Monitoring Report – Yuba County Jail
Fourth Quarter 2022
***Hedrick v. Grant*, E. D. Cal. No. 2:76-cv-00162-EFB**
June 2, 2023

I. EXECUTIVE SUMMARY

On January 30, 2019, United States Magistrate Judge Edmund F. Brennan granted final approval to an Amended Consent Decree ("ACD") designed to remedy ongoing constitutional and statutory violations in the Yuba County Jail (the "Jail"). The ACD required that Defendants complete implementation of the majority of its terms within nine months of the Court's final approval—that is, by October 30, 2019. Pursuant to the ACD, Plaintiffs' counsel are the court-appointed monitor of Defendants' compliance with the ACD.[1] This Monitoring Report is based on Plaintiffs' counsel's interviews with class members and review of documents covering the fourth quarter of 2022, as well as two tours of the Jail on November 8, 2022 and May 17, 2023.

Plaintiffs' counsel identified several areas of non-compliance during the review period. Among the most serious are:

1. Inadequate medical and mental health staffing;

2. Continued use of restrictive housing as long-term housing for class members with severe mental illness;

3. Improper custodial interference with mental health treatment;

4. The unexplained discontinuation of a schizophrenic class member's community prescribed medications;

5. Inadequate and untimely medical and mental-health assessments and treatment for class members housed in safety and step-down cells;

6. Inadequate sick-call triage practices; and

7. Refusals to provide relevant information.

[1] Plaintiffs' counsel represent all people incarcerated at the Yuba County Jail, including but not limited to all persons detained in cooperation with other entities of the local, state, or federal governments, such as immigration detainees.

II. INADEQUATE MEDICAL AND MENTAL HEALTH STAFFING

Section IV.A of the Amended Consent Decree requires that Defendants maintain, "at all times," the healthcare staffing levels contained in Exhibit C to the Amended Consent Decree. The staffing table in Exhibit C is reprinted below:

Minimum Staffing Pattern

Yuba County, CA Adult Staffing Plan - ADP 385										
Position	Scheduled Hours							Total Hours	FTEs	Facility
	SUN	MON	TUE	WED	THU	FRI	SAT			
Day Shift										
HSA/RN		8.0	8.0	8.0	8.0	8.0		40.0	1.00	Adult
Weekend RN sick call	8.0						8.0	16.0	0.40	Adult
RN		8.0		8.0		8.0		24.0	0.60	Adult
LVN	8.0	8.0	8.0	8.0	8.0	8.0	8.0	56.0	1.40	Adult
Clerk	8.0	8.0	8.0	8.0	8.0	8.0	8.0	56.0	1.40	Adult
Evening/Night Shift										
RN	8.0	8.0	8.0	8.0	8.0	8.0	8.0	56.0	1.40	Adult
LVN	8.0	8.0	8.0	8.0	8.0	8.0	8.0	56.0	1.40	Adult
Night Shift										
RN	8.0	8.0	8.0	8.0	8.0	8.0	8.0	56.0	1.40	Adult
LVN	8.0	8.0	8.0	8.0	8.0	8.0	8.0	56.0	1.40	Adult
Medical and Mental Health Providers										
Medical Director		3.0		3.0		3.0		9.0	0.23	Adult
PA/FNP		8.0	8.0	8.0	8.0	8.0		40.0	1.00	Adult
On-site Psychiatrist		8.0						8.0	0.20	Adult
Telepsych			8.0	8.0				16.0	0.40	Adult
MFT/LCSW		8.0	8.0	8.0	8.0	8.0		40.0	1.00	Adult
MFT/LCSW	8.0			8.0	8.0	8.0	8.0	40.0	1.00	Adult
Totals								569.0	14.23	

To verify compliance with this staffing plan, Plaintiffs' counsel reviewed the staffing data included in Defendants' second and third quarterly productions for one randomly chosen week in each month of the review period.[2] Using this data, Plaintiffs' counsel compiled tables of the daily hours worked for each employee during the week at issue. We then compared the information in these tables to the requirements in Exhibit C to the ACD.

Plaintiffs identified **multiple deficiencies** for each of the audited weeks, the most concerning of which are listed for each week below. Defendants' mental health staffing improved significantly during Q4, though it still fell short of the ACD's requirements. And Defendants' PA/FNP staffing was severely deficient during each of the audited weeks.

