend our thanks to: Deputy Mayor Maurice L. Kemp, and, and Don Steigman, Chief Operating Officer, Jackson Health System for their time in meeting with the independent Monitors and their advice and actions. We also extend our thanks to the leadership teams of both organizations.

The narratives for both the Settlement Agreement and the Consent Agreement provide the analyses of findings, work accomplished to date, and recommendations. [1]

[1] The work of the monitoring team is assisted by subject matter experts: Nancy A. DeFerrari, B.S., CJM, Adam Chidekel, Ph.D., CCHP, Angela Goehring, R.N., M.S.A., C.C.H.P., and Catherine M. Knox M.N., R.N., CCHP-RN.

Consent Agreement - Medical and Mental Health Care

Introduction

The Independent Monitors acknowledge and commend the improvements in the County's compliance with the provisions of the Consent Agreement, with no paragraphs in non-compliance. Since Compliance Report # 9, 95 paragraphs are in substantial compliance, as compared to 45 paragraphs seven months ago.

The Monitors highlight the following critical information and time lines:

- The Court's Order governing production of the Monitors' compliance reports notes that the Monitors ". . . shall be responsible for independently verifying representations from the Defendants regarding progress toward compliance, examining supporting documentation, where applicable."

- This report examines the County's compliance with the provisions of the Consent Agreement at the time of the on-site tour (February 2019), based on the documentation provided before the tour, and any relevant information provided on-site, and/or immediately after the tour's conclusion. As noted above, the findings are not a "snap shot" but rather a thorough review of the historical and trend data, and information provided by the County.

- The County has been diligent in producing materials required by the Summary Action Plan,[2] resulting in improvements as noted throughout this report.

- The County's production of materials and documents required by the Summary Action Plan, in and of itself, **did not**, as the Monitors consistently noted, result in any *re-assessment of compliance* with the associated paragraphs of the Consent Agreement prior to the on-site tour.

- As the Monitors noted in their contributions to the Joint Declarations Regarding Status of Compliance, as required by the Order establishing the Summary Action Plan process, the measure of whether the initiatives, policies, procedures, training, etc. undertaken by the County pursuant to the Summary Action plan resulted in compliance with the various provisions of the Consent Agreement will be assessed during the on-site tour(s).

- The Independent Monitors toured the facilities, held meetings, and reviewed documents February 11 – 14, 2019.

[2] IBID

- ***Before the issuance of draft report,*** on February 27, 2019, the Monitors provided the County with specific information about any paragraphs of the Consent Agreement determined by the Monitors to not be in full compliance. This was an extraordinary step in the review process of this Compliance Report. Twenty-three (23) paragraphs were identified at that time as being in partial compliance. It is the Monitors position that this interim step in the process did not open the door to considering rewritten or updated materials related to specific paragraphs found to be less than compliant during or before the tour; rather this step invited factual correction.

- This extraordinary extra step was agreed upon by the parties in furtherance of the language of the Summary Action Plan order, that the parties and the Independent Monitors shall meet and confer to determine whether Defendants achieved compliance on all the paragraphs based on the 10th compliance tour.

- The parties spoke via telephone on March 7, 2019, and further agreed to conduct a formal meet and confer via telephone on March15, 2019. Conversations were held between the Monitors and CHS leadership during the week of March 11, 2019 to further clarify issues and provide information. Because of the additional clarifications provided by the Defendants the findings for three paragraphs were changed from partial to substantial compliance.

- On March 10, 2019, the Independent Monitors transmitted their finalized draft Compliance Report # 10 to all parties.

- A telephonic "meet and confer" was held with all parties on March 15, 2019. During that call, the County requested clarification on the compliance findings of three paragraphs. The County agreed to provide any additional questions to the Monitors. The County noted that their written review of the draft compliance report would be provided to the Monitors by the close of business on March 18, 2019. The Department of Justice also agreed to provide their comments by March 18, 2019.

- To assist the County, the Monitors developed remedial actions for those paragraphs remaining in partial compliance. These were discussed during and immediately after the on-site tour. These suggestions by the Monitors were provided to the County on March 14, 2019. During the telephonic meet and confer of March 15, 2019, the County deferred discussion of these recommended action steps, indicating the County's wished to examine the final #10 Compliance Report before proceeding.

- On March 18, 2019 the County provided comments for the final draft (March 10, 2019). The County's comments, however, responded to a draft dated *February 27, 2019*, rather than the draft provided to all parties dated March 10, 2019. The Monitor re-sent the March 10th draft to the County on March 20th, and requested comments by March 21, 2019, a deadline the County met. The Department of Justice provided comments on the draft dated March 10, 2019 on March 15, 2019

- The Monitors carefully considered all of the County's comments in preparing this final report.

In summary, the process to prepare both the draft the #10 Compliance Report and this final reports differed from those of the previous nine compliance reports. The Monitors are pleased to participate in any process that moves the Defendants further toward compliance.

We acknowledge that there are differences of professional opinion between the Independent Monitors and the Defendants as to compliance ratings. It is the Monitors' independent judgment included in this report.

The Monitors are very encouraged by the progress made in the last year, and recognize the momentum for improvement. Collaboratively, these improvements have been made, and the Monitors look forward to the time we can report full compliance to the Court.

U.S. v. Miami-Dade County
Consent Agreement – Compliance Report # 10 - Status of Compliance[1]

Report # /Date	Substantial Compliance	Partial Compliance	Non-Compliance	Not Applicable/Not Due/Other	Total Paragraphs
1 – 11/5/13	1	56	40	22	119
2 – 5/22/14	0	38	73	8	119
3 – 11/28/14	2	19	98	0	119
4 -7/3/15	6	35	75	0	116[2]
5 – 2/15/16	4	50	61	0	115
6 - 9/9/16	10	65	40	0	115
7 – 4/4/17	16	51	48	0	115
8 – 1/18/18	29	70	16	0	115[3]
9 – 8/24/18	48	60	7	0	115
10 – 3/22/19	95	20	0	0	115

Defendants shall ensure constitutionally adequate treatment of inmates' medical and mental health needs. Defendants' efforts to achieve this constitutionally adequate treatment will include the following remedial measures regarding: (1) Intake Screening; (2) Health Assessments; (3) Access to Medical and Mental Health Care; (4) Medication Administration and Management; (5) Record Keeping; (6) Discharge Planning; and (7) Mortality and Morbidity Reviews.

Medical and Mental Health Care

Intake Screening

III. A. 1. a. Qualified Medical Staff shall sustain implementation of the County Pre-Booking policy, revised May 2012, and the County Intake Procedures, adopted May 2012, which require, inter alia, staff to conduct intake screenings in a confidential setting as soon as possible upon inmates' admission to the Jail, before being transferred from the intake area, and no later than 24 hours after admission. Qualified Nursing Staff shall sustain implementation of the Jail and CHS' Intake Procedures, implemented May 2012, and the Mental Health Screening and Evaluation form, revised May 2012, which require, inter alia, staff to identify and record observable and non-observable medical and mental health needs, and seek the inmate's cooperation to provide information.

Monitor: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: N/A

Recommendations for achieving compliance, if applicable: N/A

III. A. 1. b. CHS shall sustain its policy and procedure implemented in May 2012 in which all inmates received a mental health screening and evaluation meeting all compliance indicators of National Commission on Correctional Health Care J-E-05. This screening shall be conducted as part of the intake screening process upon admission. All inmates who screen positively shall be referred to qualified mental health professionals (psychiatrist, psychologist, psychiatric social worker, and psychiatric nurse) for further evaluation.

Monitor: Johnson

MH Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: CHS has continued to perform quarterly audits with Tool #2 Mental Health Evaluation at Intake and Tool #46A Behavioral Health Assessments and Access to Mental Health Care at Intake; and, provided training to Nurses on the intake referral process in June 2018. Tool #2 has shown overall good performance with ongoing efforts to complete MH referrals in the appropriate time frame (67% in December 2018). Tool #46A has also shown overall good performance. Independent chart review by the MH Monitors supports the audit tool findings.

Recommendations for sustaining compliance: To maintain compliance continue to track and improve completion of MH referrals at intake in the appropriate time frames.

III. A. 1. c. Inmates identified as in need of constant observation, emergent and urgent mental health care shall be referred immediately to Qualified Mental Health Professionals for evaluation, when clinically indicated. The Jail shall house incoming inmates at risk of suicide in suicide-resistant housing unless and until a Qualified Mental Health Professional clears them in writing for other housing.

Monitor: Johnson

MH Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: CHS has continued to perform quarterly audits with Tool #1 Suicide Risk Assessment (at Intake) and Tool #2 Mental Health Evaluation at Intake. Tool #1 has shown that 40% of suicide risk assessments were fully completed at intake in February 2019 (down from 70% in November 2018). The County places patients who are acutely suicidal while in intake into Observation Cells (suicide resistant housing) or in the open intake area under the direct observation of an officer. This was observed during the February tour. Physical capacity does not exist to place all suicidal patients in an observation cell in intake. From intake patients are transferred to the Mental Health Treatment Center in TGK where they are placed in suicide resistant cells until they are cleared from level 1 by a QMHP. Independent chart review by the MH Monitors supports the audit tool findings. CHS implemented an IT fix for this issue and improvements in completion have been noted.

Recommendations for achieving compliance, if applicable: N/A

II. A. 1. d. Inmates identified as "emergency referral" for mental health or medical care shall be under constant observation by staff until they are seen by the Qualified Mental Health or Medical Professional.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: N/A

Recommendations for achieving compliance, if applicable: N/A

III. A. 1. e. CHS shall obtain previous medical records to include any off-site specialty or inpatient care as determined clinically necessary by the qualified health care professionals conducting the intake screening.

Monitors: Johnson/Greifinger

MH Compliance Status: **Partial Compliance**
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: CHS is not routinely requesting previous medical records from inpatient or other outside MH care at intake based on review of CHS-HIM Request Log for Medical Records from Outside Facilities and independent chart review (e.g., records were not requested for a patient who indicated recent involuntary psychiatric hospitalization via Baker Act or another who reported ongoing outpatient psychiatric treatment). CHS BH notes routinely indicate that they have reviewed prior records contained in the EHR (by checking a box). However, relevant data contained in the EHR is not consistently reviewed and utilized in clinical decision making. Medical records for patients returning from competency restoration are routinely reviewed, included in the chart, and utilized in clinical decision making.

For patients with somatic illness, there is now ongoing documentation of requests for outside records contained in the electronic medical record. Logs are maintained documenting the dates of requests and dates of receipt for such records.

Recommendations for achieving/sustaining compliance: Develop a method to insure previous MH records are requested at intake and reviewed when clinically necessary. Document the clinically utility of data from prior medical records in diagnostic and clinical decision making when appropriate.

III. A. 1. f. CHS shall sustain implementation of the intake screening form and mental health screening and evaluation form revised in May 2012, which assesses drug or alcohol use and withdrawal. New admissions determined to be in withdrawal or at risk for withdrawal shall be referred immediately to the practitioner for further evaluation and placement in Detox.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: N/A

Recommendations for achieving compliance, if applicable: N/A

III. A. 1. g. (See also III.A.1.a.) CHS shall ensure that all Qualified Nursing Staff performing intake screenings receive comprehensive training concerning the policies, procedures, and practices for the screening and referral processes.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: N/A

Recommendations for achieving compliance, if applicable: N/A

Health Assessments

III. A. 2. a. Qualified Medical Staff shall sustain implementation of CHS Policy J-E-04 (Initial Health assessment), revised May 2012, which requires, inter alia, staff to use standard diagnostic tools to administer preventive care to inmates within 14 days of entering the program. [NB: This requirement is not about diagnostic tools or prevention – it is about the entirety of the health assessment. It was driven by detainees not getting, or getting inadequate initial health assessments.

Monitor: Greifinger

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: All incoming inmates are screened for acute and chronic conditions during the intake process. Any who screen positive are seen by a licensed independent practitioner within the first 24 hours. A complete health assessment is performed and a treatment plan is written and initiated, including continuity of medication, laboratory testing, and appropriate follow-up within 14 days. All who screen negative have a health assessment scheduled with an RN within 14 days.

Recommendations for achieving compliance, if applicable: N/A

III. A. 2. b. Qualified Mental Health Staff will complete all mental health assessments incorporating, at a minimum, the assessment factors described in Appendix A.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: N/A

Recommendations for achieving compliance, if applicable: N/A

III. A. 2. c. Qualified Mental Health Professionals shall perform a mental health assessment following any adverse triggering event while an inmate remains in the MDCR Jail facilities' custody, as set forth in Appendix A.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Mental health assessments routinely occur that include a suicide risk assessment within 24 hours of a triggering event (e.g., self-harming incident or suicidal ideation) based on chart review. These metrics are tracked monthly in the Mental Health Review Committee minutes. The Suicide Risk Assessment is a stand-alone form and is included in part in some of the other clinical forms. Standardization the versions of the suicide risk assessments across all forms could help ensure the entire tool is utilized

Recommendations for achieving compliance, if applicable: N/A

III. A. 2. d. Qualified Mental Health Professionals, as part of the inmate's interdisciplinary treatment team (outlined in the "Risk Management" Section, *infra*), will maintain a risk profile for each inmate based on the Assessment Factors identified in Appendix A and will develop and implement interventions to minimize the risk of harm to each inmate.

Monitor: Johnson

Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: The risk profile is created by completion of the "Risk for Injury to Self or Others" portion of the "Problem/Target Symptoms Identified" Section of the Interdisciplinary Treatment Plan (IDTP). Prior to December 2018 this form did not include the Suicide Risk Assessment (SRA). Chart review showed that not all sections of the IDTP are completed for each inmate. Appendix A specifically addresses Suicide Risk Assessment Factors. The CAT-RAG portion of the IDTP contains "Individual Suicide Risk Reduction Factors" (a text box that is consistently left blank). The SRA from the IDTP does not uniformly populate into subsequent Psychiatry Notes reducing the utility of any recent updates. Interventions to reduce the risk of harm to each inmate are not planned, treatment goals in IDTP do not routinely address safety, and documentation subsequent to Mental Health Treatment Plans, particularly for Level 1 patients, do not demonstrate performance of interventions (other than psychiatric medication monitoring) to address risk factors and provide the interventions necessary to help patient achieve the goals documented in the IDTP. The IDTPs do not consistently meet the elements described in NCCHC Standard MH-G-03.

Recommendations for achieving compliance: Ensure that all staff complete all sections of the IDTP, including the creation of specific Interventions in the "Individual Suicide Risk Reduction Factors" text box in the Cat-RAG tool where strategies to address the individual risk factors identified in the assessment can be documented. Ensure that the documentation from the IDTP SRA; "populates" into the Psychiatry Progress Notes to better ensure monitoring of risk profile and progress towards reducing risk factors is made. Review IDTP short-term and long-term goals to ensure they are related to the presenting problems that lead to placement in Level I or Level II.

III. A. 2. e. An inmate assessed with chronic disease shall [be] seen by a practitioner as soon as possible but no later than 24-hours after admission as a part of the Initial Health Assessment, when clinically indicated. At that time medication and appropriate labs, as determined by the practitioner, shall be ordered. The inmate will then be enrolled in the chronic care program, including scheduling of an initial chronic disease clinic visit.

Monitor: Greifinger

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Since the last visit, with the practitioner visit for health assessment advanced to the first 24 hours after admission for patients with acute or chronic problems identified through the intake assessment. The chronic care treatment plan is established and implemented on day one of incarceration.

Recommendations for achieving compliance, if applicable: N/A

III. A. 2. f. (Covered in III.A.1.a.) and (III.A.2.e.) All new admissions will receive an intake screening and mental health screening and evaluation upon arrival. If clinically indicated, the inmate will be referred as soon as possible, but no longer than 24-hours, to be seen by a practitioner as a part of the Initial Health Assessment. At that time, medication and appropriate labs as determined by the practitioner are ordered.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Since the last visit, with the practitioner visit for health assessment advanced to the first 24 hours after admission for patients with acute or chronic problems identified through the intake assessment. The chronic care treatment plan is established and implemented on day one of incarceration.

Recommendations for achieving compliance, if applicable: N/A

III. A. 2. g. All individuals performing health assessments shall receive comprehensive training concerning the policies, procedures, and practices for medical and mental health assessments and referrals.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Through record review, intake staff performance continues to be acceptable.

Recommendations for achieving compliance, if applicable: N/A

Access to Medical and Mental Health Care

III. A. 3. a. (1) The sick call process shall include… written medical and mental health care slips available in English, Spanish, and Creole.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: N/A

Recommendations for achieving compliance, if applicable: N/A

III. A. 3. a. (2) The sick call process shall include…opportunity for illiterate inmates and inmates who have physical or cognitive disabilities to confidentially access medical and mental health care.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The September 2018 Deliverables included a County ADA Log and data set in a graph format. It did not include data on patients with cognitive disabilities. CHS' CA Self-Assessment they indicated they developed quarterly audit Tool #48 ADA Log to assist with tracking provision of ADA appropriate accommodations for this provision. Results from October 2018 indicate 80% of patients audited received accommodations appropriate for the ADA disability. The tool was not specific to the sick call process. Multiple ADA patients, medical/MH staff, and Correctional Officers continue to verbally report that assistance in completing sick calls is provided to ADA patients by Social Workers or Correctional Counselors. Chart review showed that sick call visits are occurring for ADA patients. To maintain compliance, tracking of ADA patients with cognitive disabilities, as previously reported by the County; and, Social Work follow-up visits required by CHS-056 Patients Requiring Special Needs Policy, sec. V.D.4.c. should be happening.

Since the last tour, privacy doors have been installed for sick call. Sick call performance remains acceptable.

Recommendations for achieving compliance, if applicable: N/A

III. A. 3. a. (3) The sick call process shall include…a confidential collection method in which designated members of the Qualified Medical and Qualified Mental Health staff collects the request slips every day

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: N/A

Recommendations for achieving compliance, if applicable: N/A

III. A. 3. a. (4) The sick call process shall include…an effective system for screening and prioritizing medical and mental health requests within 24 hours of submission and priority review for inmate grievances identified as emergency medical or mental health care.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: CHS has continued to track sick call process with Tool #7 and grievances with Tool #26. Overall performance in both tools on measures that directly address this provision have been good albeit with a recent (December 2018) decrease from 80% to 60% completion of grievances within the appropriate time frame. Sick calls are date stamped and scanned into the EHR. Sick call visits are clearly labeled as such in the EHR. A grievance task force was developed and meets on a monthly basis to review audit data and discuss process improvements and completion of any related CAPs.

Recommendations for achieving compliance, if applicable: N/A

III. A. 3. b. CHS shall continue to ensure all medical and mental health care staff are adequately trained to identify inmates in need of acute or chronic care, and medical and mental health care staff shall provide treatment or referrals for such inmates.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: CHS continues to audit Chronic Care (CC) visits and has divided them into various Medical CC illnesses (e.g., Hypertension). The patients audited also include patients who also receive mental health care. A list of SMI patients who also receive CC was provided during the tour. Chart review showed that appropriate acute and chronic medical care referrals are being made and that acute and chronic medical care is being appropriately provided to mentally ill patients.

Through medical record review, chronic care is timely and appropriate. Clinicians need ongoing training and supervision to meet CHS' chronic care guidelines, issued in 2018.

