

**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**

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**Independent Monitors' Report No. 4**

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**July 3, 2015**

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## **Introduction – Compliance Report # 4**

This is the fourth report by 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 separately addresses the Settlement Agreement and the Consent Agreement. Shared comments from the Monitors regarding compliance for the Miami-Dade Department of Corrections and Rehabilitation (MDCR) and Corrections Health Services, Jackson Health System (CHS) are provided herein.

The Monitors toured the week of May 11, 2015. Several members of the Monitoring team were on site for additional visits since the last tour (week of October 20, 2014).<sup>1</sup> Prior to the May tour, the Monitoring team reviewed materials, and individually and collectively conferred with the parties through telephone conferences.

The Monitors express their recognition and appreciation for the hard work and leadership of both MDCR Director Marydell Guevara and CHS Director Jesus Estrada. We also extend our thanks to: Miami Dade County Mayor Carlos A. Gimenez, District 4 County Commissioner Sally A. Heyman, Deputy Mayor Russell Benford, Carlos A. Migoya, President and CEO of Jackson Health System, and Don Steigman, Chief Operating Officer, Jackson Health System for their time in meeting with the independent Monitors and their advice. Overall, the County's commitment to improve the conditions of confinement and work to meet compliance goals is evident. We also appreciate their collaboration with the members of the Monitoring team. We further recognize and report on the hard work and the time that the staff of both MDCR and CHS invested to provide helpful documents and insight as the Monitors prepared for this tour.

### **Attention of the Court**

Since the filing of Compliance Report # 3, the County's representatives have been before the Court on two occasions regarding areas of non-compliance with the Consent Agreement (November 17, 2014 and January 27, 2015). At the conclusion of the January hearing the Judge requested that the parties appear again before him following the completion of the report of the Monitors' May 2015 tour. That hearing is scheduled for July 16, 2015.

The result of the December hearing was the production of a document by the defendants establishing due dates for the requirements of the Consent Agreement (referred to as the Summary Action Plan (SAP)). For the purposes of future compliance reviews, the Monitors will be conducting their reviews based on a Revised Summary Action Plan (SAP-Revised) which is a simplified and slightly modified version of the SAP. The parties also developed a document referred to as Consent Agreement Internal Working Document (IWD). This very

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<sup>1</sup> Dr. Amanda Ruiz was on-site April 11- 13; Susan McCampbell was on site January 5-6, 2015, January 27, 2015, April 24, 2015.

detailed road map was a product of the Department of Justice's attorneys, the attorneys for the defendants, and representatives of CHS and MDCR. The Monitors were involved at the initiation of the IWD, but not since. The Monitors have expressed their concerns to DOJ about the process and the resulting document. The Monitors want to assure that there is no future confusion with the SAP, IWD, and the scope of independent monitoring, and believe the parties have reached a way to do that.

### **Format of this Report**

This document reports on the defendants' compliance with specific provisions of both the Settlement Agreement and the Consent Agreement. The report also comments on many of the paragraphs that were not identified by the defendants as ready for review in May 2015, but for which the Monitors have observations and recommendations.

### **Compliance Updates**

As will be noted in this report, the County has made progress toward compliance. For a summary of the status of paragraphs in the Settlement Agreement, please see page 2; and for the Consent Agreement, see page 49.

### **Areas of Progress, Areas of Concern**

The most notable areas of progress and concerns are:

#### **Progress - MDCR Staffing**

As a result of the comprehensive staffing analysis conducted by MDCR and reviewed by County government, substantial progress has been made in current and future hiring. The County has committed to hiring almost 500 certified and civilian staff over the next 24 - 36 months. This should not only assure that posts required by the Settlement Agreement are filled, but reduce the amount of overtime currently being expended. The Mayor's commitment to implementing this plan is noted.

#### **Concern - CHS; Staffing**

The Monitors were so concerned about the staffing levels in CHS that meetings were initiated with Jackson Health System executives prior to leaving Miami at the conclusion of the May tour. JHS' staffing and hiring plan provides strong encouragement for providing the required resources. The Monitors remain concerned about the identification and care of inmates on the mental health caseload, as well as the impact on security operations when CHS resources fall short. CHS needs to assure there is an infrastructure of administrative support for the required operational functions.

#### **Progress - Opening of TGK Mental Health Units**

MDCR has relocated the acute mental health inmate population from the Pre-Trial Detention Center to units located at the newly named Mental Health Treatment Center in the Turner-Guilford-Knight facility. The County devoted the financial resources necessary to retrofit units, train staff, and assure medical and mental staff are providing services to this population. The housing substantially improves conditions for inmates and staff. There are still logistical and procedural matters to be refined, but the Monitors acknowledge and commend this critical work. The final housing unit to be retrofitted will be ready for occupancy soon.

### **Progress – Collaboration CHS and MDCR**

The parties continue to move forward with creating new and improved working relationships and collaborations. The County cannot, in the view of the Monitors, achieve and sustain compliance with either Agreement without a high level of commitment and collaboration. As evidence of working together, the two agencies are planning to implement joint written directives.

### **Concern – Completion of Policies/Procedures/Written Directives**

Both MDCR and CHS need to complete their written directives that address provisions of both Agreements, develop lesson plans, train staff, and evaluate the implementation. There have been delays in the process, and working with the members of the monitoring team, quality work is getting done.

### **Concern – Prison Rape Elimination Act of 2003**

The County has been audited for compliance with the standards promulgated by the Dept. of Justice to the Prison Rape Elimination Act of 2003. There are several areas that the Monitors will review in the next tour to measure compliance in areas which we believe will benefit from further refinement -- implementation of protocols and medical documentation are two of those areas.

### **Concern – MDCR’s Future Leadership**

The Monitors continue to be impressed with Director Guevara’s leadership while at the same time acknowledging the impact of the Florida Retirement System’s Deferred Retirement Option Plan on the agency’s leadership (as well as other public safety organizations around the state). The Monitors urge the County’s leadership to engage in succession planning in MDCR to assure a smooth transition as leaders retire.

### **Concern – Jail Bed Replacement**

The conditions of confinement in the Training and Treatment Center (TTC) and the Pre-Trial Detention Center (PTDC) underscore the need for new jail bed construction in order to address Constitutional levels of confinement. There is currently no plan in place to replace jail beds. The Monitors suggest this needs to be a priority for County government.

### **Progress/Concern – TAAP Unit, Data Driven Jail, CHS Bi-Annual Reporting**

MDCR has initiated a Trend Analysis and Action Planning Unit (TAAP) was initiated to consolidate the review of critical incidents, including uses of force, and collect, examine, and respond to trends in data. The unit has been aggressively working to produce high quality reports, which include plans of action.

CHS' data reporting, analysis and plans of action has not been as extensive or robust as MDCR's initiatives. The Monitors urge CHS to work alongside the TAAP unit (as a CHS employee now does) to refine the data collection functions.

The County is urged to remember that the processes around data collection, analysis and correction are for the use of the defendants, not the Monitors. This work is critical to sustaining compliance.

### **Progress – Criminal Justice System Collaboration**

The stakeholders in the justice system are continuing to meet to address issues such as diversion of persons with mental illness from the jail and long-term population issues.

### **Progress – MDCR's Compliance Process/Management**

MDCR's director has re-defined the compliance management process, with improvements noted by the Monitors working with the Settlement Agreement. As noted earlier in this report, the work toward gaining and maintaining compliance is for the benefit of the County, with the Monitors as subsidiary users. The hard work of Chief Jones and Assistant Director Schuh, along with the Compliance Unit is appreciated. CHS is urged to assure the same level of leadership and administrative support for compliance initiatives.

### **Path Forward**

The Monitors congratulate the County, MDCR and CHS for the progress made to date. The work is acknowledged, even with more to do. The road to achieving and maintaining compliance is seldom a straight line. If the parties continue to learn from the process, refine systems, and encourage staff, the process will have multiple successes.

The Monitors hope that the information in this report will continue to inform the work of all parties. We urge MDCR and CHS to ensure communication and collaboration are maintained with the Monitors being able to assist as needed.

## Settlement Agreement

### Introduction

During this tour, the Monitors reviewed those specific paragraphs in the Settlement Agreement as requested by MDCR. A member of the monitoring team toured all facilities and all housing units to assure that there was not present harm identified for either inmates or staff.<sup>2</sup> The results of these tours were provided to MDCR's Director. Overall, the team member conducting the inspection found the facilities to be in good condition, inmates interviewed noting few outstanding issues, and staff on-post and helpful.

An important distinction drawn in this compliance report is acknowledging the work accomplished at the time of this tour by MDCR and CHS on shared provisions of either the Settlement Agreement and/or the Consent Agreement. Paragraphs from these agreements that are duplicative are identified. If the paragraph requires specific MDCR action, but not CHS action, or vice versa, compliance is noted if the entity achieved an element of compliance.<sup>3</sup> As such, there are paragraphs in which the comments of the medical and psychiatric Monitors are removed, and reference provided to the companion paragraph in the Consent Agreement. There are some paragraphs in the Settlement Agreement in which the input of the physicians will be sought as compliance monitoring moves forward.

For the Settlement Agreement, at the request of MDCR, the paragraphs not reviewed are noted in Appendix A. However, where the Monitors have a comment or observation, these comments are provided below.

### Settlement Agreement - Summary of Compliance

Report #	Compliance	Partial Compliance	Non-Compliance	Not Applicable/Not Due/Other	Total
1	1	26	23	6	56
2	7	27	22	0	56
3	13	31	10	2	56
4	23	32	0	1	56

<sup>2</sup> For this tour, sub-monitor Darnley R. Hodge, Sr. was added to the tour. He inspected each of the MDCR facilities and provided the value of his experience and insight to the monitoring team and to the MDCR Director.

<sup>3</sup> For example, any paragraph that begins with the language, "MDCR shall or will" is evaluated for compliance based on MDCR's documentation and proofs of practice. If there is an element of CHS responsibility (e.g. in medical care), the appropriate paragraph of the Consent Agreement is noted.

**Settlement Agreement - Summary of Compliance  
Tour the Week of May 11, 2015**

Subsection of Settlement Agreement	Page	Compliance	Partial Compliance	Non-Compliance	Comments/Notes:
<b>III. A. Protection from Harm</b>					
<b>1. Safety and Supervision</b>					
III.A.1.a. (1)			x		Per MDCR not reviewed
III.A.1.a. (2)			x		Per MDCR not reviewed
III.A.1.a. (3)		x			Per MDCR not reviewed
III.A.1.a. (4)	13	x			
III.A.1.a. (5)		x			Per MDCR not reviewed
III.A.1.a. (6)		x			Per MDCR not reviewed
III.A.1.a. (7)		x			Per MDCR not reviewed
III.A.1.a. (8)			x		Per MDCR not reviewed
III.A.1.a. (9)			x		Per MDCR not reviewed
III.A.1.a. (10)			x		Per MDCR not reviewed
III.A.1.a. (11)			x		Per MDCR not reviewed
<b>2. Security Staffing</b>					
III.A.2. a.	14	x			
III.A.2. b.	14	x			
III.A.2.c.	15	x			
III.A.2.d.	16				Due 180 days from March 9, 2015 (9/9/15)
<b>3. Sexual Misconduct</b>					
III. A.3.		x			Per MDCR not reviewed; but conferred with MDCR before an during May tour See notes page vi regarding documentation for next tour.
<b>4. Incidents and Referrals</b>					
III. A.4 a.		x			Per MDCR not reviewed
III.A.4. b.		x			Per MDCR not reviewed
III.A.4.c.			x		Per MDCR not reviewed
III.A.4.d.	17	x			Consent III.A.5.c.2. vii.
III.A.4.e.	18		x		Per MDCR not reviewed
III.A.4.f.			x		
<b>5. Use of Force by Staff</b>					
III.A. 5 a.(1) (2) (3)	19		x		

Subsection of Settlement Agreement	Page	Compliance	Partial Compliance	Non-Compliance	Comments/Notes:
III.A.5. b.(1), (2) i, ii, iii, iv, v, vi	19		x		For MH see Consent Agreement III.B.3. 40
III.A. 5. c. (1)		x			Per MDCR not reviewed
III.A. 5. c. (2)			x		Per MDCR not reviewed
III.A. 5. C. (3)	21	x			
III.A. 5. C. (4)		x			Per MDCR not reviewed
III.A. 5. C. (5)		x			Per MDCR not reviewed See Consent Agreement III.B.3. see page 64
III.A. 5. c. (6)	21	x			See Consent Agreement III.B.3. see page 64
III.A. 5. c. (7)		x			Per MDCR not reviewed
III.A. 5. c. (8)		x			Per MDCR not reviewed
III.A. 5. c. (9)	23		x		See Consent Agreement III.B.3. 64
III.A. 5. c. (10)	24	x			See Consent Agreement III.B.3. 64
III.A. 5. c. (11)	24		x		See Consent Agreement III.B.3. see page 64
III.A. 5. c. (12)	25		x		See Consent Agreement III.B.3. see page 64
III.A. 5. c. (13)		x			Per MDCR not reviewed
III.A. 5. c. (14)	26		x		
III.A.5. d. (1) (2) (3) (4)			x		Per MDCR not reviewed
III.A.5. e. (1) (2)			x		Per MDCR not reviewed
III.A.6. a. (1) (2) (3) (4) (5)			x		Per MDCR not reviewed
III.A.6.b.	27		x		
III.A.6.c.	27		x		
<b>III. B. Fire and Life Safety</b>					
III.B.1.			x		Per MDCR not reviewed
III.B.2.		x			Per MDCR not reviewed
III.B.3.			x		Per MDCR not reviewed
III.B.4.	29		x		
III.B. 5.			x		Per MDCR not reviewed
III.B.6	31		x		
<b>III. C. Inmate Grievances</b>					
III.C. 1.,2.,3.,4.,5.,6.	32	x			See also Consent Agreement III.A.3.a.(4)
<b>D. Audits and Continuous Improvement</b>					
III.D.1. a. b.			x		Per MDCR not reviewed. See also Consent Agreement III. D. 1. 2.
III.D. 2.a. b.	36		x		See also Consent Agreement III. D. 2. Pages 80 – 85.

Subsection of Settlement Agreement	Page	Compliance	Partial Compliance	Non-Compliance	Comments/Notes:
IV. Compliance and Quality Improvement					
IV. A.			x		Per MDCR not reviewed
IV. B.			x		Per MDCR not reviewed
IV. C.			x		Per MDCR not reviewed
IV. D.		x			Per MDCR not reviewed

## **Protection From Harm**

### **Safety and Security**

Regarding improvements that assure inmate and staff safety, work continues to update MDCR's inmate classification system. Taking the recommendations from technical assistance provided by the National Institute of Corrections regarding inmate classification, re-classification and housing decisions, progress continues to implement the significant recommendations. This process contains risk assessments. MDCR has identified alternatives processes to support this critical work rather than waiting for the planning implementation of a new information system. MDCR should consider engaging assistance from experts in the field as the process moves forward, particularly regarding validation of the system.

Rounds are being conducted, as verified during this tour. The camera updates have been completed. Specialized training continues. Issues regarding the transfer of employees between facilities need to be addressed based on the negotiations of the collective bargaining agreement, which it was reported to the Monitors as having stalled.

### **Security Staffing**

As noted earlier in this report, the County has made a major commitment to hire approximately 500 staff based on the comprehensive staffing analysis. These increases in both civilian and certified staff address cuts made over the past decade to MDCR staffing, as well as to hire staffing needed to comply with the provisions of both the Settlement Agreement and Consent Agreement. The increases in MDCR's budget were submitted by the Mayor to the Board of County Commissioners. MDCR has a measured and realistic hiring plan. The Monitors will review progress between now and the next tour.

### **Sexual Misconduct**

Report # 3 noted that MDCR had been audited for compliance with the standards promulgated under the Prison Rape Elimination Act of 2003 (PREA). MDCR was found in compliance. It is the position of the Monitors that the procedures covered by this PREA audit will not be reassessed unless there is information or findings that require a review. There were several such issues identified before and after this tour including: CHS' governing policies, the level of detail in the Sexual Assault Response Team Protocols (SART), and the medical/mental health review of inmates who report victimization. At this time, this paragraph remains in compliance. The Monitors will work with CHS and MDCR between now and the next tour to clarify these current, or any other emerging issues.

## **Incidents and Referrals**

The paragraphs regarding incidents and referrals are moving toward compliance. The Monitor reviewed the report writing updated lesson plans and provided comments. There are no issues at this time about MDCR's staff promptly reporting to Qualified Medical Staff about any inmate medical needs.

## **Use of Force by Staff**

MDCR continues to make measured progress in addressing uses of force (response to resistance) through policy review, recently implemented updated training, and review of employee, supervisory and leadership reporting through the TAAP Unit. The quality of written reports has improved, as well as improvements in supervisory reviews.

The TAAP Unit will be producing quarterly data reports regarding uses of force. The Monitor's review of the reports since the last tour indicates robust reporting. Improvements to analyses and production of action plans, and action plan follow-ups are anticipated. The Monitor reviewed the updated lesson plans for use of force and report writing and provided recommendations and comments.

The Monitor reviewed all use of force reports for January 2015 (as the Monitor did for June 2014 reports) and provided comments and engaged in conversations with MDCR leadership and the TAAP unit regarding concerns, observations and recommendations.

Attention continues to be necessary to uses of force involving inmates on the mental health caseload. CHS' mental health staffing and mental health leadership needs significant improvement, which, when implemented, in the Monitors' opinions should reduce the uses of force for the inmates on the mental health caseload.

The recently implemented Crisis Intervention Training (CIT) that includes both MDCR and CHS staff is a model for jails nationally.

MDCR's policies regarding use of restraints are in compliance with the Settlement Agreement; however, CHS' policies need attention.

Investigations into uses of force continue to improve; however attention needs to be made to complete the operating procedures for the Security and Internal Affairs Bureau (SIAB). There also needs to be immediate attention to collaboration regarding use of force reviews between TAAP and SIAB to assure that there is a coordinated approach avoiding any compromises to the integrity and outcome of investigations and employee discipline. A written protocol describing the working responsibilities between SIAB and TAPP reviews might be a way to accomplish this objective.

## **Early Warning System**

The policy governing the early warning system is in final draft. Reports are being produced by the system. More attention is needed to analysis of the information, noting trends both for individuals and events, and developing action plans as necessary.

## **Fire and Life Safety<sup>4</sup>**

The primary focus of this tour was to review documents and conduct assessments of housing units at Boot Camp, Training and Treatment Center, Turner Guilford Knight (TGK), Pretrial Detention Center (PTDC), and Metro West Detention Center (MWDC). MDCR has made changes in the following areas of Fire and Life Safety since the October 2014 tour:

- Improvements in documenting and recording cleaning chemical inventory and use. All facilities are diluting cleaning chemicals following the manufacturer's recommendations, thus significantly reducing safety and health risks to both staff and inmates using those chemicals.
- Development of a "how to do it" Janitorial Manual for cleaning and disinfecting all surfaces and equipment throughout all facilities. The document is thorough, and training of staff and inmates on the use of procedures therein will be easy to understand and to follow. This manual could and should serve as a model to jails throughout the US.
- Completion of Annual Fire Safety inspections for fire alarms, smoke detectors, fire pumps, and fire extinguishers for 2015 with corrective action taken for the few non-conformities identified.
- Implementation of a training plan and curriculum for fire and life safety equipment training for all staff. Staff training is scheduled to begin in May 2015.
- The kitchen at PTDC continues to be remodeled. A new temporary kitchen is under construction that will house the food service until the existing kitchen can be completely rebuilt as a cook/chill operation.

## **Fire Drills**

The Monitor noted issues of concern after reviewing fire drills conducted during the last six months. The information regarding the Monitor's review is noted in the analysis of the provision.

## **Fire Response and Prevention**

Prior to the tour, the Monitor reviewed fire and life safety inspection reports for the months of November, December 2014 and January, February and March of 2015 that documented violations and demonstrated that corrections were completed. The

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<sup>4</sup> A listing of documents reviewed and individuals interviewed is available upon request.

reports were thorough, demonstrating compliance with DSOP 10-022 and this provision of the Settlement Agreement.

MDCR DSOP 10-022, Fire Response and Prevention Plan is in the revision process. The policy establishes a MDCR Safety Officer position within CAB with the responsibility to coordinate and ensure compliance with all life safety and fire safety codes and regulations. It also provides for training of officers including facility specific Fire Safety Sanitation Officers (FSSOs) for each facility. Further, the policy requires monthly inspections of fire and emergency equipment and procedures to assure compliance by CAB with all applicable MDCR policies. It requires quarterly checks of all SCBA units, gauges, hose connections, and straps to ensure their readiness for use. Bi-annually all kitchen cooking hood extinguishing systems are inspected by a contracted vendor and the hood filters are inspected and cleaned as necessary by vendor.

DSOP 10-022 requires that the local fire authority having jurisdiction, i.e. Miami-Dade County Fire Rescue or the City of Miami Fire Rescue, conduct annual inspections. Miami-Dade Fire Rescue Department annually completes its independent annual fire safety inspection of each facility. Those reports included corrections taken and follow up inspections by the respective fire department.

MDCR maintains a facility specific inventory identifying the location of all fire extinguishers, automatic external defibrillators (AEDs), and SCBAs. A complete inventory of sprinkler heads, smoke detectors, strobe lights, fire alarm pull stations, heat sensors, and shut off valves is documented. Boot Camp and TTC are not equipped with sprinklers but are equipped with smoke detectors, strobes, pull stations, heat sensors and shut off valves. Fire pumps are located for MWDC, TGK and TTC.

The Self-Contained Breathing Apparatus (SCBA) inventory is complete. SCBAs are inspected daily by the unit officer and documented in the applicable housing unit logbook. CAB inspects SCBAs during the monthly fire safety inspections. The SCBA annual testing for 2015 has been completed for all facilities and all units were functional. MDCR contracts with a vendor to flow test SCBA units.

Fire extinguishers are inspected every three years under contract and the extinguishers are inspected weekly by each facility's FSSO as noted on each fire extinguisher tag. MDCR documented that the fire extinguisher testing by the vendor is completed for 2015 for all fire extinguishers. MDCR renewed a five-year contract with a vendor to annually inspect, test, and certify the fire alarm systems for all MDCR facilities. The new contract period is 4/1/14-3/31/19.

The Facility Safety/Sanitation Officer (FSSO) conducts a fire safety inspection weekly of the entire facility to which they are assigned, including flow valves and a visual check of the power generator, where applicable. On this tour the Monitor reviewed selected weekly reports from each facility visited. The Monitor noted that

at least at PTDC, the weekly inspections are really monthly inspections as the FSSO completes certain floors each week during the month because of the size of the facility. Reports the Monitor reviewed noted deficiencies, service ticket numbers were recorded on the report to demonstrate that Facilities Management Bureau had been notified. Records from Facilities Management Bureau demonstrated the repairs were completed. Copies of the reports are provided to the facility's captain and to CAB.

The Monitor believes that MDCR should review the necessity of continuing the weekly FSSO inspections, or at a minimum justify the need for each inspection requirement/element. For example, the Monitor does not believe that it is necessary to check weekly every fire extinguisher; monthly is more appropriate, as long as the tags on each extinguisher are completed with the date of inspection and the extinguisher has not been damaged or discharged.

### **Emergency Keys**

DSOP policy 10-023, Key Control, is in a final revision. The emergency keys for all facilities are notched, and equipped with glow sticks. Each facility has a "Red Box" containing the key that accesses the emergency key box located in the Shift Commander's office. The "Red Box" is accessible by breaking the glass front using an attached hammer. The revision to DSOP 10-023, needs to reflect the established common location for the "Red Box".

Each facility had a different process for inspections of emergency keys. For example one facility included copies of incident reports for broken or lost keys; one facility provides a list of the incident report numbers. Others provided no incident information. TTC maintains a complete set of alternate emergency keys for TKG, MWDC and PTDC; Boot Camp should be included. DSOP 10-023 requires that emergency keys be tested monthly; and the policy should specify the testing procedures to be followed by each facility's key control officer. Each facility uses a different format for reporting.

MDCR should develop a consistent form for reporting, along with a written process included in DSOP 10-023 as to what position/post reviews and approves the reports, and whether CAB should receive copies. CAB procedures should likewise be updated.

When DSOP Policy 10-023 is revised and a consistent reporting format is established and implemented this provision of the Settlement Agreement will be in substantial compliance.

### **Chemical Control**

MDCR is revising DSOP 10-010 "Chemical Control". The Monitor provided comments on the draft in February 2014. Sanitation Officers for each facility have

been trained on chemical safety and appropriate dilution of chemicals; and providing updated training will be necessary. The training materials addressed chemical safety and dilutions, but did not include the process of how officers will assure that inmate workers are adequately supervised. The Monitor reviewed and provided written comments and suggestions to improve the chemical sanitation curriculum. Because of the significant changes to the revision to the policy, the training curriculum will need to be revised. When the Sanitation Officers are trained, they, in turn will train the inmates on safe and effective use the chemicals.