- Week of October 16, 2022

  LVN – The ACD requires that at least one LVN be working at the Jail 24 hours per day, seven days per week, for a total of 168 hours per week. Defendants' LVNs collectively worked only 134.45 of the 168 hours required, including 17.7 hours on Sunday, October 16; 19.1 hours on Wednesday, October 19; 19.1 hours on

[2] Plaintiffs reviewed Defendants' staffing data for weeks beginning October 16, November 6, and December 11, 2022.

Thursday, October 20; 12.3 hours on Friday, October 21; and only 6 hours on Saturday, October 22.

MFT/LCSW – The ACD requires that Defendants' MFT/LCSWs collectively work at least 80 hours each week at the Jail. During the week of October 16, Defendants' MFT/LCSWs worked only 70.5 of the 80 required hours, including no hours at all on Wednesday, October 19, and only 2.17 hours on Thursday, October 20.

PA/FNP – The ACD requires that Defendants' PA/FNPs collectively work at least 40 hours each week. During the week of October 16, Defendants' PA/FNPs worked a total of only 3.67 hours, or less than *one tenth* of the hours required by the ACD.

Psychiatry – The ACD requires that an on-site psychiatrist work at least eight hours per week at the Jail, and that an additional 16 hours of psychiatry coverage be provided by either an on-site psychiatrist or a telepsychiatrist. During the week of October 16 Defendants' psychiatrist worked only 16 of the 24 required hours.

- Week of November 6, 2022

LVN – Although Defendants' LVNs collectively worked more than the total number of required hours for the week as a whole, a large fraction of these hours were clustered during the first half of the week of November 6. Defendants' LVNs worked only 19.28 hours on Thursday, November 10; only 13 hours on Friday, November 11; and only 13.5 hours on Saturday, November 12.

MFT/LCSW – Similarly, although Defendants' MFT/LCSWs worked more than the total number of required hours for the week of November 6, these hours were clustered during the second half of the week. Defendants' MFT/LCSWs worked only 1.75 of the required 8 hours on Sunday, November 6, and none of the required 8 hours on Monday, November 7.

PA/FNP – Defendants' PA/FNP worked only 11.54 of the required 40 hours during the week of November 6.

- Week of December 11, 2022

LVN – Although Defendants' LVNs collectively worked more than the total number of required hours for the week as a whole, they worked only 16 hours on Sunday, December 11, only 17.77 hours on Wednesday, December 14, and only 4.87 hours on Saturday, December 17.

PA/FNP – Defendants' PA/FNP worked only 4.92 of the required 40 hours during the week of December 11.

During a previous tour of the Jail, Wellpath representatives suggested that the staffing data they provide to class counsel does not include the hours worked by certain salaried Wellpath employees who do not clock in or out when they work at the Jail. ***If Defendants contend that any of the deficiencies noted above are a product of their inadequate data and do not accurately reflect the medical and/or mental health staffing during the audited weeks, we ask that they provide sworn affidavits or similar evidence in support of their position. Such documentation should specify the identity of the salaried employee, the date(s) on which he or she worked, and number the number of hours worked on each date. Otherwise, Defendants must work with Wellpath to eradicate these unacceptable and dangerous staffing shortages.***

III. RESTRICTIVE HOUSING REVIEWS

Section IX.A of the ACD states that "Defendants shall strive to limit the placement of inmates in Segregated Housing for prolonged periods of time." To this end, Defendants must "review the placement of inmates in Segregated Housing at least once a month" and "more frequently if necessary for certain categories of inmates, such as…individuals with serious mental illness." Classification officers also must "consult medical staff concerning each inmate's progress toward the goal of placing the inmate in general population." ACD at 55.

On November 11, 2022, Plaintiffs requested that Defendants produce "full printout[s]" of all "housing classification review" documents for six class members. On December 2, 2022, Defendants produced incomplete documentation for only five class members. Plaintiffs again requested complete classification reports for the six class members in a letter dated December 28, 2022, explaining that the "comment" section of the documents had been "cut off" and that this made it "difficult for Plaintiffs to evaluate compliance" with the ACD provisions quoted above. Defendants did not respond to this letter and Plaintiffs still have not received the requested documentation. Defendants' January 11, 2023 response to the relevant findings in Plaintiffs' previous monitoring report, meanwhile, states only that Defendants "consider[] the totality of the circumstances in determining if the inmate should be rehoused or remain in Ad Seg."

Please produce the requested documentation and explain (a) who conducts the required classification reviews, (b) what factors are considered in these reviews, and (c) which medical staff, if any, are consulted for purpose of these reviews.