Recommendations for achieving compliance, if applicable: N/A

Medication Administration and Management

III. A. 4. a. CHS shall develop and implement policies and procedures to ensure the accurate administration of medication and maintenance of medication records.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: CHS has developed policies and procedures to ensure accurate administration of medication and maintenance of medication records. The psychiatrist is notified after repeated medication refusals. Counseling is provided by a nurse. Percent adherence to each medication is included in these communications. Bubble packing and unit dosing for psychotropic medications is occurring. Medication delivery has improved further with the implementation of a new procedure for medication administration including both real time and video auditing of medication delivery by CHS and MDCR. CHS plans to transition from its current Medication Administration Record in Sapphire to the MAR in Cerner, its EHR. CHS has also hired a pharmacy manager since the last tour.

CHS has developed performance measurement tools to assess medication timeliness and continuity, as well as tools to measure appropriate nursing and clinical response to medication refusals. CHS has established a 'buddy' system so that there is timely clinician response when the prescribing clinician is not in attendance.

CHS will continue to reinforce appropriate documentation and notice to clinicians for patients who refuse their medication. CHS will fully implement the Cerner medication administration module in the HER.

Recommendations for sustaining compliance: Follow through with implementation of the Cerner EHR.

III. A. 4. b. (1) Within eight months of the Effective Date…Upon an inmate's entry to the Jail, a Qualified Medical or Mental Health Professional shall decide and document the clinical justification to continue, discontinue, or change an inmate's reported medication for serious medical or mental health needs, and the inmate shall receive the first dose of any prescribed medication within 24 hours of entering the Jail;

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: CHS continues to audit this measure with Tool #10 with 100% performance on all measures for several consecutive quarters. The first dose of medication continues to be given consistently within the first 24 hours of entering the jail.

Clinical justification for medication changes at intake was consistently documented during chart review in MH Initial Bio-Psycho-Social evaluations.

Since the last visit, with the practitioner visit for health assessment advanced to the first 24 hours after admission for patients with acute or chronic problems identified through the intake assessment. The chronic care treatment plan is established and implemented on day one of incarceration.

Recommendations for achieving compliance, if applicable: N/A

III. A. 4. b. (2) Within eight months of the Effective Date. A medical doctor or psychiatrist shall evaluate, in person, inmates with serious medical or mental health needs, within 48 hours of entry to the Jail.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Audit Tool #2, questions 1 and 4 track this provision. Follow-up within the referral time frame by a QMHP (Q1) has been at 90-100% over the last two audits; referral from the QMHP to a Psychiatrist within referral time frames (Q4) has not consistently occurred per policy but has improved over the last two audits from 50% to 67%. Chart review indicates MH Initial evaluation by either a Family Practice or Psychiatric Advanced Registered Nurse Practitioner on the MH team is consistently occurring for emergency or urgent referrals at intake. While not an evaluation by a psychiatrist, it serves the understood purpose of this provision to ensure psychiatric evaluation of patients within 48 hours of entry to the jail.

Since the last visit, with the practitioner visit for health assessment advanced to the first 24 hours after admission for patients with acute or chronic problems identified through the intake assessment. The chronic care treatment plan is established and implemented on day one of incarceration.

Recommendations for sustaining compliance, if applicable: N/A

III. A. 4. c. Psychiatrists shall conduct reviews of the use of psychotropic medications to ensure that each inmate's prescribed regimen is appropriate and effective for his or her condition. These reviews should occur on a regular basis, according to how often the Level of Care requires the psychiatrist to see the inmate. CHS shall document this review in the inmate's unified medical and mental health record.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Psychiatrists review use of prescribed psychotropic medications at each follow-up visit per Level of Care and make adjustments as clinically indicated and documents changes in the EHR.

Recommendations for achieving compliance, if applicable: N/A

III. A. 4. d. Medication Administration and Management CHS shall ensure nursing staff pre-sets psychotropic medications in unit doses or bubble packs before delivery. If an inmate housed in a designated mental health special management unit refuses to take his or her psychotropic medication for more than 24 hours, the medication administering staff must provide notice to the psychiatrist. A Qualified Mental Health Professional must see the inmate within 24 hours of this notice.

Monitor: Johnson

Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: CHS has continued to audit this provision with Tool #11. The last audit results indicate that clinicians are notified 10% of the time and took the appropriate clinical response 10% of the time. CHS is now using unit or bubble packs for psychotropic medications.

Recommendations for achieving compliance: Follow through on corrective action to notify psychiatrists if a patient refuses to take medication for more than 24 hours and have a QMHP follow-up within 24 hours of notice.

III. A. 4. e. CHS shall implement physician orders for medication and laboratory tests within three days of the order, unless the inmate is an "emergency referral," which requires immediately implementing orders. [NB: Lab tests in this measure are only those related to medications. Email DOJ 8/27/13]

Monitors: Johnson/Greifinger

MH Compliance Status: **Partial Compliance**
Med Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: Review of audit Tools #21 and 22 indicate that baseline lab orders associated with potentially toxic medications (e.g., Lithium) are being ordered inconsistently and was at 40% in the January audit. Lithium levels were checked 10% of the time and indication of the clinical acknowledgement and evaluation of lab results only occurred 50% of the time. Tools #22 showed low monitoring of lipid profiles and hemoglobin A1c in patients prescribed antipsychotic medication at 60% and 30% respectively. Chart review reflected the same patterns associated potentially toxic medications (e.g., Carbamazepine) and labs to monitor metabolic syndrome.

Recommendations for achieving compliance: Develop treatment protocols for Bipolar Disorder, Schizoaffective Disorder, and Schizophrenia that include guidance on the psychotropic prescribing and monitoring for these illnesses and commonly prescribed potentially toxic medications. Provide training for the protocols. Continue to audit these measures. Consider methods to institute early ordering of appropriate labs for potentially toxic medications (e.g., IT enhancement that prompts inclusion of a lab order set whenever a potentially toxic medication is ordered).

III. A. 4. f. (See III.A.4.a.) Within 120 days of the Effective Date, CHS shall provide its medical and mental health staff with documented training on proper medication administration practices. This training shall become part of annual training for medical and mental health staff

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Training of RNs occurred for medication administration in August 2018. Ongoing real-time and video audits of medication administration practices are occurring with real-time coaching on appropriate medication delivery or a coaching memo is issued respectively.

Recommendations for achieving compliance, if applicable: N/A

Record Keeping

III. A. 5. a. CHS shall ensure that medical and mental health records are adequate to assist in providing and managing the medical and mental health needs of inmates. CHS shall fully implement an Electronic Medical Records System to ensure records are centralized, complete, accurate, legible, readily accessible by all medical and mental health staff, and systematically organized. [NB: Specific aspects of medical record documentation are addressed elsewhere, e.g. medication administration. This paragraph, then, applies to all aspects of medical records not addressed elsewhere. Thus, these various paragraphs are independent and MDCR may reach compliance with this paragraph, for example, despite non-compliance with other aspects of medical record keeping.]

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: CHS has ensured that medical and mental health records are adequate to assist in providing and managing the medical and mental health needs of inmates. CHS has fully implemented Cerner (Electronic Medical Records System) as stated for the purpose of this provision. Chart review, both independently and with the Medical Monitor, showed while overall care is adequate, there are instances where a few of the psychiatrists and MH ARNPs fail to consistently enter appropriate MH diagnoses, which in some cases led to treatment that no longer appeared to match the diagnoses of record; inconsistent documentation of communications with the patient to support treatment decision (e.g., subjective area of the progress notes); inconsistent inclusions of assessments that explain the rationale for treatment decisions (e.g., decisional capacity evaluations for patients with life endangering medical illness). Corrective action is taking place. For example, the Interim Medical Director of Behavioral Health provided several email communications to ARNPs coaching them on importance of appropriate documentation of diagnosis. The CHS CMO indicated that he plans to work with MH leadership to update the MH note templates in the EHR to improve documentation. The electronic MAR remains separate from the EHR but there is a plan in place to transfer to the e-MAR in the EHR.

Recommendations for sustaining compliance: MH note templates, develop protocols of care for SMI diagnoses, and develop a way to audit psychiatrist and ARNP charts to provide feedback and create opportunities to provide guidance on appropriate documentation. Implement e-MAR per the CHS Pharmacy Insourcing Proposal Timeline.

Train and supervise nursing, medical, and mental health staff to effectively evaluate patients' rationale for refusing life-threatening conditions through interview, documentation, and interdisciplinary treatment planning

III. A. 5. b. CHS shall implement an electronic scheduling system to provide an adequate scheduling system to ensure that mental health professionals see mentally ill inmates as clinically appropriate, in accordance with this Agreement's requirements, regardless of whether the inmate is prescribed psychotropic medications.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The County continues to utilize SMART Goal Action Plans to reduce the percentage of No Show Appointments at each facility. Results from July to December 2018 were reviewed for TGK, MWDC, and PTDC. Each facility has followed through on their correction action plans with improvements at all facilities. Overbooking was an issue at each facility and has improved in part due to decreasing the appointment list of providers by the CHS CMO. PTDC has reduced No Shows due to facility malfunction, movement delays, and lockdowns by creating new patient care spaces closer to the units, repairs on malfunctioning elevators, and using the stairs with patients when clinically appropriate. The daily no show reports are discussed at each facility on a daily basis and results of audits are reviewed at the facility FCQI meetings and the CHS CQI meeting.

Recommendations for achieving compliance, if applicable: N/A

III. A. 5. c. (See III.A.5.a.) CHS shall document all clinical encounters in the inmates' health records, including intake health screening, intake health assessments, and reviews of inmates.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: N/A

Recommendations for achieving compliance, if applicable: N/A

III. A. 5. d. CHS shall submit medical and mental health information to outside providers when inmates are sent out of the Jail for health care. CHS shall obtain records of care, reports, and diagnostic tests received during outside appointments and timely implement specialist recommendations (or a physician should properly document appropriate clinical reasons for non-implementation).

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Tool #9 Evaluation of Care Prior to and after ED Visits tracks this provision and audits between June 2018 and December 2018 indicate the measures are consistently being met when patients are sent out to the ED and when they return. Audit Tool #41 Continuity of Care on Transfer to Acute Care Facility is performed quarterly and baseline results were included in the August 6, 2018 Deliverable submission. At that time, all baseline measures were at 0%. Over the next two measurement cycles all

measures improved including prior deficiencies in fully completing the transfer summary which improved from 29% in November 2018 to 90% in January 2019.

CHS has improved acknowledgement of outside clinical visits and testing since the last tour. There is improved acknowledgment of consultants' recommendations, as confirmed through medical record review.

Recommendations for achieving compliance, if applicable: N/A

Discharge Planning

III. A. 6. a. (1) CHS shall provide discharge/transfer planning…Arranging referrals for inmates with chronic medical health problems or serious mental illness. All referrals will be made to Jackson Memorial Hospital where each inmate/patient has an open medical record.

Monitors: Johnson/Greifinger

MH Compliance Status: **Partial Compliance**
Med Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: CHS implemented an excellent process for identifying soon-to-be-released patients. Once identified, CHS staff conducts face-to-face discharge planning including the provision of medication or prescription of medication at a pharmacy convenient to the patient. This program was in effect for one full month before the Monitors' tour. Patients who may be released without notice are informed of treatment options in the community; in addition, they are informed as to how to access their medication from CHS within a few days of their release.

The County tracks this provision with audit Tools 25 and 49. Discharge planning is happening 100% of the time per the audits and appropriate referrals are being provided prior to discharge, to Jackson Memorial Hospital and other care providers. Chart review supports the audit findings. Unplanned releases are provided information on resources for follow-up care and can be assisted by CHS if they return to the jail and request it within 24 hours of release.

Recommendations for achieving compliance: Continue to implement this new program.

III. A. 6. a. (2) Providing a bridge supply of medications of up to 7 days to inmates upon release until inmates can reasonably arrange for continuity of care in the community or until they receive initial dosages at transfer facilities. Upon intake admission, all inmates will be informed in writing and in the inmate handbook they may request bridge medications and community referral upon release.

Monitors: Johnson/Greifinger

MH Compliance Status: **Partial Compliance**
Med Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: Reviewed audit Tools 25 and 49 as above. Bridge medications were requested via the intra EHR messaging system 10% of the time and actually provided 10% of the time for planned releases; and Bridge medications were requested 30% of the time for unplanned releases. There was no data on actual bridge medications provided for unplanned releases. Patients have the option to return to the jail within 24 hours of release to request a 7-day supply of bridge medications. They are informed of this option on Intake and in the Inmate Handbook and a community resource pamphlet. Data obtained during the tour by the Medical Monitor demonstrated that in the prior 30-days, CHS provided a 7-day supply of bridge medications to 58% of released

inmates with chronic medical health problems or serious mental illness who had been identified for discharge planning purposes.

Recommendations for achieving compliance: Continue to implement this new program.

III. A. 6. (3) Adequate discharge planning is contingent on timely notification by custody for those inmates with planned released dates. For those inmates released by court or bail with no opportunity for CHS to discuss discharge planning, bridge medication and referral assistance will be provided to those released inmates who request assistance within 24-hours of release. Information will be available in the handbook and intake admission awareness paper. CHS will follow released inmates with seriously critical illness or communicable diseases within seven days of release by notification to last previous address.

Monitors: Johnson/Greifinger

MH Compliance Status: **Partial Compliance**
Med Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: See III.A.6.a.(1 & 2).

Recommendations for achieving compliance: See III.A.6.a.(2).

Mortality and Morbidity Reviews

III. A. 7. a. Defendants shall sustain implementation of the MDCR Mortality and Morbidity "Procedures in the Event of an Inmate Death," updated February 2012, which requires, inter alia, a team of interdisciplinary staff to conduct a comprehensive mortality review and corrective action plan for each inmate's death and a comprehensive morbidity review and corrective action plan for all serious suicide attempts or other incidents in which an inmate was at high risk for death. Defendants shall provide results of all mortality and morbidity reviews to the Monitor and the United States, within 45 days of each death or serious suicide attempt. In cases where the final medical examiner report and toxicology takes longer than 45 days, a final mortality and morbidity review will be provided to the Monitor and United States upon receipt.

Monitors: Johnson/Greifinger

MH Compliance Status: **Partial Compliance**
Med Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: During the tour Mortality and Morbidity (M&M) reviews from 2018 were reviewed with CHS. Overall, M&M reviews have improved since the last tour. However, it was noted during the onsite review that several typographical/grammatical errors were noted, multiple key clinical data points were not included in the summaries, some of the medical terminology was incorrect, and as a result the CAPs were incomplete. CHS indicated the M&M reviews were written by non-clinical staff with final review and mark-up by clinical leadership. Many of the errors are unlikely to have occurred had a clinician prepared the M&M review.

Recommendations for achieving compliance: Initial drafts of mortality and morbidity reviews should be completed by clinicians who were not involved in the patient's care. These initial reviews should be augmented by senior health professionals and discussed critically by an interdisciplinary morbidity and mortality review committee. This committee should develop a relevant corrective action plan, to be monitored over time. The CAPs should be aggregated and monitored over time for the purpose of identifying system problems or persistent opportunities for improvement.

III. A. 7. b. Defendants shall address any problems identified during mortality reviews through training, policy revision, and any other developed measures within 90 days of each death or serious suicide attempt.

Monitors: Johnson/Greifinger

MH Compliance Status: **Partial Compliance**
Med Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: See III. A. 7. a. above.

Recommendations for achieving compliance: See III. A. 7. a. above

III. A. 7. c. Defendants will review mortality and morbidity reports and corrective action plans bi-annually. Defendants shall implement recommendations regarding the risk management system or other necessary changes in policy based on this review. Defendants will document the review and corrective action and provide it to the Monitor.

Monitors: Johnson/Greifinger

MH Compliance Status: **Partial Compliance**
Med Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: The County has continued to provide Biannual reviews to the Monitors. The overall quality, analysis, and CAPs have improved since the last biannual report.

Recommendations for achieving compliance: See III. A. 7. a. above

Medical Care

Acute Care and Detoxification

III. B. 1. a. CHS shall ensure that inmates' acute health needs are identified to provide adequate and timely acute medical care.

Monitor: Greifinger

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: In December 2018, CHS instituted a leveling system for the infirmary and medical beds. This provides the appropriate level of nursing monitoring and provides for shift-to-shift handoffs; these are well-documented. There are call lights in the four rooms proximate to the nursing station.

Recommendations for achieving compliance, if applicable: N/A

III. B. 1. b. (See III.B.1.a.) CHS shall address serious medical needs of inmates immediately upon notification by the inmate or a member of the MDCR Jail facilities' staff or CHS staff, providing acute care for inmates with serious and life-threatening conditions by a Qualified Medical Professional.

Monitor: Greifinger

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: CHS reports 98% of staff trained for providing acute care. Medical record review reveals good performance for patients requesting acute care.

Recommendations for achieving compliance, if applicable: N/A

III. B. 1. c. CHS shall sustain implementation of the Detoxification Unit and the Intoxication Withdrawal policy, adopted on July 2012, which requires, inter alia, County to provide treatment, housing, and medical supervision for inmates suffering from drug and alcohol withdrawal.

Monitor: Greifinger

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour:

Recommendations for achieving compliance, if applicable: N/A

Chronic Care

III. B. 2. a. CHS shall sustain implementation of the Corrections Health Service ("CHS") Policy J-G-01 (Chronic Disease Program), which requires, inter alia, that Qualified Medical Staff perform assessments of, and monitor, inmates' chronic illnesses, pursuant to written protocols.

Monitor: Greifinger

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Chronic care guidelines have been implemented. Performance is measured and the results are shared with relevant clinicians. The performance measurement tools are evolving in a constructive manner. As a result, the use of the emergency department of the hospital has been reduced with no adverse effects on patients. Reduced ED use, when medically appropriate, is safer and less resource intensive for MDCR.

Recommendations for achieving compliance, if applicable: N/A

III. B. 2. b. (See III. B. 2. a.) Per policy, physicians shall routinely see inmates with chronic conditions to evaluate the status of their health and the effectiveness of the medication administered for their chronic conditions. [NB: The Medical Monitor will interpret "see" in this particular requirement as meaning physicians play a leadership and oversight role in the management of patients with chronic conditions; Qualified Medical Staff may perform key functions consistent with their licensure, training, and abilities. This interpretation was approved by DOJ during the telephone conference of 8/19/13.]

Monitor: Greifinger

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See III. B. 2. a

Recommendations for achieving compliance, if applicable: N/A

Use of Force Care

III. B. 3. a. The Jail 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 custody. Qualified Medical Staff shall perform 15-minute checks on an inmate in restraints. For any custody-ordered restraints, Qualified Medical Staff shall be notified immediately in order to review the health record for any contraindications or accommodations required and to initiate health monitoring.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Per the Biannual Report, there were no patients placed in restraints between July 2018 and December 2018.

Recommendations for achieving compliance, if applicable: N/A

III. B. 3. b. The Jail shall ensure that inmates receive adequate medical care immediately following a use of force.

Monitor: Greifinger

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour:

Recommendations for achieving compliance, if applicable: N/A

III. B. 3. c. Qualified Medical Staff shall question, outside the hearing of other inmates or correctional officers, each inmate who reports for medical care with an injury, regarding the cause of the injury. If a health care provider suspects staff-on- inmate abuse, in the course of the inmate's medical encounter, that health care provider shall immediately:

1) take all practical steps to preserve evidence of the injury (e.g., photograph the injury and any other physical evidence);
2) report the suspected abuse to the appropriate Jail administrator; and
3) complete a Health Services Incident Addendum describing the incident.