On this tour the Monitor reviewed the chemical control inventory and distribution process with the Fire Safety Sanitation Officers (FSSOs) at Boot Camp, TGK, and PTDC and found them to be implemented correctly. The chemical storage rooms at all facilities toured were well organized, and secure. Safety Data Sheets (SDSs) were available for all chemicals stored in the respective chemical control rooms. MDCR is installing mechanical dilution systems for chemicals at all facilities. All laundry washers in each facility will also have electronic systems to dispense detergent and bleach directly into the washers, eliminating the risk of inmate workers misusing laundry chemicals for personal laundry.

### **Housing Unit Inspections**

As reported in previous tour reports, housing units, cells and dormitories were generally maintained in a clean condition with no significant fire hazards visible. Inmates were storing commissary and personal belongings in their personal property bags. At PTDC, TGK, and Boot Camp, housing dormitories, cells, showers, and toilets were clean and well organized.

In reviewing daily inspections reports completed by the housing unit managers on each shift for Boot Camp, PTDC, and TGK, the reports rarely identified any deficiencies. Deficiencies that required maintenance repairs may be noted on one shift, not found on the other two when, in fact, the deficiency was never resolved on the shift in which it was first identified. This demonstrates a lack of effective supervisory review by oncoming shifts and little oversight by facility commanders to assure issues are resolved in timely manner. The content of the MDCR inspection reports suggest that officers are unclear about the purpose of the shift inspections and most likely more training and supervision is needed. Apparently facility leadership does not see the reports as adding value to improve conditions for inmates and staff. The Monitor strongly urges MDCR to reconsider continuing these inspections until the facilities' leadership develops a clear set of measureable objectives and parameters designed to benefit staff and inmate safety, not merely a "check off the box" exercise.

### **Preventive Maintenance and Repairs to Fire and Life Safety Equipment**

MDCR should review its process to assure that fire and life safety service tickets for repairs are completed within 48 hours, unless parts have to be ordered.

At TKG, the newly remodeled housing units housing mental health inmates are maintained clean, well lit and effectively organized. The Monitor noted that the fire extinguishers had not been inspected in accordance with MDCR policy, as evidenced by the tags not noting inspection dates for the first four months of 2015, even though the annual service inspections were completed in March.

### **Policies and Procedures**

As of this tour there are several written directives under revision. There is an updated schedule for review and approval provided. It is necessary to move these directives forward to begin the training process for implementation.

When the revised policies are implemented, the Monitor will review written evidence of their implementation in accordance with the procedures specified, including effectiveness of training.

### **Staffing Analysis**

The Construction Management Division completed a staffing review as recommended in the Monitor's previous report. As of the May tour there are a large number of vacant positions that MDCR should considering filling as a means to reduce the backlog of open service tickets. The Monitor recommends MDCR's leadership review the staffing needs, and assures processes are in place to handle priority work orders.

### **Inmate Grievances**

The inmate grievance process is in compliance with the mandates of the Settlement Agreement for MDCR, however, more work remains to be done with CHS' response and management of grievances.

### **Audits and Continuous Improvement**

MDCR is working to develop quarterly reports to provide the data the department believes is necessary to safely manage the jail facilities. MDCR did not include these specific paragraphs of the Settlement Agreement for review during this tour. The Monitors have been providing feedback on reports since the last tour.

### **Compliance and Quality Improvement**

MDCR did not include these specific paragraphs of the Settlement Agreement for review during this tour. This report includes recommendations to complete the revision process for policies, procedures, protocols, and training curriculum.

## **Conclusion**

The Monitors, again, commend MDCR for their hard work in gaining compliance with 23 paragraphs of the Settlement Agreement. We urge the perspective of both MDCR and CHS staff be that these changes are for the benefit of MDCR and CHS; not for DOJ and not for the Monitors.

We look forward to learning of efforts to address the areas of concern included in the Introduction to this report.

## Settlement Agreement – Paragraphs Reviewed This Tour

### III. 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.

Paragraph	III. A. 1. Safety and Supervision: a. MDCR will take all reasonable measures to ensure that inmates are not subjected to harm or the risk of harm. While some danger is inherent in a jail setting, MDCR shall implement appropriate measures to minimize these risks, including: (4) Document all security rounds on forms or logs that do not contain pre-printed rounding times. Video surveillance may be used to supplement, but not replace, rounds by correctional officers.		
Compliance Status:	Compliance: 5/15/15	Partial Compliance: 10/24/14, 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	None at this time.		
<i>Measures of Compliance:</i>	<u>Protection from Harm:</u> 1. Policies and procedures on reporting and logging. 2. Policy on use of video surveillance. 3. Review of staffing in housing units through observation and logs. 4. Interviews with inmates, employees Examination of logs.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	DSOP 11-020 Physical Sight Check Procedures governs this provision. Review of a sample of logs by the monitoring team during tours of each facility shows compliance.		
Monitor's Recommendations:	MDCR should continue the self-audit process to assure compliance with this provision and accepted correctional practice.		

### 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:

Paragraph	III. A. 2. Security Staffing: 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.		
Compliance Status:	Compliance: 5/15/15	Partial Compliance: 10/24/14, 3/28/14	Non-Compliance: Not yet due (11/27/13)
Unresolved/partially resolved issues from previous tour:	There are no unresolved issues		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Completion of a comprehensive staffing analysis. 2. Review by the monitor. 3. Documentation of discussions, recommendations by the monitor regarding the comprehensive staffing analysis.		
Steps taken by the County to Implement this paragraph:	The Mayor has agreed to place funding in the upcoming budget request to the Board of County Commissioners to begin implementation of approximately 500 new positions. Many of these positions were eliminated as cost saving measures in previous budget systems. The Mayor's commitment to meeting the needs identified in the staffing assessment is a further indication of the County's commitment to meeting the requirements of both Agreements.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR has a hiring plan in place based on realistic goals and the release of County funds.		
Monitor's Recommendations:	Assess/evaluate the hiring plan; provide periodic updates to the Monitors.		

Paragraph <u>Coordinate with Drs. Ruiz and Stern</u>	III. A. 2. Security Staffing: b. MDCR shall ensure that the staffing plan includes staffing an adequate number of correctional officers at all times to escort inmates to and from medical and mental health care units.		
Protection from Harm: Compliance Status:	Compliance: 5/15/15	Partial Compliance: 10/24/14, 3/28/14	Non-Compliance: 7/19/13
Unresolved/partially resolved issues from previous tour:	See III.A.2.a.		
Measures of Compliance:	<u>Protection from Harm:</u> 1. Staffing plan; staffing for escorts in each facility. 2. Policies and procedure for officer escorts to and from medical and mental health care units. 3. Overtime records, if any.		

	<p>4. Consultation with Drs. Ruiz and Stern; interview with medical and mental health personnel</p> <p>5. Review of patient scheduling deficiencies (e.g. cancelled, rescheduled appointments).</p> <p><u>Medical Care:</u></p> <ul style="list-style-type: none"> <li>Audit Step a: (Inspection) This compliance measure will be assessed by exception, i.e. any credible reports of lack of staff from CHS, MDCR and/or inmates to escort inmates to and from the medical health care appointments.</li> </ul> <p><u>Mental Health:</u></p> <ol style="list-style-type: none"> <li>Staffing plan; staffing for escorts in each facility.</li> <li>Policies and procedure for officer escorts to and from medical and mental health care units.</li> <li>Overtime records, if any.</li> <li>Consultation with Drs. Ruiz and Stern; interview with medical and mental health personnel</li> <li>Review of patient scheduling deficiencies (e.g. cancelled, rescheduled appointments).</li> </ol>		
Steps taken by the County to Implement this paragraph	<p><u>Protection from Harm:</u> See III. A. 2. a. See IIIA.2.a.</p> <p><u>Medical Care:</u> See III.A.2.a.</p> <p><u>Mental Health:</u> See III.A.2.a.</p>		
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	<p><u>Protection from Harm:</u> See III. A. 2. a. The staffing adequacy and deployment will be reviewed prior to and during the next tour.</p> <p><u>Medical Care:</u> <u>Mental Health:</u> No information was providing indicating a shortage of security staff to meet this requirement. Will be reviewed in future tours.</p>		
Monitors' Recommendations:	<p><u>Protection from Harm:</u> See III. A. 2. a.</p> <p><u>Medical Care:</u> <u>Mental Health:</u> None at this time.</p>		
Paragraph	<p>III. A. 2. Security Staffing:</p> <p>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.</p>		
Compliance Status:	Compliance: 5/15/15	Partial Compliance: 10/24/14; 3/28/14	Non-Compliance: Not yet due 11/27/13
Unresolved/partially resolved issues from previous tour:	See III.A.2.a.		
Measures of Compliance:	<p><u>Protection from Harm:</u></p> <ol style="list-style-type: none"> <li>Completed staffing plan; discussion of recommendations by the monitor, if any.</li> <li>Determination of the need for more hiring, if any.</li> </ol>		

	<ol style="list-style-type: none"> <li>3. Hiring plan, if needed, with timetable.</li> <li>4. Results of hiring, if needed.</li> </ol>
Steps taken by the County to Implement this paragraph:	See III. A. 2. a. The Mayor's budget containing the positions required will be considered by the Board of County Commissioners during the budget process, which concludes in September 2015.
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	See III. A. 2. a. The Mayor's office is acknowledged for taking the information provided by MDCR's comprehensive staffing analysis and acting to address position shortages created by previous budget cuts, and including positions necessary to comply with both Agreements.
Monitor's Recommendations:	See III. A. 2. a.

Paragraph	III. A. 2. Security Staffing: d. Every 180 days after completion of the first staffing analysis, MDCR shall conduct and provide to DOJ and the Monitor staffing analyses examining whether the level of staffing recommended by the initial staffing analysis and plan continues to be adequate to implement the requirements of this Agreement. If the level of staffing is inadequate, the parties shall re-evaluate and agree upon the timetable for the hiring of any additional staff.		
Compliance Status:	Compliance:	Partial Compliance:	Not Yet Due: 5/15/15 10/24/14; 3/28/14
Unresolved/partially resolved issues from previous tour:	See III. A.2. This report is due 9/9/15		
Measures of Compliance:	<u>Protection from Harm:</u> <ol style="list-style-type: none"> <li>1. Report from MDCR comparing if recommended staffing is adequate to implement the requirements of this agreement.</li> <li>2. Review of overtime costs; vacancies and vacancy trends.</li> <li>3. Re-evaluation of hiring and hiring timetable, if needed.</li> <li>4. Review/comment by the monitor of report in III.A.2.a., above.</li> </ol>		
Steps taken by the County to Implement this paragraph:	This report is due 9/9/15		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	This report is due 9/9/15		
Monitor's Recommendations:	See III. A. 2. a. The County and MDCR need to develop the capacity to conduct periodic reviews of staffing to assure long-term compliance with this provision.		

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

<p><u>Paragraph</u> <u>Coordinate with Drs. Ruiz and Stern</u></p>	<p>4. Incidents and Referrals d. MDCR shall develop and implement a policy to screen incident reports, use of force reports, and inmate grievances for allegations of staff misconduct and refer an incident or allegation for investigation if it meets established policy criteria.</p>		
<p>Protection from Harm: Compliance Status:</p>	<p>Compliance: 5/15/15</p>	<p>Partial Compliance: 10/24/14</p>	<p>Non-Compliance: 3/28/14, 7/19/13 (not yet due)</p>
<p>Unresolved/partially resolved issues from previous tour:</p>	<p>Assure that companion CHS policies are in place, and medical providers are trained at recognizing signs and symptoms of use of force, use of excessive force, and inmate/inmate assault and sexual assault.</p>		
<p><u>Measures of Compliance:</u></p>	<p><u>Protection from Harm:</u></p> <ol style="list-style-type: none"> <li>1. Policies and procedures regarding incident reports, including criteria for screening for critical incidents (see also III.A.3);</li> <li>2. Documentation of referrals of grievances for investigations; outcomes.</li> <li>3. Corrective actions for incidents not referred as required.</li> <li>4. Review of medical and mental health policies and procedures regarding referrals/notifications of inmate injuries that might be result from staff misconduct, use of excessive force, inmate/inmate sexual assault, etc.</li> <li>5. Medical and mental health policies and procedure regarding review of medical grievances to screen for critical incidents.</li> <li>6. Documentation of referrals to investigators by medical and/or mental health staff, if any.</li> </ol> <p><u>Medical Care:</u></p> <ul style="list-style-type: none"> <li>• Audit Step a: (Inspection) Medical policies and procedures address the screening of medical grievances for allegations of staff misconduct and their referral for investigation when appropriate.</li> <li>• Audit Step b: (Inspection) When interviewed, CHS leaders report screening medical incident reports and grievances for allegations of staff misconduct and referring for investigation when indicated by policy.</li> <li>• Audit Step c: (Inspection) Medical grievances and incident reports which contain allegation so of staff misconduct are referred for investigation.</li> </ul> <p><u>Mental Health:</u></p> <ol style="list-style-type: none"> <li>1. Policies and procedures regarding incident reports, including criteria for screening for critical incidents (see also III.A.3);</li> <li>2. Documentation of referrals of grievances for investigations; outcomes.</li> <li>3. Corrective actions for incidents not referred as required.</li> <li>4. Review of medical and mental health policies and procedures regarding referrals/notifications of inmate injuries that might be result from staff misconduct, use of excessive force, inmate/inmate sexual assault, etc.</li> <li>5. Medical and mental health policies and procedure regarding review of medical grievances to screen for critical incidents.</li> <li>6. Documentation of referrals to investigators by medical and/or mental health staff, if any.</li> </ol>		
<p>Steps taken by the County to</p>	<p><u>Protection from Harm:</u></p>		

Implement this paragraph:	See above. DSOP 11-003; DSOP 15-001; DSOP 11-041.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	<u>Protection from harm:</u> Documentation of referrals from inmate grievances to SIAB was provided.  <u>Medical Care/Mental Health:</u> None at this time.
Monitors' Recommendations:	<u>Protection from Harm/Medical Care/Mental Health:</u> Need to coordinate with CHS to assure all inmate medical care includes visual screening for these incidents.

Paragraph <u>Coordinate with Drs. Ruiz and Stern</u>	4. Incidents and Referrals f. MDCR shall continue to train all corrections officers to immediately inform a member of the Qualified Medical Staff when a serious medical need of an inmate arises.		
Protection from Harm: Compliance Status:	Compliance:	Partial Compliance: 5/15/15, 10/24/14, 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	Same status as Report # 3. See below, need for lesson plan revision		
<i>Measures of Compliance:</i>	<u>Protection from Harm:</u> 1. Policies and procedures regarding training for notifications for Medical Care and mental health emergencies. 2. Lesson plans; training schedule. 3. Documentation of knowledge gained (e.g. pre and post tests) 4. Evidence of remedial training, if needed. 5. Review of incidents in which medical/mental health issues reported and not reported. 6. Minutes of meetings between security and medical/mental health.		
Steps taken by the County to Implement this paragraph:	<u>Protection from Harm:</u> Need for updating of lesson plans		
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	<u>Protection from Harm:</u> Directive completed; need to review lesson plan.		
Monitor's Recommendations:	<u>Protection from Harm:</u> Provide updated lesson plan to Monitors.  <u>Medical Care/Mental Health:</u> Will review curriculum when completed.		

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

Paragraph	III. A. 5. Use of Force by Staff a. Policies and Procedures (1) MDCR shall sustain implementation of the "Response to Resistance" policy, adopted October 2009. In accordance with constitutional requirements, the policy shall delineate the use of force continuum and permissible and impermissible uses of force, as well as emphasize the importance of de-escalation and non-force responses to resistance. The Monitor shall provide ongoing assistance and annual evaluation regarding whether the amount and content of use of force training achieves the goal of reducing excessive use of force. The Monitor will review not only training curricula but also relevant data from MDCR's bi-annual reports. (2) MDCR shall revise the "Decontamination of Persons" policy section to include mandatory documentation of the actual decontamination time in the response to resistance reports. (3) The Jail shall ensure that each Facility Supervisor/Bureau Commander reviews all MDCR incidents reports relating to response to resistance incidents. The Facility Supervisor/Bureau Commander will not rely on the Facility's Executive Officer's review.		
Compliance Status:	Compliance:	Partial Compliance: 5/15/15, 10/24/14, 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	The growth in experience of the TAAP Unit will continue to greatly enhance the review of uses of force by staff.		
<i>Measures of Compliance:</i>	<u>Protection from Harm:</u> 1. Policies and procedures regarding use of force, response to resistance, including reporting and review protocols. 2. Monitor's annual evaluation of relevant data, including whether the amount and content of use of force training achieves the goal of reducing use of excessive force; review of bi-annual reports from MDCR. 3. Policies and procedures regarding decontamination; corresponding medical policies/procedures. 4. Policies and procedures on review of incident reports (see also III.A.4.a, III.A. 4.b.) by Facility Supervisor/Bureau Commander. 5. Review of reports; data.		
Steps taken by the County to Implement this paragraph:	Establishment of the TAAP Unit. Training was provided to the unit members by a founder of one of the first use of force review units in a county jail. Additionally the monitor has sat with them to review reports, answer questions and provide suggestions.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	MDCR has delivered quarterly reports; which will be refined as their internal processes become more sophisticated. Additionally, there is a need for a written protocol between TAAP and Investigations to assure appropriate review and/or employee discipline.		
Monitor's Recommendations:	Continue training for TAAP members; provide meaningful critique of their work, data analysis and reports. Develop written protocols for collaboration/coordination between TAAP and SIAB.		

Paragraph Coordinate with Dr. Ruiz See Consent Agreement III.B.3. (page	III. A. 5. Use of Force by Staff b. Use of Restraints (1) MDCR shall revise the "Recognizing and Supervising Mentally Ill Inmates" policy regarding restraints		
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64)	<p>(DSOP 12-005) to include the following minimum requirements:</p> <ul style="list-style-type: none"> <li>i. other than restraints for transport only, mechanical or injectable restraints of inmates with mental illness may only be used after written approval order by a Qualified Health Professional, absent exigent circumstances.</li> <li>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.</li> <li>iii. the form of restraint selected shall be the least restrictive level necessary to contain the emerging crisis/dangerous behavior.</li> <li>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.</li> <li>v. restraints shall never be used as punishment or for the convenience of staff. Threatening inmates with restraint or seclusion is prohibited.</li> <li>vi. any standing order for an inmate’s restraint is prohibited.</li> </ul> <p>(2) MDCR shall revise its policy regarding restraint monitoring to ensure that restraints are used for the minimum amount of time clinically necessary, restrained inmates are under 15 minute in-person visual observation by trained custodial staff. For any custody-ordered restraints, Qualified Medical Staff are notified immediately in order to review the health record for any contraindications or accommodations required and to initiate health monitoring.</p>		
Protection from Harm: Compliance Status:	Compliance:	Partial Compliance: 5/15/15, 10/24/14, 3/28/14, 7/19/14	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	See also Consent Agreement III.B.3.		
<i>Measures of Compliance:</i>	<p><u>Protection from Harm:</u></p> <ol style="list-style-type: none"> <li>1. Policies and procedures regarding recognizing and supervising inmates with mental illness; use of restraints; monitoring those in restraints and elements of this paragraph of the Settlement Agreement.</li> <li>2. Corresponding medical and mental health policies/procedures. Consistency between the directives of security and medical/mental health.</li> <li>3. Minutes of meetings between security and medical/mental health in which these topics are reviewed/discussed; or other documentation of collaboration, and problem-solving.</li> <li>4. Review of uses of restraints; required logs.</li> <li>5. Identification of employees requiring training.</li> <li>6. Review of use of seclusion.</li> <li>7. Lesson plans and schedule for training.</li> <li>8. Maintenance of data regarding uses of force involving inmates on the mental health caseload, by facility.</li> </ol>		
Steps taken by the County to Implement this paragraph:	<p><u>Protection from Harm:</u> This paragraph is placed in compliance as MDCR’s policies and procedures meet the requirements. See the comments in section III.B.3. of the Consent Agreement regarding work that needs to be done in CHS</p>		
Monitors’ analysis of conditions to assess compliance, verification of	<p><u>Protection from Harm:</u> Work completed, except lesson plans are pending</p>		

the County's representations, and the factual basis for finding(s)	
Monitors' Recommendations:	<p><u>Protection from harm:</u> CHS companion policies needs to be developed.</p> <p>Lesson plans need to be completed, provided to the monitors for review, and implemented.</p>

Paragraph	<p>III. A. 5.c. (3) MDCR shall require initial administrative review by the facility supervisor of use of force reports within three business days of submission. The Shift Commander/Shift Supervisor or designee shall ensure that prior to completion of his/her shift, the incident report package is completed and submitted to the Facility Supervisor/Bureau Commander or designee.</p>		
Compliance Status:	Compliance	Partial Compliance: : 5/15/25, 10/24/14, 3/28/14, 7/19/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour:			
Measures of Compliance:	<p><u>Protection from Harm:</u></p> <ol style="list-style-type: none"> <li>1. Policies and procedures regarding use of force reports; supervisory review of reports; time deadlines.</li> <li>2. Review of incident reports; review of a sample of use of force incident report packages for each facility.</li> <li>3. Review of investigations.</li> <li>4. Remedial, corrective action if necessary</li> <li>5. Lesson plans regarding supervisory review of use of force reports.</li> </ol>		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Directives are in place. A review of use of force reports for January 2015 indicates compliance. TAAP Monitors compliance by reviewing all use of force reports.		
Monitor's Recommendations:	TAAP continue to monitor compliance; lesson plans need to be developed and reviewed by the Monitors.		

Paragraph <u>Coordinate with Dr. Stern and Dr. Ruiz</u>	<p>III. A. 5.c. (6) MDCR shall maintain its criteria to identify use of force incidents that warrant a referral to IA for investigation. 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.</p>		
Protection from Harm: Compliance Status:	Compliance: 5/15/15	Partial Compliance: 10/24/14	Non-Compliance: 7/19/13
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 10/14	Non-Compliance: Not audited

Mental Health: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: Not audited
Unresolved/partially resolved issues from previous tour:	The written directive is in place; need for monitoring of referrals based on my review of June’s use of force packages. See also Settlement Agreement III.A.5.a.		
<i>Measures of Compliance:</i>	<p><u>Protection from Harm:</u></p> <ol style="list-style-type: none"> <li>1. Policies and procedures regarding criteria for referrals to IAB for use of force investigations.</li> <li>2. Review of reports.</li> <li>3. Review of medical and mental health policies and procedures for referrals regarding injuries consistent with excessive use of force, and other related critical incidents.</li> <li>4. Documentation of referrals from medical/mental health to IAB.</li> <li>5. Minutes of meeting between security and medical/mental health in which these topics are discussed/reviewed.</li> <li>6. Treatment of inmates at outside hospitals.</li> <li>7. PREA policies, data.</li> <li>8. Review of investigations.</li> <li>9. Review of remedial or corrective action plans, if any.</li> </ol> <p><u>Medical Care:</u></p> <ul style="list-style-type: none"> <li>• (duplicate) CONSENT044 (IIIB3c) Audit Step b: (Inspection) When interviewed, nurses and practitioners on staff report that when they evaluate patients with any injury, they always consider whether the injury might be the result of staff-on-inmate abuse, and if so, (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.</li> <li>• Audit Step a: (Chart Review) Medical records of inmates subject to use of force where the force may be excessive, show evidence of referral (with patient permission) to jail authorities.</li> </ul> <p><u>Mental Health:</u> See Protection from Harm</p> <p>Use of force reports as they relate to inmate with SMI and evidence of their adequate treatment both before and after the incident will be reviewed.</p>		
Steps taken by the County to Implement this paragraph:	<p><u>Protection from Harm:</u> MDCR has established the TAAP Unit (See III.A.5.a).</p> <p><u>Medical Care:</u></p> <p><u>Mental Health: See Protection from Harm</u></p>		
Monitors’ analysis of conditions to	<u>Protection from Harm:</u>		

<p>assess compliance, verification of the County's representations, and the factual basis for finding(s)</p>	<p>See III.A.5.a.</p> <p><u>Medical Care:</u> MDCR did not request the Medical Monitor to audit this provision. However, it did ask for audit of provision III.B.3.c. in the Consent Agreement that includes an audit step that is identical to an audit step here III.B.3.c. (Audit Step b). During that audit, the Monitor found compliance.</p> <p><u>Mental Health:</u> See previous compliance report.</p>
<p>Monitor's Recommendations:</p>	<p><u>Protection from Harm:</u> See III.A.5.a.</p> <p><u>Medical Care:</u> None.</p> <p><u>Mental Health:</u> Use of Force incidents involving patients on the mental health caseload should be specifically tracked. This would assist in differentiating problematic cases of possible staff misconduct from routine staff assist when necessary, such as cell extractions and medication administration.</p>

<p>Paragraph <u>See also PREA policies/procedures.</u></p>	<p>III.A.5.c. (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:</p> <ul style="list-style-type: none"> <li>i. engaged in use of unnecessary or excessive force;</li> <li>ii. failed to report or report accurately the use of force; or</li> <li>iii. retaliated against an inmate or other staff member for reporting the use of excessive force; or</li> <li>iv. interfered with an internal investigation regarding use of force.</li> </ul>		
<p>Compliance Status:</p>	<p>Compliance:</p>	<p>Partial Compliance: 5/15/15, 10/24/14</p>	<p>Non-Compliance: 3/28/14, 7/19/13</p>
<p>Unresolved/partially resolved issues from previous tour:</p>	<p>See III.A.5.a</p>		
<p><i>Measures of Compliance:</i></p>	<p><u>Protection from Harm:</u></p> <ol style="list-style-type: none"> <li>1. Personnel policies and procedures regarding employee discipline; relevant portions of CBAs.</li> <li>2. Employee disciplinary reports; investigations.</li> <li>3. Employee disciplinary sanctions.</li> <li>4. Records of hearings, including arbitration hearings, if any.</li> <li>5. Documentation of terminations for cause.</li> </ol>		
<p>Steps taken by the County to Implement this paragraph:</p>			

Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Partial compliance is noted based on the review of the use of force reports and subsequent employee discipline for January 2015. SIAB and TAAP are meeting weekly to discuss the progress of reviews/investigations. However, there needs to be a written protocol regarding the boundaries of their collective reviews and imposition of discipline.
Monitor's Recommendations:	Develop a written protocol to govern use of force reviews and employee discipline between SIAB and TAAP.