IV. CUSTODIAL INTERFERENCE WITH MENTAL HEALTH TREATMENT

On May 25, 2023, Plaintiffs' counsel alerted Defendants to documentation in a class member's medical records indicating that, in [redacted], a custody officer actively interfered with an evaluation of class member [redacted] by a telepsychiatrist. This documentation, which consisted of the telepsychiatrist's notes from the evaluation, states, in relevant part: "Cont to endorse active s/h ideations, plan to starve

himself/poison with water or any other available way 'I can pull trigger now if I have gun' **Jail authority presented in room commented 'no he would not.'**" (emphasis added). As Plaintiffs' counsel explained in their May 25 email to Defendants, the bolded text above suggests that the custody officer was not only present in the room during Mr. [redacted]'s psychiatric evaluation—a serious problem in itself—but also *actively interfered with the evaluation* by interrupting Mr. [redacted] and disputing his description of his own symptoms to the telepsychiatrist.

In light of this evidence, Plaintiffs demanded that Defendants (1) identify the officer involved in this incident, (2) investigate the officer's conduct, (3) discipline and/or train the officer if warranted, and (4) identify any other concrete steps Defendants will take to ensure that such highly inappropriate custodial interference with class members' mental health treatment does not continue. In response, counsel for Defendants wrote that "custodial personnel will reminded/trained to insure there are no interruption during medical or mental healthcare visits for inmates. Personnel matters will be handled internally and will not be shared as requested, suffice it to say the matter will be investigated and handled as deemed appropriate."

Please provide documentation showing when the promised training occurred and who attended this training.

V. UNEXPLAINED DISCONTINUATION OF COMMUNITY PRESCRIBED MENTAL HEALTH MEDICATIONS

The ACD states that "all inmates who, at the time of booking, are prescribed medications in the community, and it is verified those medications are currently being taken, shall be timely continued on those medications, or prescribed comparable appropriate medication, unless a physician, NP, PA, or psychiatrist makes a clinical determination…that the medications are not necessary for treatment, and documents the clinical justification for discontinuing a community-prescribed medication." ACD at 20.

Defendants did not comply with these requirements when class member [redacted] was booked into the Jail in [redacted]. Mr. [redacted] suffers from schizophrenia but at the time of his arrest was compliant with medications he had been prescribed in the community. Jail mental health staff initially reported that Mr. [redacted] was "calm" and was willing and able to participate in treatment. But for reasons that are not clear, Jail mental health staff apparently refused his multiple requests to continue his medications—even after they successfully "verified [the medications] from the pharmacy." Without his medications, Mr. [redacted] quickly decompensated and became increasingly hostile and aggressive. [redacted] It is possible that at least some of this could have been avoided had Jail staff complied with the continuity of care provisions in the ACD. At the

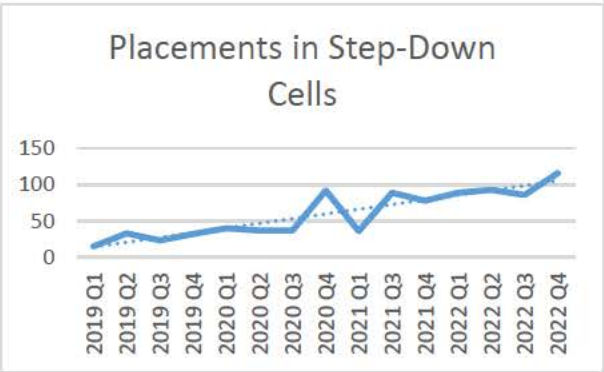
very least, Jail staff were required to document a clinical justification for discontinuing his community prescribed medications. Their failure to do so is a clear violation of the ACD.

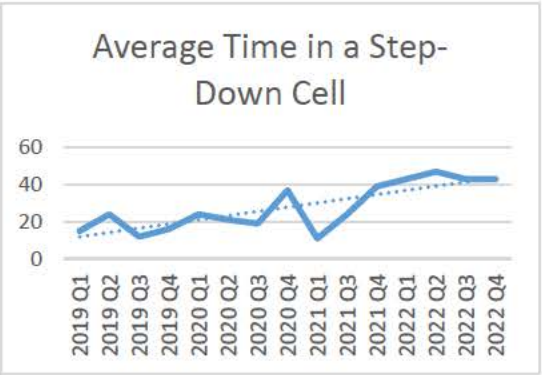
VI. SAFETY AND STEPDOWN CELLS

A. Improper Use of Stepdown Cells as a Substitute For Adequate Mental Health Treatment

As during prior monitoring periods, Defendants continued to house certain class members in stepdown cells for weeks or even months at a time. A number of class members have been housed in a step-down cell until the 120-hour cap in the ACD is reached. Defendants then, as required by the ACD, transport the person to Rideout. When Rideout does not admit the person, Defendants place the person back in the step-down cell. The cycle then repeats. For example, Defendants' incident reports and "5150 referral forms" indicate that class member [redacted] cycled between the Jail's safety/stepdown cells and Rideout [redacted]. (Indeed, based on class counsel's brief interaction with Mr. [redacted] during the May 17, 2023 Jail tour, he [redacted].)