Monitor: Greifinger

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour:

Recommendations for achieving compliance, if applicable: N/A

MENTAL HEALTH CARE AND SUICIDE PREVENTION

Referral Process and Access to Care

III. C. 1. a. Defendants shall ensure constitutional mental health treatment and protection of inmates at risk for suicide or self-injurious behavior. Defendants' efforts to achieve this constitutionally adequate mental health treatment and protection from self- harm will include the following remedial measures regarding…
CHS shall develop and implement written policies and procedures governing the levels of referrals to a Qualified Mental Health Professional. Levels of referrals are based on acuteness of need and must include "emergency referrals," "urgent referrals," and "routine referrals," as follows:
"Emergency referrals" shall include inmates identified as at risk of harming themselves or others, and placed on constant observation. These referrals also include inmates determined as severely decompensated, or at risk of severe decompensation. A Qualified Mental Health Professional must see inmates designated "emergency referrals" within two hours, and a psychiatrist within 24 hours (or the next Business day), or sooner, if clinically indicated.
"Urgent referrals" shall include inmates that Qualified Mental Health Staff must see within 24 hours, and a psychiatrist within 48 hours (or two business days), or sooner, if clinically indicated.
"Routine referrals" shall include inmates that Qualified Mental Health Staff must see within five days, and a psychiatrist within the following 48 hours, when indicated for medication and/or diagnosis assessment, or sooner, if clinically indicated.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Internal Audit Tool #44 was created to track this provision and was noted to be repeated quarterly in the County CA Self-Assessment. Baseline results from June 2018 indicated that 30% of referrals were completed in the indicated time frame and that follow-up by a psychiatrist was timely in 0% of charts reviewed. The tool has not been repeated since June 2018. CHS also reported that Tools 46a and 46b track this provision both at Intake and via Sick Call. The results are reported in the monthly MHRC minutes. Outcomes over the last few months has continued to improve with all measures being between ~80-100%. While follow-up with a psychiatrist is not occurring within 48 hours per this provision, patients are being seen for MH Initial evaluation by either a Family Practice or Psychiatric Advanced Registered Nurse Practitioner on the MH team is consistently occurring for emergency or urgent referrals at intake. While not an evaluation by a psychiatrist, it serves the understood purpose of this provision to ensure psychiatric evaluation of patients within the context of referrals at intake. However, in referrals resulting from Sick Call showed timely follow-up by QMHP, and Psychiatry if needed, as only occurring 54% of the time as of December 2018 (down from 75% in November 2018).

Recommendations for sustaining compliance: Continue to audit this provision quarterly with appropriate CAPs to improve QMHP evaluation within the indicated referral time frames as well as follow-up by a psychiatrist within 48 hours of QMHP evaluation when clinically indicated.

III. C. 1. b. Referral Process and Access to Care
CHS will ensure referrals to a Qualified Mental Health Professional can occur:

1. At the time of initial screening;
2. At the 14-day assessment; or
3. At any time by inmate self-referral or by staff referral.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour

Recommendations for achieving compliance, if applicable: N/A

Mental Health Treatment

III. C. 2. a. CHS shall develop and implement a policy for the delivery of mental health services that includes a continuum of services; provides for necessary and appropriate mental health staff; includes treatment plans for inmates with serious mental illness; collects data; and contains mechanisms sufficient to measure whether CHS is providing constitutionally adequate care.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: This is a global provision and entails many areas of care. Overall, CHS has continued to improve in the provision of a continuum services across all facilities. MH staffing is appropriate for the services provided. They are working to fill the Medical Director of Behavioral Health position and currently have an Interim Director until the position is filled. Treatment plans have improved for therapy services and have moved closer to being more patient specific as described in NCCHC Standard MH-G-03. CHS' analysis of data has improved and through associated CAPs appears to have led to improvements in care.

Recommendations for achieving compliance, if applicable: N/A

III. C. 2. b. CHS shall ensure adequate and timely treatment for inmates, whose assessments reveal mental illness and/or suicidal ideation, including timely and appropriate referrals for specialty care and visits with Qualified Mental Health Professionals, as clinically appropriate.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: CHS has tracked adherence to this provision with several audit tools (e.g., Tools 1, 2, 46A, 46B, etc.). Review of associated audit tools and charts indicates that CHS is providing overall adequate, but not always timely, treatment. Referrals for evaluation by a QMHP are appropriate and are entered within a sufficient time frame.

Recommendations for achieving compliance, if applicable: N/A

III. C. 2. c. Each inmate on the mental health caseload will receive a written initial treatment plan at the time of evaluation, to be implemented and updated during the psychiatric appointments dictated by the Level of Care. CHS shall keep the treatment plan in the inmate's mental health and medical record.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Treatment plans are created by the ARNP, and updated by the Psychiatrist, as part of patients' initial evaluation. For the majority of providers, the plan continues to be patient-centered, contain a description of the services available to a patient based on their level of care, and the most common changes observed are medication adjustments. A minority of providers add further specification to the plan. IDTPs have improved. While not patient specific as described in NCCHC Standard MH-G-03, they have moved closer to that goal. High service utilizers (e.g., SMI with a repeated grievance history) continue to have patient specific treatment plans.

Recommendations for sustaining compliance: Continue to work on creating treatment plans that contain concrete, measurable, and observable goals that are patient specific.

III. C. 2. d. CHS shall provide each inmate on the mental health caseload who is a Level I or Level II mental health inmate and who remains in the Jail for 30 days with a written interdisciplinary treatment plan within 30 days following evaluation. CHS shall keep the treatment plan in the inmate's mental health and medical record.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour:

Recommendations for achieving compliance, if applicable: N/A

III. C. 2. e. In the housing unit where Level I inmates are housed (9C) (or equivalent housing) for seven continuous days or longer will have an interdisciplinary plan of care within the next seven days and every 30 days thereafter. In addition, the County shall initiate documented contact and follow-up with the mental health coordinators in the State of Florida's criminal justice system to facilitate the inmate's movement through the criminal justice competency determination process and placement in an appropriate forensic mental health facility. The interdisciplinary team will:

(1) Include the treating psychiatrist, a custody representative, and medical and nursing staff. Whenever clinically appropriate, the inmate should participate in the treatment plan.
(2) Meet to discuss and review the inmate's treatment no less than once every 45 days for the first 90 days of care, and once every 90 days thereafter, or more frequently if clinically indicated; with the exception being inmates housed on 9C (or equivalent housing) who will have an interdisciplinary plan of care at least every 30 days.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: IDTT are occurring per this provision and audits that track their occurrence are reviewed monthly in the MHRC meetings.
During the tour CHS provided documentation (e.g., emails) that show contact with the court mental health coordinators for the criminal justice competency determination process. This provision is also sufficiently tracked in the MHRC meetings on a monthly basis.

Recommendations for achieving compliance, if applicable: N/A

III. C. 2. f. CHS will classify inmates diagnosed with mental illness according to the level of mental health care required to appropriately treat them. Level of care classifications will include Level I, Level II, Level III, and Level IV. Levels I through IV are described in Definitions (Section II.). Level of care will be classified in two stages: Stage I and
Stage II.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Chart review by the MH Monitor team reflects overall appropriate level assignment. Prior to the last tour CHS developed quarterly internal audit tools 32-37 to assess if leveling is appropriate. The CHS CA Self-Assessment identified the tools as the way they are tracking adherence to this provision. Based on the results, CHS identified ambiguity in the criteria for leveling/releveling patients due to interpretive overlap in some of the level criteria for Level IB and Level II. They planned to clarify criteria for leveling/releveling prior to the next tour. Since the last tour, the changed Level I to Level I smocked and I unsmocked to indicate if they require a suicide smock or not. Level IB no longer exists. A procedural directive (PD) or policy update reflecting this change was not provided to the monitors. The audits have not been repeated since June 2018.

Recommendations for sustaining compliance: To maintain compliance, please continue to audit Level of care; and, please provide the CHS-058-B policy update or PD that reflects the elimination of Level IB and the creation of Level I smocked/unsmocked.

III. C. 2. g. Stage I is defined as the period of time until the Mental Health Treatment Center is operational. In Stage I, group- counseling sessions targeting education and coping skills will be provided, as clinically indicated, by the treating psychiatrist. In addition, individual counseling will be provided, as clinically indicated, by the treating
psychiatrist.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: CHS is now accurately tracking individual and group therapy attendance during the MHRC monthly meetings, analyzing the data, and instituting appropriate CAPs. Some psychiatrists have noted in their treatment plans that they are providing supportive individual therapy during their follow-up visits.

Recommendations for achieving compliance, if applicable: N/A

III. C. 2. g. (1) Inmates classified as requiring Level IV level of care will receive:
Managed care in the general population; Psychotropic medication, as clinically appropriate; Individual

counseling and group counseling, as deemed clinically appropriate, by the treating psychiatrist; and valuation and assessment by a psychiatrist at a frequency of no less than once every 90 days.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Chart review indicates that patients are receiving services indicated in this provision. Audit of this level has not been repeated since June 2018. Individual and group counseling is generally provided as "available" and treatment plans often specify the interventions required by level instead of articulating patient specific treatment goals as described in NCCHC Standard MH-G-03.

Recommendations for sustaining compliance: QMHPs should: clearly articulate the biopsychosocial signs, symptoms, or problems addressed in their interventions; specify the individualized treatment interventions provided by specifically stating the skills they taught and reinforced (i.e. anger management, assertiveness, medication management, social skills training, etc.); and, indicate patient progress towards meeting treatment goals.

III. C. 2. g. (2) Inmates classified as requiring Level III level of care will receive:
i. Evaluation and stabilizing in the appropriate setting;
ii. Psychotropic medication, as clinically appropriate;
iii. Evaluation and assessment by a psychiatrist at a frequency of no less than once every 30 days;
iv. Individual counseling and group counseling, as deemed clinically appropriate by the treating psychiatrist; and
v. Access to at least one group counseling session per month or more, as clinically indicated.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See III.C.2.g.(1).

Recommendations for sustaining compliance: QMHPs should: clearly articulate the biopsychosocial signs, symptoms, or problems addressed in their interventions; specify the individualized treatment interventions provided by specifically stating the skills they taught and reinforced (i.e. anger management, assertiveness, medication management, social skills training, etc.); and, indicate patient progress towards meeting treatment goals.

III. C. 2. g. (3) Inmates classified as requiring Level II level of care will receive:
i. evaluation and stabilizing in the appropriate setting;
ii. psychotropic medication, as clinically appropriate;
iii. private assessment with a Qualified Mental Health Professional on a daily basis for the first five days and then once every seven days for two weeks;
iv. evaluation and assessment by a psychiatrist at a frequency of no less than once every 30 days; and
v. access to individual counseling and group counseling as deemed clinically appropriate by the

treating psychiatrist.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Chart review indicates that patients are receiving services indicated in this provision. Audit of this level has not been repeated since June 2018. Individual and group counseling is generally provided as "available" and treatment plans often specify the interventions required by level instead of articulating patient specific treatment goals as described in NCCHC Standard MH-G-03. Rounding providers often document provision of "supportive" or "skills building" interventions but the specificity of psychosocial problem or specific skill targeted is absent making it impossible for subsequent providers to assess effectiveness of intervention, reinforce gains, and provide continuity of care.

Recommendations for sustaining compliance: See III.C.2.g.(1).

III. C. 2. g. (4) Inmates classified as requiring Level I level of care will receive:
i. evaluation and stabilizing in the appropriate setting;
ii. immediate constant observation or suicide precautions;
iii. Qualified Mental Health Professional in-person assessment within four hours,
iv. psychiatrist in-person assessment within 24 hours of being placed at a crisis level of care and daily thereafter
v. psychotropic medication, as clinically appropriate; and
vi. individual counseling and group counseling, as deemed clinically appropriate by the treating psychiatrist.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Chart review indicates CHS is meeting the requirements of this provision. Audit of this level has not been repeated since June 2018.

Recommendations for sustaining compliance: See III.C.2.g.(1).

III. C. 2. h. Stage II will include an expansion of mental health care and transition services, a more therapeutic environment, collaboration with other governmental agencies and community organizations, and an enhanced level of care, which will be provided once the Mental Health Treatment Center is opened. The County and CHS will consult regularly with the United States and the Monitor to formulate
a more specific plan for implementation of Stage II.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: CHS provided documentation of partnerships with the South Florida Behavioral Health Network including a list of network providers, meeting minutes from the quarterly stakeholder meetings, forms used for the Jail In-Reach and Jail Out-Reach programs, summary of the Jail In-Reach program and Jail Diversion program. Utilization of these programs is analyzed during the monthly MHRC meetings.

Recommendations for achieving compliance, if applicable: N/A

III. C. 2. i. CHS will provide clinically appropriate follow-up care for inmates discharged from Level I consisting of daily clinical contact with Qualified Mental Health Staff. CHS will provide Level II level of care to inmates discharged from crisis level of care (Level I) until such time as a psychiatrist or interdisciplinary treatment team makes a clinical determination that a lower level of care is appropriate.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: A review of charts found results consistent with the rate of success documented in Tool #1 from January 2018. Chart review demonstrated that staff have made multiple attempts to see patients who were out to court which increases the likelihood that patients will be seen as required. However, on audit Tool #1 staff are given credit for completing 5-Day Rounding for documenting the attempt when a patient is not seen. The 5-Day Rounding is a patient safety mechanism and it is important to have accurate information about actual completion of services so that appropriate scheduling or other decisions can be made

Recommendations for sustaining compliance: It is recommended that results of the audit tool reflect actual completion of the appointment not staff effort as this will provide a more accurate reflection of conditions.

III. C. 2. j. CHS shall ensure Level I services and acute care are available in a therapeutic environment, including access to beds in a health care setting for short-term treatment (usually less than ten days) and regular, consistent therapy and counseling, as clinically indicated.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Review of the County's MH Bed analysis indicates there are sufficient beds to manage Level I patients. Chart review for Level I patients revealed that patients are seen daily by psychiatrists as required. Regular, consistent therapy and counseling, as clinically indicated was not documented in the chart. For a number of patients who are presenting with acute psychosis this is understandable; however, there are patients with behavioral, mood disturbance, and/or severe charges, who are treated at Level I who can benefit from these services to address their

psychosocial stressors, reinforce medication adherence, and teach non-pharmacological strategies to address their presenting problems (i.e., impulse control, anger management, sleep hygiene, etc.).

Recommendations for sustaining compliance: To maintain compliance, treating psychiatrists should refer patients who have psychosocial problems for counseling and therapy when clinically indicated.

III. C. 2. k. CHS shall conduct and provide to the Monitor and DOJ a documented quarterly review of a reliable and representative sample of inmate records demonstrating alignment among screening, assessment, diagnosis, counseling, medication management, and frequency of psychiatric interventions.

Monitor: Johnson

Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: See III.A.5.a. Level Audits have not been repeated since June 2018 and do not include measures for alignment of diagnosis, counseling, and medication management.

Recommendations for achieving compliance: See III.A.5.a. Recommend developing a means of measuring (e.g., audit tool) that tracks this provision.

Suicide Assessment and Prevention

III. C. 3. a. Defendants shall develop and implement a policy to ensure that inmates at risk of self-harm are identified, protected, and treated in a manner consistent with the Constitution. At a minimum, the policy shall:
(1) Grant property and privileges to acutely mentally ill and suicidal inmates upon clinical determination by signed orders of Qualified Mental Health Staff.
(2) Ensure clinical staff makes decisions regarding clothing, bedding, and other property given to suicidal inmates on a case-by-case basis and supported by signed orders of Qualified Mental Health Staff.
(3) Ensure that each inmate on suicide watch has a bed and a suicide-resistant mattress, and does not have to sleep on the floor.
(4) Ensure Qualified Mental Health Staff provide quality private suicide risk assessments of each suicidal inmate on a daily basis.
(5) Ensure that staff does not retaliate against inmates by sending them to suicide watch cells. Qualified Mental Health Staff shall be involved in a documented decision to place inmates in suicide watch cells.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The County has made considerable efforts to gain compliance with this provision. Chart review has confirmed that inmates are granted property and privileges upon clinical determination; and decisions about clothing, bedding, and other property are given to suicidal inmates and supported by orders. The Behavioral Health Rounding Tool has enabled CHS and MDCR to ensure that all patients on suicide watch receive a bed and a suicide-resistant mattress. QMHPs are involved in documented decisions to place inmates into suicide watch cells thus ensuring decisions are appropriate. Documentation and observation of staff during the tour demonstrated that staff offer each inmate access to private services on a daily basis. However, documentation in the records do not demonstrate daily provision of suicide risk assessments. While staff document that they ask inmates if they are suicidal on a daily basis, asking this question does not meet the NCCHC standard of suicide risk assessment contained in Section MH-G-04.

Recommendations for sustaining compliance: To maintain compliance, please demonstrate daily provision of suicide risk assessment (e.g., clinically appropriate focused suicide risk assessment).

III. C. 3. b. When inmates present symptoms of risk of suicide and self-harm, a Qualified Mental Health Professional shall conduct a suicide risk screening **and assessment** instrument that includes the factors described in Appendix A. The suicide risk screening and assessment instrument will be validated within 180 days of the Effective Date and every 24 months thereafter.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The suicide risk assessment includes the factors described in Appendix A and has been validated. Tool #1 tracks this provision. QMHPs were not routinely completing suicide risk assessments due to an issue with the electronic form. CHS implemented an IT fix for this issue and improvements in completion have been noted.

Recommendations for sustaining compliance: Continue to audit this provision.

III. C. 3. c. County shall revise its Suicide Prevention policy to implement individualized levels of observation of suicidal inmates as clinically indicated, including constant observation or interval visual checks. The MDCR Jail facilities' supervisory staff shall regularly check to ensure that corrections officers implement the ordered levels of observation.

Monitor: Johnson

Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: CHS has revised its Suicide Prevention policy per the requirement of this provision. The County scheduled a joint training on the Black Creek System to review 15-minute Interval Tracking in order to document provision of individualized levels of observation of suicidal inmates. Chart review of documentation for Level I and other patients who have been referred to QMHP on an Emergent Basis demonstrates that orders for Constant Observation are entered in the EHR. Some documentation of MDCR providing constant observation is entered into progress notes completed by nursing staff and QMHP. Constant Observation by custody was observed in Intake for suicidal patients sitting in the open area. MDCR verbally reported that Supervisory Custody Staff regularly review observation logs/Black Creek to ensure observation is happening at appropriate intervals. MDCR provided the Facility Welfare Check Audit dated November 18, 2018. The audit was created to audit policy DSOP 11-020 "Facility Check Procedures" and directly addresses Settlement Agreement provisions III.A.1.a. (3) and III.A.1.a. (6). The audit included data from MWDC, PTDC and TGK. Per the report, the Audit Objectives included, "…reviewing documentation to ensure supervisors completed the required checks and to ensure supervisors periodically reviewed the system and applied the appropriate corrective action if violations occurred." Only information from TGK included 15-minute checks consistent with direct observation of suicidal inmates. This data was not included from MWDC and PTDC (e.g., suicidal inmates under constant observation who are awaiting transfer to TGK). However, a systematic report documenting compliance with this provision was not received by the monitors.

Recommendations for achieving compliance: Please repeat the Facility Welfare Check Audit so that it demonstrates compliance with Constant Observation of Suicidal Inmates at all facilities.