Paragraph Coordination with Dr. Stern	III.A.5.c. (10) The Jail will ensure that inmates receive any required medical care following a use of force.
Compliance Status:	Compliance: 5/15/15, 10/24/14, 3/28/14
Unresolved/partially resolved issues from previous tour:	Partial Compliance: 7/19/13
Measures of Compliance:	Non-Compliance:
	NA
	<ol style="list-style-type: none"> <li>1. Policies and procedures regarding medical care following a use of force, including use of digital recordings.</li> <li>2. Incident reports.</li> <li>3. Review of inmate medical records</li> <li>4. Interview with medical personnel.</li> <li>5. Lesson plans.</li> </ol> <p><u>Medical Care:</u></p> <ul style="list-style-type: none"> <li>• (duplicate) CONSENT043 (IIB3b) Audit Step a: (Chart Review) Detainees subjected to Use of Force are evaluated immediately afterwards: <ol style="list-style-type: none"> <li>a) documentation reflects the nature of the force and any patient symptoms,</li> <li>b) evaluation is conducted by, or under the direct supervision of, an RN or practitioner,</li> <li>c) the content of the evaluation is clinically appropriate, including evaluation of reasonably possible injuries based on the nature of the force, symptoms, or findings.</li> </ol> </li> </ul>
Steps taken by the County to Implement this paragraph:	
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	It appears from a review of the use of force reports from January 2015 that inmates are appropriately referred to medical by MDCR. See comments of Dr. Stern in Consent Agreement III.B.3.b.
Monitors' Recommendations:	MDCR continue self-monitoring.  <u>Medical Care:</u> Please see CONSENT043 (IIB3b), and discussion on page 40.

Paragraph <u>Coordination with Dr. Stern</u>	III. A. 5.c. (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
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	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.		
Protection from Harm: Compliance Status:	Compliance:	Partial Compliance: 5/15/15	Non-Compliance: 10/24/14, 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:			
<i>Measures of Compliance:</i>	Protection from Harm: 1. Policies and procedures regarding production of reports, and corrective action plans meeting above criteria. 2. Quarterly reports, and corrective action plans. 3. Review of quarterly medical/mh QA/QI reporting.		
Steps taken by the County to Implement this paragraph:	<u>Protection from Harm:</u> See above; complete the appropriate directive.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	<u>Protection from Harm:</u> The TAAP Unit provides 100% sampling of reports. Need to review CHS compliance CA III.B.3. Will be in compliance with direction 4-018 is implemented. <u>Medical Care:</u> No issues were referred to the Medical Monitor by the Security Monitor during this visit.		
Monitor's Recommendations:	Review of medical, although not required by this paragraph, should also include the quality of medical evaluations by CHS.		

Paragraph	III.A.5.c. (12) Every 180 days, MDCR shall evaluate use of force reviews for quality, trends and appropriate corrective action, including the quality of the reports, in accordance with MDCR's use of force policy.		
Compliance Status:	Compliance:	Partial Compliance: 5/15/15	Non-Compliance: 10/24/14, 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:			
<i>Measures of Compliance:</i>	1. Policies and procedures regarding uses of force. 2. Semi-annual report/evaluation of uses of force/quality control. 3. Corrective action plans, if any. 4. Documentation of meetings with MDCR leadership regarding the report's findings; documentation of collaboration with medical/mh staff, if necessary.		
Steps taken by the County to Implement this paragraph:	MDCR anticipates that quarterly reviews will be in effect. Action plans, and action plan updates/follow-ups will be included with the reporting.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Reports produced by TAAP, including the semi-annual Inmate Violence Reports for 2015, and the first quarter report for CY 2015 indicate substantial data collection and analysis.  Will be in compliance with direction 4-018 is implemented.		
Monitor's Recommendations:	Assure that supervisor and command staff personnel are reading the TAAP reports, are informed about trends for their assigned facilities, and are accountable for the information.		

Paragraph	III.A.5.c. (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.		
Compliance Status:	Compliance:	Partial Compliance: 5/15/15	Non-Compliance: 10/24/14, 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	See above III.A.5. (11) and IV A - C.		
<i>Measures of Compliance:</i>	<u>Protection from Harm:</u> 1. Policies and procedures regarding unauthorized uses of force and/or allegations of excessive force. Evaluation of uses of force involving inmates on the mental health caseload. 2. MDCR annual reporting, by facility. 3. Review of incidents. 4. Review of baseline for determining increases/decreases, and subsequent data reporting. 5. Observation and interview. 6. Review of a corrective action plans, if needed		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Will be in compliance with direction 4-018 is implemented, along with reviews of action plans, if needed, and action plan follow-ups as relevant.		
Monitor's Recommendations:	Complete the directive; monitor action planning activity and follow-ups. Document collaboration with training, policy development, and facility leadership.		

### III. A.6. Early Warning System

Paragraph	III. A. 6. Early Warning System 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.		
Compliance Status:	Compliance:	Partial Compliance: 5/15/15	Non-Compliance: 10/24/14, Not yet due, 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	See III.A.6.a.		
<i>Measures of Compliance:</i>	<u>Protection from Harm:</u> 1. Policies and procedures regarding EWS and reporting. 2. Reports on EWS (180 days and bi-annually), as specified above. 3. MDCR changes policies, procedures, pre-service or in-service training as a result of the information generated by the early warning system.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Report provided. MDCR will go to quarterly reporting. MDCR needs to finalize and implement DSOP 4-017		
Monitor's Recommendations:	Provide anticipated quarterly reporting to the monitor; complete/implement directive.		

Paragraph	III. A. 6. Early Warning System c. <u>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.</u>		
Compliance Status:	Compliance:	Partial Compliance: 5/15/15	Non-Compliance: 10/24/14 not yet due; 3/28/14, 7/19/13
Unresolved/partially resolved issues from previous tour:	See III.A.6.a.		
<i>Measures of Compliance:</i>	<u>Protection from Harm:</u> 1. Policies and procedures regarding annual report. 2. Production of a review of the EWS; recommendations for changes, if needed. 3. MDCR changes policies, procedures, pre-service or in-service training as a result of the information generated by the early warning system.		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and	Directive DSOP 4-107 needs to be completed and implemented.		

the factual basis for finding(s)	
Monitor's Recommendations:	<ol style="list-style-type: none"><li>1. Complete and issue the directive.</li><li>2. Provide proposed reporting formats to the Monitors for review ahead of the annual report.</li><li>3. Include in self-audit process.</li></ol>

**III. B. Fire and Life Safety**

Paragraph(s):	<p><b>III. B. Fire and Life Safety</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.</p>		
Compliance Status:	Compliance:	Partial Compliance: 5/15; 10/14; 3/14; 7/13	Non-Compliance:
Unresolved/partially resolved issues from previous tour(s):			
<i>Measures of Compliance:</i>	<p><u>Fire and Life Safety:</u></p> <ol style="list-style-type: none"> <li>1. Establishment of a MDCR or facility specific policy outlining the policy and procedures including staff responsibility and accountability for conducting fire drills within each facility at least once every three months on each shift. The policy shall include applicable drill reports that outline at a minimum start and stop times of the drills and the number of inmates who were moved as part of the drills, a formal review process for each drill that identifies the root cause of any identified non-conformities, along with documented verified corrective actions taken as a result of the analysis.</li> <li>2. Appointment of facility specific fire safety officers that assures at least one trained designated officer on duty on all shifts to oversee fire drills and verify corrective actions as necessary for non-conformities.</li> <li>3. Development of a confidential annual drill schedule that meets the minimum requirements of the "Settlement Agreement."</li> <li>4. Documented evidence that the fire drills are conducted that meet the minimum requirements specified.</li> </ol>		
Steps taken by the County to Implement this paragraph:	<p>DSOP 10-022 entitled "Fire Response and Prevention Plan" requires that the AIB commander or Departmental Safety Officer (DSO) conduct fire drills. It further states that there be a quarterly fire drill on each shift, in each area of the facility" as outlined in the "MDCR Fire Drill Procedures."</p> <p>It establishes four levels of drills: They include                  Level I: Simulations (Walk/Talk Through the procedure                  Level II: Alarm Activation, Deployment of SCBA, and Inmate Evacuation Within the Facility                  Level III: Deployment of Artificial Smoke and SCBA                  Level IV: Evacuation Outside of Facility with Interagency Response.                  The only requirement on how many of each type are acceptable is that there must be a Level IV fire drill twice per year. A copy of the MDCR Accreditation and Inspections Bureau Fire Drill Report form is required to be completed and forwarded to the Shift Supervisor/Commander and the Facility/Bureau Supervisor for review and signature before forwarding to CAB. The drills are scored using a numerical score for acceptability.</p> <p>MDCR has established Policy 10-006 that establishes emergency procedures and evacuation. Correspondingly, each facility also has developed a facility specific policy/plan for fire response that supplements the DSOP 10-006. Many provisions restate much of the MDCR policy.</p>		
Monitor's analysis of conditions to	DSOP Policy 10-022 and 10-006 are currently being revised and is pending approval, lesson plan development and		

assess compliance, verification of the County's representations, and the factual basis for finding(s)

training. MDCR has formally appointed one Fire Safety/Sanitation Officer for each facility. MDCR has established an annual fire drill schedule for each facility.

Prior to the tour, MDCR provided copies of fire drill reports for each facility from October through March demonstrating one fire drill per month on all three shifts. For each facility there should have been 18 drill reports completed in that time frame. The monitor reviewed the 17 drill reports for Boot Camp, 18 drill reports for MWDC, 17 drill reports for PTDC, 20 drill reports for TGK, and 17 drill reports for TTC. Reports show that of all drills, most were level 2. There were no Level 3 or 4 drills conducted. DSOP 10—022 requires a minimum of one Level IV drill every six months. Specifically Boot Camp had one level one, MWDC had 0 level one drills, PTDC had 3 level one drills, TGK had 1 level one drill, and TTC had 2 level one drills.

Boot Camp drill times ranged from 5 minutes to 17 minutes with an average of 10 minutes. MWDC drill times ranged from 4 minutes to 14 minutes with an average of 7 minutes. PTDC drill times ranged from 4 minutes to 20 minutes with an average of 8 minutes. TGK drill times ranged from 3 minutes to 20 minutes with an average of 10 minutes. TTC drill times ranged from 5 minutes to 20 minutes with an average of 11 minutes. These drill times appear very short, when you review the requirements for a level II drill.

More importantly there were very few comments from either the Fire Safety Officer or the Shift Commanders about drill issues identified. At Boot Camp, out of 17 drill reports, the Fire Safety Officer had no comments and the shift supervisor either always said essentially "good job" or had no comments on all drills. Apparently no issues were found for six months of drills. At MWDC, of 18 drill reports, the reports had no comments or "good job" on 14 reports from the Fire Safety Officers and the Shift Commander had no comments or "good job" on 15 reports. At PTDC out of 17 reports, the Fire Safety Officer had no comments on 10 reports and the shift commander had no comments on 13 reports. At TGK out of 20 reports, the Fire Safety Officer had no comments on 12 reports and the Shift Commander had no comments on 16 reports. At TTC, the Fire Safety Officer had no comments 15 of 17 reports and the Shift Commander had no comments on 15 reports. In fact the only comments recorded were regarding the location of the SCBA units. The lack of comments and suggestions for improving performance may suggest that the Fire Safety Officer and Shift Commander have not been effectively trained on what and how to assess drill performance. The lack of comments is especially noteworthy considering as of this tour MDCR has not even begun the 8 hour fire safety training course for officers. One would certainly expect drill deficiencies on almost all drills. For the few drill comments provided, there is no evidence of any changes either to policy, training, or practice as a result. MDCR management should focus attention to addressing non-conformities and inconsistencies. The monitor found no evidence of documented corrective actions taken as a result of the drills. As found on the last tour, a drill is completed with either no expectations or any modifications to procedures or training.

CAB maintains copies of all drills, but has not used the information to determine any need for changes to either policy or training curriculum. It appears that the drill reports only serve to demonstrate that required drills are conducted as required in the provision, but lacks evidence of how the information learned during the drills is utilized. Further there is no evidence that any Facility Captain uses the information to make improvements. CAB needs to insist on drills that include movement of inmates to assure effective response in case of an emergency. I again suggest that MDCR consider revising the drill policy to establish two types of drills, one with movement of inmates and one with simulated

	<p>movement. The local fire department should be provided a copy of the annual schedule and invited to participate in any drill for their training purposes and to address interagency coordination issues. At a minimum the policy continues to need clarification.</p> <p>The monitor requests that he receive the fire drill reports monthly, along with a summary documenting any non-conformity identified and how it was addressed. By reviewing monthly, the monitor will have adequate time to review and provide comments and better prepare for future visits.</p> <p>It is imperative that officer know and understand who, when, how, and why they need to respond to a fire or smoke or other type of emergency. That includes knowing how and where to evacuate both inmates, visitors and staff should that become necessary. Simulating drills without movement of inmates does not demonstrate any proficiency or knowledge of safe and effective response and evacuation methods. The MDCR objective should be that all officers understand the fire response and evacuation plan for the facility in which they are assigned and should be able to demonstrate that understanding. This is important considering the six month bidding process that officers can use to move to different facilities. All officers should be part of drills at least once every three years. That goal is more important than the quarterly frequency.</p>
<p>Monitor's Recommendations:</p>	<ol style="list-style-type: none"> <li>1. Provide the monitor a copy of the draft revision of 10-022 prior to establishing an effective date. Make sure that all training documents reflect the revised policy. It should also be included in the "biennial training" specified in III B-6.</li> <li>2. MDCR needs to develop specific fire drill objectives and expectations for Fire Safety Officers, Shift Commanders, Facility Managers, Tier Officers and support staff for all drills. Assure that a drill schedule provides how the objectives and expectations will be measured, assessed, reported, reviewed on every drill on every shift. Assure that Fire Safety Officers and Shift Commanders are trained on the objectives, procedures, expectations before the next tour.</li> <li>3. Monthly provide copies of the fire drills reports for all drills conducted for all facilities on each shift for monitor's review. The reports need to include a summary of the non-conformities identified, the documented corrective actions taken, and how you measured that the corrective actions were effective to address the issue.</li> <li>4. Clarify the minimum and/or maximum number of drill types for each facility as appropriate. Consider establish only two types of drills a suggested in the Monitor's analysis.</li> <li>5. Provide a copy of the 2016 fire drill schedule for MDCR by January, 2016.</li> <li>6. Require each facility manager to provide a written response when all drills each month are not conducted.</li> <li>7. Provide the list of the designated fire safety/sanitation officers (FSSO). MDCR should consider a fire safety officer for each shift at each facility.</li> </ol>

Paragraph(s):	<b>III. B. Fire and Life Safety</b> 6. MDCR shall provide competency-based training to correctional staff on proper use of fire and emergency equipment, at least biennially.		
Compliance Status:	Compliance:	Partial Compliance: 5/15	Non-Compliance: 10/14; 3/14; 7/13
Unresolved/partially resolved issues from previous tour(s):			
<i>Measures of Compliance:</i>	<u>Fire and Life Safety:</u> 1. Establishment of either an MDCR or facility specific policy and procedures for competence-based biennial training for correctional staff on safe and effective use of all fire and emergency equipment. 2. Written training outline/syllabus for the training that identifies all elements for safe and effective use of all fire and emergency equipment including training time. 3. Written procedure on how MDCR will identify each officer and staff who is required to receive training, the training date, name of the officer trained competency measurement score, and trainer. 4. Verification by sign-in logs of participants, and validation of successful completion of training. 5. Observation of implementation.		
Steps taken by the County to Implement this paragraph:	DSOP Policy 10-022 and 10-006 was approved by the Monitors and DOJ and is currently pending release by MDCR regarding fire safety response including proper use of fire and emergency equipment. The lesson plan for proper use of fire and emergency equipment needs to be completed using the most recent changes to the affected policies. The revised policy will include the process they will use to identify all officers and civilian employees that will need to receive training, the qualifications of the trainer and how competency will be measured and the process for remedial training when either testing or practice identifies lack of skills or understanding. However, the process to meet this provision has not started.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	On this tour MDCR staff provided a copy of the 8 hour "Fire and Life Safety Lesson Plan, dated July 21, 2014. The plan includes both a pre and post-test instrument consisting of 50 questions and a practicum for officers to demonstrate proficiency. (The Fire and Life Safety Course Syllabus calls for a 20 question pre and post-test and the Lesson Plan calls for a 25 question pre and post-test. Not sure which is correct?) MDCR has not provided a pass/fail percentage for the test or for the practicum The provision is clear that it is the biennial training on the "safe and effective use of all fire and emergency equipment" is measured when the "biennial training" process is implemented. As of this tour MDCR stated that they intend to commence training on May 25, 2015 with a maximum of 25 participants per 8-hour block of instruction. In reviewing the material, there is no provision stating next steps that will occur should a participant not successfully pas either the post-test or the practicum. Further, as outlined in the previous report MDCR should create a process for refresher training for employees who are not able to practically demonstrate proficiency on routine fire drills. The refresher training should be based upon identified shortcomings from internal fire drills, both internal and external fire safety inspections and existing fire safety laws, regulations, and standards. As the biennial training lesson plan is created, this provision is now partially compliant. To obtain "substantial compliance", MDCR will need to revise the training plan to assure conformance to the latest approved edition of Policies 10-022 and 10-006 and be able to demonstrate at least 50% successful completion rate for all staff on all shifts for each facility.		
Recommendations	1. Approve MDCR DSOP Policies 10-022 and 10-006 or establish a separate policy that establishes the requirement		

	<p>for competency based biennial training for all correctional staff on safe and effective use of fire and emergency equipment. Include in the policy the fire and emergency equipment for which training will be provided.</p> <ol style="list-style-type: none"><li>2. Assure the training plan that outlines how the policy will be implemented and include a schedule for completion of the first round of refresher training.</li><li>3. Assure the Lesson Plan and curriculum is consistent in the post-test requirements and the pass/fail criteria for both the post test and the practicum.</li><li>4. Provide evidence of development and implementation of the refresher training program as established in the provision.</li></ol>
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### III. C. Inmate Grievances

<p>Paragraph <u>Coordinate with Drs. Ruiz and Stern</u> See also Consent Agreement III.A.3.a.(4)</p>	<p>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:</p> <ol style="list-style-type: none"> <li>1. Ensure that each grievance receives follow-up within 20 days, including responding to the grievant in writing, and tracking implementation of resolutions.</li> <li>2. Ensure the grievance process allows grievances to be filed and accessed confidentially, without the intervention of a correctional officer.</li> <li>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.</li> <li>4. Ensure priority review for inmate grievances identified as emergency medical or mental health care or alleging excessive use of force.</li> <li>5. Ensure management review of inmate grievances alleging excessive or inappropriate uses of force includes a review of any medical documentation of inmate injuries.</li> <li>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.</li> </ol>		
<p>Protection from Harm: Compliance Status:</p>	<p>Compliance: 5/15/15</p>	<p>Partial Compliance: 10/24/14, 3/28/14, 7/19/13</p>	<p>Non-Compliance:</p>
<p>Unresolved/partially resolved issues from previous tour:</p>	<p>See also Consent Agreement III.A.3.a.(4)</p>		
<p><i>Measures of Compliance:</i></p>	<p><u>Protection from Harm:</u></p> <ol style="list-style-type: none"> <li>1. Policies and procedures regarding inmate grievances per the specifications above.</li> <li>2. Updated inmate handbook.</li> <li>3. Review of grievance forms (Creole, English, Spanish)</li> <li>4. Review of procedures for LEP inmates, and illiterate inmates.</li> <li>5. Review of a sample of grievances.</li> <li>6. Observation of grievances boxes and processing of grievances.</li> <li>7. Interview with inmates.</li> <li>8. Evidence of referral of grievances alleging use of force; sexual assault.</li> <li>9. Quarterly tracking/data reporting; recommendations, if needed.</li> <li>10. Documentation of collaboration between security and medical/mental health regarding inmate grievances.</li> <li>11. Quarterly report of trends, by facility; corrective action plans, if any.</li> </ol> <p><u>Medical Care:</u> See also Consent Agreement III.A.3.a.(4)</p> <p><u>Mental Health:</u> See also Consent Agreement III.A.3.a.(4)</p>		

Steps taken by the County to Implement this paragraph:	<u>Protection from Harm:</u> Handbook is completed. Grievance report reviewed.
Monitors' analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	<u>Protection from Harm:</u> Next tour – continue to review of grievance trends, and review of a sample of inmate grievances. MDCR should use the information gained from review of grievances to inform changes in operations.
Monitors' Recommendations:	<u>Protection from Harm:</u> MDCR should collaborate with CHS to assure CHS' policies are in place.

### III. D. Audits and Continuous Improvement

<p>Paragraph <u>Coordinate with Drs. Ruiz and Stern, and Grenawitzke</u></p>	<p>D. Self Audits 2. Bi-annual Reports a. Starting within 180 days of the Effective Date, MDCR will provide to the United States and the Monitor bi-annual reports regarding the following:                      (1) Total number of inmate disciplinary reports                      (2) Safety and supervision efforts. The report will include:                          i. a listing of maximum security inmates who continue to be housed in dormitory settings;                          ii. a listing of all dangerous contraband seized, including the type of contraband, date of seizure, location and shift of seizure; and                          iii. a listing of inmates transferred to another housing unit because of disciplinary action or misconduct.                      (3) Staffing levels. The report will include:                          i. a listing of each post and position needed at the Jail;                          ii. the number of hours needed for each post and position at the Jail;                          iii. a listing of correctional staff hired to oversee the Jail;                          iv. a listing of correctional staff working overtime; and                          v. a listing of supervisors working overtime.                      (4) Reportable incidents. The report will include:                          i. a brief summary of all reportable incidents, by type and date;                          ii. data on inmates-on-inmate violence and a brief summary of whether there is an increase or decrease in violence;                          iii. a brief summary of whether inmates involved in violent incidents were properly classified and placed in proper housing;                          iv. number of reported incidents of sexual abuse, the investigating entity, and the outcome of the investigation;                          v. a description of all suicides and in-custody deaths, including the date, name of inmate, and housing unit;                          vi. number of inmate grievances screened for allegations of misconduct and a summary of staff response; and                          vii. number of grievances referred to IA for investigation.                      b. The County will analyze these reports and take appropriate corrective action within the following quarter, including changes to policy, training, and accountability measures.</p>		
<p>Protection from Harm: Compliance Status:</p>	<p>Compliance:</p>	<p>Partial Compliance: 5/15/15, 10/24/14</p>	<p>Non-Compliance: 3/28/14, Not Yet Due (10/27/13)</p>
<p>Fire and Life Safety: Compliance Status:</p>	<p>Compliance:</p>	<p>Partial Compliance: 5/15/15, 10/24/14</p>	<p>Non-Compliance: 3/28/14, Not Yet Due(10/27/13)</p>

<p>Unresolved/partially resolved issues from previous tour:</p>	<p>The data was provided; pending recommended quarterly reporting changes by DOJ. See also III.D.a.b.</p>
<p><i>Measures of Compliance:</i></p>	<p><u>Protection from Harm:</u>                      1. Policies and procedures regarding self-audits.                      2. Bi-Annual Reports.                      3. Corrective action plans, if needed.                      4. Evidence of implementation of corrective action plans, if any.</p> <p><u>Fire and Life Safety:</u>                      Same as the measures of compliance as Protection from Harm</p> <p><u>Medical Care/Mental Health:</u> See Consent Agreement III.D.2.a.(6)</p>
<p>Steps taken by the County to Implement this paragraph:</p>	<p><u>Protection from Harm:</u>                      Documentation is available; but MDCR needs to ask DOJ to consider modifying the requirements to eliminate as not useful:                      2.a.(2) i., 2.a.(2) ii., 2.a.(3). i – v (as partially duplicative of the staffing analysis), 2.a. (4)i.(exclude summary defer to list), 2.a.(4) ii., 2.a.(4) iv. to allow BJA’s Survey of Sexual Violence to suffice, 2.a.</p> <p><u>Fire and Life Safety:</u></p> <p><u>Medical Care/Mental Health:</u> See Consent Agreement III.D.2.a.(6)</p>
<p>Monitor’s analysis of conditions to assess compliance, verification of the County’s representations, and the factual basis for finding(s)</p>	<p><u>Protection from Harm:</u>                      Document with data produced; analysis not provided (d).</p> <p><u>Fire and Life Safety:</u> Fire and life safety data needs to be analyzed for trends, etc. with action plans if necessary</p> <p><u>Medical Care./Mental Health:</u> See Consent Agreement III.D.2.a.(6)</p>
<p>Monitor’s Recommendations:</p>	<p><u>Protection from Harm:</u>                      Complete the directive and provide the analysis and action plans (and action plan updates).</p> <p><u>Fire and Life Safety:</u>                      Provide evidence of analysis of data along with action plans that comply with MDCR policies/procedures.</p> <p><u>Medical Care/Mental Health:</u> See Consent Agreement III.D.2.a.(6)</p>

## Consent Agreement

Report # 4 addresses the paragraphs in Consent Agreement, and in some instances the Settlement Agreement, designated for the Monitors' review by the County during this tour; and identifies those paragraphs that were not identified by the County for review. The Monitors strongly stress that their comments for paragraphs not specifically requested for review this tour are very important to current issues and future compliance. These comments are included below and the Monitors urge the County's consideration of these findings and recommendations.