Mr. [redacted]'s experience is not unique. During the fourth quarter of 2022 alone, class members [redacted], [redacted], and [redacted] were placed in a step-down cell nine, ten, and twelve times, respectively. As shown in the charts below, Defendants' use of stepdown cells has been increasing—both in terms of the number and length of placements—since the monitoring phase of this case began in 2019.





While we do not object to the use of stepdown cells when needed, we *do* object to Defendants using stepdown cells as a substitute for adequate treatment of class members' underlying mental health conditions. Given the apparent barriers to class members receiving adequate inpatient mental health care at Rideout and Sutter-Yuba Behavioral Health, ***Defendants must either locate alternative inpatient mental health beds for such***

class members or create appropriately therapeutic housing options at the Jail itself rather than housing such class members in stepdown cells indefinitely.[3]

During the November 8 tour, Defendants reported some progress in developing on-site competency restoration programs for persons found incompetent to stand trial, though they also reported that such persons continue to wait many months before beds become available in state facilities. In our December 2 monitoring report we asked several questions about these programs, including:

1. *How many class members are currently participating in the Jail-Based Competency Treatment and Early Access and Stabilization programs?*

2. *How many have participated since these programs became available at the Jail?*

3. *Are there any limits on who can participate (e.g., limits based on security classification or housing location within the Jail)?*

Defendants' January 11, 2023 response to the December 2 monitoring report did not respond to any of these questions.

Please provide the previously requested information about the JBCT and EAS programs.

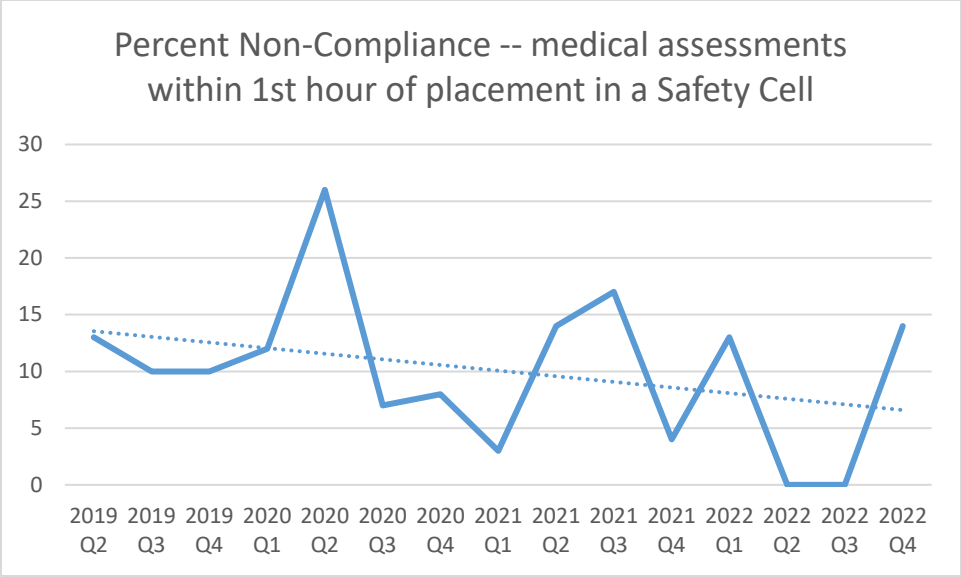
B. Medical and Mental Health Assessments of Class Members in Safety and Stepdown Cells

The ACD includes multiple deadlines relating to the placement and evaluation of class members in safety and stepdown cells. Defendants' compliance with these deadlines was mixed during Q4.