III. C. 3. d. CHS shall sustain implementation of its Intake Procedures adopted in May 2012, which specifies when the screening and suicide risk assessment instrument will be utilized.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour:

Recommendations for achieving compliance, if applicable: N/A

III. C. 3. e. CHS shall ensure individualized treatment plans for suicidal inmates that include signs, symptoms, and preventive measures for suicide risk.

Monitor: Johnson

Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: The County has reviewed policy CHS-058A and revised the Interdisciplinary Treatment Plan. The County developed and utilized Audit Tool #23 Mental Health Treatment Planning to review clinical performance. Despite the improvements these steps have produced, a review of charts of level I inmates did not find individualized treatment plans for suicidal inmates that included signs, symptoms, and preventive measures for suicide risk as described in NCCHC Standards MH-G-03 (Treatment Plans) and MH-G-04 (Suicide Prevention Program). See III.A.2.d.

Recommendations for achieving compliance: See III.A.2.d.

III. C. 3. f. Cut-down tools will continue to be immediately available to all Jail staff that may be first responders to suicide attempts.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour:

Recommendations for achieving compliance, if applicable: N/A

III. C. 3. g. The Jail will keep an emergency response bag that includes appropriate equipment, including a first aid kit, CPR mask or Ambu bag, and emergency rescue tool in close proximity to all housing units. All custodial and medical staff shall know the location of this emergency response bag and the Jail will train staff how to use its contents.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: 98% of custody staff are trained and the officers demonstrated to the medical and MH monitors that they knew where to locate the

emergency equipment. An MDCR audit showed some untrained staff, however, the results of this audit were corrected.

Recommendations for achieving compliance, if applicable: N/A

III. C. 3. h. County shall conduct and provide to the Monitor and DOJ a documented quarterly review of a reliable and representative sample of inmate records demonstrating: (1) adequate suicide screening upon intake, and (2) adequate suicide screening in response to suicidal and self-harming behaviors and other suicidal ideation.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The County has been utilizing Audit Tool #1 to demonstrate their efforts to meet compliance with this provision. The County modified the Suicide Risk Assessment (SRA) so that staff can proceed with utilizing the clinical tool when inmates who do not willingly provide information. This has resulted in uniformly better risk assessments and has increased the successful completion of the SRA forms which has led to consistently improved performance in this area. Audit Tool #1 measures the performance of staff utilizing the SRA when a patient is placed on suicide precaution. The tool does not review the performance of staff who utilize the SRA and do not place patients on suicide precaution. A review of records used in completed Audit Tool #1 and clinical records of other patients revealed that the data field "Individual Suicide Risk Reduction Factors" in the Cat-RAG Suicide Risk Assessment is rarely completed. Discussion with staff revealed that there may be a perception that this overlaps with the "Risk Reduction Suicide Factors" Section of the same form and not a part of the form where a specific and individualized Risk Reduction Plan could be produced for each patient.

Recommendations for sustaining compliance: Recommend utilizing audit Tool #1 to evaluate all SRAs completed to ensure that staff are levelling patients appropriately, ordering suicide precaution when indicated, and using suicide precaution appropriately. Determine the utility of the "Individual Suicide Risk Reduction Factors" Section of the Cat-RAG Suicide Risk Assessment and utilize as indicated.

Review of Disciplinary Measures

III. C. 4.

a. The Jail shall develop and implement written policies for the use of disciplinary measures with regard to inmates with mental illness or suspected mental illness, incorporating the following

(1) The MDCR Jail facilities' staff shall consult with Qualified Mental Health Staff to determine whether initiating disciplinary procedures is appropriate for inmates exhibiting recognizable signs/symptoms of mental illness or identified with mental illness; and

(2) If a Qualified Mental Health Staff determines the inmate's actions that are the subject of the disciplinary proceedings are symptomatic of mental illness, no disciplinary measure will be taken.

b. A staff assistant must be available to assist mentally ill inmates with the disciplinary review process if an inmate is not able to understand or meaningfully participate in the process without assistance.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The County uses Internal Audit Tool #43 to measure compliance with this provision. During the tour this tool was reviewed with the Chief Psychologist who completed an audit of January 2019 demonstrating 100% compliance with completing Disciplinary Review Tool in the EHR. Charts that were audited by Chief Psychologist were re-audited with the MH Sub-Monitor who validated the that results were accurate. Additionally, the Monitor reviewed the charts of additional patients from a list of SMI patients as well as 15 CHS Disciplinary Review Forms were reviewed. QMHPs consistently evaluate for SMI and Cognitive Impairment; however, in 11 of 15 cases, question #9 which requires documentation of whether or not special accommodations as per CHS-056 Patients with Special Needs, was left blank. There was not one instance found where a patient was identified as needing assistance. The monitor was unable to verify if staff assistants are provided to assist with the disciplinary review process if an inmate is unable to understand or meaningfully participate in the process without assistance. The Monitor does not have access to CJIS (The electronic system used by Custody to track Disciplinary Reviews).

Recommendations for sustaining compliance: As part of the Disciplinary Review Evaluation, CHS QMHP, QMP, or MDCR should review the ADA List to determine if the patient has been identified as having special needs so that staff assistance can be arranged if the patient is cleared to participate in the Disciplinary Review Process. It may be beneficial to add an item to Audit Tool 43 so that the reviewer can verify that the Disciplinary Review Assessment Form is completed in its entirety each time an Assessment is performed.

Mental Health Care Housing

III. C. 5. a. The Jail shall maintain a chronic care and/or special needs unit with an appropriate therapeutic environment, for inmates who cannot function in the general population.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Both the MHTC and the Medical Housing units fulfill this provision. Chart review and onsite touring demonstrated utilization of both for SMI patients.

Recommendations for achieving compliance, if applicable: N/A

III. C. 5. b. The Jail shall remove suicide hazards from all areas housing suicidal inmates or place all suicidal inmates on constant observation.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR continues to retrofit housing units (e.g., showers at MWDC) per its 5-year capitol plan.

Recommendations for achieving compliance, if applicable: N/A

III. C. 5. c. The Jail shall allow suicidal inmates to leave their cells for recreation, showers, and mental health treatment, as clinically appropriate. If inmates are unable to leave their cells to participate in these activities, a Qualified Medical or Mental Health Professional shall document the individualized clinical reason and the duration in the inmate's mental health record. The Qualified Medical or Mental Health Professional shall conduct a documented re-evaluation of this decision on a daily basis when the clinical duration is not specified.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The County enhanced the Black Creek Watch Tour System so that MDCR can document out of cell time and produce reports of total out of cell time for MHTC inmates. Psychiatry notes were modified in the EHR which auto-populates the fields for privileges and provides the Psychiatrist with the ability to document exceptions. During the tour, Black Creek Watch Reports for individual patients were requested for one week. The report demonstrated that inmates were being offered both showers and recreation. It also demonstrated that MDCR is documenting when these activities are offered and refused. Additionally, it documented when inmates were out to court. A comparison of the Black Creek Watch Reports and documentation in the EHR

demonstrated consistency in reporting between the two systems. The Black Creek Report did not document when patients left their cells to meet with clinical staff.

Recommendations for sustaining compliance: Continue to utilize the Black Creek Watch Tour System to document out of cell activities. Recommend comparing the Out of Cell Time Reports with the services provided to improve reliability and validity of the data.

III. C. 5. d. County shall provide quarterly reports to the Monitor and the United States regarding its status in developing the Mental Health Treatment Center. The Mental Health Treatment Center will commence operations by the end of 2014. Once opened, County shall conduct and report to the United States and the Monitor quarterly reviews of the capacity of the Mental Health Treatment Center as compared to the need for beds. The Parties will work together and with any appropriate non-Parties to expand the capacity to provide mental health care to inmates, if needed.

Monitor: Johnson

Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: The County provided a MH Bed Analysis report to the Monitoring team prior to the tour. The report noted that the County was housing Level III patients at TGK (they are normally housed at MWDC) due to an increase in their numbers. However, the Level III patients at TGK were not included in the overall patient bed count by level provided for TGK. CHS provided separate data upon request and the monitoring team verified that Level III patients were being housed at TGK. An updated report was twice requested from MDCR before the Level III patients at TGK were included in the analysis. This raises concerns about the accuracy of information reported and interagency communication on MH beds and capacity planning. The CAP does not address this shift in bed usage and if the County plans to continue this practice.

Recommendations for achieving compliance: Please update the report in conjunction with the MDCR, including the CAP if appropriate.

III. C. 5. e. Any inmates with SMI who remain on 9C (or equivalent housing) for seven continuous days or longer will have an interdisciplinary plan of care, as per the Mental Health Treatment section of this Agreement (Section III.C.2.e).

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See III.C.2.g. (1).

Recommendations for sustaining compliance: See III.C.2.g. (1).

Custodial Segregation

III. C. 6. a. (1) The Jail and CHS shall develop and implement policies and procedures to ensure inmates in custodial segregation are housed in an appropriate environment that facilitates staff supervision, treatment, and personal safety in accordance with the following: (Part a) All locked housing decisions for inmates with SMI shall include the documented input of a Qualified Medical and/or Mental Health Staff who has conducted a face-to-face evaluation of the inmate, is familiar with the details of the inmate's available clinical history, and has considered the inmate's
mental health needs and history.

Monitor: Johnson

Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: Documented input by a QMP prior to a locked housing decision is occurring 60% of the time per the January 2019 results of internal audit tool #42 (data from October to December 2018). Patients were correctly identified as SMI in only 50% of the cases, and the QMHP was consulted in 40% of the cases reviewed. The results indicate cases are not being reviewed in a timely manner and suggest that some SMI patients may be missed, at least initially, during the review process. See also: III. C. 3.c.

Recommendations for achieving compliance: Continue to audit this provision with appropriate development of CAPs to improve tracking of SMI patient placement in segregated housing. See recommendation in section III. C. 3.c.

III. C. 6. a. (1) (Part b) If at the time of custodial segregation Qualified Medical Staff has concerns about mental health needs, the inmate will be placed with visual checks every 15 minutes until the inmate can be evaluated by Qualified Mental Health Staff.

Monitor: Johnson

Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: The County reports that they place patients whom they have MH concerns in observation cells with visual checks every 15 minutes until they are evaluated emergently (within 2 hours of referral) by a QMHP. If the QMHP has concerns about their health they will relevel them, typically to a Level I if the severity of their symptoms requires 15-minute checks. Once changed to Level I, they are placed in an observation cell until they are evaluated by a QMHP and their housing status is changed. The County did not produce data to demonstrate 15-minute checks for these patients prior to evaluation by a QMHP. This provision is not verifiable by EHR chart review.
MDCR provided the Facility Welfare Check Audit dated November 18, 2018. The audit was created to audit policy DSOP 11-020 "Facility Check Procedures" and directly addresses Settlement Agreement provisions III.A.1.a. (3) and III.A.1.a. (6). The audit included data from MWDC, PTDC and TGK. Per the report, the Audit Objectives included, "…reviewing documentation to ensure supervisors completed the required checks and to ensure supervisors periodically reviewed the system and applied the appropriate corrective action

if violations occurred." Only information from TGK included 15-minute checks consistent with direct observation of suicidal inmates. This data was not included from MWDC and PTDC (e.g., suicidal inmates under constant observation who are awaiting transfer to TGK). However, a systematic report documenting compliance with this provision was not received by the monitors.

Recommendations for achieving compliance: Repeat the Facility Welfare Check Audit so that it demonstrates compliance with Constant Observation of Suicidal Inmates at all facilities.

III. C. 6. a. (2) Prior to placement in custodial segregation for a period greater than eight hours, all inmates shall be screened by a Qualified Mental Health Staff to determine (1) whether the inmate has SMI, and (2) whether there are any acute medical or mental health contraindications to custodial segregation.

Monitor: Johnson

Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: The County is monitoring this provision with use of Internal Audit Tool #42 – Custodial Segregation. During the monitoring visit, Assistant Mental Health Monitor reviewed the January 2019 Tool with the Chief Psychologist. Results of analysis revealed 40% to 60% compliance on the tasks related to placement of a patient into Segregation. The Tool demonstrated that nursing correctly identifies patients with SMI approximately 50% of the time and place QMHP Consults correctly approximately 40% of the time. QMHPs follow up in a timely manner approximately 60% of the time. A further review of patient charts from a list of SMI Patients found similar results.

Recommendations for achieving compliance: Continue to provide training on the use of forms needed to demonstrate compliance with this provision; continue to provide training on where in the chart to look to confirm presence/absence of SMI, and the steps to take when identified. Continue to utilize Internal Audit Tool #42 to monitor the process, develop CAPs as appropriate and provide feedback to staff on a regular basis.

III. C. 6. a. (3) If a Qualified Mental Health Professional finds that if an inmate has SMI, that inmate shall only be placed in custodial segregation with visual checks every 15 or 30 minutes as determined by the Qualified Medical Health Professional.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Patients placed in custodial segregation are checked visually every 30 minutes. CHS explained that if the QMHP believes a patient requires 15-minute visual checks they will relevel them to Level I. The QMHP cannot order 15-minute visual checks for an SMI patient who is going to continue to be housed in custodial segregation unit.

Recommendations for achieving compliance, if applicable: N/A

III. C. 6. a. (4). i. Inmates with SMI who are not diverted or removed from custodial segregation shall be offered a heightened level of care that includes:
i. Qualified Mental Health Professionals conducting rounds at least three times a week to assess the mental health status of all inmates in custodial segregation and the effect of custodial segregation on each inmate's mental health to determine whether continued placement in custodial segregation is appropriate. These rounds shall be
documented and not function as a substitute for treatment.

Monitor: Johnson

Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: The County is monitoring this provision with use of Internal Audit Tool #42 – Custodial Segregation. During the monitoring visit, Assistant Mental Health Monitor reviewed the January 2019 tool with the Chief Psychologist. Results of analysis revealed 50% compliance on completion of rounding three times per week. A discussion with Chief Psychologist indicated that the tool may not have been capturing improvement over time due to the three-month sampling as patients who have been measured in prior months are counted again in subsequent months. Consequently, County represents improvement in this area not captured by the tools. Assistant Mental Health Monitor reviewed 10 Charts from "SMI Patients who received CHS Disciplinary Review" List provided by County. Most patients reviewed were seen on average once per week which suggests they were treated as if they did not have an SMI while in Segregation despite being on the list of patients identified as having SMI. In three cases the SMI were missed during screening. Of note, two SMI patients who were in Segregation during 2019 received three times per week rounding plus additional services from an array of mental health providers. There were also instances observed where rounding was attempted on two occasions in one day in order to insure the patient was seen although in these cases the patients were not consistently seen three times per week as their SMI status would require.

Recommendations for achieving compliance: Continue to train staff on the procedures, forms to be used, and create systems so that they can correctly identify, classify, and provide the requisite services requires. The County needs to continue to utilize Audit Tool 42-Custodial Segregation to monitor their performance.

III. C. 6. a. (4). ii. Inmates with SMI who are not diverted or removed from custodial segregation shall be offered a heightened level of care that includes:
ii. Documentation of all out-of-cell time, indicating the type and duration of activity.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR is utilizing the Black Creek Watch System to document and track out of cell time provided to patients in Segregation. A back-up paper and pen log system is utilized to insure records are accurate as there have been Wi-Fi interruptions reported. Logs used on site to demonstrate that MDCR has permitted Recreation and Showers at least three times per week was offered for review. Black Creek Watch System Reports were also demonstrated as were the handheld Tablets used to record the information. Group schedules for Segregation were provided to demonstrate services are scheduled. A review of patient records of current Segregated patients revealed that group therapy services, psychotherapy services, and social work rounding was occurring as indicated by staff interviewed.

Recommendations for sustaining compliance: Continue to implement the services described in the 2019 Segregation Plan; continue to address challenges with the Black Creek Watch Tour System so that reports can be easily generated which capture and can demonstrate all out of cell services and/or refusals offered to patients in segregation.

III. C. 6. a. (5) Inmates with SMI shall not be placed in custodial segregation for more than 24 hours without the written approval of the Facility Supervisor and Director of Mental Health Services or designee.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: CHS has designated the reviewing QMHP as the individual who will approve placement in custodial segregation instead of the Director of MH Services. This is occurring for those SMI patients approved for placement at the time the QMHP evaluates them.

Recommendations for achieving compliance, if applicable: N/A

III. C. 6. a. (6) Inmates with serious mental illness shall not be placed into long-term custodial segregation, and inmates with serious mental illness currently subject to long-term custodial segregation shall immediately be removed from such confinement and referred for appropriate assessment and treatment.

Monitor: Johnson

Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: Since the last tour the number of SMI patients in long-term segregation has essentially remained consistent (17 in June 2018 to 18 in February 2019). Patients length of time in long-term custodial segregation range from 18 to 2050 days. They report these patients have to remain in custodial segregation for various reasons ranging from their "Own Protection" (due to Media Coverage or for Administrative reasons) to being at risk or a risk to themselves/others ("Threat to Facility Security/Staff" or "Numerous Keep Separates"). It was not immediately clear how the

County decided which "media cases" to put in to custodial segregation. During the tour the County indicated they are working on plans to move at least 2 of the patients out of segregated housing as a result of discussion during the weekly Segregation Task Force Meetings. However, at the time of the writing of this report both patients remained in segregation. The description of the weekly discussions on each patient sound fluid and factors considered for eventual removal from segregated housing appear to vary based on each patient's cases (e.g., how long should a patient remain in segregation after media coverage has significantly reduced?), and are not based on formalized, measurable goals. SMI patients now have CHS segregation treatment plans to better support their mental health while in long-term segregation.

Recommendations for achieving compliance: The Monitors recommend that CHS develop formalized, measurable goals to track when these patients have reached a point that will allow them to safely transition from segregated housing, when appropriate.

III. C. 6. a. (7) If an inmate on custodial segregation develops symptoms of SMI where such symptoms had not previously been identified or the inmate decompensates, he or she shall immediately be removed from custodial segregation and referred for appropriate assessment and treatment.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Patients who have decompensated are identified by both Custody and CHS staff during 30 minute checks, daily RN rounds, or during visits by the QMHP. The way CHS was notified is now being tracked and MDCR has developed a code ("D10") to be placed in incident reports to track referrals of this type. This provision began to be tracked on audit tool #42 and was measured at 100% prior to day 14 in custodial segregation. CHS also plans to capture this information in the RN Net Tool. A MDCR report of "D10" decompensation incidents was requested during the tour but was not provided prior to writing of this report. Chart review demonstrated that patients in segregation who decompensated were re-leveled and moved to the MHTC until their MH stabilized and they were appropriate for level change.

Recommendations for sustaining compliance: To maintain compliance with this provision, continue to audit this provision to demonstrate patients who have decompensated are being removed from segregation when it is recommended by the QMHP.

III. C. 6. a. (8) If an inmate with SMI in custodial segregation suffers deterioration in his or her mental health, decompensates, engages in self-harm, or develops a heightened risk of suicide, that inmate shall immediately be referred for appropriate assessment and treatment and removed if the custodial segregation is causing the deterioration.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See III.C.6.a.(7).

Recommendations for sustaining compliance: See III.C.6.a.(7).

III. C. 6. a. (9) MDCR staff will conduct documented rounds of all inmates in custodial segregation at staggered intervals at least once every half hour, to assess and document the inmate's status, using descriptive terms such as "reading," "responded appropriately to questions" or "sleeping but easily aroused."