### Summary of Compliance

The following is a summary of major findings since Monitors' tours were initiated.

Report #	Compliance	Partial Compliance	Non-Compliance	Not Applicable/Not Due/Other	Total Paragraphs
1	1	56	40	22	119
2	0	38	73	8	119
3	2	19	98	0	119
4	6	35	75	0	116 <sup>5</sup>

### Medical Care

#### Comments Related to Reviewed Provisions (as requested by the County):

##### Intake

Since the Monitors' last visit, the County has worked very hard on improving the Intake Screening process. This work has included significant changes to the electronic health record (EHR) forms and the Intake Screening policy. The Medical Monitor devoted an entire day closely observing the various health operations in the Intake Area. It was heartening to see the changes that have been implemented. More importantly, every staff member was working hard, conscientious about his/her work, highly effective, and treating patients with respect and human dignity.

Some problems were noted. There were delays managing the most urgent patients (those wearing pink bands wrist bands). The first three such patients encountered were already beyond the required time limits (1 hour, 1 hour, and 4 hours). Some staff were either not aware of the delay and/or not aware of how to deal with it. There is still not a mechanism to ensure that such patients are not removed from the intake area without medical clearance. While screening for intoxication or withdrawal has improved, patients are still not receiving their baseline withdrawal assessment ("COWS" and/or "CIWA").

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<sup>5</sup> Joint reporting paragraphs removed.

Further detail on these and other provisions is provided in the body of the report below.

### **Comments Related to Provisions NOT Reviewed (as requested by the County):**

#### **Staffing**

In general the adequacy of CHS' staffing in any facility is measured indirectly by the CHS' ability to effectively conduct business. In alignment with this concept, the Consent Agreement does not address staffing directly. However, the Monitors believe that CHS' medical operation is so severely understaffed that the jail will be unable to meet the requirements of the Consent Agreement without first remedying this staffing deficit.

Within the medical sphere, the predominant gaps are in nursing supervision. Evidence for this conclusion comes from a number of sources, including:

1. Key nursing functions are not being performed in the Detoxification and inpatient mental health units, such as measurement of vital signs on a regular basis;
2. Patients undergoing withdrawal are not being assessed on a regular basis
3. Spans of control and job responsibilities are too great. The three facility Health Services Administrators (HSA) have approximately 41, 39, and 110 nursing staff reporting directly to them (in addition to other staff). The HSAs directly supervise these nurses in addition to their other, non-nursing, and leadership responsibilities.
4. Performance evaluations are markedly inadequate. The Medical Monitor reviewed approximately 20 nursing personnel files as well as summary data regarding supervision. He found a number of nurses whose annual performance reviews were late (from 3 months to 2 years). The reviews that were completed showed little evidence of personalization. For example, "goals for the next year" were identical for almost all nurses.

There are also significant gaps in CHS' upper level management.

The Monitors made specific suggestions for immediate changes to staffing.

#### **Access to Care**

Access to urgent episodic care through unit officers appeared to be excellent. Both patients and living unit officers reported that access is unimpeded (in other words, COs do not attempt to triage complaints or pressure the patient to submit a sick call slip to otherwise delay access to care). Patients reported that access at MDCR is much better than at other jails in which they have been confined. Most patients rated COs' responsiveness to their health needs as between 7-10 on a scale of 1-10, where 10 is the best (only one patient rated COs at a 5); they reported being treated, for the most part, with respect.

Emergency health-related grievances need to be addressed immediately (i.e. hours). The Medical Monitor reviewed a log of the 125 emergency medical-related grievances completed in the 6 months prior to the tour. The average response time was 11 days. A single grievance was addressed on the same day it was submitted. All others (124) were addressed sometime between 2 and 44 days from the date they were submitted. According to the log, staff are allowed to take up to 7 days to address emergency grievances. Thus policy and practice regarding handling of emergency medical grievances will need to be improved.

## **Training**

The County continues to develop its training infrastructure. As it moves towards Compliance with provisions that contain training components, it will be necessary to demonstrate the following:

1. For each training, the following are defined in some permanent document (e.g. the policy specific to the content being trained; a global training policy; the training curriculum, etc.):
  - who requires training
  - the length of the training session
  - how often the training is required
  - who is qualified to conduct the training
  - how the training curriculum is controlled/modified
2. A complete and effective curriculum, i.e. one containing:
  - an appropriate amount and level of material to be taught based on the audience.<sup>6</sup>
  - varied teaching approaches, tailored to the material being taught; in general, curricula which are completely, or primarily, lecture-based, should be rare.
  - lesson plan(s) which detail what is being taught, how, for how long, and contain any educational materials required for the lesson.
3. Meaningful measurement of competency at the conclusion of a training, with provision for remediation for those participants who cannot demonstrate competency

## **Detoxification**

Earlier this year, there was a surge of patient census in the Detoxification Unit and overflow patients were sleeping on boats at the nurses' station. Jail administrators committed to

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<sup>6</sup> For example, the Medical Monitor reviewed a curriculum intended to teach Intake Screening medical staff about substance-related problems. The training was scheduled for 30 minutes, contained over 200 individual facts about substance abuse, and yet was intended for audiences that included Medical Assistants, who may only have high school diplomas.

eliminating this situation quickly, and, based on our observations, were true to their commitment.

The Medical and Mental Health Monitors advised CHS to treat all patients with acute substance related problems (intoxication, withdrawal, high risk of withdrawal) as having a primary medical problem, regardless of the presence of mental illness, and therefore, to house these patients in the Detoxification Unit under the care of a medical physician. Recently, health leaders asked the Monitors to consider allowing CHS to continue to house Level I patients (those with high risk of suicidality) in the Inpatient Mental Health Unit. The reason for this request is that, in the opinion of the CHS staff, the risk of harm due to suicide was greater than the risk of harm due to substance related problems, and as such, risks could be minimized by placement in a primarily mental health care environment.

The Medical and Mental Health Monitors agreed to consider this request after a closer evaluation during the current visit. Unfortunately, the Monitors found numerous deficiencies in the operation of both units (for example, multiple failures to measure vital signs or conduct withdrawal assessments), most of which stem from inadequate staffing (nurses and mental health professionals) and supervision. For example:

- In one case<sup>7</sup>, the Mental Health Monitor was informed that a patient on a unit meant to house Level I and Level II had 'refused' his vital signs. Upon interviewing the patient (who had no prior mental health history by his report and presentation, thus did not need to be in a Level I or II unit), it was clear that he had not refused vital signs. Rather, he had reportedly been confused with another patient. Upon interviewing the second patient, his vital signs had also not been taken. Inadequate and unsatisfactory documentation existed to explain what had occurred.
- In another case<sup>8</sup>, a patient with severe and prolonged polysubstance abuse history was interviewed. He was on detoxification protocol when incarcerated on April 24, 2015, as he reported polysubstance dependence and he "appeared to be under the influence of street drugs." According to a progress note dated April 25, 2015 from the covering psychiatrist, his detoxification medication was ranitidine 15 mg 1 tab orally twice a day (this medication is insufficient for severe detoxification symptoms). He was re-incarcerated on May 11, 2015. He was again placed on detoxification protocol and was made a mental health level 2. He was not on the detoxification unit, but rather was on unit K21 while apparently on a detoxification protocol.
- In a third case<sup>9</sup>, a patient was seen while on detoxification unit. She stated that she had not showered for past 3.5 days nor was she given a hygiene kit, thus, she had not brushed her teeth. Custody staff on-duty confirmed that she had not showered for 3.5 days nor had she received a hygiene kit. Her medical record indicated that she had refused detoxification vital sign measurement at least one day, yet there was no mention of proactive measures taken on the part of nursing staff to prompt

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<sup>7</sup> M 15-0014628

<sup>8</sup> C MR#4700975

<sup>9</sup> M JIN 15-0129083

the patient to comply. This patient was at particular risk of withdrawal seizures, as interviews with intake personnel confirmed on May 9, 2015 that the patient had been taking 2 mg Xanax twice a day and had been concurrently abusing alcohol prior to incarceration.

These deficiencies overshadow the issue originally raised and we are therefore unable to offer a final opinion on the original question raised. In other words, until the staffing deficiencies are corrected, placement of Level I patients in *either* unit is risky. Once the staffing deficiencies are corrected, we will revisit this issue.

### **Response to Resistance (Staff Use of Force)**

There is some overlap between the Settlement Agreement and Consent Agreement (with regard to Response to Resistance [RtR] and other topics). Notably, there are some medical audit steps that were attached to the Settlement Agreement. In order to simplify the jail's fulfillment of the requirements of both, where identical or similar audit steps already exist in the Consent Agreement, we are removing the corresponding audit steps from the Settlement Agreement (again, both with regard to RtR and other topics). With specific regard to Response to Resistance (RtR), there are also two medical audit steps that were only conducted as part of the Settlement Agreement. The Monitors are moving those two audit steps, one each to CA III.B.3.b. and CA III.B.3.c. The revised versions of these two provisions will appear as follows in future reports (content moved from the Settlement Agreement III.A.5.c.b.) is shown in italics):

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

#### Medical Care

Audit Step a: (Chart Review) Detainees subjected to Use of Force are evaluated immediately afterwards:

- a) for every Response to Resistance recorded by custody, there is a clinical assessment immediately thereafter, documented in the EHR (Note: an Incident Addendum does NOT satisfy this requirement)*
- b) documentation reflects the nature of the force and any patient symptoms,
- c) evaluation is conducted by, or under the direct supervision of, an RN or practitioner,
- d) the content of the evaluation is clinically appropriate, including evaluation of reasonably possible injuries based on the nature of the force, symptoms, or findings.

#### Mental Health Care

*1) For patients who were on the mental health caseload or should have been on the mental health caseload involved in a Use of Force, adequate and timely documentation exists to demonstrate referral to a QMHP and access to care.*

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.

- Audit Step a: (Inspection) Detainees interviewed following evaluation for an injury from a use of force, report being questioned by Qualified Medical Staff regarding the cause of the injury outside the hearing of other inmates or officers
- Audit Step b: (Inspection) When interviewed, nurses and practitioners on staff report that when they evaluate patients with any injury, they always consider whether the injury might be the result of staff-on-inmate abuse, and if so, (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.
- *Audit Step c: (Chart Review) Medical records of inmates subject to use of force where the force may be excessive, show evidence of referral to jail authorities.*

Because medical-related RtR was planned for review during the current tour as part of the Settlement Agreement, the Monitor collected relevant information. However, because we are shifting our reporting of medical-related RtR information from the Settlement Agreement to the Consent Agreement, and because the Consent Agreement was *not* scheduled for formal review of RtR during this tour, the fairest way to report on RtR is within this section (Comments Related to Provisions not Formally Reviewed). In other words, we are not stating any opinion regarding the jail's level of compliance with III.B.3.b. or III.B.3.c.; we are simply reporting our findings, to be used by the jail for planning purposes.

Of 20 RtRs reviewed, in 19 cases (i.e. all but one), the nurse failed to conduct and/or document adequate medical care in the patient's medical record. In one case the nurse documented staff-on-inmate injury, but the practitioner documented inmate-on-inmate injury; two patients were not evaluated immediately; and five patients were not initially evaluated by appropriately licensed personnel (i.e. they were evaluated by LPNs rather than RNs or practitioners). During five interviews with nurses who are involved in evaluation of patients after RtRs, only one LPN spoke about considering whether the injury might be the result of staff-on-inmate abuse and no one spoke of evidence preservation. Four of the five stated the officers would always remain in the exam room with the patient and they would not suggest the officer step away ("They are going to stand where they want to stand."; "Security is first, they aren't going to step out."; "Assault by staff is almost impossible, there are cameras everywhere."; "Assault by staff really doesn't happen."; "If the inmate won't tell me the truth, there's nothing I can do about it."). All five nurses did report that they would contact their direct supervisor, but they also reported that they would notify the officer presenting the patient. All five nurses interviewed were very

focused on completing the Addendum for security staff, even before discussing what steps to take with their patient. There was significant focus on the Addendum and much less on how and what is documented in the electronic health record, and most importantly creating a milieu of safety for the patient so that accurate details of injury/abuse can be stated. Finally, of 20 RtRs reviewed during this tour, in three cases the record suggested there might have been excessive use of force, but the nurse did not make a referral to jail authorities.

RtR was also evaluated as it relates to patients on the mental health caseload. According to documents submitted, patients on the mental health caseload (or that should have been on the mental health caseload) were statistically more likely to be involved in a RtR. For example, out of a reported 224 incidents evaluated in 2015, 98 involved patients on Level 4, 33 involved patients on Level 3, 8 involved patients on Level 2, and 38 involved patients on Level 1 for a total of 177.  $177/439 = 40\%$ . Given that patients with mental illness make up on average 44% (2000/4500) of the MDCR population, those with mental health disorders are statistically more likely to end up in a RtR.

Based on these findings, the Monitors recommend the following:

1. Medical staff need significant training and supervision with regard to assessment of patients after RtRs. Training will need to focus on: how to conduct a proper assessment; how to document such assessments in the medical record; the role possible mental illness may have played in the RtR; and how front line health care staff can deal with the tensions of dual-loyalty.
2. Administrators must monitor RtRs carefully using chart reviews.
3. Assessments must be conducted by RNs, practitioners, or LPNs operating under the direct supervision of one of the former two disciplines.
4. If a patient that is on the mental health caseload (or should have been on the mental health caseload) is involved in a RtR, s/he should be referred to receive adequate mental health care in a timely manner.

### **Recordkeeping**

Nurses caring for patients in any medical housing unit (Detox, Medical Housing, Inpatient MH) need to be able to easily identify the patient's nursing care plan in a way that facilitates patient care and hand off from shift to shift. Nurses we interviewed were not able to do so. We were unable to ascertain if this problem stemmed from inadequate training and/or supervision with regard to finding this information in the medical record, or whether the EHR is not well designed for this functionality.

We therefore recommend that this aspect of nursing care be examined.

## **Use of Isolation Cells**

Health care staff need to perform daily welfare checks of all inmates kept in isolation (segregated housing). This is an important fail safe mechanism to assure that this high risk population does not suffer from neglect. In the one unit visited, this is routinely not happening. The nurse only visits those inmates who require medication administration. The Medical Monitor observed the nurse skipping the cell of an inmate who does not receive medications. Another inmate reported that the nurse never stops by his cell during her rounds.

One explanation offered for the current state of affairs is that female nurses may avoid the cells of male inmates due to lewd behavior. If this is true, management needs to address this problem in a manner consistent with firm and fair treatment of inmates, and sound personnel support practices.

## **Health Assessments**

There are 3 provisions of the Consent Agreement (III.A.2.e. [CONSENT012]; III.A.2.f. [CONSENT013]; III.A.4.b.2. [CONSENT022]) which all address the timing of the assessment (assessment is an in-depth evaluation that is done after screening) of newly admitted patients. Unfortunately, the three provisions address the timing differently, leading to potential confusion. At the conclusion of the last tour, CHS and Medical and Mental Health Monitors concurred that it would be clinically appropriate to propose to DOJ clarifying/changing wording of the Consent Agreement pertaining to assessment of newly admitted detainees. Specifically, the wording would set the time limit for examination of patients with significant health findings to not greater than 48 hours, and would allow CHS to defer in depth examination of detainees who, upon Intake Screening, are healthy. The Monitors proposed such wording and await concurrence from the County, after which the Monitors will consult with DOJ.

## **Mental Health Care**

The Mental Health Monitor conducted this tour with the assistance of Brian Betz, PhD.

Provisions of the Consent Agreement on which CHS was prepared to be audited included the following:

- Intake Screening: reached compliance
- Suicide Prevention: maintained status
- Self-Audits: maintained status
- Biannual Report: maintained status
- Continuous Quality Improvement: maintained status

## **Comments for Provisions Reviewed (as requested by the County):**

### **Intake Screening**

Significant improvements were noted in the area of Intake Screening. Specifically, additional measures were added to improve confidentiality during interviews. In addition, ARNPs have been added to the intake area to provide evaluations and start medications for patients with severe mental illness. The Mental Health Monitor observed intake screening on a Saturday evening in April and was impressed by both the thorough interview and the caring nature of the QMHP on staff.

### **Suicide Prevention**

The suicide prevention policy and its implementation remain a work in progress. For this reason, CHS remains in partial compliance. One of the issues we discussed during this review was the utilization of standardized definitions across both CHS as well as MDCR and both organizations reviewing this policy before it is finalized. This is important, as future trends and analysis for accurate reporting of data will depend on all stakeholders utilizing the same language. I encourage CHS to phase out older language such as 'suicide gesture' in favor of more accepted terminology such as 'self harm' and 'suicidal intent.' I also encourage the utilization of standardized risk and psychological assessment tools for difficult patients that are anticipated to be incarcerated for long periods of time.

### **Self Audits, Continuous Quality Improvement and Bi-Annual Report**

Accurate reporting of data and analysis of that data are key components for continuous quality improvement and both quarterly and bi-annual reporting.

## **Comments for Provisions NOT Reviewed (as requested by the County):**

### **Mental Health Staffing**

Mental health staffing has reached critical levels, whose ripples impacted patient care. The following case exemplified:

Patient A entered the Jail on Day 1. He was linear and coherent. He had a history of severe mental illness, appropriately managed on an anti-psychotic, a mood-stabilizer, and a sedative. He was referred on an "urgent basis" to see a psychiatrist within 48 hours. He saw a mental health nurse practitioner. However, for reasons that are not completely understood, he was not restarted immediately on his medication; there was no evidence that his pertinent prior medical records were accessed or reviewed.

Unfortunately, that patient contact at 48 hours did not occur.

At Day 24, Patient A was described as delusional, "Talking to Fidel Castro." He was transferred to a higher level of care within the Jail. Medication was still not restarted.

At Day 29, Patient A was described as, "Naked, cluttering his words." **Now, medication was started.** He was too sick, too psychotic, too activated, pacing, disorganized, to take it.

At Day 33, Patient A, delirious and confused, was eating his feces. An emergency treatment order was administered. He passed out. Two hours later, he was transferred to intensive care with dehydration, acute renal failure, and muscle wasting. At last report, he was on dialysis.

His condition, a potentially fatal one, was entirely preventable.

At Correctional Health Services (CHS), vacancies within mental health exist at every level. There is no Chief of Psychiatry, and as a result, no true mental health leadership or supervision. Social workers are sorely needed. According to the only social worker on the day shift in TKG K21 (inpatient level of care), she is replaced by only one social work colleague on the K21 afternoon shift. Each social worker completes an average of 130 individual inmate contacts per week. As a point of reference, in Los Angeles County Twin Towers Correctional Facility, the typical expectation would be that a social worker would have an average of 45 clinical contacts per week. Additionally, the social worker in Los Angeles would be working with other clinicians (i.e., social workers, psychologists) during any given shift so as to have colleagues with whom he/she could regularly and easily consult with in the interest of patient care. Finally, according to staff, social workers do not have any clinical contact, even observational, with Level 1a or 1b inmates until such an inmate is referred to them by psychiatry. Level 1a and 1b inmates should be regularly seen by social workers and/or psychologists as a matter of course so as to provide a clinical opportunity to note any further de-compensation or conversely, any improvement, in these patients and keep the system moving.

Dr. Betz interviewed one of the psychiatrists on psychiatry on K21 during the May 2015 tour. He raised several concerns during the meeting, most notably his caseload. He stated that he regularly sees between 30-to-35 Level 1A and Level 1B inmates in an eight-hour shift. He noted that he is seeing the most acutely ill and not yet psychiatrically stable mental health inmates and to do so at the volume that he is expected to currently see them creates room for risk and bad outcome. He stated that he consistently works at least a nine-hour shift, instead of his scheduled eight-hour shift, in order to clinically see all patients who need to be seen. He stated that his work at TKG is adversely affecting his quality of life outside of the facility. He stated that he has reported his concerns about caseload, as it relates to potential for a bad clinical outcome, to the medical director. We asked him to describe a particular case. He provided the following example:

During the month of April 2015 officers brought an acutely agitated and psychotic Level 1A inmate to his office. The patient was described as a black male in his twenties. The inmate was handcuffed to a chair outside of the psychiatrist's office. The psychiatrist ordered emergency psychotropic meds (Haldol 5 mg and Ativan 2 mg ) to be given via intramuscular injection; he planned to attempt to evaluate him once the psychotropic medications had begun to take effect. The psychiatrist stated that roughly twenty minutes

later he heard loud banging and kicking coming from a nearby cell. He left his office to investigate. He noticed that the inmate banging and kicking was the inmate for whom he had ordered the emergency psychotropic meds, but that the injection of medication was never given, as the nurse assigned to administer the medications went to lunch and left the unit prior to carrying out the orders. This incident was reported to the medical director in writing, however, to his knowledge, no corrective or disciplinary action was taken as a result.

A recommended staffing matrix was requested and submitted to CHS. The recommendations included the following:

- 10 additional psychiatrists
- 20 additional social workers
- 10 additional psychologists

CHS has agreed to augment staffing at the recommended levels.

### **Use of Force**

Please see comments as noted and reviewed above with Medical Care.

### **Medication Administration and Management**

In reviewing RtRs, a video captured medication administration on the typical housing unit. This video demonstrated patients lining up for pill pass, receiving medications in a handful, and subsequently picking or choosing what they wanted to take, while in some cases throwing the other medications away. For management of correctional units, safeguards are recommended to keep patients from stockpiling dangerous medications (on which they can overdose) or stealing and selling psychotropic medications from vulnerable patients. In addition, Emergency Treatment Orders should be tracked and logged routinely.

### **Appendices**

The list of patient records reviewed is available upon request.