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR is utilizing the Black Creek Watch Tour System to document and track patient's status at the time rounds are made (i.e., out for recreation, in the shower, asleep, etc.). A back-up paper and pen log system is utilized as back up to insure records are accurate as there have been Wi-Fi interruptions reported. Staff on site demonstrated the system and showed how it is used. Black Creek Watch Tour System Reports were also demonstrated as were the handheld Tablets used to record the information. However, while it appeared as if reports for individual patients can be readily generated, reports for specific units or to demonstrate compliance with this provision across multiple units continues to pose a challenge.

Recommendations for sustaining compliance: To maintain compliance, continue to work with the Black Creek Watch Tour System so that reports for this provision can be readily provided and shared.

III. C. 6. a. (10) Inmates in custodial segregation shall have daily opportunities to contact and receive treatment for medical and mental health concerns with Qualified Medical and Mental Health Staff in a setting that affords as much privacy as reasonable security precautions will allow.

Monitor: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: CHS has begun to use Black Watch to audit nursing compliance with segregation rounding policies on a monthly basis. More frequent audits would be constructive. In addition, it would be appropriate and constructive to implement a mechanism to enter the data into the electronic medical record.

Recommendations for achieving compliance, if applicable: N/A

III. C. 6. a. (11) Mental health referrals of inmates in custodial segregation will be classified, at minimum, as urgent referrals.

Monitor: Johnson

Compliance Status: **Partial Compliance**

Activities/Analysis Since Last Tour: The County completed an assessment of this utilizing Tool 42 and measured at 40% in January 2019 (based on data from October 2018 to December 2019). RNs were trained on this provision in December 2018 using an online training. CHS provided a list of QMHP Consults from January 2019 for our review. Urgent or Emergent MH referrals of inmates in custodial segregation were entered <60% of the time and they were seen within 24 hours or sooner (Urgent 24 hour or less and Emergent 2 hours or less) <60% of the time. There were instances noted when Routine referral was entered instead of an Urgent or Emergent referral. Also, there appeared to be confusion within the RN staff as to what constitutes an SMI diagnosis (e.g., Adjustment Disorder but not a Bipolar Spectrum Disorder Diagnosis) which lead to some consults being mistakenly cancelled or discontinued, instead of completed.

Recommendations for achieving compliance: Continue to audit this provision with appropriate CAPs (e.g., retraining on what constitutes SMI) completion to effectively improve adherence to this provision.

Staff and Training

III. C. 7. a. CHS revised its staffing plan in March 2012 to incorporate a multi-disciplinary approach to care continuity and collaborative service operations. The effective approach allows for integrated services and staff to be outcomes- focused to enhance operations.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour:

Recommendations for achieving compliance, if applicable: N/A

III. C. 7. b. Within 180 days of the Effective Date, and annually thereafter, CHS shall submit to the Monitor and DOJ for review and comment its detailed mental health staffing analysis and plan for all its facilities.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour:

Recommendations for achieving compliance, if applicable: N/A

III. C. 7. c. CHS shall staff the facility based on the staffing plan and analysis, together with any recommended revisions by the Monitor. If the staffing study and/or monitor comments indicate a need for hiring additional staff, the parties shall agree upon the timetable for the hiring of any additional staff.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour:

Recommendations for achieving compliance, if applicable: N/A

III. C. 7. d. Every 180 days after completion of the first staffing analysis, CHS 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 they do not, the parties
shall re-evaluate and agree upon the timetable for the hiring of any additional staff.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour:

Recommendations for achieving compliance, if applicable: N/A

III. C. 7. e. The mental health staffing shall include a Board Certified/Board Eligible, licensed chief psychiatrist, whose work includes supervision of other treating psychiatrists at the Jail. In addition, a mental health program director, who is a psychologist, shall supervise the social workers and daily operations of mental health services.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour:

Recommendations for achieving compliance, if applicable: N/A

III. C. 7. f. The County shall develop and implement written training protocols for mental health staff, including a pre-service and biennial in-service training on all relevant policies and procedures and the requirements of this Agreement.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour:

Recommendations for achieving compliance, if applicable: N/A

III. C. 7. g. The Jail and CHS shall develop and implement written training protocols in the area of mental health for correctional officers. A Qualified Mental Health Professional shall conduct the training for corrections officers. This training should include pre-service training, annual training for officers who work in forensic (Levels 1-3) or intake units, and biennial in-service training for all other officers on relevant topics, including:

(1) Training on basic mental health information (e.g., recognizing mental illness, specific problematic behaviors, additional areas of concern);

(2) identification, timely referral, and proper supervision of inmates with serious mental health needs; and

(3) Appropriate responses to behavior symptomatic of mental illness; and suicide prevention.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour:

Recommendations for achieving compliance, if applicable: N/A

III. C. 7. h. The County and CHS shall develop and implement written policies and procedures to ensure appropriate and regular communication between mental health staff and correctional officers regarding inmates with mental illness.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The County has implemented several policies that require regular communication between mental health staff and correctional officers across multiple levels of service (e.g., ranging from facility unit staff in daily huddles to leadership during walk rounds). Communication has improved since the last tour (e.g., segregation task force).

Recommendations for sustaining compliance: Continue to identify ways to effectively improve communication across all levels of care for mentally ill patients.

Suicide Prevention Training

III. C. 8. a. The County shall ensure that all staff have the adequate knowledge, skill, and ability to address the needs of inmates at risk for suicide. The County and CHS shall continue its Correctional Crisis Intervention Training a competency-based interdisciplinary suicide prevention training program for all medical, mental health, and corrections staff. The County and CHS shall review and revise its current suicide prevention training curriculum to include the following topics, taught by medical, mental health, and corrections custodial staff:

1. suicide prevention policies and procedures;
2. the suicide screening instrument and the medical intake tool;
3. analysis of facility environments and why they may contribute to suicidal behavior;
4. potential predisposing factors to suicide;
5. high-risk suicide periods;
6. warning signs and symptoms of suicidal behavior;
7. case studies of recent suicides and serious suicide attempts;
8. mock demonstrations regarding the proper response to a suicide attempt; and
9. the proper use of emergency equipment.

Monitor: Johnson

Compliance Status: **C** Substantial Compliance

Activities/Analysis Since Last Tour:

Recommendations for achieving compliance, if applicable: N/A

III. C. 8. b. All correctional custodial, medical, and mental health staff shall complete training on all of the suicide prevention training curriculum topics at a minimum of eight hours for the initial training and two hours of in- service training annually for officers who work in intake, forensic (Levels 1S3), and custodial segregation units and biannually for all other officers.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour:

Recommendations for achieving compliance, if applicable: N/A

III. C. 8. c. CHS and the County shall train correctional custodial staff in observing inmates on suicide watch and step- down unit status, one hour initially and one-hour in-service annually for officers who work in intake, forensic (Levels 1S3), and custodial segregation units and biannually for all other officers.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour:

Recommendations for achieving compliance, if applicable: N/A

III. C. 8. d. CHS and the County shall ensure all correctional custodial staff are certified in cardiopulmonary resuscitation ("CPR").

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: During the tour, MDCR provided documentation that reflected ~99% of officers have been CPR trained, and that 100% of officers who are currently working are CPR certified. Due to the cycle of staff loss and hiring it is unlikely MDCR will reach and maintain 100% of staff being CPR trained.

Recommendations for achieving compliance, if applicable: N/A

Risk Management

III. C. 9. a. The County will develop, implement, and maintain a system to ensure that trends and incidents involving avoidable suicides and self-injurious behavior are identified and corrected in a timely manner. Within 90 days of the Effective Date, the County and CHS shall develop and implement a risk management system that identifies levels of risk for suicide and self-injurious behavior and results in intervention at the individual and system levels to prevent or minimize harm to inmates, as set forth by the triggers and thresholds in Appendix A.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Collection and analysis of data since the last tour has continued to improve. Analysis of self-harming and suicide attempts in the Biannual reports reflect ongoing improved efforts to identify trends in these incidents and implement interventions to decrease occurrence and improve outcomes. Conclusions logically followed the analysis of data and led to further improvements to better understand and utilize findings to improve care by reducing risk.

Recommendations for achieving compliance, if applicable: N/A

III. C. 9. B. The risk management system shall include the following processes to supplement the mental health screening and assessment processes:
(1) Incident reporting, data collection, and data aggregation to capture sufficient information to formulate a reliable risk assessment at the individual and system levels;
(2) Identification of at-risk inmates in need of clinical or interdisciplinary assessment or treatment;
(3) Identification of situations involving at-risk inmates that require review by an interdisciplinary team and/or systemic review by administrative and professional committees; and
(4) Implementation of interventions that minimize and prevent harm in response to identified patterns and trends.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See III.C.9.a.

Recommendations for achieving compliance, if applicable: N/A

III. C. 9. c. The County shall develop and implement a Mental Health Review Committee that will review, on at least a monthly basis, data on triggering events at the individual and system levels, as set forth in Appendix A. The Mental Health Review Committee shall:
(1) Require, at the individual level, that mental health assessments are performed and mental health interventions are developed and implemented;
(2) Provide oversight of the implementation of mental health guidelines and support plans;
(3) Analyze individual and aggregate mental health data and identify trends that present risk of harm;
(4) Refer individuals to the Quality Improvement Committee for review; and

(5) Prepare written annual performance assessments and present its findings to the Interdisciplinary Team regarding the following:

i. Quality of nursing services regarding inmate assessments and dispositions, and

ii. Access to mental health care by inmates, by assessing the process for screening and assessing inmates for mental health needs.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: N/A

Recommendations for achieving compliance, if applicable: N/A

III. C. 9. d. The County shall develop and implement a Quality Improvement Committee that shall:

(1) Review and determine whether the screening and suicide risk assessment tool is utilized appropriately and that documented follow-up training is provided to any staff who are not performing screening and assessment in accordance with the requirements of this Agreement;

(2) Monitor all risk management activities of the facilities;

(3) Review and analyze aggregate risk management data;

(4) Identify individual and systemic risk management trends;

(5) Make recommendations for further investigation of identified trends and for corrective action, including system changes; and

(6) Monitor implementation of recommendations and corrective actions.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Sections (2) - (6) of this provision are being met based on review of CQI and FCQI Meeting minutes, and the Biannual Report. However, section (1) is still a work in progress. CHS instituted an IT fix to improve completion of the Suicide Risk Assessment. However, completion of SRA forms continues to be an issue based on the February 2019 audit Tool #1 Suicide Risk Assessment results as 40% of charts reviewed contained a completed SRA.

Recommendations for sustaining compliance: Continue to Audit SRA use and completion with follow through on CAPs.

Audits and Continuous Improvement

Self Audits

III.D.1.b. Qualified Medical and Mental Health Staff shall review data concerning inmate medical and mental health care to identify potential patterns or trends resulting in harm to inmates in the areas of intake, medication administration, medical record keeping, medical grievances, assessments and treatment.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: CHS produced a biannual evaluation of its quality improvement plan that will drive the development and implementation of a QI Plan for 2019. Minutes of the QI committee are improved, with presentation of data. CHS is beginning to analyze grievance data, looking for trends and possible CAPs. The CAPs for clinical performance improvement are data driven. They have led to improved systems of care. Answers to grievances are somewhat more responsive to the issue mentioned by the patient.

Recommendations for achieving compliance, if applicable: N/A

III.D.1.c. The County and CHS shall develop and implement corrective action plans within 30 days of each quarterly review, including changes to policy and changes to and additional training.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See III.D.1.b.

Recommendations for achieving compliance, if applicable: N/A

Bi-annual Reports

III.D.2.a. 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:

1) All psychotropic medications administered by the jail to inmates.
2) All health care delivered by the Jail to inmates to address serious medical concerns. The report will include:
   i. number of inmates transferred to the emergency room for medical treatment and why;
   ii. number of inmates admitted to the hospital with the clinical outcome;
   iii. number of inmates taken to the infirmary for non-emergency treatment; and why; and
   iv. number of inmates with chronic conditions provided consultation, referrals and treatment, including types of chronic conditions.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Analyses of data and identification of trends have continued to improve since the last tour. Conclusions logically followed the analysis of the data and CAPs appear to be more meaningfully structured to potentially lead to better understanding of findings to improve the delivery of care.

Recommendations for achieving compliance, if applicable: N/A

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:
All suicide-related incidents. The report will include:
(i) all suicides;
(ii) all serious suicide attempts;
(iii) list of inmates placed on suicide monitoring at all levels, including the duration of monitoring and property allowed (mattress, clothes, footwear);
(iv) all restraint use related to a suicide attempt or precautionary measure; and
(v) information on whether inmates were seen within four days after discharge from suicide monitoring.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See III.D.2.a.(2)

Recommendations for achieving compliance, if applicable: N/A

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:

(i) inmates who are on the mental health caseload, classified by levels of car
(ii) inmates who report having participated in general mental health/therapy counseling and group schedules, as well as any waitlists for groups
(iii) inmates receiving one-to-one counseling with a psychologist, as well as any waitlists for such counseling; and
(iv) inmates receiving one-to-one counseling with a psychiatrist, as well as any waitlists for such counseling.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See III.D.2.a.(2). This measure is also being tracked monthly in the MHRC minutes.

Recommendations for achieving compliance, if applicable: N/A

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: 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.

Monitor: Johnson

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See III.D.2.a.(2)

Recommendations for achieving compliance, if applicable: N/A

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.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See III.D.2.a.(2)

Recommendations for achieving compliance, if applicable: N/A

II.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.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See III.D.1.b.

Recommendations for achieving compliance, if applicable: N/A

Compliance and Quality Improvement

V. 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.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: This is an over-arching provision; a number of other provisions fall under its umbrella, all of which are compliant.

Recommendations for achieving compliance, if applicable: N/A

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.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: CHS has implemented its policies. CHS demonstrates improved practices in this area.

Recommendations for achieving compliance, if applicable: N/A

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.

Monitors: Johnson/Greifinger

MH Compliance Status: Substantial Compliance
Med Compliance Status: Substantial Compliance
Activities/Analysis Since Last Tour: N/A
Recommendations for achieving compliance, if applicable: N/A

Report of Compliance
Settlement Agreement
Status of Compliance
March 22, 2019

Introduction

Compliance Report #10 describes the outcomes of Miami-Dade Corrections and Rehabilitation's (MDCR) initiatives to reaching compliance of the requirements in the Settlement Agreement. The findings in this report are informed before and during the on-site tour by review of documents, interviews with staff and inmates, observations of operations, and discussions with the County while on-site.

Chart 1 - Summary of Compliance - Settlement Agreement
As of Compliance Tour # 10

Report # /Date	Compliance	Partial Compliance	Non-Compliance	Not Applicable/Not Due/Other	Total
1 – 11/5/13	1	26	23	6	56
2 – 5/22/14	7	27	22	0	56
3 – 11/28/14	13	31	10	2	56
4 -7/3/15	23	32	0	1	56
5 – 2/15/16	30	26	0	0	56
6 - 9/9/16	30	26	0	0	56
7 – 4/4/17	53	3	0	0	56
8 – 1/18/18	37	19	0	0	56
9 – 8/24/18	42	14	0	0	56
10 – 3/18/19	56	0	0	0	56

Protection from Harm

The Monitor commends the hard work of the County to reach 100% compliance with the Settlement Agreement. The Monitor particularly acknowledges and recognizes the process of developing internal audits and critical self-evaluation as critical to achieving, and then to sustaining compliance with the Settlement Agreement.

Director Junior and his leadership team are also commended. The Monitors look forward to confirming sustained compliance in remaining on-site tours.

Areas of focus going forward

Inmate/Inmate violence and Uses of Force

Paragraph III. A. 1. a. (11) provides: "MDCR shall continue its efforts to reduce inmate-on-inmate violence in each Jail facility annually after the Effective Date. If reductions in

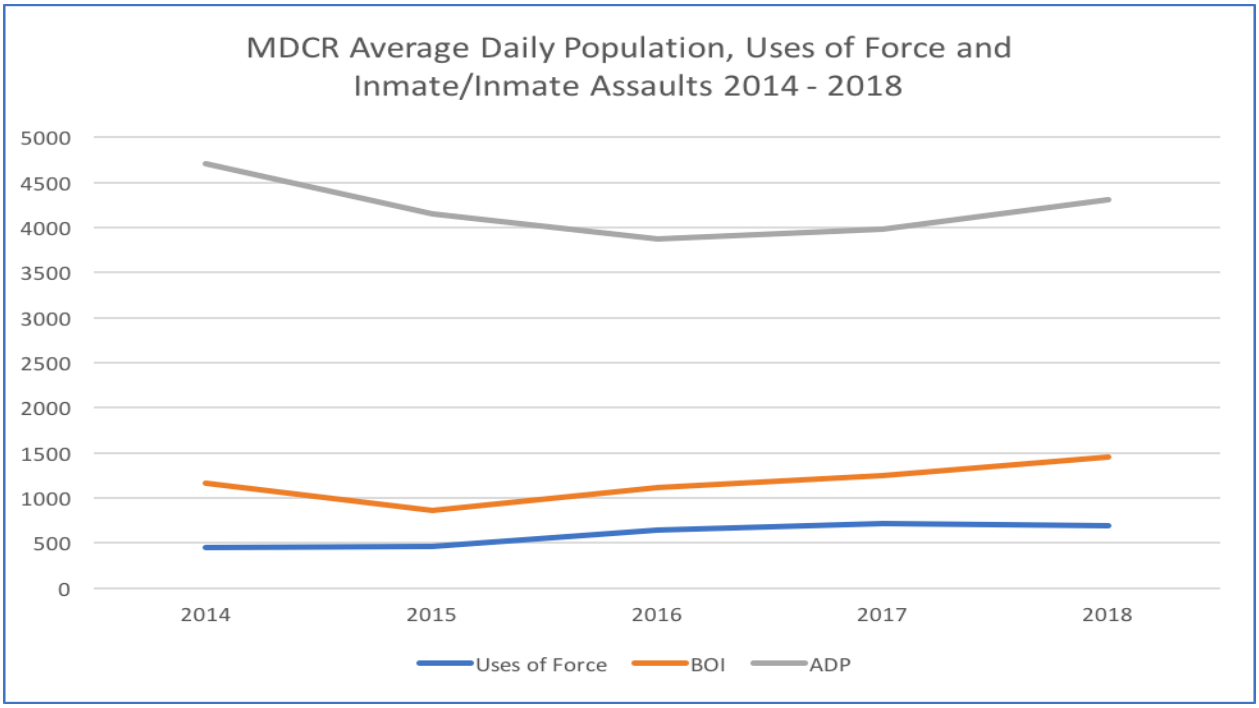
violence do not occur in any given year, the County shall demonstrate that its systems for minimizing inmate-on-inmate violence are operating effectively."

Paragraph III. A. 5. c. (12) provides: "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."

Data provided by the County to the Monitor does not demonstrate current compliance with either of these paragraphs. In the County's January 2019 self-assessment of compliance with provisions of the Settlement Agreement, it assessed both above paragraphs as being in substantial compliance. For paragraph III. A. 1. A. (11), the steps taken to reach compliance is an audit of reductions in uses of force and inmate/inmate assaults. For paragraph III. A. 5. c. (12) the County offers the quarterly reports and plans of action and countermeasures.

The County notes decreases in the last quarter of 2018. Looking at the data, the decline in inmate/inmate assaults is 5% in Quarter 4 (October – December 2018) as compared to Quarter 3 (July - September 2018). The County's data reporting inmate/inmate assaults for 2018 is 17% higher than 2017 total (2018 – 1,455, 2017 – 1,238). For uses of force, the change from Quarter 3 to Quarter 4 of 2018 represents a 21% decrease. Reviewing 2017 to 2018, the uses of force decreased 4% (712 in 2017, 685 in 2018). From 2017 to 2018, the average daily population for the jai system increased 85, after experiencing a decrease in the previous three years.

Chart 2 – Inmate Average Daily Population, Inmate/Inmate Assaults (BOI), Uses of Force 2014 – 2018



The Monitor assigns a rating of compliance with these two paragraphs to acknowledge and recognize of the significant progress to date. This progress includes the data collected, collaboration between MDCR and CHS, problem-solving, development of counter-measures and implementation, and working to effect action plans. The County believes that these initiatives will result in compliance with annual lower numbers as required by the Settlement Agreement. The County has maintained that many of the uses of force result from the staff separating inmates who are engaged in fights. Therefore, it seems purdent to engage in problem-solving regarding decreasing inmate/inmate fights as a means to lower uses of force.

The Monitor notes that if prior to the next tour the County is not able to demontrate sustained, objective and meaningful reductions in inmate/inmate violence and uses of force, we will collaboratlvely reconsider the compliance rating.

The County has devoted considerable resources in identifying the causes, and constantly updating "countermeasures" to address the violence levels (use of force and inmate/inmate assaults). The work began in March, 2017. The model and strategy of using data to drive discussions and decision-making is exemplary. Some of the County's current recommendations were proposed by the Monitor in 2016.

The County's initiatives and analyses include, but are not limited to:

- Addressing the issues identified in the audit of inmate disciplinary processes so it will act as an appropriate deterrent to prevent and correct institutional rule violations.
- Relooking at portions of the classification process including the "keep separate" designations and PREA designations which may impact the housing options open to inmates.
- Relocating of inmates who have conflicts with other inmates.
- Creating and increasing inmate programming.
- Improving menus.
- Applying direct supervision principles to improve inmate safety.
- Identifying specific inmates who are candidates for personal interventions.
- Working to reduce contraband introduction and flow.

These initiatives are laudable. The County is urged to focus on direct causation rather that symptoms of issues – for example, the need to relocate inmates to reduce violence may result from deficiencies in the classification systems. Many strategies are intertwined in terms of assessing singular impact. Some initiatives don't go far enough, for example adoption of the principles of direct supervision inmate management rather than focusing on training staff. While a very good step, re-envisioning facilities with all the foundations needed for direct supervision is not yet described.

Most importantly, the core of a safe facility, the inmate classification system, has not been validated. This has been a theme since this monitoring began, with such a report being the

basis for the Monitor being able to report that the system works. This has been delayed, for a variety of reasons, and is not completed. Yet it is, in the view of the Monitor, essential. [See below for a further discussion.]

Also of concern are the number of inmates on the mental health caseload involved in inmate/inmate altercations and uses of force. MDCR and CHS estimate that 56% of the inmate population at any one time is on the behavioral health caseload, with 19% of the population assigned to either Level I, II or III status. According to MDCR's data, in 2018, 399 inmates on the Levels I –III on the mental health caseload were involved in a use of force. Inmates on Levels I – III involved in inmate/inmate assaults were numbered 760. Not confusing the number of incidents with the number of inmates involved (as more than one inmate is generally involved in many incidents), this number is concerning. The Monitor urges, as a part of the County's countermeasures initiatives, that the County address uses of force and inmate/inmate violence focus on inmates on the behavioral health caseload, collaborating with CHS.

MDCR is planning to implement the use of conducted electrical weapons (CEW), otherwise known by their brand name, Taser, to address violence. The Director believes that by supervisory staff having this use of force option is available will be a deterrent to inmates, and keep staff safe by their not having to intervene, hands-on, to break up a fight when inmates do not respond to employees' direction to stop fighting. Supervisors only will be authorized to use the instruments. This option is not included with the list of initiatives/strategies provided by MDCR. The directives governing this use of force option and the lesson plans were just reviewed by the Monitors and the DOJ; we anticipate seeing updated documents and corresponding lesson plans prior to implementation.

Analysis, Audits and Self-Critical Analysis

The County is commended for beginning the Trend Analysis and Action Planning (TAAP) Unit – which evaluates 100% of uses of force. Their work has been instrumental in sustaining compliance with many of the provisions of the Settlement Agreement as well as improving operations and keeping staff and inmates safe.

MDCR is also commended for setting up a schedule of internal audits, and engaging in self-critical review. This is an evolving process as staff learn how to conduct and report these findings. The Monitor encourages MDCR to assure that the findings of these audits and reports are clearer and that the action plans, if needed, directly address the findings. Collaborative review among the leadership teams may also improve the work product.

Validation of the Classification System

Paragraph III. A. 1. A. (2) provides: "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."

The parties agreed since 2014 that a validation study would provide the information the Monitor needs to conduct an annual review of the system. The County has been pursuing a new jail management information system almost since the monitoring began. The implementaiton has, for a variety of reasons, not happened. Therefore the data needed to report on compliance with this pargraph is also delayed. In Compliance Report # 8, January 18, 2018, the Monitor recommended (as well as during the exit interview for tour # 8, December 7, 2017), that the County engage a subject matter expert (SME) to assist with this work. The SME was not engaged until July of 2018; with the SME, on-site in October 2018. While the Monitor observes that the County should have acted more expeditiously to engage the subject matter expert due to the criticality of this paragraph of the Settlement Agreement, the expert has been on-site and is currently preparing findings, and presumably recommendations.

Given that the process is underway, the Monitor finds this paragraph to be in compliance, with the expectation that the report, and any recommendations will be finalized prior to the next on-site tour. If this process is not concluded before the next on-site tour, the rating of this paragraph will be reviewed.

Staffing

The County government has been supportive of the staffing needs of MDCR. Additionally, MDCR working with CHS, has evaluated staffing in support of CHS operations. There was agreement regarding staffing level. This was excellent work, and should be reviewed periodically.

Investigations

MDCR has worked to establish increased investigative capacity through jail-based, trained, investigators, and re-starting the "gang" unit – to address strategic threat groups (STG).

Inmate Grievances

CHS and MDCR's collective work to review and improve the inmate grievance process, review, and action is noteworthy. The related paragraphs in both the Settlement Agreement and Consent Agreement are in compliance.

Follow-up for the Next On-Site Tour

The following paragraphs of the Settlement Agreement, are now identified as being in Substantial Compliance, and will require follow-up by the County and the Monitor prior to and during the next compliance tour. MDCR is acknowledged for conducing audits, several of which identified non-conformities with policy/Settlement Agreement.

1. III.A.1. a. 2. – Validation of the inmate classification system, provide the Monitor with the information to assess the system.

2. III. A.1. a. 8. – Improvements in the way in which contraband is identified, and the MDCR's ability to effectively develop, implement and assess the impact of action plans to address this security challenge.

3. III.A. 1. 9 – Review the effectiveness of the action plan to assure training takes place within the required time frame.

4. III. A. 1. 10 - Review the effectiveness of the action plan to assure training takes place as required.

5. III. A. 1. a. (11) – The County must demonstrate with data and activities/action a lower number for violence and uses of force prior to the next on-site tour.

6. III. A. 2. b. – Update the audit which addressees the escort of inmates to and from medical and mental health appointments, and include the total number of clinic visits and clarify in the audit the definition of "movement delays".

7. III. A. 4. e. – Report on the findings of subsequent audits regarding the report writing requirement.

8. III. A. 4. f. – Report on the findings of subsequent audits regarding reporting of medical needs of inmates.

9. III. A. 5. b. – Provide revisions, as developed to the use of force policy (DSOP 11-041), including the training strategies planned/implemented regarding de-escalation techniques.

10. III. A. 5. c. (6), III. A. 5.c. 10. – Review the updated CHS Tool # 30.

11. III. A. 5. c. (11) – Provide an updated audit, with clear findings, and assessment of the effectiveness of action plan (1/14/19).

12. III. A. 5. c. (12) – Demonstrate effectiveness of strategies to reduce uses of force, particularly involving inmates on the behavioral health caseload.

13. III. A. 6. b. – Provide a list of staff members identified through the EWS, and any corrective actions taken (for the period 1/1/19 – 6/30/19)

14. III. D. 1. a.– Provide evidence of reports, audits, etc. to demonstrate the continuous quality improvements.

15. III. D. 2. - Provide evidence of reports, audits, etc. to demonstrate the continuous quality improvements.

16. IV. A. IV. B., IV. C, IV. D – Assure that revisions to existing policies covered by this Agreement, and any new policies, are provided in a timely manner for review by the Monitors and DOJ.

Improving Jail Facilities

The Monitor understands that the County continues to move forward with plans to replace the Pre-Trial Detention Center (PTDC). As noted in Compliance Report #7, PTDC was built in 1959, and has a well-documented history, until the last ten years, of lack of preventive maintenance, impacting the condition of the building. The physical plant of a jail ages 3.5 years for every year in operation. Therefore, PTDC has a physical plant age of 210 years old.[3] It is challenging to the staff to manage this aging facility from the perspective of maintenance, and safety of inmates and staff. The elevators in PTDC are not currently certified by the County inspectors, reflecting difficult maintenance and contractor issues. The Monitor hopes that the momentum to improve the facilities, operations, and staffing is not negatively impacted by the absence of concrete planning for bed replacement.

The Monitor specifically commends the work of the leadership at PTDC who daily manage this facility.

Next Steps – Sustainability

The Monitor commends and acknowledges the hard work of the County in achieving 100% substantial compliance with the Settlement Agreement. This report identifies, above, the reviews to be undertaken by the County and the Monitor prior to/during the next on-site tour. Through MDCR's assertive self-auditing and self-critical analysis, even if non-conformities are identified, the Monitor is confident that the processes are in place to address any issues via plans of action. This sustainability will assure that this Settlement Agreement will be concluded as soon as possible.

[3] Martin, Mark D. and Thomas A. Rosazza, Resource Guide for Jail Administrators, U. S. Department of Justice, National Institute of Corrections, December 2004, page 70 http://static.nicic.gov/Library/020030.pdf

Settlement Agreement

Review of Provisions

The County shall take all actions necessary to comply with the substantive provisions of this Agreement detailed below. Compliance with the Agreement will be measured both by whether the technical provisions are implemented and whether the conditions of confinement in the Jail meet the requirements of the United States Constitution.

A. PROTECTION FROM HARM

Consistent with constitutional standards, the MDCR Jail facilities shall provide inmates with a reasonably safe and secure environment to ensure that they are protected from harm. MDCR shall ensure that inmates are not subjected to unnecessary or excessive force by the MDCR Jail facilities' staff and are protected from violence by other inmates. The MDCR 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.

B. III. A. Safety and Supervision

III. A. 1. 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)

(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.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR continues to conduct annual review of policies/procedures. A memorandum dated December 21, 2108 summarized the reviews for this year.

Recommendations for Sustaining compliance, if applicable: N/A

(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.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Substantial Compliance is noted here; although the County has not completed a validation study of the classification

system that would allow the Monitor, and the jail, to assess if the system is housing inmates based on level of risk and supervision needs. The ability of MDCR to conduct this assessment was sidetracked when the planned jail management information system could not be implemented, and a new vendor had to be identified and retained. The data to be generated by an information system needed for a jail of this size would provide the information needed to validate the classification system. Validation means that the criteria used to house inmates keeps them safe.

The County has contracted with a subject matter expert to do the long-discussed validation study. In Compliance Report # 8, January 18, 2018, the Monitor recommended (and during the exit interview for tour # 8, December 7, 2017), that the County engage a subject matter expert. (SME). The plans to engage the SME did not begin until July of 2018; with the SME, on-site in October. While the Monitor observes that the County should have acted more expeditiously to engage the subject matter expert as this is directly related to compliance with one paragraph of the Settlement Agreement, the expert has been on-site and is currently preparing findings, and presumably recommendations.

Prior to the next compliance tour, the Monitor requests that this report be provided, and any action items identified in the report be implemented. The Monitor will reassess compliance based on this work prior to the next tour.

Recommendations for sustaining compliance: Complete the validation study, implement any recommendations, and provide the report and action plans to the Monitor.

(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. See also CA III. C. 6. a. (1)

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: An internal audit was conducted for the period July – September 2018, dated November 18, 2019. The audit's objectives were to determine if security rounds were being conducted at irregular intervals and documented. The Black Creek Watch Tour Manager System's data was used. The audit concluded a 97% compliance. There were findings regarding rounds at PTDC. The audit included the rounds at the Mental Health Treatment Center at TGK. An action plan was provided with plans to improve performance with the security lieutenant conducting monthly audits. Improvements to the audit should be inclusion of the specific requirements of the Consent Agreement.

Recommendations for Sustaining compliance, if applicable: N/A

(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.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See above III. A. 1. a. 3.

Recommendations for sustaining compliance, if applicable: N/A

(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:

(i) PTDC – 24 safety cells, by July 1, 2013
(ii) PTDC – 10B disciplinary wing, by December 31, 2013; kitchen, by Jan. 31, 2014;
(iii) Women's Detention Center – kitchen, by Sept. 30, 2014;
(iv) Training and Treatment Center - all inmate housing units areas and kitchen, by Apr. 30, 2014;
(v) Turner Guilford Knight Correctional Center – kitchen; future intake center; by May 31, 2014; and
(vi) Metro West Detention Center – throughout all areas; by Aug. 31, 2014.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The County provided evidence that the cameras are repaired when reported via the electronic tech work order system.

Recommendations for sustaining compliance, if applicable: N/A

(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.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See above III. A. 1. a. 3.

Recommendations for sustaining compliance, if applicable: N/A

(7) Security supervisors shall conduct daily rounds on each shift in the inmate housing units, and document the results of their rounds.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See above III. A. 1. a. 3. The County also audited compliance with PREA provisions/standards/policies, and identified an issue with the documentation of unannounced rounds. An action plan was developed, dated December 9, 2018. This finding does not change the compliance with this paragraph, and the County is commended for the critical self-analysis that identified the issue. It is anticipated that the issue will be corrected prior to the next on-site tour, and before the next PREA audits.

Recommendations for sustaining compliance, if applicable: N/A

(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.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR produced two documents and a corrective action plan. The third quarter report of shakedowns and contraband noted that although the number of shakedowns per quarter dropped in the first part of 2018. The data reported shakedowns per facility as well as the number of contraband items recovered, which has decreased by half from 2015 through 2017.

In addition to the report, MDCR also audited their compliance with policy for the period July – September 2018. This resulted in a corrective action plan to address deficiencies, including the number of pills found, weapons recovered, and the lapse in the disciplinary process for inmates found with contraband.

MDCR is recognized both for the quarterly reporting and action plans, but also for conducting an audit of procedures.

Recommendations to improve performance from the Monitor are:

- As has been identified over several years in the Monitor's comments, address the large percentage of "other" found (in this report 23%) which does not enhance prevention.
- Address the issue of recovery of pills. This has been an issue over the reports as well, and requires close collaboration with CHS. In this audit, 17% of

recoveries were for medication. While CHS described to the Monitors an aggressive strategy to identify the medication and the possible patient, this was not incorporated in MDCR's audit's findings or action plan. This is a serious matter, as one inmate did overdose on medication that he was able to get from other inmates in his housing unit.

- Update/revise the findings to more useful information, for example, rather than report on "personal clothing items", which constituted 24% of recoveries, identifying exactly what was recovered informs an action planning process.

Recommendations for sustaining compliance: This paragraph is in Substantial Compliance, and further review of findings, changes, etc., that have been made over the last five years, will be reviewed during the next on-site tour.

(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.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR audited compliance with the policy, DSOP 6-008, which implements this paragraph. Compliance with this paragraph has long been a challenge because of the bid assignment process, which can occur more often than annually. The audit (9/2/18) found that the process of orienting staff within 30 days is not effective, with no staff receiving the training within the required time period. A subsequent audit (11/30/18) found that 23% of those transferred did not receive the training within the required period, a substantial improvement over the results of the September audit. MDCR's critical self-assessment identified the non-conformity, and the action plans are remedying the findings. The Monitor will review the outcome of the subsequent audits during the next on-site compliance tour.

Recommendations for sustaining compliance: Continue to evaluate the outcomes of the internal audit findings and effectiveness of the action plans.

(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.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR provided an audit of this provision (11/7/18) to determine compliance with this provision and agency policy. The audit found that 77% of staff assigned to special management units had completed refresher training; and the remaining 23% were scheduled to receive training by

12/31/18. The MDCR requirement for training exceeds the 8 hours of training required by this paragraph of the Settlement Agreement. A corrective action plan was also provided, which includes the anticipated positive impact of a newly purchased training management system. MDCR's critical self-assessment identified the non-conformity, and the action plans are remedying the findings. The Monitor will review the outcome of the subsequent audits during the next on-site compliance tour.

Recommendations for sustaining compliance: Continue to evaluate the outcomes of the internal audit findings and effectiveness of the action plans.

(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. See also Settlement Agreement III. A. 5. c. (12)

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See Settlement Agreement Introduction to this report, above.

Recommendations for sustaining compliance: See Settlement Agreement Introduction to this report, above.

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:

a. Within 150 days of the Effective Date, MDCR shall conduct a comprehensive staffing analysis and plan to determine the correctional staffing and supervision levels necessary to ensure reasonable safety. Upon completion of the staffing plan and analysis, MDCR will provide its findings to the Monitor for review. The Monitor will have 30 days to raise any objections and recommend revisions to the staffing plan.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR continues to analyze staffing and update plans. MDCR has indicated in their recent budget request, they have asked to fill all vacant positions. MDCR and CHS consulted and reviewed MDCR staffing) to assure that CHS activities are supported. They jointly produced a report (dated January 25, 2019, affirming that MDCR staff meets the needs of CHS.

Recommendations for sustaining compliance, if applicable: N/A

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.

(2)

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See III. A. a., above. MDCR/CHS jointly conducted an audit to determine if inmates were accessing health care/movements in a timely manner. The results indicated some delays, including 59% of delays (N=157) attributed to "movement delays" due to facility operations. The audit did not identify the total number of clinic visits, which would have provided context to the findings. An action plan was developed for each facility. The Monitors (SA and CA) will review the outcome of the subsequent audits during the next on-site compliance tour.

Recommendations for sustaining compliance: Continue to evaluate the outcomes of the internal audit findings and effectiveness of the action plans.

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.

Monitor: McCampbell

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See III. A. a., above

Recommendations for Sustaining compliance, if applicable: N/A

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.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See III. A. a., above

Recommendations for sustaining compliance, if applicable: N/A

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.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR's completed a successful audit of PREA compliance per the PREA standards. MDCR continues to assess on-going compliance through internal audits. While MDCR maintains compliance, the Monitor will not conduct a reassessment of compliance with the PREA standards. The next PREA audits are due in 2020.

Recommendations for sustaining compliance, if applicable: N/A

III. A. 4. Incidents and Referrals

a. MDCR shall ensure that appropriate managers have knowledge of critical incidents in the Jail to take action 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.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR continues to self-monitor compliance with internal policy relative to this requirement.

Recommendations for sustaining compliance, if applicable: N/A

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.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR also provides timely notification to the parties regarding such incidents.

Recommendations for sustaining compliance, if applicable: N/A

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:

(3) unique tracking number;
(4) inmate(s) name;
(5) housing classification;
(6) date and time;
(7) type of incident;
(8) any injuries to staff or inmate;
(9) any medical care;
(10) primary and secondary staff involved;
(11) reviewing supervisor;
(12) any external reviews and results;
(13) corrective action taken; and
(14) administrative sign-off.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR continues to work on the implementation of a management information system.