**Status of Compliance - Consent Agreement (Medical and Mental Health) for  
Tour May 11 - 15, 2015**

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

Purple = Collaboration with Protection from Harm

Orange = Medical Only

Green = Mental Health Only

Subsection of Agreement	Page	Compliance	Partial Compliance	Non-Compliance	Comments:
<b>A. MEDICAL AND MENTAL HEALTH CARE</b>					
<b>1. Intake Screening</b>					
III.A.1.a.	54		Med /MH		
III. A. 1. b.	57	MH			
III. A. 1. c.	58		MH		
III.A.1.d.	60	Med	MH		
III.A.1.e.	61	Med	MH		
III.A.1.f.	62		Med/MH		
III.A.1.g.	63		Med/MH		
<b>2. Health Assessments</b>					
III.A.2.a.				Med	Med Not Reviewed
III. A. 1. b.				MH	MH Not Reviewed
III. A. 1. c.				MH	MH Not Reviewed
III. A. 1. d.				MH	MH Not Reviewed
III.A.2.e.				Med	Med Not Reviewed
III.A.2.f. (Covered in (IIIA1a) and C (IIIA2e))				MH/Med	MH/Med Not Reviewed
III.A.2.g.				MH/Med	MH/Med Not Reviewed
<b>3. Access to Med and Mental Health Care</b>					
III.A.3.a.			MH/Med		Med Not Reviewed
III.A.3.a.(1)		MH/Med			
III.A.3.a.(2)		Med		MH	MH Not Reviewed
III.A.3.a.(3)		MH/Med			
III.A.3.a.(4)				MH/ Med	MH/Med Not Reviewed
III.A.3.b.				MH/Med	MH/Med Not Reviewed
<b>4. Medication Administration and Management</b>					
III.A.4.a.				MH/Med	MH/Med Not Reviewed

Subsection of Agreement	Page	Compliance	Partial Compliance	Non-Compliance	Comments:
III.A.4.b(1)				MH/Med	MH/Med Not Reviewed
III.A.4.b(2)				MH/Med	MH/Med Not Reviewed
III. A. 4. c.				MH	MH Not Reviewed
III. A. 4. d.				MH	MH Not Reviewed
IIIA.4.e.				MH/Med	MH/Med Not Reviewed
III.A.4.f. (Covered in III.A.4.a.)				MH/Med	MH/Med Not Reviewed
<b>5. Record Keeping</b>					
III.A.5.a.			MH/ Med		MH/Med Not Reviewed
III.A.5 b.			MH		MH/Med Not Reviewed
III.A.5.c.(Covered in III.A.5.a.)			MH/ Med		MH/Med Not Reviewed
III.A.5.d.			MH/ Med		MH/Med Not Reviewed
<b>6. Discharge Planning</b>					
III.A.6.a.(1)			MH/Med		MH/Med Not Reviewed
III.A.6.a.(2)			MH/Med		MH/Med Not Reviewed
III.A.6.a.(3)			MH;/Med		MH/Med Not Reviewed
<b>7. Mortality and Morbidity Reviews</b>					
III.A.7.a.				MH/ Med	MH/Med Not Reviewed
III.A.7.b.				MH/ Med	MH/Med Not Reviewed
III.A.7.c.				MH/Med	MH/Med Not Reviewed
<b>B. MEDICAL CARE</b>					
<b>1. Acute Care and Detoxification</b>					
III.B.1.a.				Med	Med Not Reviewed.
III.B.1.b. (Covered in III.B.1.a.)				Med	Med Not Reviewed.
III.B.1.c.				Med	Med Not Reviewed.
<b>2. Chronic Care</b>					
III.B.2.a.				Med	Med Not Reviewed.
III.B.2.b. (Covered in III.B.2.a.)				Med	Med Not Reviewed.
<b>3. Use of Force Care</b>					
III.B.3.a.	64				Med/MH Not Reviewed.
III.B.3.b.				Med/MH	Med /MH Not Reviewed.
III.B.3.c. (1) (2) (3)			Med		MH Not Reviewed

<b>C. MENTAL HEALTH CARE AND SUICIDE PREVENTION</b>					
<b>1. Referral Process and Access to Care</b>					
III. C. 1. a. (1) (2) (3)				MH	MH Not Reviewed
III. C. 1. b.				MH	MH Not Reviewed
<b>2. Mental health treatment</b>					
III. C. 2. a.				MH	MH Not Reviewed
III. C. 2. b.				MH	MH Not Reviewed
III. C. 2. c.				MH	MH Not Reviewed
III. C. 2. d.				MH	MH Not Reviewed
III. C. 2. e. (1) (2)				MH	MH Not Reviewed
III. C. 2. f.				MH	MH Not Reviewed
III. C. 2. g.				MH	MH Not Reviewed
III. C. 2. g. (1)				MH	MH Not Reviewed
III. C. 2. g. (2)				MH	MH Not Reviewed
III. C. 2. g. (3)				MH	MH Not Reviewed
III. C. 2. g. (4)				MH	MH Not Reviewed
III. C. 2. h.				MH	MH Not Reviewed
III. C. 2. i.				MH	MH Not Reviewed
III. C. 2. j.				MH	MH Not Reviewed
III. C. 2. k.				MH	MH Not Reviewed
<b>3. Suicide Assessment and Prevention</b>					
III. C. 3. a. (1) (2) (3) (4) (5)	66			MH	
III. C. 3. b.	67			MH	
III. C. 3. c.	68			MH	
III. C. 3. d.	69	MH			
III. C. 3. e.	70			MH	
III. D. 3. f.	77			MH	
III.C.3.g.	71			Med/MH	
III. C. 3. h.	73			MH	
<b>4. Review of Disciplinary Measures</b>					
III. 4. a. (1) (2) and b.				MH	MH Not Reviewed
<b>5. Mental Health Care Housing</b>					
MHIII. 5. a.				MH	MH Not Reviewed
III. 5. b.				MH	MH Not Reviewed
III. 5. c.				MH	MH Not Reviewed
III. 5. d.				MH	MH Not Reviewed
III. 5. e.				MH	MH Not Reviewed

6. Custodial Segregation					
III. 6. a. (1)				MH	MH Not Reviewed
III. 6. a. (2)				MH	MH Not Reviewed
III. 6. a. (3)				MH	MH Not Reviewed
III. 6. a. (4) i				MH	MH Not Reviewed
III. 6. a. (4) ii				MH	MH Not Reviewed
III. 6. a. (5)				MH	MH Not Reviewed
III. 6. a. (6)				MH	MH Not Reviewed
III. 6. a. (7)				MH	MH Not Reviewed
III. 6. a. (8)				MH	MH Not Reviewed
III. 6. a. (9)				MH	MH Not Reviewed
III.C.6.a.(10)				MH/Med	MH/Med Not Reviewed
III. 6. a. (11)				MH	MH Not Reviewed
7. Staffing and Training					
III. C. 7. a.				MH	MH Not Reviewed
III. C. 7. b.				MH	MH Not Reviewed
III. C. 7. c.				MH	MH Not Reviewed
III. C. 7. d.				MH	MH Not Reviewed
III. C. 7. e.				MH	MH Not Reviewed
III. C. 7. f.				MH	MH Not Reviewed
III. C. 7. g. (1)(2)(3)				MH	MH Not Reviewed
III. C. 7. h.				MH	MH Not Reviewed
8. Suicide prevention training					
III. C. 8. a. (1 - 9)				MH	MH Not Reviewed
III. C. 8. b.				MH	MH Not Reviewed
III. C. 8. c.				MH	MH Not Reviewed
III. C. 8. d.				MH	MH Not Reviewed
9. Risk Management					
III. C. 9. a.	74			MH	
III. C. 9. b. (1)(2)(3)(4)	75			MH	
III. C. 9. c. (1)(2)(3)(4)(5)	76			MH	
III. C. 9. d. (1)(2)(3)(4)(5)(6)	77			MH	
D. AUDITS AND CONTINUOUS IMPROVEMENT					
1. Self Audits					
III.D.1.a.				MH	
III.D.1.b.	78	Med		MH	
III.D.1.c.	79	Med /MH			

2. Bi-annual Reports					
III.D.2.a. (1)		MH			
III.D.2.a. (2)	80	Med	MH		
III.D.2.a. (3)	81		MH		
III.D.2.a. (4)	82		MH		
III.D.2.a. (5)	82		MH		
III.D.2.a.(6)	83	Med/MH			
III.D.2.b.(Covered in IIID1c)	84	Med	MH		
IV. COMPLIANCE AND QUALITY IMPROVEMENT					
IV.A	86		Med/MH		
IV.B				MH/Med	MH/Med Not Reviewed
IV.C	87		MH		Med Not reviewed.

### III. A. MEDICAL AND MENTAL HEALTH CARE

#### 1. Intake Screening

<p>Paragraph Author: Stern and Ruiz</p>	<p>CONSENT 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.</p>		
<p>Medical Care: Compliance Status:</p>	<p>Compliance:</p>	<p>Partial Compliance: 7/13; 10/14; 5/15</p>	<p>Non-Compliance: 3/14 (Not reviewed)</p>
<p>Mental Health Care: Compliance Status:</p>	<p>Compliance</p>	<p>Partial Compliance: 3/14; 10/14; 3/14; 5/15</p>	<p>Non-Compliance: 7/13 (Not reviewed)</p>
<p><i>Measures of Compliance:</i></p>	<p><u>Medical Care:</u></p> <ul style="list-style-type: none"> <li>• Audit Step a: (Inspection) Intakes conducted in a confidential setting</li> <li>• Audit Step b: (Chart Review) Intakes conducted as soon as possible upon admission, no later than 24 hours</li> <li>• Audit Step c: (Inspection) Jail and CHS Intake Procedures followed</li> <li>• Audit Step d: (Inspection) Intake form calls for recording of observable and non-observable medical needs</li> <li>• Audit Step e: (Chart Review) Intake form has documentation of observable and non-observable medical needs</li> <li>• Audit Step f: (Inspection) Intake done by LPN or RN</li> <li>• Audit Step g: (Chart Review) Intake done by LPN or RN</li> <li>• Audit Step h: (Inspection) Policy or training documents specify an appropriate training strategy for nurses who perform intake medical screening (e.g. who is trained, how often, qualifications of trainers, curriculum, lesson plans, teaching materials, assessment of competency with knowledge and skills) .</li> <li>• Audit Step i: (Inspection) Training records show that nurses who perform intake medical screening receive training as specified in policy.</li> </ul> <p><u>Mental Health Care, as above and:</u></p> <ol style="list-style-type: none"> <li>1. Record review that qualified mental health staff are conducting mental health screening and evaluation</li> <li>2. Results of internal audits</li> <li>3. Review for policies, procedures, practices.</li> <li>4. Review of in-service training.</li> <li>5. Interview of staff and inmates</li> </ol>		
<p>Steps taken by the County to Implement this paragraph:</p>	<p><u>Medical Care:</u> Soundproofing has been added to the intake screening nurses' station. The intake policy was revised to reflect the requirements of the Consent Agreement. A training curriculum was developed and delivered to nurses who do (or might be assigned to) intake screening. Considerable work was invested in redesigning the various EHR forms (and their interoperability) used during the intake process to address the requirements of the Consent Agreement.</p>		

Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):

Medical Care:

The Monitor reviewed numerous medical and training records, toured the Intake area, and spoke with front line staff, managers, and patients. A tremendous amount of progress was made since the last tour. Medical assistants, nurses, social workers, and physicians observed providing direct patient care all demonstrated competency and compassion.

The following problems remain.

1. There are still delays in processing patients through the Intake area who require expedition ("pink band"). At the moment I arrived at Intake to observe the process, there were 3 "pink band" patients for whom completion of their evaluation was already delayed beyond the 4-hour requirement (5 hours, 5 hours, and 8 hours). The Intake area did not appear particularly busy at that point. Further, upon questioning a couple of nurses about how this situation (delays beyond the time limit) is supposed to be handled, they did not have a response.
2. When questioned about the proper handling of "pink band" patients who are called to go to court, staff were not aware of current policy that the patient could not be taken out without consultation with the practitioner.
3. The training curriculum related to this provision is the first one to be developed in response to this Consent Agreement. It shows increasing sophistication compared to prior curricula. This (and other curricula) need further development to achieve compliance with the Consent Agreement. Missing elements include: requirements for trainers, lesson plans that provide more structure than simply a list of the facts to be spoken by the instructor, active learning where appropriate, and assessment of actual learning.
4. Patients are still not being weighed during the intake process. The Monitor identified this problem in his first (November 2013).
5. With regard to weights, a new problem has developed. Due to software changes, the EHR requires pre-screening nurses to enter weight and height information before being allowed to proceed with checking a patient in. Since no height and weights are being measured, staff enter "dummy" values (height=1 cm, weight = 1 kg). Thus, in addition to not recording the patient's actual height and weight, the EHR now contains nonsense information.
6. The EHR does not allow a nurse to enter an approximate date for the onset of medical problems. For example, I observed a patient being screened inform the nurse that he had schizophrenia. The nurse asked how long he has had the problem, to which the patient responded "2 to 3 years." The nurse entered the date of onset as "5/14/12." The nurse informed me that the EHR would not accept anything other than an exact date, so she had no choice but to enter the date of 3 years prior to the date of the screening. While he may have been diagnosed on 5/14/12, documentation of this date a) denotes that this was what the patient reported, and b) connotes that an event occurred on this date, e.g. the patient was admitted to a hospital, which is not necessarily what occurred. Thus the EHR forced the nurse to enter misinformation.

Mental Health Care:

We reviewed numerous medical records, toured the Intake area, and spoke with front line staff and managers. There has been a vast improvement in the LEO Lobby and the intake screening area as a whole. Staff have access to translation lines and confidentiality has been improved with the exception of one station.

The following problems remain:

- It is difficult to determine whether the social worker screening the inmate at booking has read prior mental health records (no notation is made in the record of such). It is difficult to determine, at present, whether or not the social worker who screened the inmate at booking has performed even a cursory review of the inmate's past Correctional Health and/or Jackson Health psychiatric record. It would be beneficial to add a component to the intake screening

	<p>form and/or the bio-psychosocial assessment that indicates that a reasonable review of the inmate’s prior mental health record was conducted, as doing so would potentially prevent placing an inmate at an inappropriate behavioral health observation level. A clinical example of the need to perform a cursory review of an inmate’s mental health records at intake would be that of ZW<sup>10</sup> who went through intake on November 18, 2014. He has a history of State Hospital placement, a history of schizoaffective disorder, a history of being prescribed mood stabilizing psychotropic medication, and he reported suicidal ideation at the time of his arrest (i.e., “I was tazed [sic] three times by officers and told them to just go ahead and kill me.”). Despite his mental health history in the EHR and his report of suicidal ideation at the time of the arrest, intake social work made him a Level 4. Note that four days later his behavioral health observation status was changed to a Level 1A and five days later a Use of Force incident was logged against this inmate, as he required cell extraction.</p> <ul style="list-style-type: none"> <li>• When delivering inmates to TGG, law enforcement officers provide key information about the arrest, including any risk of suicide. For the agencies that are equipped with computers in the police cars, this information is uploaded automatically to MDCR and then available to the pre-screening nurse. Unfortunately, there is a software error that prevents the transmission of the suicide risk information. Thus the pre-screening nurse must remember to ask the arresting officer about this orally.</li> </ul>
<p>Monitors’ Recommendations:</p>	<p><u>Medical Care:</u></p> <ol style="list-style-type: none"> <li>1. There is a patient “on deck” bench currently located directly outside the nurse screening area. Patients sitting here are inches away from one of the chairs for patients being interviewed by the Charge Nurse and therefore within earshot. This bench should be relocated out of earshot of patients being interviewed.</li> <li>2. The training curriculum (for both MDCR and CHS) for this (and other trainings) and/or the appropriate policy, needs further development. As this curriculum currently reads, there are 8 straight hours of lecture (presumably with time for questions). Missing are such elements as: how the curriculum is to be revised (by whom, how often); frequency and length of training (e.g. x hours upon hiring and every x years); requirements to serve as a trainer; active learning activities (e.g. a large part of the Intake training relates to use of the EHR. Thus it may be appropriate to conduct parts of the training in a computer lab incorporating supervised exercises); a description of how competency is assessed at the end of the training session; a description of any additional training that may be required after the classroom training (e.g. supervisor shadowing) and how that is conducted and documented; policy regarding how changes can be made to the training curriculum (for both MDCR and CHS).</li> <li>3. Delays in processing of “pink band” patients must be eliminated.</li> <li>4. Front line staff need to know what to do when they anticipate (or observe) delays in the processing of “pink band” patients.</li> <li>5. Procedures and training need to be provided such that pink band patients cannot be removed from the Intake area without written clearance by the QMHP and/or QMP.</li> <li>6. Related to #6, to reduce the impact of handling pink band patients on the activities of custody and court staff, the jail may want to consider creating a post for a nurse in the court during peak court hours to facilitate medication delivery and any necessary monitoring.</li> <li>7. Though accepted as satisfactory for this tour, in the future, the staff training logs maintained by the jail (and shared with the Monitor) should include the names of all employees <i>eligible</i> for the training in question along with the status of their training. In other words, the training log shared with the Monitor was a log of all staff who completed the training. It is impossible for management (or the Monitor) to discern from such a list whether there are any staff who have missed and still require training.</li> </ol>

<sup>10</sup> W

	<p>8. Patient weights should be measured during the intake process as part of vital sign measurement. If, for a given patient, such information cannot be obtained, the EHR should not force staff to enter nonsense information.</p> <p>9. The EHR must be programmed such that users are not forced to enter misinformation regarding dates of previous medical events. If the patient reports that something happened at some approximate time in the past, the medical record must be able to allow the write to document this information with fidelity.</p> <p><u>Mental Health Care:</u></p> <p>1. The electronic interface between law enforcement, MDCR, and the pre-screening nurse needs to be repaired such that suicide risk information gathered by the arresting officer is automatically presented to the pre-screening nurse when s/he reviews the arresting officer's report.</p> <p>2. In summary, a required EHR review at the time of booking would likely substantially reduce the number of inappropriate behavioral health observation level placements and other mistakes, thereby resulting in a safer and more secure environment for inmates, sworn staff, and civilian staff alike.</p>
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<p>Paragraph Author: Ruiz</p>	<p>CONSENT III. A. 1. Intake Screening:</p> <p>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.</p>		
Compliance Status this tour:	Compliance: 5/15	Partial Compliance: 3/2014; 10/14	Non-Compliance:
Unresolved/partially resolved issues from previous tour:	Reviews were conducted; Monitors noted that they have work that remains.		
<i>Measures of Compliance:</i>	<ol style="list-style-type: none"> <li>1. Results of internal audits demonstrating compliance with NCCHC indicator J-E-05</li> <li>2. Results of internal audits demonstrating completion of intake screening upon admission</li> <li>3. Result of internal audit demonstrating 90% or more of inmates who screen positively shall be referred to qualified mental health professionals for further evaluation</li> <li>4. Record review</li> <li>5. Interview of staff and inmates</li> </ol>		
Steps taken by the County to Implement this paragraph:	<p>CHS has written policy: Mental Health Screening and Evaluation. It states: "Inmates receive a mental health screening. Inmates with positive screens receive a mental health evaluation."</p> <p>MDCR policy (DSOP 14-008) regarding access to mental health care states, "It is the policy of the Miami-Dade Corrections and Rehabilitation Department (MDCR) to provide inmates with medical, dental and mental health services while housed in a MDCR detention facility. All inmates in need of health services shall be identified and given access to care in a timely manner as well as afforded continuity of care. Healthcare encounters, including medical and mental health interviews, examinations and procedures shall be conducted in a private setting and in a manner that encourages the inmate's subsequent use of health services."</p>		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	<p>CHS has retrofitted clinical space for improved confidentiality and it has QMHPs (social workers and ARNPs) available at intake to screen patients with signs or symptoms of mental illness.</p> <p>Dr. Betz toured the space that has been retrofitted so as to improve confidentiality. There is a separate room with two workstations where patients with acute symptoms of mental illness are screened to determine appropriate level of</p>		

	<p>behavioral health observation. Dr. Betz interviewed an QMHP<sup>11</sup> who was working the day shift in the mental health screening area. She confirmed that the mental health screening area is staffed with two LCSWs during the day shift and with two ARNPs from 3-to-11 pm. The intake social worker confirmed that policy is for inmates wearing a pink band to be evaluated by an LCSW or ARNP within two hours and to be seen by psychiatry within 24 hours of their mental health screening. She stated that LCSWs and ARNPs email the charge nurse to follow up on the status of all inmates that they have assigned to Level 1A or 1B status before the end of their shift so as to ensure proper follow up. Finally, the QMHP said that if an inmate is assigned to Level 2 status at intake screening, a social worker sees the inmate again within 4 hours to reassess the appropriateness of the Level 2 status. Level 2 inmates are seen by psychiatry within 48 hours of booking.</p> <p>Dr. Betz reviewed the EHR of five inmates assigned to Level 1A status at the time of booking. Of the files that all appeared to have been seen within two hours of booking by the mental health screening team and all were seen by psychiatry within 24-hours of booking. Names and medical record numbers are available in the appendix or upon request.<sup>12</sup> In addition, although formal written reviews by CHS were not provided for review, CHS leadership was aware and informed us of outliers and issues related to timely screening.</p> <p>Given the fact that CHS openly provided verbal reports of opportunities for improvement, the data we reviewed showed the majority of the patients were seen timely, and a process is in place for proper screening and referral, this paragraph was moved into compliance.</p>
<p>Monitor's Recommendations:</p>	<p>The Monitor recommends:</p> <ol style="list-style-type: none"> <li>1. Complete written self-audits of accuracy of level / triage system for mental health care and access to care.</li> <li>2. On a regular basis, complete written self-audits of accuracy of leveling system for mental health care and access to care.</li> </ol>

<p>Paragraph Author: Ruiz</p>	<p>CONSENT III. A. 1. Medical and Mental Health Care, Intake Screening: 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.</p>		
<p>Compliance Status this tour:</p>	<p>Compliance:</p>	<p>Partial Compliance: 5/15</p>	<p>Non-Compliance: 3/14; 10/14</p>
<p>Unresolved/partially resolved issues from previous tour:</p>	<p>The Mental Health Monitor recommends CHS differentiate urgent referrals from emergent referrals and assign / triage care as needed.</p> <p>In addition, she recommends review of all adverse events related to inmates with mental health and/or and substance use issues for qualitative analysis and corrective action.</p>		
<p>Measures of Compliance:</p>	<ol style="list-style-type: none"> <li>1. Record review of adherence to screening, assessment, and trigger events as described in Appendix A</li> <li>2. Review of housing logs;</li> <li>3. Review of observation logs for patients placed on suicide precaution.</li> </ol>		

<sup>11</sup> G. Diaz LCSW

<p>Steps taken by the County to Implement this paragraph:</p>	<p>4. Review of adverse events and deaths of inmates with mental health and substance misuse issues.</p> <ol style="list-style-type: none"> <li>1. CHS has written and updated policies relevant to Basic Mental Health Care, Suicide Prevention and Use of Restraint and Seclusion.</li> <li>2. MDCR policy (DSOP 12-003) outlines Suicide Prevention and Response Plan. It covers the responsibility of all staff to identify inmates at risk of suicide. In reference to housing, it states:</li> <li>3. If an inmate displays signs of suicidal tendencies, he/she shall be placed in a single suicidal non-stripped cell separate from other inmates. The inmate shall be under direct observation until IMP mental health staff has evaluated the inmate's degree of risk. A Physical Sight Check Sheet shall be documented at intervals not to exceed 15 minutes by sworn staff and/or medical staff. Checks may be documented more than 4 times per hour.</li> </ol>
<p>Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)</p>	<p>MDCR/CHS policy requires "appropriate intervention" for inmates at risk of suicide. In practice, an inmate who is determined to present a danger to himself by clinical staff in the LEO lobby should immediately be given a pink wrist band, booked into the facility, have his mug shot taken (if it is possible to do so based on inmate's behavior), be stripped, be placed in a Ferguson gown, and be placed in an isolation cell in the intake area under constant observation custody staff. Of note, determination of risk of self-harm in the LEO lobby may occur because (1) the inmate expressed a desire to harm himself to clinical staff in the LEO lobby, (2) the arresting officer informed clinical staff in the LEO lobby of an inmates stated desire to harm himself and/or witnessed behavior in the field that would suggest the inmate presents a danger to himself, (3) and/or clinical staff in the LEO lobby witnessed inmate behavior that suggested the inmate potentially posed a danger to himself. An emergency mental health referral will be made by clinical staff in the intake area. The inmate will be screened by a qualified mental health professional (QMHP) within two hours of the referral being made. The QMHP will then determine the inmate's level of acuity and will determine if suicide precautions must remain in-place. The QMHP will provide custody staff with the inmates assigned level of behavioral health observation (i.e., 1A, 1B with Ferguson gown discontinued, etc.). Understanding of and compliance with the aforementioned procedures was affirmed by Captain Key (Correctional Captain for the TGK Intake facility) and G. Diaz, LCSW in the Intake Mental Health Screening area.</p> <p>Regarding the policy for suicide prevention as it relates to custody staff, Dr. Betz interviewed numerous custody staff at multiple MDCR facilities during the May 2015 tour in an effort to determine their understanding of and compliance with the Correctional Health Services Suicide Prevention Plan. Specifically, Dr. Betz interviewed Captain Kim and officers Blash and Sal at the TTC (Stockade) facility, Captain Rodriguez and officers Berry, Azama, Gibbons, and Batiste at Metro West, Lieutenant Green and Sgt. Reese at the Boot Camp facility, and Lieutenant Angrand, Corporal Williams, and multiple other custody officers at TGK. All custody officers interviewed were able to articulate what should be done if an inmate expresses suicidal ideation and/or appears to present a danger to himself (i.e., the urgency and means by which such an inmate must be evaluated by a QMHP). All custody staff were aware of the requirement to perform 15-minute checks for those on suicide precautions. All custody staff were able to produce the "cut-down kit" on their respective housing units.</p> <p>Of note: There were no inmates in any of the isolation cells during Dr. Betz's tour of the Intake facility at TGK, However, there were three inmates in Ferguson gowns seated together being monitored by a custody officer. All three men were being released from custody and were awaiting psychiatric clearance prior to release. While not in an isolation cell, all three men were being monitored by a custody officer. Dr. Betz interviewed two of the inmates: CN and DD<sup>13</sup>. Neither man was exhibiting or reporting gross symptoms of psychiatric impairment. Both men denied suicidal and homicidal</p>

	ideation. Both men had a reasonable plan for self-care upon release and were able to state how and where they would receive mental health care on an outpatient basis upon release.
Monitor's Recommendations:	See above.

Paragraph Author: Stern and Ruiz	CONSENT III.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.		
Medical Care: Compliance Status:	Compliance: 7/13; 5/15	Partial Compliance:	Non-Compliance: 3/14 (Not Reviewed); 10/14
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 5/15; 7/13	Non-Compliance: 3/14 (Not Reviewed); 10/14
<i>Measures of Compliance:</i>	<p><u>Medical Care:</u></p> <ul style="list-style-type: none"> <li>Audit Step a: (Inspection) Interview with Intake nurses reveals that after identification of "emergency referral" in Intake, patient stays under constant observation.</li> <li>Audit Step b: (Chart Review) a patient identified as having an emergency medical need is seen by a practitioner immediately.</li> </ul> <p><u>Mental Health Care, as above and:</u></p> <ol style="list-style-type: none"> <li>Record review of adherence to screening, assessment, and trigger events as described in Appendix A</li> <li>Review of housing logs;</li> <li>Review of observation logs for patients placed on suicide precaution.</li> <li>Interview of staff and inmates</li> </ol>		
Steps taken by the County to Implement this paragraph:	<p><u>Medical:</u> Non applicable</p> <p><u>Mental Health Care:</u> MDCR identifies persons who are unstable medically or psychiatrically and require urgent referrals with a pink wristband. This includes patients that are returns from State mental hospitals or purple bands.</p>		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<p><u>Medical Care:</u> According to staff, this provision does not really apply to medical patients, because anyone sick enough to need constant observation for medical reasons is so sick that they would be evacuated to the hospital. The Monitor's observations supported this contention.</p> <p><u>Mental Health Care:</u></p> <ol style="list-style-type: none"> <li>Staff do not handle all potentially suicidal patients as required by the policy (which is undergoing revisions). The policy states that these patients will remain under constant observation while awaiting evaluation by the QMHP. The Medical Monitor observed 3 patients identified at risk for suicide. Staff placed 1 in a cell with random 15-minute checks, not constant observation. They placed the other 2 patients in the general seating area. While this was, in effect, constant observation, when they were interviewed, it was clear that the patients were being placed in the general seating area because custody staff felt that that kept them calmer (which is true, and therefore effective), not because staff were aware of the need for the patients to be under constant observation, per se.</li> <li>The suicidal patient (above) placed initially in a cell complained to the Medical Monitor about being cold. Indeed, the room in which he was being held (clothed only in a safety smock) was quite cold. Staff informed the Monitor that those</li> </ol>		

	rooms are usually cold. Further, staff stated that no safety blankets are kept in the Booking area.  MH patients identified as requiring constant observation are placed in one of two rooms in the booking area. In that location, custody staff observe them every 15 minutes, and nursing staff observe them “as required.” Nurses document their rounds in custody records, thus there is no record of their nursing assessments in the patient’s medical record.
Monitors’ Recommendations:	<p><u>Medical Care:</u> None</p> <p><u>Mental Health Care:</u></p> <ol style="list-style-type: none"> <li>1. Patients identified as requiring closer observation for MH reasons require an individualized order for monitoring by health care personnel. In the absence of such order, they should be placed on the highest level of observation (constant, one-on-one) until further evaluation by a MH professional.</li> <li>2. If a patient is placed on intermittent observation (15 minutes), the interval of observation should be random intervals of 15 minutes or less, not constant (and therefore predictable) intervals of 15 minutes.</li> <li>3. Nursing assessments done during periods of closer observation may be recorded in a custody log, but they must be recorded in the patients’ health care record.</li> </ol>

Paragraph Author: Stern and Ruiz	CONSENT 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.		
Medical Care: Compliance Status:	Compliance: 5/15	Partial Compliance:	Non-Compliance: 7/13 (Not Reviewed), 3/14 (Not Reviewed); 10/14
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 5/15; 10/14	Non-Compliance: 7/13 (Not Reviewed); 3/14 (Not Reviewed)
<i>Measures of Compliance:</i>	<p><u>Medical Care:</u></p> <ul style="list-style-type: none"> <li>• Audit Step a: (Chart Review) Necessary previous medical records are ordered in Intake and are in the chart (or there is evidence of reasonable effort to obtain the records).</li> <li>• Audit Step b: (Chart Review) Previous medical records in the chart are reviewed timely by a practitioner.</li> </ul> <p><u>Mental Health Care, as above and:</u></p> <ol style="list-style-type: none"> <li>1. Policy regarding obtaining collateral information and previous psychiatric and medical records</li> <li>2. Review of records</li> <li>3. Interview of staff and inmates</li> </ol>		
Steps taken by the County to Implement this paragraph:	<p><u>Medical Care:</u> See below</p> <p><u>Mental Health Care:</u> The electronic health record contained prior records from Jackson. In addition, many of the charts reviewed contained records from outside providers, as well, which had been scanned into the EHR.</p>		
Monitors’ analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the	<p><u>Medical Care:</u> There was excellent performance on the indicators for this provision</p> <p><u>Mental Health Care:</u></p>		

County's representations, and the factual basis for finding(s):	Although many records are available from prior contacts within the Jackson system, no progress notes made reference to the content of outside medical records. In addition, audits that were submitted by CHS demonstrated that they are aware (or should have been aware) that they do not review outside records despite having access to them.
Monitors' Recommendations:	<p><u>Medical Care:</u> None</p> <p><u>Mental Health Care:</u></p> <ol style="list-style-type: none"> <li>To ensure that records are reviewed from contacts both within JMS and outside JMS, CHS should add a notation within the progress note that reminds the provider to summarize prior notes including prior diagnoses and relevant findings such as medications administered in the emergency department or discharge medications.</li> <li>Practitioners should review available medical records or should document why they did not.</li> </ol>

Paragraph <u>Author: Stern</u>	<p>CONSENT 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.</p>		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 10/14; 5/15	Non-Compliance: 3/14 (Not Reviewed)
<i>Measures of Compliance:</i>	<ul style="list-style-type: none"> <li>Audit Step a: (Inspection) Intake screening form calls for assessment of drug or alcohol use and withdrawal</li> <li>Audit Step b: (Chart Review) Intake screening forms include documentation of assessment of drug or alcohol use and withdrawal</li> <li>Audit Step c: (Chart Review) Patients screening positive for withdrawal or withdrawal risk referred to practitioner</li> <li>Audit Step d: (Chart Review) Patients referred to practitioner for withdrawal or withdrawal risk receive further evaluation and, if necessary, placement in Detox.</li> <li>Audit Step e: (Inspection) Policy or training documents specify an appropriate training strategy for nurses who perform intake screening for drug and alcohol use and withdrawal (e.g. who is trained, how often, qualifications of trainers, curriculum, lesson plans, teaching materials, assessment of competency with knowledge and skills) .</li> <li>Audit Step f: (Inspection) Training records show that nurses who perform intake assessments of drug or alcohol use and withdrawal receive training as specified in policy.</li> </ul>		
Steps taken by the County to Implement this paragraph:	Some training materials have been developed. Staff have received training. CHS has made many significant modifications to the EHR responsive to previous recommendations from the Medical Monitor.		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<p>As a result of a recent change in the EHR, CIWA and COWS testing is no longer being performed while a patient is still in the Intake area. A baseline for these screening tests need to be completed while patients are still in the Intake area, and prior to the administration of any medications for withdrawal.</p> <p>CHS' training materials (and training logs) suffer from the same deficiencies described above in III.A.1.a.. For example, the slide set used to train CHS staff contains no fewer than 200 individual facts about drugs and drug abuse, presented in lecture mode over a period of 30 minutes. From an pedagogic standpoint, it is unreasonable to think that staff (especially LPNs and medical assistants) can absorb, assimilate, remember, and utilize such a formidable body of clinical information in such a short period of time delivered in such a teaching mode.</p>		
Monitors' Recommendations:	1. The first set of CIWA and COWS tests need to be obtained while the patient is still in Intake and prior to administration of any medications. While these can be performed by a practitioner, there is no reason the jail cannot employ nurses or medical assistants to perform the tests.		

	2. The training materials and logs need to be further developed as described above in CONSENT001(III.A.1.a).		
Paragraph Author: Stern and Ruiz	CONSENT III.A.1.g. (Covered in CONSENT001/IIIA1a) 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.		
Medical Care: Compliance Status:	Compliance:	Partial Compliance: 10/14; 5/15	Non-Compliance: 7/13 (Not Reviewed); 3/14 (Not Reviewed)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 10/14; 5/15	Non-Compliance: 7/13 (Not Reviewed); 3/14 (Not Reviewed)
<i>Measures of Compliance:</i>	<p><u>Medical Care:</u></p> <ul style="list-style-type: none"> <li>• (duplicate) CONSENT001 (IIIA1a) Audit Step h: (Inspection) Policy specifies an appropriate training strategy (e.g. who is trained, how often) for nurses who perform intake medical screening.</li> <li>• (duplicate) CONSENT001 (IIIA1a) Audit Step i: (Inspection) an effective curriculum is used during training that addresses qualifications of trainers, curriculum, assessment of competency. [NB: Training for LPNs will include tools to make a determination of “clinically significant findings” without the need to make an assessment.]</li> <li>• (duplicate) CONSENT001 (IIIA1a) Audit Step j: (Inspection) Training records show that nurses who perform intake medical screening receive training as specified in policy.</li> </ul> <p><u>Mental Health Care, as above:</u> See Medical Care</p>		
Steps taken by the County to Implement this paragraph:	[See CA III.A.1.a.]		
Monitor’s analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County’s representations, and the factual basis for finding(s):	[See CA III.A.1.a.]		
Monitor’s Recommendations:	[See CA III.A.1.a.]		

### III. B. Medical Care

#### 3. Use of Force Care

Paragraph Author: Stern and Ruiz	<p>CONSENT 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.</p>		
Medical Care: Compliance Status:	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not Reviewed); 3/14 (Not Reviewed); 10/14; 5/15 (Not Reviewed)
Mental Health: Compliance Status	Compliance:	Partial Compliance:	Non-Compliance: 7/13 (Not Reviewed); 3/14 (Not Reviewed); 10/14; 5/15 (Not Reviewed)
<i>Measures of Compliance:</i>	<p><u>Medical Care:</u></p> <ul style="list-style-type: none"> <li>• Audit Step a: (Inspection) The clinical restraint policy states that restraints are used for the minimal amount of time clinically necessary, are observed every 15 minutes by medical and custody staff.</li> <li>• Audit Step b: (Inspection) The custody restraint policy states that qualified medical staff shall be notified immediately after application of restraints in order to review the health record for any contraindications or accommodations required and to initiate health monitoring.</li> <li>• Audit Step c: (Chart Review) For patients placed in clinical restraints: <ul style="list-style-type: none"> <li>a) the restraints are clinically necessary,</li> <li>b) the restraints are ordered by a practitioner,</li> <li>c) custody and medical staff document 15 minute safety checks.</li> </ul> </li> <li>• Audit Step d: (Chart Review) For detainees placed in custody restraints, qualified medical staff are notified immediately after application of restraints, review the health record for any contraindications or accommodations required and conduct 15 minute safety monitoring.</li> </ul> <p><u>Mental Health Care, as above and:</u></p> <ul style="list-style-type: none"> <li>• Review of adequate care provided for patients placed in restraint, <b>including chemical restraint or involuntary intramuscular injection</b>. Adequate documentation shall include evidence of attempts to de-escalate the incident and attempts at lesser restrictive means of treatment.</li> <li>• Review of mental health care provided to patients repeatedly involved in episodes of restraint for assessment of possible co-morbid mental health conditions</li> <li>• Review of differentiation between custody vs. clinical restraint in patients with mental health conditions, as noted by proper utilization of a medical order before initiation</li> </ul>		
Steps taken by the County to Implement this paragraph:	<p><u>Medical Care</u> N/A</p> <p><u>Mental Health Care:</u> Please see commentary provided under medical staffing, page 37.</p>		

<p>Monitor’s analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County’s representations, and the factual basis for finding(s):</p>	<p><u>Medical Care</u> Policies are consistent with this provision.</p> <p><u>Mental Health Care:</u> There were just two uses of clinical restraints (based both on records that were provided to the Mental Health Monitor as well as discussion with front line personnel at different facilities). These cases were reviewed and they appeared to have nothing unique about them. As a result, it is unclear what prompted the use of restraint in these to cases out of thousands of inmates that they process and treat yearly.</p> <p>In addition, the Mental Health Monitor noted several notations of “Emergency Treatment Orders” or intramuscular medications that were not documented as a restraint. I was informed that these are not considered a chemical restraint and are not tracked in any sort of systematic way for analysis or trends.</p>
<p>Monitor’s Recommendations:</p>	<p><u>Medical Care:</u> None</p> <p><u>Mental Health Care:</u> It is recommended that CHS accurately track utilization of restraints, the ‘observation chair’ and emergency treatment orders, as well as cell extractions.</p>

### III. C. Mental Health Care and Suicide Prevention

<p>Paragraph Author: Ruiz</p>	<p>CONSENT III. C. 3. Suicide Assessment and Prevention:                      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 <b>case-by-case</b> 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.</p>		
<p>Compliance Status this tour:</p>	<p>Compliance:</p>	<p>Partial Compliance: 3/14; 5/15</p>	<p>Non-Compliance: 10/14 (Not Reviewed);</p>
<p>Unresolved/partially resolved issues from previous tour:</p>	<p>CHS Suicide Prevention Program is covered in policy #CHS-059, J-G-05. It was reviewed and is being updated.                       MDCR policy specific to suicide prevention is outlined in DSOP 12-03, Inmate Suicide and Response Plan. While this policy outlines specific provisions such as the Ferguson Safety Garment and first aid response tools, it does not state that inmates will have access to suicide-resistant mattresses or blankets.</p>		
<p><i>Measures of Compliance:</i></p>	<ol style="list-style-type: none"> <li>1. Review suicide prevention policy and procedures</li> <li>2. Results of internal audits, if any</li> <li>3. Review of medical records for implementation of policies including review of the following:                             <ul style="list-style-type: none"> <li>- Property granted to inmates upon clinical determination of QMHS</li> <li>- Inmates have suicide resistant mattresses</li> <li>- Inmates have proper suicide resistant clothing</li> <li>- Quality suicide risk assessments are conducted</li> <li>- Staff do not retaliate against inmates by sending them to suicide watch cells</li> </ul> </li> </ol>		
<p>Steps taken by the County to Implement this paragraph:</p>			
<p>Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)</p>	<p>Patients on Level I are summarily disallowed from recreation, commissary, and phone privileges. These decisions are not made on a case-by-case basis. In addition, in touring the unit, we saw multiple patients sleeping on the floor rather than on a suicide resistant bed with a suicide-resistant blanket.</p>		
<p>Monitor's Recommendations:</p>	<p>Please ensure that each of the bullets of each the provisions are met. Because suicide prevention is critical to corrections, it is important that all policy revisions be vetted by corrections, medical and mental health. Decisions that impact mental health functioning impact many stakeholders. This includes recreation decisions and other privileges, which should be made on a case-by-case basis.</p>		

<p>Paragraph Author: Ruiz</p>	<p>CONSENT III. C. 3 Suicide Assessment and Prevention 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.</p>		
<p>Compliance Status this tour:</p>	<p>Compliance:</p>	<p>Partial Compliance: 5/15</p>	<p>Non-Compliance: 3/14; 10/14 (Not Reviewed)</p>
<p>Unresolved/partially resolved issues from previous tour:</p>	<p>3/2014: CHS hired a consultant to assist with its suicide prevention program. Ms. Cox's input and formal recommendations included:</p> <ol style="list-style-type: none"> <li>1. Suicide training needs to have a more functional approach that crosses all disciplines</li> <li>2. Mental Health training should be integrated and cross both corrections and medical, i.e. general training as well as are specific training by functional area</li> <li>3. <b>Training Leadership</b></li> <li>4. Role playing (set up suicide scenarios)</li> <li>5. Advisory form to be converted to electronic (define symptoms and behavior checklist)</li> <li>6. Increase the privacy in pre-booking</li> <li>7. Need for signage as how to access medical or mental health services</li> <li>8. RN's need to be placed in pre-booking</li> <li>9. Booking needs to have access to prior housing location data</li> <li>10. <b>Need to create consistency in suicide terminology</b></li> <li>11. Hardwire a consistent system to ensure the identification and tracking of individuals at risk as there is a lot of movement of inmates</li> </ol>		
<p><i>Measures of Compliance:</i></p>	<ol style="list-style-type: none"> <li>1. Suicide prevention policy and procedures</li> <li>2. Results of internal audits. CHS anticipates "100% compliance for a minimum of 4 (four) consecutive quarters."</li> <li>3. Review of medical records for implementation of policies, in accordance with triggers found in Appendix A.</li> <li>4. Review of adverse events and screening to audit against false negatives.</li> </ol>		
<p>Steps taken by the County to Implement this paragraph:</p>	<p>CHS Suicide Prevention Program is covered in policy #CHS-059, J-G-05. It is currently being reviewed and updated.</p>		
<p>Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)</p>	<p>The policy is being revised. Suicide training should include drills on site. Terminology should be consistent.</p>		
<p>Monitor's Recommendations:</p>	<p>No suicide risk assessments were identified in the charts reviewed. Please implement suicide risk assessments. A suicide risk screen is not a suicide risk assessment.</p>		

Paragraph Author: Ruiz	CONSENT III. C. 3 Suicide Assessment and Prevention c. 1. 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. c. 2. The MDCR Jail facilities' supervisory staff shall regularly check to ensure that corrections officers implement the ordered levels of observation.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/14; 5/15	Non-Compliance: 10/14 (Not Reviewed)
Unresolved/partially resolved issues from previous tour:	3/2014: Review of the attempted suicide /self-harm cases indicated that patients were not placed on constant observation. This finding is confirmed by the fact that several patients succeeded in injuring themselves despite being on Level I. For example, in one case, a patient swallowed razor blades (that reportedly had the plastic casing) while on Level I.		
<i>Measures of Compliance:</i>	<ol style="list-style-type: none"> <li>1. Review of suicide prevention policies and procedures to include observations of inmates at risk of suicide at staggered checks every 15 minutes and 1:1 as clinically necessary</li> <li>2. Results of internal audits and adverse events, including MDCR audits of custody observation checks</li> <li>3. Review of medical records for implementation of policies</li> </ol>		
Steps taken by the County to Implement this paragraph:	CHS Suicide Policy is in the process of an update.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	<p>As indicated above, CHS has been in the process of updating its policy. The practice of updating its policy and its implementation has been hampered by staffing, as also previously discussed.</p> <p>Regarding observation levels, as indicated above, MDCR's policy states that before evaluation by the mental health staff, the patient will be placed on direct observation. MDCR policy equates constant observation with direct observation. Patients on direct observation or constant observation are not being flagged, tracked or identified in any meaningful way. Their documentation in the medical record is no different than any other patient on 15-minute staggered checks. As a result, it is nearly impossible to identify whether the direct observation was implemented by custody or noted by mental health staff.</p> <p>Policy also identifies "close supervision" (15-minute checks) as the "default" for suicidal inmates. Privileges are not assigned on an individualized basis, nor are recreation periods. <i>"An inmate with suicidal tendencies, statements or attempts shall not be stripped, unless requested and documented by IMP or IMP mental health staff. Unless otherwise authorized in writing by the appropriate medical authority, inmates determined by IMP or IMP mental health staff to have suicidal tendencies shall be assigned to quarters that provide close supervision in accordance to the facilities' classification plan."</i></p> <p>Thus, in practice, high-risk inmates (Level IB) are treated no differently than high-high (Level IB) risk inmates. This may be the result of staffing.</p>		
Monitor's Recommendations:	Implement constant observation as clinically indicated. In addition, please track all inmates placed on constant observation and amend policy to reflect this.		

<p>Paragraph Author: Ruiz</p>	<p>CONSENT III. C. 3 Suicide Assessment and Prevention: 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.</p>		
<p>Compliance Status this tour:</p>	<p>Compliance: 5/15</p>	<p>Partial Compliance: 3/14</p>	<p>Non-Compliance: 10/14 (Not Reviewed)</p>
<p>Unresolved/partially resolved issues from previous tour:</p>	<ol style="list-style-type: none"> <li>1. 3/2014: Hiring plans must include a QMHP for the night shift as soon as possible.</li> <li>2. The Associate Director of Mental Health should review: <ul style="list-style-type: none"> <li>• Number of patients referred to psychiatrist by QMHP per day</li> <li>• Number of patients referred to psychiatrist by QMHP per day by Level</li> <li>• <b>Accuracy of 'Leveling'</b></li> <li>• Accuracy of suicide screen and mental health screen</li> </ul> </li> </ol>		
<p><i>Measures of Compliance:</i></p>	<ol style="list-style-type: none"> <li>1. Manual of mental health policies and procedures</li> <li>2. Results of internal audits, if any</li> <li>3. Review of medical records for implementation of policies, including screening and suicide risk assessments.</li> </ol>		
<p>Steps taken by the County to Implement this paragraph:</p>	<p>CHS policy 059, is in the process of an update.</p>		
<p>Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)</p>	<p>Intake screening is in compliance.</p>		
<p>Monitor's Recommendations:</p>	<p>The Associate Director of Mental Health / Chief Psychiatrist should review:</p> <ul style="list-style-type: none"> <li>• Number of patients referred to psychiatrist by QMHP per day</li> <li>• Number of patients referred to psychiatrist by QMHP per day by Level</li> <li>• <b>Accuracy of 'Leveling'</b></li> <li>• Accuracy of suicide screen and mental health screen</li> <li>• Number of patients prescribed psychotropic medication per Level</li> </ul>		

Paragraph Author: Ruiz	CONSENT III. C. 3 Suicide Assessment and Prevention: e. CHS shall ensure individualized treatment plans for suicidal inmates that include signs, symptoms, and preventive measures for suicide risk.		
Compliance Status this tour:	Compliance:	Partial Compliance: 5/15	Non-Compliance: 3/14; 10/14 (Not Reviewed)
Unresolved/partially resolved issues from previous tour:	CHS acknowledged non-compliance with this provision in October 2014.		
<i>Measures of Compliance:</i>	<ol style="list-style-type: none"> <li>1. Manual of mental health policies and procedures</li> <li>2. Results of internal audits, if any</li> <li>3. Review of medical records for implementation of policies and training reflecting preventive measures, signs and symptoms in individualized treatment plans.</li> </ol>		
Steps taken by the County to Implement this paragraph:	CHS provided copies of pre-printed forms with treatment plans for a sample of patients that were reviewed.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The sample of treatment plans reviewed were adequate. However, it should be noted that some treatment plans recommended modalities such as substance abuse groups and other forums that do not appear to be available at the jail at this time. Additionally, the treatment plans submitted were for 2014. No treatment plans were submitted for 2015.		
Monitor's Recommendations:	None.		

Paragraph Author: Ruiz	CONSENT III. C. 3 Suicide Assessment and Prevention f. Cut-down tools will continue to be immediately available to all Jail staff that may be first responders to suicide attempts.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/14 ; 5/15	Non-Compliance: 10/14 (Not Reviewed);
Unresolved/partially resolved issues from previous tour:	MDCR notes that cut down tools are available in the security booth locate on every floor in the PTDC. MDCR notes that the location is equally central in other facilities. Monitors will evaluate during next tour.		
<i>Measures of Compliance:</i>	<ol style="list-style-type: none"> <li>1. On-site check for cut-down tool.</li> <li>2. Manual of mental health policies and procedures</li> <li>3. Results of internal audits or on-site inspections, if any</li> <li>4. Incident reports documenting use of cut-down tool</li> </ol>		
Steps taken by the County to Implement this paragraph:	MDCR policy 12-003 section J states, "Rescue tools shall be secured and maintained in all facilities in designated locations prescribed in each facility's SOP."		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	Some custody staff were not aware of the location of cut-down tools, or, where they were aware, they were unable to access them. Staff was routinely aware of the purpose of cut-down tools.		
Monitor's Recommendations:	Consider utilizing drills for staff to orient them to emergency procedures for suicide response. This was also previously recommended by Ms. Cox, an independent consultant.		