Recommendations for sustaining compliance, if applicable: N/A

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. See also Consent III. A.3. (4)

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR and CHS conducted an audit of the inmate grievance process related to allegations of staff misconduct (1/14/19). MDCR also developed a self-monitoring tool to assess on-going compliance. The findings of the sample included in the audit were that 100% of grievances were reported as required. Internal recommendations for improving flow of grievances were included as an action plan.

The Consent Agreement also contains language regarding grievances. The medical and mental health monitors found these corresponding provisions in compliance.

Recommendations for sustaining compliance, if applicable: N/A

e. Correctional staff shall receive formal pre-service and biennial in-service training on proper incident reporting policies and procedures.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Pre-service and in-service training continues which includes these lesson plans. MDCR conducted an audit of the requirements of this provision (12/12/18). The audit revealed areas of non-conformity with policy, including demonstration of proficiency. MDCR has implemented a corrective action plan, as well as assuring that the trainees are re-tested.

MDCR's critical self-assessment identified the non-conformity, and the action plans are remedying the findings. The Monitor will review the outcome of the subsequent audits during the next on-site compliance tour.

Recommendations for sustaining compliance, if applicable: Continue to evaluate the outcomes of the internal audit findings and effectiveness of the action plans.

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.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR conducted an audit of lesson plans (11/30/18) regarding the provisions of this paragraph. MDCR's critical self-assessment identified the non-conformity, and the action plans are remedying the findings. The Monitor will review the outcome of the subsequent audits during the next on-site compliance tour.

Recommendations for sustaining compliance, if applicable: Continue to evaluate the outcomes of the internal audit findings and effectiveness of the action plans.

III. A. 5. Use of Force by Staff

a. Policies and Procedures

a. 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.

b. MDCR shall revise the "Decontamination of Persons" policy section to include mandatory documentation of the actual decontamination time in the response to resistance reports.

c. 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.

(15)

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour:

Recommendations for Sustaining compliance, if applicable: N/A

b. Use of Restraints See also Consent Agreement III.B.3.c.

(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 injectible 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.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR produced an audit relating to the use of de-escalation techniques (1/7/19). Improvements to the current procedures and

training were identified. A Training "Note' was also provided identifying de-escalation techniques. The audit identified that there is not a clear definition of "de-escalation techniques" in the use of force policy, and noted that amendments will be made to that policy. The Director issued, on 1/18/19, a revision to the use of force policy regarding de-escalation. When revisions are completed, the Monitor requests the policy be re-submitted to the parties for review.

Use of de-escalation techniques is a training issue, and the information provided does not indicate how the training (pre-service and in-service) may be modified (other than the training "NOTE"). Prior to the next tour, the Monitor would like to see any updated lesson plans, along with training strategies.

MDCR also produced an audit (1/14/19) that recommendations of the TAAP unit are being implemented specifically about supplemental or refresher training. The remedial action from this audit includes that the TAAP Unit Review Sergeant will be more pro-active in working with Training to assure that individuals recommended for training receive it in a timely manner.

The Medical and Mental Health Monitors found the corresponding requirements of the Consent Agreement to be in compliance.

Recommendations for sustaining compliance: Continue to evaluate the outcomes of the internal audit findings and effectiveness of the action plans.

c. Use of Force Reports. See also Consent Agreement III. B. 3

(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.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Remains in Substantial Compliance.

Recommendations for sustaining compliance, if applicable: N/A

(2) MDCR shall ensure that use of force reports:
- i. are written in specific terms and in narrative form to capture the details of the incident in accordance with its policies;
- 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;
- iii. contain an accurate account of the events leading to the use of force incident;
- iv. include a description of any weapon or instrument(s) of restraint used, and the manner in which it was used;
- v. are accompanied with any inmate disciplinary report that prompted the use of force incident;
- vi. state the nature and extent of injuries sustained both by the inmate and staff member;
- vii. contain the date and time any medical attention was actually provided

viii. include inmate account of the incident; and
ix. note whether a use of force was videotaped, and if not, explain why it was not videotaped.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR provided a report addressing the Monitors' previous recommendations regarding more aggressive oversight of the use of force packages by TAAP. MDCR has also identified a jail-based investigator to coordination with the facility commander and internal affairs to facilitate reviews. These are both positive contributions to the investigative process.

Recommendations for sustaining compliance, if applicable: N/A

(16) (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.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See above III. A. 5.c. (2)

Recommendations for sustaining compliance, if applicable: N/A

(17) (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.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The TAAP Unit continues to track compliance with these provisions.

Recommendations for sustaining compliance, if applicable: N/A

(18) (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.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The TAAP Unit reviews 100% of use of force reports, and identifies the issues noted in this paragraph. The Division Chief is notified by TAAP, as required.

Recommendations for sustaining compliance, if applicable: N/A

(6) MDCR shall maintain its criteria to identify use of force incidents that warrant a referral to IA for investigation. This 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. See also Consent Agreement III. B. 3. b.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The TAAP Unit reviews 100% of use of force reports, and identifies the issues noted in this paragraph. CHS also develop a tool (#30) to randomly assess if inmates involved in a use of force are properly and timely screened. An action plan is in place to address the findings of the CHS tool.

The Medical Monitor has found the corresponding requirement in the Consent Agreement to be in substantial compliance.

Recommendations for sustaining compliance: Review the updated CHS tool regarding us of force care.

(7) Security supervisors shall continue to ensure that photographs are taken of all involved inmates promptly following a use of force incident, to show the presence of, or lack of, injuries. The photographs will become evidence and be made part of the use of force package and used for investigatory purposes.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The TAAP Unit reviews 100% of use of force reports, and identifies the issues noted in this paragraph.

Recommendations for sustaining compliance, if applicable: N/A

(8) MDCR shall ensure that a supervisor is present during all planned uses of force and that the force is videotaped.

Monitor: McCampbell

Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR produced an audit of this provision (9/21/18), and an issue regarding the quality of a video recording was identified. Compliance was noted in the presence of supervisors for planned uses of force and cell extractions.

Recommendations for sustaining compliance, if applicable: N/A

(19) (9) Where there is evidence of staff misconduct related to inappropriate or unnecessary force against inmates, the Jail shall initiate personnel actions and systemic remedies, including an IA investigation and report. MDCR shall discipline any correctional officer with any sustained findings of the following:

i. engaged in use of unnecessary or excessive force;
ii. failed to report or report accurately the use of force; or
iii. retaliated against an inmate or other staff member for reporting the use of excessive force; or
iv. interfered with an internal investigation regarding use of force.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: There were no inappropriate or unnecessary force against an inmate identified during the monitoring period.

Recommendations for sustaining compliance, if applicable: N/A

(10) The Jail will ensure that inmates receive any required medical care following a use of force. See also Consent Agreement III. B. 3. b.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See III.A. 5. c. 6.

Recommendations for sustaining compliance, if applicable: N/A

(11) Every quarter, MDCR shall review for trends and implement appropriate corrective action all uses of force that required outside emergency medical treatment; a random sampling of at least 10% of uses of force where an injury to the inmate was medically treated at the Jail; and a random sampling of at least 5% of uses of force that did not require medical treatment.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR provided an audit (9/21/18) to address this paragraph. This audit examined all 8 uses of force, for the audit period, for which inmates received medical care outside the jail; a 10% sample of the 125

uses of force for inmates treated in-house; and a 5% sample of the 16 uses of force for inmates who did not require medical treatment. The audit reviewed the mental health level of the inmates involve, the cause of the incidents, de-escalation techniques used by staff, and the facility location/shift.

As with other audits, better identification of findings would have improved the document. An action plan was included (1/14/19) addressing de-escalation, timeliness of follow-up by the facilities of TAAP recommendations, and past due reports.

Recommendations for sustaining compliance: Continue to evaluate the outcomes of the internal audit findings and effectiveness of the action plans.

(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. See also Consent Agreement III. B. 3. b.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: A report was provided covering the period July 1, 2018 – December 31, 2018. There is substantial documentation provided regarding uses of force and action plans. This use of force action plans is coupled with MDCR's initiatives to address inmate/inmate violence/assaults.

Previously the Monitor found this paragraph in compliance, but as the initiatives have not yielded the results required of this language.

MDCR's findings included:

- needed improvements to the inmate disciplinary process,
- how inmates with violent behavior are flagged and managed,
- needed enhancements to improve inmate supervision through the application of direct supervision principles,
- removal of inmates with keep separate designations, PREA designations and separation of inmates with a Level I mental health diagnosis,
- continuing improvements to determining the causes of inmate/inmate assaults (e.g. decrease the number of undetermined causes),
- developing of incentives for positive inmate behaviors, and
- addressing issues with food and commissary services.

An action plan accompanies the findings. Many of these initiatives were included in Compliance Report # 6 as the Monitors' recommendations (September 2016).

MDCR is compliant with this paragraph; but the issues regarding implementation of effective strategies to reduce uses of force are on-going.

Recommendations for sustaining compliance: Continue to evaluate the outcomes of the internal audit findings and effectiveness of the action plans.

(20) MDCR shall maintain policies and procedures for the effective and accurate maintenance, inventory and assignment of chemical and other security equipment.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR provided an audit conducted regarding compliance with this provision for the third quarter of 2018 (10/3/18). The audit found compliance in all facilities, and included an action plan to improve the documentation of the sign-in/sign-out logs, due to be implemented by October 2018.

Recommendations for Sustaining compliance, if applicable: N/A

(21) (14)MDCR shall continue its efforts to reduce excessive or otherwise unauthorized uses of force by each type in each of the Jail's facilities annually. If such reduction does not occur in any given year, MDCR shall demonstrate that its systems for preventing, detecting, and addressing unauthorized uses of force are operating effectively.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Since the initiation of this monitoring, there has not been a finding of excessive or otherwise unauthorized uses of force.

Recommendations for sustaining compliance, if applicable: N/A

d. Use of Force Training

(22) Through use of force pre-service and in-service training programs for correctional officers and supervisors, MDCR shall ensure that all correctional officers have the knowledge, skills, and abilities to comply with use of force policies and procedures.
(23) At a minimum, MDCR shall provide correctional officers with pre-service and biennial in-service training in use of force, defensive tactics, and use of force policies and procedures.
(24) In addition, MDCR shall provide documented training to correctional officers and supervisors on any changes in use of force policies and procedures, as updates occur.
(25) MDCR will randomly test at least 5% of the correctional officer staff annually to determine their knowledge of the use of force policies and procedures. The testing instrument and policies shall be approved by the Monitor. The results of these assessments shall be evaluated to determine the need for changes in training practices or frequency. MDCR will document the review and conclusions and provide it to the Monitor.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR provided an audit of the required testing of the provision requiring random testing of 5% of correctional officer staff annually. A total of 124 staff were tested, representing all levels of rank. Twelve staff failed the test; resulting in notification to the chain-of-command and a meeting with the Training Bureau staff prior to re-testing. Two staff failed the second time, and were placed in an 8-hour training program.

Recommendations for sustaining compliance, if applicable: N/A

e. Investigations

(26) MDCR shall sustain implementation of comprehensive policies, procedures, and practices for the timely and thorough investigation of alleged staff misconduct.

(27) MDCR shall revise its "Complaints, Investigations & Dispositions" policy (DSOP 4-015) to ensure that all internal investigations include timely, thorough, and documented interviews of all relevant staff and inmates who were involved in, or witnessed, the incident in question.

i. MDCR shall ensure that internal investigation reports include all supporting evidence, including witness and participant statements, policies and procedures relevant to the incident, physical evidence, video or audio recordings, and relevant logs.

ii. MDCR shall ensure that its investigations policy requires that investigators attempt to resolve inconsistencies between witness statements, i.e. inconsistencies between staff and inmate witnesses.

iii. MDCR shall ensure that all investigatory staff receives pre-service and in-service training on appropriate investigations policies and procedures, the investigations tracking process, investigatory interviewing techniques, and confidentiality requirements.

iv. MDCR shall provide all investigators assigned to conduct investigations of use of force incidents with specialized training in investigating use of force incidents and allegations, including training on the use of force policy.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See also III. A. 5.c. (2) MDCR provided, as noted in III.C.5.c. (2), an update regarding plans to enhance investigative functions within MDCR.

The Monitor reviewed a sample of investigations and found the work to be completed, and well documented. An agency of this size should have investigative capacity. MDCR has also updated/improve investigative capacity and response to security threat groups (gangs) of which there are more than 70 documented in the County. Training is being provided to these individuals (and jail-based investigators).

The TAAP Unit continues to play a vital role in insuring that the requirements are met.

Recommendations for sustaining compliance, if applicable: N/A

III. A. 6. Early Warning System

a. Implementation

(1) MDCR will develop and implement an Early Warning System ("EWS") that will document and track correctional officers who are involved in use of force incidents and any grievances, complaints, dispositions, and corrective actions related to the inappropriate or excessive use of force. All appropriate supervisors and investigative staff shall have access to this information and monitor the occurrences.

(2) At a minimum, the protocol for using the EWS shall include the following components: data storage, data retrieval, reporting, data analysis, pattern identification, supervisory assessment, supervisory intervention, documentation, and audit.

(3) MDCR Jail facilities' senior management shall use information from the EWS to improve quality management practices, identify patterns and trends, and take necessary corrective action both on an individual and systemic level.

(4) IA will manage and administer the EWS. IA will conduct quarterly audits of the EWS to ensure that analysis and intervention is taken according to the process described below.

(5) The EWS will analyze the data according to the following criteria:

i. number of incidents for each data category by individual officer and by all officers in a housing unit;

ii. average level of activity for each data category by individual officer and by all officers in a housing unit;

iii. identification of patterns of activity for each data category by individual officer and by all officers in a housing unit; and

iv. identification of any patterns by inmate (either involvement in incidents or filing of grievances).

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR provided an audit of the early warning system and intervention system alert processes, dated 1/17/19. The audit period was 7/1 – 11/30/18. The audit looked at 555 of the 108 EWS alerts during the audit period. Where action was deemed warranted by the facility's leadership, the matters were closed on average in 13 days. For alerts resulted in responses, these were handled in 4 days. There were findings about the need to improve documentation. No action plan was determined to be needed.

MDCR has concluded that the EWIS is effective in routinely and systematically alerting MDCR supervisors of the need to review the performance of employees involved in uses of force.

Recommendations for sustaining compliance, if applicable: N/A

b. MDCR will provide to DOJ and the Monitor, within 180 days of the implementation date of its EWS, and on a bi-annual basis, a list of all staff members identified through the EWS, and any corrective action taken.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The Monitor did not review the list of staff, and will review at next on-site tour.

Recommendations for sustaining compliance, if applicable: N/A

c. On an annual basis, MDCR shall conduct a documented review of the EWS to ensure that it has been effective in identifying concerns regarding policy, training, or the need for discipline.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See above III. A. 6. a.

Recommendations for sustaining compliance, if applicable: N/A

III. B. FIRE AND LIFE SAFETY

MDCR shall ensure that the Jail's emergency preparedness and fire and life safety equipment are consistent with constitutional standards and Florida Fire Code standards. To protect inmates from fires and related hazards, MDCR, at a minimum, shall address the following areas:

B. 1. Necessary fire and life safety equipment shall be properly maintained and inspected at least monthly. MDCR shall document these inspections.

Monitor: DeFerrari
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR provided an audit of their Fire and Life Safety training and a Fire Equipment Audit including action plans for continued improvement. MDCR also provided annual external inspection reports from vendors and the Fire inspector. Inventories and internal monthly inspections records for all facilities were also provided. Fire hose inspections were not completed for 2018, however, MDCR received approval to remove the fire hoses from the facilities and a letter confirming approval was included in provided documentation. The removal of the hoses was reported to be accomplished within weeks of this tour. All fire extinguishers observed were up to date on inspections.

Recommendations to provide on-going enhancement:

- PTDC elevators (and any facility elevators) must meet annual certification for use; regardless of issues with the vendor.
- Blockage of means of egress was a continuing theme during internal inspections at Metro West and TGK. Concentrate on improvements.
- There does not seem to be a consistent process across facilities as to how to accurately record that an extinguisher was replaced and in some cases terminology was different i.e. "surplus", "spare" and "storage". Consider options to clarify the process.
- Ensure that MDCR follows through on the actions necessary to correct any issues identified on the action plan

Recommendations for sustaining compliance, if applicable: N/A

B. 2. MDCR shall ensure that fire alarms and sprinkler systems are properly installed, maintained, and inspected. MDCR shall document these inspections.

Monitor: DeFerrari
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR provided copies of all applicable annual inspections to include documentation of repairs made by outside vendors. Sprinkler heads observed appeared to be in good repair.

Recommendations for sustaining compliance, if applicable: N/A

B. 3. Within 120 days of the Effective Date, emergency keys shall be appropriately marked and identifiable by sight and touch and consistently stored in a quickly accessible location; MDCR shall ensure that staff are adequately trained in the location and use of these emergency keys.

Monitor: DeFerrari
Compliance Status: Subastanti Compliance

Activities/Analysis Since Last Tour: MDCR provided a self-audit of the Key Control Training. MDCR continues to provide documentation showing supervisors are trained on emergency keys whenever they change facilities; most always within accepted time frames.

Recommendations for sustaining compliance, if applicable: N/A

B. 4. Comprehensive fire drills shall be conducted every three months on each shift. MDCR shall document these drills, including start and stop times and the number and location of inmates who were moved as part of the drills.

Monitor: DeFerrari
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR provided a six (6) month Fire Drill Audit dated January-June 2018 as well as a sampling of quarterly drill audit compliance reports. An action plan (dated Sept 17, 2018) for improvements was also included. Most drills were completed within appropriate time frames. Staff deficiencies are addressed immediately after completion of each drill.

Recommendations for continued enhancements:

- The same deficiencies continue to be noted during fire drills. Staff are verbally corrected after each drill. To cement correct behavior MDCR should consider having staff repeat the drills correctly on the spot rather than wait until the next month.
- Ensure that MDCR follows through on the actions necessary to correct any issues identified on the action plan.

Recommendations for sustaining compliance, if applicable: N/A

B. 5. MDCR shall sustain its policies and procedures for the control of chemicals in the Jail, and supervision of inmates who have access to these chemicals.

Monitor: DeFerrari
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: Documents provided were inventory sheets for large supply areas. An "Inmate Sanitation Worker" sign-in sheet was reviewed. MDCR provided two (2) Chemical Control Audits dated April-June and July-September 2018. Both audits were accompanied by action plans. Observation included tours of janitor closets in all facilities and some larger supply/warehouse areas.

MDCR instituted identifying the quantity of inventoried items issued i.e. bottles, gallons, cases, bars, ounces etc. for their large supply closets. Janitor closets have posted inventories that are checked at the beginning and ending of each shift.

Recommendations for continued enhancements:

- Develop a method of identifying which janitorial items are placed in each cell each day to ensure accountability. Note the "in" and "out" times as well as the list of items placed into and retrieved from, the cells.
- The "Inmate Sanitation Worker" sign in sheet provided seemed to show employees receiving the training. Documentation showing the *inmate workers* were trained was **not** found in provided documents.
- Ensure that MDCR follows through on the actions necessary to correct any issues identified on the action plan.

Recommendations for sustaining compliance, if applicable: N/A

B. 6. MDCR shall provide competency-based training to correctional staff on proper use of fire and emergency equipment, at least biennially.