<p>Paragraph Author: Stern and Ruiz</p>	<p>CONSENT III. C. 3 Suicide Assessment and Prevention (CONSENT068) g. The Jail will keep an emergency response bag that includes appropriate equipment, including a first aid kit, CPR mask or Ambo 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.</p>		
<p>Medical Care: Compliance Status:</p>	<p>Compliance:</p>	<p>Partial Compliance: 5/15</p>	<p>Non-Compliance: 7/13 (Not Reviewed); 3/14 (Not Reviewed); 10/14 (Not Reviewed)</p>
<p>Mental Health Care: Compliance Status:</p>	<p>Compliance:</p>	<p>Partial Compliance: 5/15</p>	<p>Non-Compliance: 7/13; 3/14 (Not Reviewed); 10/14 (Not Reviewed)</p>
<p><i>Measures of Compliance:</i></p>	<p><u>Medical Care:</u></p> <ul style="list-style-type: none"> <li>• Audit Step a: (Inspection) there is an emergency response bag in close proximity to all housing units. The bag contains, at a minimum, a CPR mask or bag-mask ventilator, material to control bleeding, gloves, eye protection, and a cut-down tool. [If unit officers have been trained in compression-only CPR, the Medical Monitor will accept, instead, that a CPR mask or bag-mask ventilator is brought to the scene of all emergencies by responding CHS staff. If all staff carry CPR masks, the Medical Monitor will accept this in lieu of placement of the masks in the emergency response bag.]</li> <li>• Audit Step b: (Inspection) There is an inventory mechanism in place to ensure that emergency response bags are where they should be, have the proper contents, and the contents are operational. [Tamper seals may be used to decrease the frequency of verification of the contents of each bag.]</li> <li>• Audit Step c: (Inspection) when interviewed, custodial and medical staff correctly describe the location of emergency response bags.</li> <li>• Audit Step d: (Inspection) Policy specifies an appropriate first aid training strategy for housing unit officers (e.g. who is trained, how often).</li> <li>• Audit Step e: (Inspection) an effective curriculum is used during first aid training that addresses qualifications of trainers, curriculum, assessment of competency.</li> <li>• Audit Step f: (Inspection) Training records show that housing unit officers receive first aid training as specified in policy.</li> </ul> <p><u>Mental Health Care:</u></p> <ol style="list-style-type: none"> <li>1. On-site review of first aid kit and resources.</li> <li>2. Review of record of education / training to CHS and officers in emergency response</li> <li>3. Review of adverse events</li> </ol>		
<p>Steps taken by the County to Implement this paragraph:</p>	<p><u>Medical Care:</u> The jail provided training records for officers showing that 100% of sworn staff are up to date in CPR training.</p> <p><u>Mental Health Care:</u> As above.</p>		

<p>Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):</p>	<p><u>Medical Care:</u>                  The emergency response bags used by medical staff are not all properly equipped, nor is there a good mechanism for inventory control. For example, not all the bags contain disposable suction or glucometers or these items are contained outside the bag where they can be lost. O2 tanks are inventoried by placing check marks on the inventory list, rather than documenting the actual pressure. The bag contents as defined on the "First Aid Signature Log" and "Emergency Equipment Check List" do not match. Inventory is checked every day, not every shift.</p> <p>For the emergency response bags located on the living units, in the units visited, most were present, in good condition, had been inventoried as required, and staff were able to locate them and verbalize the steps required to restock a used bag. In one location, however, some COs did not know that the PPE (Personal Protective Equipment) was contained in the emergency response bag on the unit.</p> <p>there was some lack of knowledge and confusion among custody staff regarding the location and contents.</p> <p>Most During a witnessed emergency response, for example, medical staff did not use an emergency response bag located on their living unit, and instead waited for one brought from a distant location.</p> <p><u>Mental Health Care:</u>                  Not Reviewed</p>
<p>Monitors' Recommendations:</p>	<p><u>Medical Care:</u></p> <ol style="list-style-type: none"> <li>1. Medical and custody staff need additional training in the location and use of emergency response equipment.</li> <li>2. Underlying this recommendation is the need for regular training drills. These should be specified in policy and documented in training records. They should be jointly conducted (custody and health care).</li> <li>3. Officer training needs to include first aid, in addition to CPR.</li> <li>4. Training materials need to be augmented (see Recommendation #3 above in CONSENT001/III.A.1.a).</li> <li>5. The content of emergency bags used by medical staff should be augmented as recommended by Monitor Gehring during the visit. The contents should be defined in policy and should match the inventory lists.</li> <li>6. Smaller items should be kept inside the locked bag, to reduce the chances of their being lost. To address the complexity of checking glucometers, MDC should consider using simple glucometers (as are used at PTDC) that do not have to be tested every 24 hours.</li> <li>7. Bags should be checked every shift (a check can be limited to assuring that the lock is intact and that other non locked items are present).</li> </ol> <p><u>Mental Health Care:</u>                  Not Reviewed</p>

Paragraph Author: Ruiz	CONSENT III. C. 3 Mental Health Care and Suicide Prevention: 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.		
Compliance Status this tour:	Compliance:	Partial Compliance: 5/15	Non-Compliance: 3/14; 10/14 (Not Reviewed);
Unresolved/partially resolved issues from previous tour:	3/2014: The Quality Department and Director of CHS plan to develop a dashboard of key performance indicators related to the 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. This report is pending.		
<i>Measures of Compliance:</i>	<ol style="list-style-type: none"> <li>1. Result of internal quarterly review and dashboard with key performance indicators</li> <li>2. Review of morbidity and mortality reports from inmate death</li> <li>3. Representative sample of inmate records.</li> </ol>		
Steps taken by the County to Implement this paragraph:	CHS is in the development phases of a dashboard. In terms of data that was submitted related to suicide screening and self-harm incidents in the past year, the Bi-Annual Report and the synopsis that was provided did not contain accurate information. For example, one data set did not contain information for 2014. Another graph indicated that there were no events of self-harm or suicide attempts in July and September of 2014.		
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	The Bi-annual report and other information that was submitted did not contain accurate and complete data.		
Monitor's Recommendations:	Please provide accurate data, including analysis, in quarterly and bi-annual reviews.		

### III. C. Mental Health Care and Suicide Prevention

#### 9. Risk Management

Paragraph Author: Ruiz	CONSENT III. C. 9. Risk Management 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.		
Compliance Status this tour:	Compliance:	Partial Compliance: 3/14; 5/15	Non-Compliance: 10/14 (Not Reviewed)
Unresolved/partially resolved issues from previous tour:	3/2014: In addition to the Quantros system, the Mental Health Monitor recommend continued interdisciplinary review of all inmate deaths of patients that have either been on the mental health caseload or received psychotropic medication for evidence of patterns and possible interventions at the individual and system levels to prevent or minimize harm to inmates.		
<i>Measures of Compliance:</i>	<ol style="list-style-type: none"> <li>1. CHS has proposed implementation of Quantros Incident Reporting System. Quality / Risk Management is to meet monthly and will incorporate MDCR.</li> <li>2. Review of minutes of monthly meetings, suicides, adverse events, and Quantros reports.</li> <li>3. Review of morbidity and mortality reports for qualitative and systematic analysis</li> </ol>		
Steps taken by the County to Implement this paragraph:			
Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)	CHS is in the development phases of a dashboard. In terms of data that was submitted related to suicide screening and self-harm incidents in the past year, the Bi-Annual Report and other synopses that were provided did not contain accurate information. For example, one data set did not contain information for 2014. Another graph indicated that there were no events of self-harm or suicide attempts in July and September of 2014.		
Monitor's Recommendations:	CHS is encouraged to collaborate with both JHS and MDCR in developing its Bi-Annual report and Risk Management Units for data analysis.		

<p>Paragraph Author: Ruiz</p>	<p>CONSENT III. C. 9. Mental Health Care and Suicide Prevention: Risk Management 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.</p>		
<p>Compliance Status this tour:</p>	<p>Compliance:</p>	<p>Partial Compliance: 3/14; 5/15</p>	<p>Non-Compliance: 10/14 (Not Reviewed);</p>
<p>Unresolved/partially resolved issues from previous tour:</p>			
<p><i>Measures of Compliance:</i></p>	<ol style="list-style-type: none"> <li>1. CHS has proposed implementation of Quantros Incident Reporting System. Quality / Risk Management is to meet monthly and “will incorporate” JHS investigation criteria.</li> <li>2. Review of minutes of monthly meetings, suicides, adverse events, and Quantros reports.</li> <li>3. Review of medication error reports, false positives or negatives on screenings in triage and access to care issues, etc. for qualitative and systematic analysis</li> </ol>		
<p>Steps taken by the County to Implement this paragraph:</p>			
<p>Monitor’s analysis of conditions to assess compliance, verification of the County’s representations, and the factual basis for finding(s)</p>	<p>CHS has yet to develop a reliable risk assessment mechanism for capturing or referring at risk individuals at the individual or system levels. This was exemplified both by the review of numerous cases and by the review of gaps in care.</p>		
<p>Monitor’s Recommendations:</p>	<p>CHS is encouraged to collaborate with both JHS and MDCR in developing its Bi-Annual report and Risk Management Units for data analysis. In doing so, it may develop its dashboard to track trends and gaps in care before adverse outcomes occur.</p>		

<p>Paragraph Author: Ruiz</p>	<p>CONSENT III. C. 9. Risk Management 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:</p> <p>(1) Require, at the individual level, that mental health assessments are performed and mental health interventions are developed and implemented;</p> <p>(2) Provide oversight of the implementation of mental health guidelines and support plans;</p> <p>(3) Analyze individual and aggregate mental health data and identify trends that present risk of harm;</p> <p>(4) Refer individuals to the Quality Improvement Committee for review; and</p> <p>(5) Prepare written annual performance assessments and present its findings to the Interdisciplinary Team regarding the following:</p> <p>i. Quality of nursing services regarding inmate assessments and dispositions, and</p> <p>ii. Access to mental health care by inmates, by assessing the process for screening and assessing inmates for mental health needs.</p>		
<p>Compliance Status this tour:</p>	<p>Compliance:</p>	<p>Partial Compliance: 3/14 ; 5/15</p>	<p>Non-Compliance: 10/14 (Not Reviewed)</p>
<p>Unresolved/partially resolved issues from previous tour:</p>	<p>3/2014: The Mental Health Review Committee has been implemented. Individuals have not been referred to the committee.</p>		
<p><i>Measures of Compliance:</i></p>	<ol style="list-style-type: none"> <li>1. Review of minutes of monthly meetings and agenda</li> <li>2. Review of suicides and adverse events</li> <li>3. Review of referrals process for at risk individuals</li> <li>4. Review of Quantros reports.</li> <li>5. Review of internal quality / risk audits</li> </ol>		
<p>Steps taken by the County to Implement this paragraph:</p>			
<p>Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)</p>	<p>To date, the Quality and Safety Committee has focused primarily on suicide reviews and policy updates. There was no review or analysis of aggregate risk management data or systemic analysis of risk management trends. This may have been because the March discussion entertained an upgrade to a new Quantros system that is more 'user friendly.'</p>		
<p>Monitor's Recommendations:</p>	<p>While waiting for a more user-friendly Quantros update, I urge CHS to implement simple tracking mechanisms via a dashboard and Excel to analyze and identify risk management data trends.</p>		

<p>Paragraph Author: Ruiz</p>	<p>CONSENT III. C. 9. Mental Health Care and Suicide Prevention: Risk Management 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.</p>		
<p>Compliance Status this tour:</p>	<p>Compliance:</p>	<p>Partial Compliance: 3/14; 5/15</p>	<p>Non-Compliance: 10/14 (Not Reviewed)</p>
<p>Unresolved/partially resolve issues from previous tour:</p>	<p>3/2014: The Quality and Safety Committee has started meeting monthly. Its focus has been on the Department of Justice report, approval of policies and procedures, and improving safety, typically in response to an adverse event or outcome.</p>		
<p><i>Measures of Compliance:</i></p>	<ol style="list-style-type: none"> <li>1. Review of screenings by psychiatry</li> <li>2. Review of monthly Quality Meeting minutes</li> <li>3. Review of suicides and adverse events</li> <li>4. Review of Quantros reports.</li> <li>5. Review of internal quality / risk audits</li> </ol>		
<p>Steps taken by the County to Implement this paragraph:</p>			
<p>Monitor's analysis of conditions to assess compliance, verification of the County's representations, and the factual basis for finding(s)</p>	<p>To date, the Quality and Safety Committee has focused primarily on suicide reviews and policy updates. There was no review or analysis of aggregate risk management data or systemic analysis of risk management trends. This may have been because the March discussion entertained an upgrade to a new Quantros system that is more 'user friendly.'</p>		
<p>Monitor's Recommendations:</p>	<p>As indicated above, while waiting for a more user-friendly Quantros update, I urge CHS to implement simple tracking mechanisms via a dashboard and Excel to analyze and identify risk management data trends.</p>		

### III. D. Audits and Continuous Improvement

#### 1. Self Audit Steps

Paragraph Author: Stern and Ruiz	CONSENT III.D.1.b. Qualified Medical and Mental Health Staff shall review data concerning inmate medical and mental health care to <b><i>identify potential patterns or trends resulting in harm</i></b> to inmates in the areas of intake, medication administration, medical record keeping, medical grievances, assessments and treatment.		
Medical Care: Compliance Status:	Compliance: 5/15	Partial Compliance:	Non-Compliance: 7/13 (Not Reviewed); 3/14 (Not Reviewed); 10/14 (Not Reviewed)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 7/13; 3/14; 5/15	Non-Compliance: 10/14 (Not Reviewed);
<i>Measures of Compliance:</i>	<p><u>Medical Care:</u></p> <ul style="list-style-type: none"> <li>Audit Step a: (Inspection) Review of appropriate documents (e.g. meeting minutes) reveal that at least quarterly CHS staff review data regarding medical care to identify potentially harmful patterns or trends. Such review will include not only the active cause of the patterns or trends, but also the underlying (or root) cause(s).</li> </ul> <p><u>Mental Health Care:</u></p> <ol style="list-style-type: none"> <li>Review of Mental Health Review Committee minutes</li> <li>Review of Quality Assurance Committee minutes</li> <li>Review of any reports or analyses generated by MDCR Medical Compliance</li> </ol>		
Steps taken by the County to Implement this paragraph:	<p><u>Medical Care:</u> <u>CHS hired a new Associate Director of Quality and Safety to spearhead these operations.</u></p> <p><u>Mental Health Care:</u> Meeting minutes</p>		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<p><u>Medical Care:</u> I reviewed Quality and Safety Committee Meeting minutes. The minutes were sparse with regard to root cause analysis results and related plans, however, the focus of the meetings right now is more toward organizational structural issues, so this is not wholly inappropriate. However, as time progresses during the life of this Consent Agreement, I will expect a shift toward more RCAs.</p> <p><u>Mental Health Care:</u> The minutes were not detailed with regard to root cause analyses or with regard to problem solving for potentially harmful patterns or trends. Rather, there appeared to be a tendency to deflect accountability.</p>		
Monitor's Recommendations:	<p><u>Medical Care:</u> None</p> <p><u>Mental Health Care:</u> None</p>		

Paragraph Author: Stern and Ruiz	CONSENT 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.		
Medical Care: Compliance Status:	Compliance: 5/15	Partial Compliance:	Non-Compliance: 7/13 (Not Reviewed); 3/14 (Not Reviewed); 10/14 (Not Reviewed)
Mental Health Care: Compliance Status:	Compliance: 5/15	Partial Compliance:	Non-Compliance: 7/13 (Not Reviewed); 3/14 (Not Reviewed); 10/14 (Not Reviewed)
<i>Measures of Compliance:</i>	<p><u>Medical Care:</u></p> <ul style="list-style-type: none"> <li>Audit Step a: (Inspection) Review of appropriate documents reveals that within 30 days of quarterly reviews, MDCR staff have developed and implemented corrective action plans addressing potentially harmful patterns or trends in medical care. The corrective action plans address the active and underlying (or root) cause(s) in a sustainable manner (e.g. changes to policy, procedures, job descriptions, training curricula.)</li> </ul> <p><u>Mental Health Care:</u> Review of corrective action plans. Corrective plans shall be submitted in a timely manner and shall be qualitative; addressing causes not just symptoms of harm.</p>		
Steps taken by the County to Implement this paragraph:	<p><u>Medical Care:</u> <u>CHS hired a new Associate Director of Quality and Safety to spearhead these operations.</u></p> <p><u>Mental Health Care:</u> As above</p>		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<p><u>Medical Care:</u> Progress on this provision is reflected both in Quality and Safety Committee Meeting minutes I reviewed as well as my first hand knowledge of corrective action plans undertaken over the past 6 months. For example, a rather sizeable corrective action has been the redesign of all the data entry fields used by staff during the Intake process, based on feedback from the Monitors.</p> <p><u>Mental Health Care:</u> As above</p>		
Monitor's Recommendations:	<p><u>Medical Care:</u> None</p> <p><u>Mental Health Care:</u> None</p>		

**III. D. Audits and Continuous Improvement****2. Bi-annual Reports**

Paragraph Author: Stern and Ruiz	<p>CONSENT 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:</p> <p>(1) All psychotropic medications administered by the jail to inmates.</p> <p>(2) All health care delivered by the Jail to inmates to address serious medical concerns. The report will include:</p> <p>i. number of inmates transferred to the emergency room for medical treatment and why;</p> <p>ii. number of inmates admitted to the hospital with the clinical outcome;</p> <p>iii. number of inmates taken to the infirmary for non-emergency treatment; and why; and</p> <p>iv. number of inmates with chronic conditions provided consultation, referrals and treatment, including types of chronic conditions.</p>		
Medical Care: Compliance Status:	Compliance: 5/15	Partial Compliance:	Non-Compliance: 7/13 (Not yet due – Not Reviewed); 3/14 (Not Reviewed); 10/14 (Not Reviewed)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 5/15	Non-Compliance: 7/13 (Not yet due – Not Reviewed); 3/14 (Not Reviewed); 10/14 (Not Reviewed)
<i>Measures of Compliance:</i>	<p><u>Medical Care:</u></p> <ul style="list-style-type: none"> <li>Audit Step a: (Inspection) The Medical Monitor receives bi-annual reports of health care delivered to inmates including the volume of and reason for episodic clinic visits, chronic care clinic visits, ER transfers, and hospitalizations.</li> </ul> <p><u>Mental Health Care:</u> Review of bi-annual reports, to be submitted in a timely manner and to include accurate data.</p>		
Steps taken by the County to Implement this paragraph:	<p><u>Medical Care:</u> CHS produced a Bi-Annual report.</p> <p><u>Mental Health Care:</u> CHS produced a Bi-Annual report.</p>		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<p><u>Medical Care:</u> The submitted report substantially satisfied the requirements (the number of inmates taken to the infirmary was not included). The report contains other detailed data that are of minimal value in a summary report.</p> <p><u>Mental Health Care:</u> The submitted report was not accurate. It did not include the reason why inmates were transferred to the emergency department. It contained inaccurate data for suicide and self-harm. It appeared that there was little review of the document before it was submitted.</p>		
Monitor's Recommendations:	<p><u>Medical Care:</u> As MDC works with the Monitors to develop a global quality improvement process, it is the Medical Monitor's hope that emphasis will shift from producing periodic reports as required by this provision, to developing, maintaining, and using,</p>		

	<p>on-going patient safety monitoring tools, such as a “dashboard” and a quality improvement status document. As such, MDC will be able to know the status of key safety indicators at any point in time, without waiting for 3, 6, or 12 month mile posts. In the meantime, to conserve resources, I would recommend that MDC limit the next bi-annual report to only those elements required by the Consent Agreement.</p> <p><u>Mental Health Care:</u> As MDC works with the Monitors to develop a global quality improvement process, it is the Medical Monitor’s hope that emphasis will shift from producing periodic reports as required by this provision, to developing, maintaining, and using, on-going patient safety monitoring tools, such as a “dashboard” and a quality improvement status document. As such, MDC will be able to know the status of key safety indicators at any point in time, without waiting for 3, 6, or 12 month mile posts.</p>
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<p>Paragraph Author: Ruiz</p>	<p>CONSENT 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:</p> <ul style="list-style-type: none"> <li>• all suicides;</li> <li>• all serious suicide attempts;</li> <li>• list of inmates placed on suicide monitoring at all levels, including the duration of monitoring and property allowed (mattress, clothes, footwear);</li> <li>• all restraint use related to a suicide attempt or precautionary measure; and</li> <li>• information on whether inmates were seen within four days after discharge from suicide monitoring.</li> </ul>
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Mental Health: Compliance Status:	Compliance:	Partial Compliance: 5/15	Non-Compliance: 10/14 (Not Reviewed)
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<i>Measures of Compliance:</i>	<ul style="list-style-type: none"> <li>• The Mental Health Monitor receives bi-annual reports of health care delivered to inmates including the volume of and reason for episodic clinic visits, follow-up/chronic care clinic visits, ER transfers, and hospitalizations.</li> <li>• Bi-annual reports are be submitted in a timely manner and to include accurate data supportive of its conclusions.</li> </ul>
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Steps taken by the County to Implement this paragraph:	NA
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Monitor’s analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County’s representations, and the factual basis for finding(s):	<p>The submitted report was not accurate. It did not include the reason why inmates were transferred to the emergency department. Data analysis is critical, as it tells administration what is occurring in its facility. For example, if 80% of patients sent out to the emergency department are on the mental health caseload, that is pertinent information. If that is occurring on the night shift, that is further pertinent information.</p> <p>The report contained inaccurate data for suicide and self-harm. It appeared that there was little review of the document before it was submitted.</p>
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Monitor's Recommendations:	None
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Paragraph Author: Ruiz	CONSENT 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: All health care delivered by the Jail to inmates to address serious medical concerns. The report will include: (4) Inmate counseling services. The report and review shall include: i. inmates who are on the mental health caseload, classified by levels of care; 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.		
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 5/15	Non-Compliance: 10/14 (Not Reviewed)
Measures of Compliance:	<ul style="list-style-type: none"> <li>The Mental Health Monitor receives bi-annual reports of health care delivered to inmates including the volume of and reason for episodic clinic visits, evidence of timely follow-up/chronic care clinic visits, group therapy and individual therapy.</li> <li>Bi-annual reports are be submitted in a timely manner and to include accurate data supportive of its conclusions.</li> </ul>		
Steps taken by the County to Implement this paragraph:	MDCR produced a report		
Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	The submitted report was not accurate. It did not include the reason why inmates were transferred to the emergency department. It contained inaccurate data for suicide and self-harm. It did not include waitlists for groups nor an analysis of why there were no waitlists (i.e. the groups are poorly attended, unpopular, disallowed due to staffing, one is left to wonder...)		
Monitor's Recommendations:	None.		

Paragraph Author: Ruiz	CONSENT 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: (5) 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.		
Mental Health: Compliance Status:	Compliance:	Partial Compliance: 5/15	Non-Compliance: 10/14 (Not Reviewed)
Measures of Compliance:	<ul style="list-style-type: none"> <li>The Mental Health Monitor receives bi-annual reports of health care delivered regarding inmates involved in disciplinary reports at each level of care, the date of any hearing that may have resulted as a result of the</li> </ul>		

	<p>disciplinary action or report, whether a QMHP participated in the disciplinary action, and the outcome.</p> <ul style="list-style-type: none"> <li>• Bi-annual reports are be submitted in a timely manner and to include accurate data supportive of its conclusions.</li> </ul>
Steps taken by the County to Implement this paragraph:	CHS submitted a log of inmate disciplinary reports for the month of March 2015. The log documented whether the patient was stable to attend the disciplinary hearing.
Monitor’s analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County’s representations, and the factual basis for finding(s):	<p>The disciplinary mental health log documented whether the patient was stable enough from a mental health perspective to attend the disciplinary hearing. We were informed that if the patient is not stable to attend the hearing, the discipline is subsequently dropped after a period of time. [This statement was not confirmed by policy or another modality.] We asked what happened with the charge and whether it was recorded in the patient’s file or medical record; a firm answer was not provided. CHS was open to exploring further options for utilizing this practice as a more meaningful intervention for patients with severe mental illness.</p> <p>The disciplinary mental health log submitted by mental health was not confirmed by custody.</p>
Monitor’s Recommendations:	None.

Paragraph Author: Stern and Ruiz	<p>CONSENT 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:...</p> <p>Reportable incidents. The report will include:</p> <ol style="list-style-type: none"> <li>a brief summary of all reportable incidents, by type and date;</li> <li>[Joint audit with MH] a description of all suicides and in-custody deaths, including the date, name of inmate, and housing unit; and</li> <li>number of grievances referred to IA for investigation.</li> </ol>		
Medical Care: Compliance Status:	Compliance: 5/15	Partial Compliance:	Non-Compliance: 7/13 (Not Reviewed); 3/14 (Not Reviewed); 10/14 (Not Reviewed)
Mental Health Care: Compliance Status:	Compliance: 5/15	Partial Compliance:	Non-Compliance: 7/13 (Not Reviewed); 3/14 (Not Reviewed); 10/14 (Not Reviewed)
Measures of Compliance:	<p><u>Medical Care:</u></p> <ul style="list-style-type: none"> <li>• Audit Step a: (Inspection) The Medical Monitor receives bi-annual reports of inmate injuries, medical emergencies and in-custody deaths. [NB: For the purpose of this report, MDCR should include deaths which occur outside the MDCR facility (e.g. hospital) and regardless of whether or not the inmate was in custody, if the death resulted from a health status/condition that existed while the inmate was at MDCR.</li> </ul> <p><u>Mental Health Care:</u></p> <ol style="list-style-type: none"> <li>Review of bi-annual reports</li> <li>Review of incident reports</li> <li>Review of inmate deaths, including those which died following transfer from MDCR to Jackson Healthcare</li> </ol>		
Steps taken by the County to Implement this paragraph:	<p><u>Medical Care:</u> MDC produced a Bi-Annual report.</p> <p><u>Mental Health Care:</u> MDCR produced a Bi-Annual report.</p>		
Monitors’ analysis of conditions to assess compliance, including	<p><u>Medical Care:</u> The submitted report substantially satisfied the requirements.</p>		

documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<p><u>Mental Health Care:</u> Although CHS' Bi-Annual report contained several inconsistencies, MDCR's Bi-Annual report, mental health grievances and its reportable incidents are timely.</p>
Monitors' Recommendations:	<p><u>Medical Care:</u> As MDC works with the Monitors to develop a global quality improvement process, it is the Medical Monitor's hope that emphasis will shift from producing periodic reports as required by this provision, to developing, maintaining, and using, on-going patient safety monitoring tools, such as a "dashboard" and a quality improvement status document.</p> <p><u>Mental Health Care:</u> I encourage CHS to work with MDCR to analyze its data and develop a meaningful quality improvement process that is sustainable beyond the monitoring cycle.</p>

Paragraph Author: Stern and Ruiz	<p>CONSENT III.D.2.b. (Covered in CONSENT 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.</p>		
Medical Care: Compliance Status:	Compliance: 5/15	Partial Compliance:	Non-Compliance: 7/13 (Not Reviewed); 3/14 (Not Reviewed); 10/14 (Not Reviewed)
Mental Health Care: Compliance Status:	Compliance:	Partial Compliance: 3/14; 5/15	Non-Compliance: 7/13 (Not Reviewed); 10/14 (Not Reviewed)
<i>Measures of Compliance:</i>	<p><u>Medical Care:</u></p> <ul style="list-style-type: none"> <li>(duplicate) CONSENT111 (IID1c) Audit Step a: (Inspection) Review of appropriate documents reveals that within 30 days of quarterly reviews, MDCR staff have developed and implemented corrective action plans addressing potentially harmful patterns or trends in medical care. The corrective action plans address the active and underlying (or root) cause(s) in a sustainable manner (e.g. changes to policy, procedures, job descriptions, training curricula.)</li> </ul> <p><u>Mental Health Care:</u></p> <ol style="list-style-type: none"> <li>Review of Quarterly Reviews</li> <li>Review of corrective action plans</li> <li>Review of implementation of CAP</li> <li>Review of policy and procedure, as applicable</li> </ol>		
Steps taken by the County to Implement this paragraph:	<p><u>Medical Care:</u> See CONSENT111 (IID1c)</p> <p><u>Mental Health Care:</u> (IID1c)</p>		
Monitors' analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the	<p><u>Medical Care:</u> See CONSENT111 (IID1c)</p> <p><u>Mental Health Care:</u> (IID1c)</p>		

factual basis for finding(s):	
Monitors' Recommendations:	<p><u>Medical Care:</u> See CONSENT111 (IID1c)</p> <p><u>Mental Health Care:</u> (IID1c)</p>

#### IV. COMPLIANCE AND QUALITY IMPROVEMENT

<p>Paragraph Author: Stern and Ruiz</p>	<p>CONSENT IV.A Within 180 days of the Effective Date, the County and CHS shall revise and develop policies, procedures, protocols, training curricula, and practices to ensure that they are consistent with, incorporate, address, and implement all provisions of this Agreement. The County and CHS shall revise and develop, as necessary, other written documents such as screening tools, logs, handbooks, manuals, and forms, to effectuate the provisions of this Agreement. The County and CHS shall send any newly-adopted and revised policies and procedures to the Monitor and the United States for review and approval as they are promulgated. The County and CHS shall provide initial and in-service training to all Jail staff in direct contact with inmates, with respect to newly implemented or revised policies and procedures. The County and CHS shall document employee review and training in policies and procedures.</p>		
<p>Medical Care: Compliance Status:</p>	<p>Compliance:</p>	<p>Partial Compliance: 5/15</p>	<p>Non-Compliance: 7/13 (Not Reviewed); 3/14 (Not Reviewed); 10/14 (Not Reviewed)</p>
<p>Mental Health Care: Compliance Status:</p>	<p>Compliance:</p>	<p>Partial Compliance: 3/14; 5/15</p>	<p>Non-Compliance: 7/13 (Not Reviewed); 10/14 (Not Reviewed)</p>
<p><i>Measures of Compliance:</i></p>	<p><u>Medical Care:</u></p> <ul style="list-style-type: none"> <li>• Audit Step a: (Other) this compliance measure will be assessed by exception, i.e. failure to meet any of the 3 requirements below as they pertain to any other provision of the Consent Agreement.                             <ul style="list-style-type: none"> <li>a) Develop/revise operational documents to implement the Consent Agreement,</li> <li>b) Provide initial and in-service training to relevant jail staff with respect to new/revise policies and procedures,</li> <li>c) Send new policies and procedures to Medical Monitor for approval.</li> </ul> </li> </ul> <p><u>Mental Health Care:</u></p> <ol style="list-style-type: none"> <li>1. Policies and procedures</li> <li>2. Schedule for production, revision, etc. of written directives, logs, screening tools, handbooks, manuals, forms, etc.</li> <li>3. Schedule for pre-service and in-service training</li> <li>4. Lesson plans</li> <li>5. Evidence training completed and knowledge gained (e.g. pre and post tests)</li> <li>6. Observation</li> <li>7. Staff interviews.</li> </ol>		
<p>Steps taken by the County to Implement this paragraph:</p>	<p><u>Medical Care:</u> Discussed elsewhere as applicable</p> <p><u>Mental Health Care:</u> Not reviewed</p>		
<p>Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):</p>	<p><u>Medical Care:</u> Discussed elsewhere as applicable</p> <p><u>Mental Health:</u> CHS has yet to develop, write and implement policies and procedures related to continuous quality improvement on a meaningful basis. It is not doing systematic data collection or analysis at this time. It is in the process of developing a dashboard.</p>		

Monitor's Recommendations:	<p><u>Medical Care:</u> Discussed elsewhere as applicable</p> <p><u>Mental Health Care:</u> As MDC works with the Monitors to develop a global quality improvement process, it is the Medical Monitor's hope that emphasis will shift from producing periodic reports as required by this provision, to developing, maintaining, and using, on-going patient safety monitoring tools, such as a "dashboard" and a quality improvement status document. As such, MDC will be able to know the status of key safety indicators at any point in time, without waiting for 3, 6, or 12 month mile posts.</p>
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Paragraph Author: Stern and Ruiz	CONSENT IV.C. 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.		
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Medical Care Compliance Status:	Compliance: 5/15	Partial Compliance:	Non-Compliance: 7/13 (Not Reviewed); 3/14 (Not Reviewed); 10/14 (Not Reviewed)
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Mental Health Compliance Status:	Compliance:	Partial Compliance: 3/14; 5/15	Non-Compliance: 7/13 (Not Reviewed); 10/14 (Not Reviewed)
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<i>Measures of Compliance:</i>	<p><u>Medical Care:</u></p> <ul style="list-style-type: none"> <li>• Audit Step a: (Inspection) there is evidence of annual review of policies and procedures for any needed changes.</li> <li>• (duplicate) CONSENT119 (IV.A) Audit Step a: (Other) this compliance measure will be assessed by exception, i.e. failure to meet any of the 3 requirements below as they pertain to any other provision of the Consent Agreement.             <ul style="list-style-type: none"> <li>c) Send new policies and procedures to Medical Monitor for approval.</li> </ul> </li> </ul> <p><u>Mental Health Care:</u></p> <ol style="list-style-type: none"> <li>1. Review of policies and procedures</li> <li>2. Review of implementation of policies and procedures, as noted in Medical Care</li> <li>3. Review of committee meeting minutes and/ or documentation reflecting annual review of policies and updates, as needed.</li> </ol>		
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Steps taken by the County to Implement this paragraph:	<p><u>Medical Care:</u> MDC has been actively reviewing and revising policies to align them with the Consent Agreement.</p> <p><u>Mental Health Care:</u> MDC is in the process of revising policies.</p>		
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Monitor's analysis of conditions to assess compliance, including documents reviewed, individuals interviewed, verification of the County's representations, and the factual basis for finding(s):	<p><u>Medical Care: Compliance</u> MDC has shown steady improvement in its policy writing process. In addition to revising the remaining policies that touch on the Consent Agreement, there is a significant challenge facing MDC in the next phase of policy development. CHS lies at the intersection between two parent organizations: MDCR and JHS. Both organizations already have their own policies, most of which do not directly affect CHS. However, a sizable minority of polices in both parent organizations do directly affect CHS. Seamlessly integrating these policies across the 3 organizations will not be easy.</p> <p><u>Mental Health Care:</u> As stated above, CHS and MDCR are in the process of revising their policies. Likely because the Assistant Director of Mental Health position remains open at this time, the majority of the mental health policies remain outstanding.</p>		
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<p>Monitor's Recommendations:</p>	<p><u>Medical Care:</u>                  The Medical Monitor has recommended that CHS, in conjunction with its two parent organization, construct a policy framework to deal with the challenge of seamlessly integrating jail health policies across the 3 organizations (MDCR, CHS, JHS). In addition to the standard goals of policies, this framework should have as its goal the following:</p> <ol style="list-style-type: none"> <li>1. Custody staff know what is expected of health care staff, and vice versa, in activities that involve both disciplines;</li> <li>2. Changes to policies that involve both disciplines should be made with the input of both disciplines;</li> <li>3. To the extent that there are separate polices in these situations, changes to either policy should be synchronized with the corresponding policy in the other discipline;</li> <li>4. The appropriate policy should be easy to find. Custody and health care staff should only have to go to ONE site to find ALL policies relevant to their work.</li> </ol> <p><u>Mental Health Care:</u>                  None</p>
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**Appendix A**  
**Settlement Agreement**  
**Per MDCR – Paragraphs Not Reviewed for Compliance**

Paragraph	Requirement	Status as of this Tour	Monitors' Comments
III.A.1.a.(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.	Partial Compliance	Compliance waiting finalizing written polices and procedures – Compliance anticipated in January '16 tour. The lead monitor reviewed all the use of force report for January 2015 and met with the TAAP unit to discuss findings and concerns.
III.A.1.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.	Partial Compliance	MDCR continues to work to complete a task plan for reforming the classification system. There are sufficient beds per current inmate classification.
III.A.1.a.(3)	Develop and implement a policy requiring correctional officers to conduct documented rounds, at irregular intervals, inside each housing unit, to ensure periodic supervision and safety. In the alternative, MDCR may provide direct supervision of inmates by posting a correctional officer inside the day room area of a housing unit to conduct surveillance.	Compliance	The monitor's tour of all facilities and all units evaluated logs and found no issues.
III.A.1.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.	Compliance	
III.A.1.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	Compliance	

Paragraph	Requirement	Status as of this Tour	Monitors' Comments
	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.		
III.A.1.a.(7)	Security supervisors shall conduct daily rounds on each shift in the inmate housing units, and document the results of their rounds.	Compliance	
III.A.1.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: Random daily visual inspections of four to six cells per housing area or cellblock; Random daily inspections of common areas of the housing units; Regular daily searches of intake cells; and Periodic large scale searches of entire housing units.	Partial Compliance	
III.A.1.a. (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.	Partial Compliance	Awaiting MDCR's implementation of DSOPs 6-008 and 6-048.
III.A.1.a. (10)	Correctional officers assigned to special management units, including disciplinary segregation and protective custody, shall receive eight hours of specialized training for working on that unit on at least an annual basis.	Protection from Harm - Partial Compliance Mental Health - Partial Compliance	CIT training underway; next tour Dr. Ruiz will evaluate the records of training. Officers need to know the location of the cut-down tools, there must be immediate access to the tools.
III.A.1.a.(11)	MDCR shall continue its efforts to reduce inmate-on-inmate violence in each Jail facility annually after the Effective Date. If reductions in violence do not occur in any given year, the County shall demonstrate that its systems for minimizing inmate-on-inmate violence are operating effectively.	Partial Compliance	Reporting and data analysis progressing with the TAAP Unit.
III.A.3	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.	Compliance	By the January 2016 tour, the following issues need to be addressed: <ul style="list-style-type: none"> <li>• CHS policy/procedure;</li> <li>• Review of medical records for inmates who allege sexual abuse with plans of action for improvement as necessary.</li> <li>• While MDCR was in compliance based on the auditor's review in July 2015, these areas of concern were noted by the Monitors.</li> <li>• Review the SART protocols for specific direction to team members</li> </ul>
III.A.4.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	Compliance	

Paragraph	Requirement	Status as of this Tour	Monitors' Comments
	property, escapes and escape attempts, and fires.		
III.A.4.b.	Staff shall report all suicides and other deaths immediately, but no later than one hour after the incident, to a supervisor, Internal Affairs ("IA"), and medical and mental health staff.	Compliance	
III.A.4.c.	<p>MDCR shall employ a system to track, analyze for trends, and take corrective action regarding all reportable incidents. The system should include at least the following information:</p> <ol style="list-style-type: none"> <li>1. unique tracking number;</li> <li>2. inmate(s) name;</li> <li>3. housing classification;</li> <li>4. date and time;</li> <li>5. type of incident;</li> <li>6. any injuries to staff or inmate;</li> <li>7. any medical care;</li> <li>8. primary and secondary staff involved;</li> <li>9. reviewing supervisor;</li> <li>10. any external reviews and results;</li> <li>11. corrective action taken; and</li> <li>12. administrative sign-off.</li> </ol>	Partial Compliance	Mental Health monitor requests that as possible MDCR track incidents for inmates on the mental health load, by level.
III.A.4.e.	Correctional staff shall receive formal pre-service and biennial in-service training on proper incident reporting policies and procedures.	Partial Compliance	Lesson plans need to be developed based on update policies/procedures; reviewed by members of the monitoring team.
III.A.5.c. (1)	MDCR shall develop and implement a policy to ensure that staff adequately and promptly report all uses of force within 24 hours of the force.	Compliance	
III.A. c. (2)	<p>MDCR shall ensure that use of force reports:</p> <ol style="list-style-type: none"> <li>a. are written in specific terms and in narrative form to capture the details of the incident in accordance with its policies;</li> <li>b. describe, in factual terms, the type and amount of force used and precise actions taken in a particular incident, avoiding use of vague or conclusory descriptions for describing force;</li> <li>c. contain an accurate account of the events leading to the use of force incident;</li> <li>d. include a description of any weapon or instrument(s) of restraint used, and the manner in which it was used;</li> <li>e. are accompanied with any inmate disciplinary report that prompted the use of force incident;</li> <li>f. state the nature and extent of injuries sustained both by the inmate and staff member</li> <li>g. contain the date and time any medical attention was actually provided;</li> <li>h. include inmate account of the incident; and</li> <li>i. note whether a use of force was videotaped, and if not, explain why it was not videotaped.</li> </ol>	Partial Compliance	

Paragraph	Requirement	Status as of this Tour	Monitors' Comments
III.A.5.c.(4)	The Facility Supervisor/Bureau Commander or his/her designee shall submit the MDCR Incident Report (with required attachments) and a copy of the Response to Resistance Summary (memorandum) to his/ her Division Chief within 14 calendar days. If the MDCR Incident Report and the Response to Resistance Summary (memorandum) are not submitted within 14 calendar days, the respective Facility Supervisor/Bureau Commander or designee shall provide a memorandum to his/her Division Chief explaining the reason(s) for the delay.	Compliance	
III. A. 5.c. (5)	The Division Chief shall review use of force reports, to include a review of medical documentation of inmate injuries, indicating possible excessive or inappropriate uses of force, within seven business days of submission, excluding weekends. The Division Chief shall forward all original correspondences within seven business days of submission, excluding weekends to Security and Internal Affairs Bureau.	Compliance	See also Consent Agreement III.B.3. Use of Force Care.
III.A.5.c. (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.	Compliance	
III.A.5.c. (8)	MDCR shall ensure that a supervisor is present during all planned uses of force and that the force is videotaped.	Compliance	
III.A. 5.c. (13)	MDCR shall maintain policies and procedures for the effective and accurate maintenance, inventory and assignment of chemical and other security equipment.	Compliance	
III.A.5.d.	<p>Use of Force Training</p> <p>(1) 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.</p> <p>(2) 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.</p> <p>(3) 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.</p> <p>(4) 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.</p>	Partial Compliance	
III.A.5.e.	<p>(1) MDCR shall sustain implementation of comprehensive policies, procedures, and practices for the timely and thorough investigation of alleged staff misconduct.</p> <p>(2) MDCR shall revise its "Complaints, Investigations &amp; Dispositions" policy (DSOP</p>	Partial Compliance	

Paragraph	Requirement	Status as of this Tour	Monitors' Comments
	<p>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.</p> <ul style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>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.</li> <li>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.</li> </ul>		
III.A.6.a	<ul style="list-style-type: none"> <li>(1) Implementation 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.</li> <li>(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.</li> <li>(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.</li> <li>(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.</li> <li>(5) The EWS will <u>analyze the data according to the following criteria:</u> <ul style="list-style-type: none"> <li>i. number of incidents for each data category by individual officer and by all officers in a housing unit;</li> <li>ii. average level of activity for each data category by individual officer and by all officers in a housing unit;</li> <li>iii. identification of patterns of activity for each data category by individual officer and by all officers in a housing unit; and</li> <li>iv. identification of any patterns by inmate (either involvement in</li> </ul> </li> </ul>	Partial Compliance	Directive needs to be completed.

Paragraph	Requirement	Status as of this Tour	Monitors' Comments
III. B. 1.	<p>incidents or filing of grievances).</p> <p>Necessary fire and life safety equipment shall be properly maintained and inspected at least monthly. MDCR shall document these inspections.</p>	Partial Compliance	<ol style="list-style-type: none"> <li>1. Consider amending the written directive system to eliminate the redundancy of facility specific provisions for fire prevention and safety in the facility specific SOPs to assure consistency with 10-022. There should be one fire response and prevention plan policy for all of MDCR with facility fire response and prevention limited to each facility's fire and life safety equipment. All facility specific plans need to be consistent with the latest revision of 10-022.</li> <li>2. Assess the need for the weekly FSSO inspections to assure justification of the frequency that you currently require.</li> <li>3. Clarify language in Policy 10-0022 as to the responsibility of the reviewer of the weekly and monthly reports.</li> <li>4. Clarify language in Policy 10-022 as to who has the responsibility and accountability for assuring non-conformities identified in the weekly FSSO and monthly CAB inspections are tracked to assure timely corrective action resolutions are completed and the issues formally closed.</li> <li>5. Assure that Policy 10-022 establishes a verifiable procedure as to how non-conformities/violations are investigated and resolved that includes a formal close out with assigned responsibility and accountability.</li> </ol>
III.B.2.	MDCR shall ensure that fire alarms and sprinkler systems are properly installed, maintained and inspected. MDCR shall document these inspections.	Compliance	
III.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.	Partial Compliance	<ol style="list-style-type: none"> <li>1. Complete the revision of MDCR Policy 11-023 to reflect the common location of emergency key access box and the location of the emergency keys, a consistent inspection format and</li> </ol>

Paragraph	Requirement	Status as of this Tour	Monitors' Comments
			<p>inspection parameters, and a process to test the keys in the appropriate locks. Once completed, revise the training curriculum to reflect the revised policy and expectations.</p> <ol style="list-style-type: none"> <li>2. Provide evidence of training to the revised policy and procedure.</li> <li>3. Include a requirement for the CAB fire safety inspections to include a requirement for an unannounced demonstration by officers in the control room and those officers that would be accessing the key on emergency key access and key identification by touch and/or a testing of the keys during fire drills.</li> </ol>
III.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.	Partial Compliance	<ol style="list-style-type: none"> <li>1. Complete and approve the revised Chemical Control Policy 10-010.</li> <li>2. Revise the chemical safety, dilution, and use training program for sanitation officers, who can, then correctly train correction officers that supervise inmate workers. Assure the training Power Point slides and curriculum follows the revised DSOP 10-010...</li> <li>3. Provide evidence of training of all sanitation officers for each shift and inmate workers who have responsibility to use or supervise inmates using chemicals in housing areas, kitchens, classrooms, etc. for all facilities.</li> </ol>
III. D. 1. a. b.	<p>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.</p> <ol style="list-style-type: none"> <li>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</li> </ol>	Partial Compliance	MDCR will be producing quarterly reports.

Paragraph	Requirement	Status as of this Tour	Monitors' Comments
	<p>shall include the following information:</p> <ul style="list-style-type: none"> <li>(1) documented or known injuries requiring more than basic first aid;</li> <li>(2) injuries involving fractures or head trauma;</li> <li>(3) injuries of suspicious nature (including black eyes, injuries to the mouth, injuries to the genitals, etc.);</li> <li>(4) injuries that require treatment at outside hospitals;</li> <li>(5) self-injurious behavior, including suicide and suicide attempts;</li> <li>(6) inmate assaults; an</li> <li>(7) allegations of employee negligence or misconduct.</li> </ul> <p>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.</p>		
IV. A.	<p>1. 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.</p>	Partial Compliance	
IV. B.	<p>2. 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.</p>	Partial Compliance	
IV. C.	<p>3. 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.</p>	Partial Compliance	
IV. D.	<p>4. 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.</p>	Compliance	

## Appendix B – May 2015 - Compliance Review Process

Regarding compliance and partial compliance of paragraphs of the Consent Agreement and Settlement Agreement, the Monitors advised Miami-Dade County on April 9, 2015:

- “Partial Compliance” indicates that Defendants achieved compliance on some of the components of the relevant provision of the Agreement, but significant work remains.
- Going forward our review will be guided by the Revised Summary Action Plan<sup>14</sup> developed by the County and filed with the Court.
- During the May tour the Monitors will audit the provisions of the Consent Agreement scheduled to be compliant during this tour based on the Summary Action Plan. We will rate each provision as Compliant, Partially Compliant, or Non-Compliant based on the documentation presented, interviews, etc.
- Please refer to Report #3 to identify the provisions of the Consent Agreement (CA) and Settlement Agreement (SA) that were determined previously to be in Partial Compliance. Some of these provisions are NOT among those scheduled for evaluation during the May tour. We will address these provisions as follows:
- Unless information comes to our attention before or during the May (or really any subsequent) tour suggesting that the previous rating of PC has substantially changed, we will continue to report these provisions as PC, and include in the narrative that the provision was not specifically assessed.
- If information and/or documentation comes to our attention before or during the May tour indicating that conditions required by the CA or SA have changed, we will describe this in the narrative of the relevant paragraph. We will then report the provision as PC or Non-Compliant depending on the nature of the new information/documentation, etc.
- The Monitors reserve the opportunity to review CHS’ and MDCR’s current compliance with any provision of the CA or SA for which we have concerns that the safety of staff and/or inmates is in jeopardy, and/or where there is an articulated threat to safety and welfare
- The Monitors again remind the County that we provide a draft copy of our report because we want – and need – your feedback to make the report are as accurate and helpful as possible. So please take advantage of that review opportunity to suggest any changes or clarifications with regard to the assignment of PC (or any other part of the report) so that we can make any necessary corrections before finalizing the report.

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<sup>14</sup> See Appendix C

**Appendix C- Summary Action Plan (Section Title, Audit Cycle)  
As of May 15, 2015**

CONSENT AGREEMENT SECTION	SUB-SECT.	PROVISION TITLE	AUDIT CYCLE
III.A	1	Intake Screening	05/11/15
III.A	2	Health Assessments	05/31/16
III.A	3	Access to Medical and Mental Health Care	11/30/16
III. A	4	Medication Administration and Management	05/31/16
III.A	5	Record Keeping	05/31/16
III. A	6	Discharge Planning	11/30/15
III.A	7	Mortality and Morbidity Reviews	11/30/15
III.B	1	Acute Care and Detoxification	11/30/16
III. B	2	Chronic Care	05/31/16
III.B	3	Use of Force Care	11/30/16
III.C	1	Referral Process and Access to Care	05/31/16
III.C	2	Mental Health Treatment	11/30/15
III.C	3	Suicide Assessment and Prevention	11/30/15
III.C	4	Review of Disciplinary Measures	11/30/15
III.C	5	Mental Health Care Housing	11/30/15
III.C	6	Custodial Segregation	11/30/15
III.C	7	Staffing and Training	11/30/15
III.C	8	Suicide Prevention Training	11/30/15
III.C	9	Risk Management	05/11/15
III.D	1	Self Audits	05/11/15
III.D	2	Bi Annual Reports	05/11/15
IV.A		Compliance and Quality Improvement	05/11/15
IV.B		Compliance and Quality Improvement	11/30/16
IV.C		Compliance and Quality Improvement	05/11/15

To be audited 5/2015
To be audited 11/2015
To be audited 5/2016
To be audited 11/2016