Monitor: DeFerrari
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR provided an audit of Fire and Life Safety dated January 1, 2015 to November 30, 2018. The audit included data with pre-and post-test scores and an overall compliance rating for the number of staff attending training. It also included an action plan for improvement dated November 30, 2018. MDCR is operationalizing a newly purchased computerized Training Management System to assist in managing training requirements.

Recommendations for continued enhancements:

- Staff attendance at scheduled training remains an issue, making it difficult to assure staff trained in an efficient manner and in compliance with MCDR policies. The action planned addressed strategies for improving attendance and addressing those employees who had unexcused absences. MDCR is encouraged to continue to

track the level of attendance improvement to see if the plan is effective.

- Ensure that MDCR follows through on the actions necessary to correct any issues identified on the action plan.

Recommendations for sustaining compliance, if applicable: N/A

III. C. INMATE GRIEVANCES

MDCR shall provide inmates with an updated and recent inmate handbook and ensure that inmates have a mechanism to express their grievances and resolve disputes. MDCR shall, at a minimum:

1. Ensure that each grievance receives follow-up within 20 days, including responding to the grievant in writing, and tracking implementation of resolutions.
2. Ensure the grievance process allows grievances to be filed and accessed confidentially, without the intervention of a correctional officer.
3. Ensure that grievance forms are available on all units and are available in English, Spanish, and Creole. MDCR shall ensure that illiterate inmates, inmates who speak other languages, and inmates who have physical or cognitive disabilities have an adequate opportunity to access the grievance system.
4. Ensure priority review for inmate grievances identified as emergency medical or mental health care or alleging excessive use of force.
5. Ensure management review of inmate grievances alleging excessive or inappropriate uses of force includes a review of any medical documentation of inmate injuries.
6. A member of MDCR Jail facilities' management staff shall review the grievance tracking system quarterly to identify trends and systemic areas of concerns. These reviews and any recommendations will be documented and provided to the Monitor and the United States.

See also Consent Agreement III.A.3.a.(4) and III. D. 1.b.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR provided an audit of the inmate grievance process and on-going improvements (12/3/18).

Recommendations for sustaining compliance, if applicable: N/A

III. D. AUDITS AND CONTINUOUS IMPROVEMENT

1. Self Audits
MDCR shall undertake measures on its own initiative to address inmates' constitutional rights or the risk of constitutional violations. The Agreement is designed to encourage MDCR Jail facilities 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.

a. On at least a quarterly basis, command staff shall review data concerning inmate safety and security to identify and address potential patterns or trends resulting in harm to inmates in the areas of supervision, staffing, incident reporting, referrals, investigations, classification, and grievances. The review shall include the following information:

(28) documented or known injuries requiring more than basic first aid;
(29) injuries involving fractures or head trauma;
(30) injuries of suspicious nature (including black eyes, injuries to the mouth, injuries to the genitals, etc.);
(31) injuries that require treatment at outside hospitals;
(32) self-injurious behavior, including suicide and suicide attempts;
(33) inmate assaults; and
(34) allegations of employee negligence or misconduct.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: MDCR provided an audit (1/11/19) of the agency's quality assurance and self-monitoring. The audit identifies the policies and procedures but does not include a list of outcomes/reports, etc.

Recommendations for sustaining compliance: Provide examples of work products that meet this provision.

b. MDCR shall develop and implement corrective action plans within 60 days of each quarterly review, including changes to policy and changes to and additional training.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See IV. D. a., above.

Recommendations for sustaining compliance: Provide examples of work products that meet this provision.

2. Bi-annual Reports See also Consent Agreement III. D. 2.

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:

(35) Total number of inmate disciplinary reports
(36) 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.

(37) 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.

(38) 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.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: A bi-annual report is provided.

Recommendations for sustaining compliance, if applicable: N/A

b. The County will analyze these reports and take appropriate corrective action within the following quarter, including changes to policy, training, and accountability measures.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: A bi-annual report is provided along with action plans.

Recommendations for sustaining compliance, if applicable: N/A

IV. COMPLIANCE AND QUALITY IMPROVEMENT

A. Within 180 days of the Effective Date, the County 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 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 shall send any newly-adopted and revised policies and procedures to the Monitor and DOJ for review and approval as they are promulgated. MDCR 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 shall document employee review and training in policies and procedures.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: For the remaining time of this monitoring, MDCR needs to assure that updated policies and procedures covered by this Agreement are reviewed by the Monitors. New initiatives (for example, Conducted Electrical Weapon (CEW) aka Tasers) were not provided to the Monitor and DOJ prior to the implementation. This Compliance Report notes that changes/updates to the use of force policies also need this reviewed, with MDCR identifying any changes to the policy.

Recommendations for sustaining compliance: Assure that policies/procedures covered by this Agreement are reviewed by the Monitor.

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.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: See above III. D. 1.

Recommendations for sustaining compliance, if applicable: N/A

C. On an annual basis, the County shall review all policies and procedures for any changes needed to fully implement the terms of this Agreement and submit to the Monitor and DOJ for review any changed policies and procedures.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The County provides evidence that t annually the policies which are scheduled for review are completed.

Recommendations for sustaining compliance: Continue to practice of annual reviews.

D. The Monitor may review and suggest revisions on MDCR policies and procedures on protection from harm and fire and life safety, including currently implemented policies and procedures, to ensure such documents are in compliance with this Agreement.

Monitor: McCampbell
Compliance Status: Substantial Compliance

Activities/Analysis Since Last Tour: The Monitor, or the parties, did not have an opportunity to review the policies regarding use of Tasers, body cameras, and the associated lesson plans. MDCR has delayed implementation until the reviews are concluded.

Recommendations for sustaining compliance: Delay the implementation of the new policy on Tasers, and body cameras until any issues identified by the Monitor and DOJ are resolved. Examine why this important policy was not provided and make any corrections to the process.

Appendix A- 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	Mar-19
A. Medical and Mental Health Care										
1. Intake Acreening										
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 MH C	Med- C MH C
III. A. 1. b.	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH - C	MH - C	MH - PC	MH - C
III. A. 1. c.	MH - NC	MH - NC	MH - NC	MH - PC	MH - NC	MH - NC	MH - PC	MH - PC	MH - PC	MH - C
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	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	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	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	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	Med - C
III. A. 2. b.	MH - NR	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - PC	MH - C	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	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	MH - PC
III.A.2.e.	MH - NR	MH - NR	MH - NR	MH - NR	MH - NR	MH - C	MH - NC	MH - NC	Med - PC	Med - C
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	Med - C MH - C
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	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	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	Med - C MH - C

Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17	Jun-18	Mar-19
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 MH C	Med - C MH - C	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	Med - C MH - C
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	Med - C MH - C
4. Medication Administration and Management										
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	Med - C MH - C
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	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	Med - C MH - C
III. A. 4. c.	MH - PC	MH- NR	MH- NR	MH- NR	MH- NR	MH - NC	MH- PC	MH- PC	MH- C	MH- C
III. A. 4. d.	MH - PC	MH- NR	MH- NR	MH- NR	MH- NR	MH - NC	MH- NC	MH- PC	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	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	Med - C MH - C
5. Record Keeping										
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	Med - C MH - C
III.A.5 b.	MH - NC	MH - PC	MH - PC	MH - NR	MH - NR	MH- PC	MH - NC	MH - PC	MH - PC	MH - C
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	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	Med - C MH - C
Section	**Jul-13**	**May-14**	**Oct-14**	**May-15**	**Jan-16**	**Jul-16**	**Mar-17**	**Dec-17**	**Jun-18**	**Mar-19**
6. Discharge Planning										
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	Med - PC 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	Med - PC 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	Med - PC MH - PC
7. Mortality and Morbidity Reviews										
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	Med - PC MH - PC
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	Med - PC MH - PC
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	Med - PC MH - PC
B. Medical Care										
1. Acute Care and Detoxification										
III.B.1.a.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - NC	Med - PC	Med - C
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	Med - C
III.B.1.c.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - C	Med - C	Med - C
2. Chronic Care										
III.B.2.a.	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - PC	Med - PC	Med - C
III.B.2.b. (See (III.B.2.a.)	Med - NC	Med - NR	Med - NR	Med - NR	Med - NR	Med - PC	Med - NC	Med - PC	Med - PC	Med - C
3. Use of Force Care										
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	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	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	Med - C

Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17	Jun-18	Mar-19
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	MH - C
III. C. 1. b.	MH - PC	MH - NR	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - C	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	MH - C
III. C. 2. b.	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH - C
III. C. 2. c.	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC	MH - C	MH - C
III. C. 2. d.	MH - PC	MH - PC	MH - PC	MH - NR	MH - NC	MH - PC	MH - PC	MH - C	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	MH - C
III. C. 2. f.	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH - C
III. C. 2. g.	MH - NC	MH - NR	MH - NR	MH - NR	MH - NR	MH - NC	MH - C	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	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	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	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	MH - C
III. C. 2. h.	MH - PC		MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - PC	MH - PC	MH - C
III. C. 2. i.	MH - PC	MH - NR	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - C	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	MH - C
III. C. 2. k.	MH - NR	MH - NR	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC	MH - PC	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	MH - C
III. C. 3. b.	MH - PC	MH - NC	MH - NR	MH - NR	MH - PC	MH - NC	MH - NC	MH - PC	MH - PC	MH - C
III. C. 3. c.	MH - PC	MH - PC	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC	MH - PC	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	MH - C
III. C. 3. e.	MH - PC	MH - NC	MH - NR	MH - NR	MH - NC	MH - PC	MH - NC	MH - PC	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	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	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	MH - C

Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17	Jun-18	Mar-19
4. Review of Disciplinary Measures										
III. C. 4. a. (1) (2) and b.	MH - PC	MH - NC	MH - NR	MH - NR	MH - PC	MH - PC	MH - C	MH - PC	MH - PC	MH - C
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	MH - C
III. C. 5. b.	MH - NC	MH - NC	MH - NR	MH - NR	MH - NC	MH - NC	MH - NC	MH - NC	MH - PC	MH - C
III. C. 5. c.	MH - NC	MH - NC	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - PC	MH - PC	MH - C
III. C. 5. d.	MH - NR	MH - PC	MH - PC	MH - NR	MH - PC	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	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	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	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	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	MH - C
III. C. 6. a. (4) i	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - NC	MH - NC	MH - PC	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	MH - C
III. C. 6. a. (5)	MH- NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - PC	MH - PC	MH - C
III. C. 6. a. (6)	MH- NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - NC	MH - NC	MH -PC
III. C. 6. a. (7)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - NC	MH - NC	MH - C
III. C. 6. a. (8)	MH- NC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - NC	MH - NC	MH - C
III. C. 6. a. (9)	MH - C	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - PC	MH - C
III. C. 6. a.(10)	Med - NC MH - PC	Med - NR MH - NC	Med - NR MH- NR	Med - NR MH- NR	Med - PC MH - PC	Med - PC MH - PC	Med - NC MH - NC	Med - PC MH - PC	Med - C MH - PC	Med - C M - C
III. C. 6. a. (11)	MH - PC	MH - NR	MH - NR	MH - NR	MH - PC	MH - PC	MH - NC	MH - NC	MH - NC	MH -PC
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	MH - C
III. C. 7. b.	MH - NR	MH - PC	MH - NR	MH - NR	MH - C	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	MH - C
III. C. 7. d.	MH - NR	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - PC	MH - PC	MH - C	MH - C
III. C. 7. e.	MH - PC	MH - PC	MH - NR	MH - NR	MH - PC	MH - PC	MH - C	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	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	MH - C

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III. C. 7. b.	MH - PC	MH - PC	MH - NR	MH - NR	MH - NC	MH - PC	MH - NC	MH - PC	MH - PC	MH - C
8. Suicide Prevention Training										
III. C. 8. a. (1 – 9)	MH - NC	MH - NC	MH - PC	MH - NR	MH - NC	MH - NC	MH - PC	MH - C	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	MH - C
III. C. 8. c.	MH - NC	MH - NC	MH - PC	MH - NR	MH - NC	MH - NC	MH - C	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	MH - C
9. Risk Management										
III. C. 9. a.	MH - NR	MH - PC	MH - NR	MH - NR	MH - NC	MH - PC	MH - PC	MH - PC	MH - PC	MH - C
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	MH - C
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	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	MH - C
D. Audits an Continuous Improvement										
1. Self Audits										
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	Med - C MH - C
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	Med - C MH - C
2. Bi-annual Reports										
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	Med - C MH - C
III. D. 2. a. (3)			MH - NR	MH - NR	MH - PC	MH - NC	MH - PC	MH - PC	MH - PC	MH - C
III. D. 2. a. (4)			MH - NR	MH - NR	MH - NC	MH - NC	MH - PC	MH - PC	MH - PC	MH - C
III. D. 2. a. (5)			MH - NR	MH - NR	MH - PC	MH - NC	MH - PC	MH - PC	MH - PC	MH - C
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	Med - C MH - C

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	Med - C MH - C
Section	**Jul-13**	**May-14**	**Oct-14**	**May-15**	**Jan-16**	**Jul-16**	**Mar-17**	**Dec-17**	**Jun-18**	**Mar-19**
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	Med - C MH - C
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	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	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	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

Appendix B - Settlement Agreement										
Section	**Jul-13**	**May-14**	**Oct-14**	**May-15**	**Jan-16**	**Jul-16**	**Mar-17**	**Dec-17**	**Jul-18**	**Mar-19**
Safety and Supervision										
III.A.1.a. (1)	pc	pc	pc	nr	pc	c	c	c	c	c
III.A.1.a. (2)	nc	nc	pc	nr	nr	pc	pc	pc	pc	c
III.A.1.a. (3)	pc	pc	c	nr	nr	c	c	c	pc	c
III.A.1.a. (4)	pc	pc	pc	c	nr	c	c	c	c	c
III.A.1.a. (5)	pc	pc	c	nr	nr	c	c	c	c	c
III.A.1.a. (6)	pc	c	c	nr	nr	c	c	c	pc	c
III.A.1.a. (7)	pc	pc	c	nr	nr	c	c	c	pc	c
III.A.1.a. (8)	nc	nc	pc	nr	c	c	c	c	pc	c
III.A.1.a. (9)	pc	pc	pc	nr	c	c	c	c	c	c
III.A.1.a. (10)	pc	pc	pc	nr	nr	pc	c	c	c	c
III.A.1.a. (11)	pc	pc	pc	nr	nr	pc	c	pc	pc	c*
Security Staffing										
III.A.2. a.	not due	pc	pc	c	nr	c	c	c	c	c
III.A.2. b.	nc	pc	pc	c	nr	pc	c	c	pc	c
III.A.2.c.	not due	pc	pc	c	nr	c	c	c	c	c
III.A.2.d.	not audited	not due	nc	not due	c	c	c	c	c	c
Sexual Misconduct										
III. A.3.	pc	pc	c	nr	pc	pc	pc	pc	c	c
Incidents and Referrals										
III. A.4 a.	pc	pc	c	nr	nr	c	c	c	c	c
III.A.4. b.	nc	nc	c	nr	nr	c	c	c	c	c
III.A.4.c.	nc	pc	pc	nr	c	c	c	c	c	c
III.A.4.d.	not due	nc	pc	c	nr	c	c	pc	pc	c
III.A.4.e.	pc	pc	pc	nr	nr	p	c	c	c	c
III.A.4.f.	pc	pc	pc	pc	c	pc	c	c	c	c

Section	Jul-13	May-14	Oct-14	May-15	Jan-16	Jul-16	Mar-17	Dec-17	Jul-18	Mar-19
Use of Force by Staff										
III.A. 5 a.(1) (2) (3)	pc	pc	pc	pc	pc	pc	c	pc	c	c
III.A.5. b.(1), i., ii, iii, iv, v, vi (2)	pc	pc	pc	pc	nr	c	c	pc	c	c
III.A. 5. c. (1)	nc	c	pc	nr	nr	c	c	c	c	c
III.A. 5. c. (2)	nc	pc	pc	nr	pc	pc	c	pc	pc	c
III.A. 5. c. (3)	pc	pc	pc	c	nr	c	c	c	c	c
III.A. 5. c. (4)	pc	not audited	c	nr	nr	c	c	c	c	c
III.A. 5. c. (5)	pc	c	c	nr	nr	c	c	c	c	c
III.A. 5. c. (6)	nc	not audited	pc	c	nr	c	c	pc	c	c
III.A. 5. c. (7)	pc	c	c	nr	nr	c	c	c	c	c
III.A. 5. c. (8)	nc	nc	c	nr	c	c	c	c	c	c
III.A. 5. c. (9)	nc	nc	pc	pc	c	c	c	c	c	c
III.A. 5. c. (10)	pc	c	c	c	nr	c	c	nc	c	c
III.A. 5. c. (11)	nc	nc	nc	pc	nr	pc	pc	pc	c	c
III.A. 5. c. (12)	nc	nc	nc	pc	nr	pc	c	pc	c	c*
III.A. 5. c. (13)	nc	c	c	nr	nr	c	c	c	c	c
III.A. 5. c. (14)	nc	nc	nc	pc	nr	pc	c	pc	c	c
III.A.5. d. (1) (2) (3) (4)	pc	pc	pc	nr	nr	pc	c	pc	c	c
III.A.5. e. (1) (2)	nc	pc	pc	nr	nr	pc	c	pc	c	c
Early Warning System										
III.A.6. a. (1) (2) (3) (4) (5)	nc	nc	pc	nr	c	pc	c	c	pc	c
III.A.6.b.	nc	nc	not due	pc	c	pc	c	c	c	c
III.A.6.c.	nc	nc	no	pc	c	pc	c	pc	pc	c

Section	Jul-17	May-17	Oct-17	May-17	Jan-17	Jul-17	Mar-17	Dec-17	Jul-18	Mar-19
Fire and Life Safety										
III.B.1.	pc	pc	pc	nr	nr	pc	c	c	c	c
III.B.2.	c	c	c	nr	nr	pc	c	c	c	c
III.B.3.	pc	pc	pc	nr	nr	pc	c	c	c	c
III.B.4.	pc	pc	pc	pc	pc	pc	c	c	c	c
III.B. 5.	nc	pc	pc	nr	nr	pc	c	c	c	c
III.B.6	nc	nc	nc	pc	nr	pc	c	c	c	c
Inmate Grievances										
III.C. 1.,2.,3.,4.,5.,6.	pc	pc	pc	c	nr	c	c	pc	pc	c
Audits and Continuous Improvements										
PFH III.D.1. a. b.	nc	nc	pc	nr	nr	pc	c	pc	c	c
FLS III.D.1. a. b.	nc	nc	pc	nr	nr	pc	c	c	c	c
PFH III.D. 2.a. b.	not due	nc	pc	pc	pc	pc	c	pc	pc	c
Compliance and Quality Improvement										
PFH IV. A.	not due	nc	pc	nr	nr	pc	c	c	c	c
FLS IV. A.	not due	not audited	pc	nr	pc	pc	c	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	c
PFH IV.C.	not due	nc	pc	nr	c	c	c	c	c	c
FLS IV. C.	not due	nc	pc	nr	pc	c	c	c	c	c
PFH IV. D.	pc	pc	c	nr	nr	c	c	c	c	c
FLS IV. D.	pc	pc	pc	nr	pc	c	c	c	c	c

Legend:	PFH - Protection from Harm
nc = noncompliance	FLS - Fire Life Safety
pc = partial compliance	nr = not reviewed
c = compliance	