<u>One-Hour Medical Assessments</u>

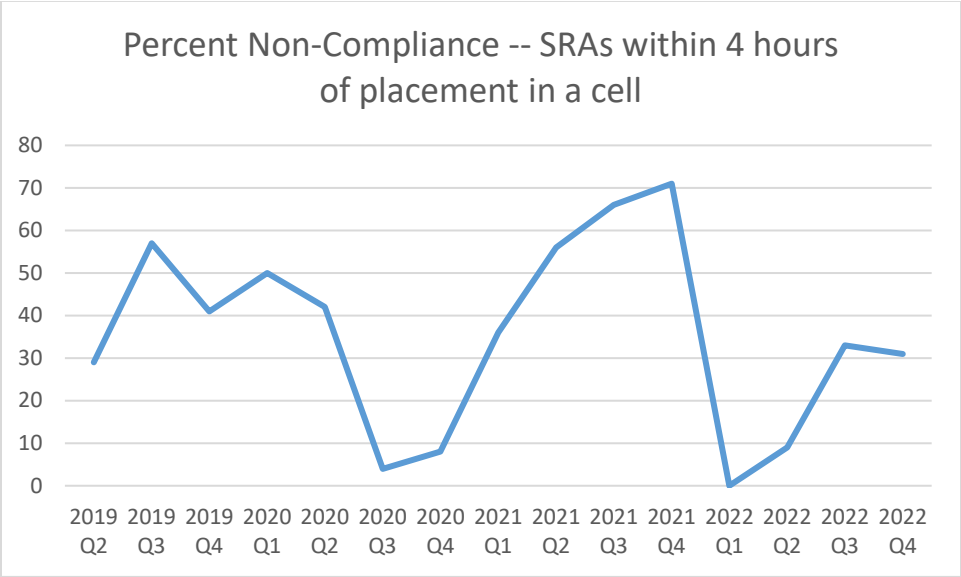
Defendants were in partial compliance with the requirement that "[a]n inmate must receive a medical assessment by a physician, PA, NP, or RN within one (1) hour (unless unsafe to do so under the circumstances) of placement into a safety cell, to determine whether said placement is appropriate." ACD at 40. Defendants documented the required 1-hour evaluation in 30 of 35 instances in which a class member was placed in a safety cell during Q4. This amounts to a significant increase in Defendants' non-compliance with this requirement since the third quarter of 2022, and a return to the high levels of non-compliance in earlier periods of this litigation.

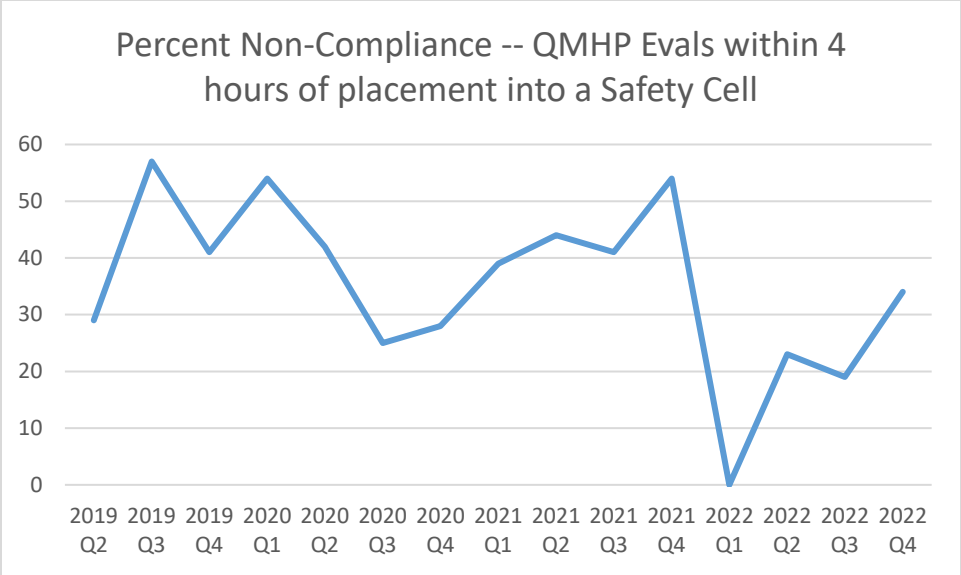
[3] *See* Letter from Gay C. Grunfeld to Defendants re: Overuse of Restrictive Housing for People with Serious Mental Illness, Sept. 17, 2021.



Suicide Risk Assessments and Mental Health Evaluations

The ACD also requires that "[a] Qualified Mental Health Professional, Physician, PA, NP, or RN must conduct a suicide risk assessment on all prisoners placed in safety cells as soon as possible, but no later than within four (4) hours of safety cell placement." ACD at 40-41. Defendants were non-compliant with this requirement in 11 of 35 safety cell placements during Q4. There is little sign of improvement over time in the timeliness of suicide risk assessments and initial mental health evaluations after placement in a safety cell. This is dangerous and unacceptable.



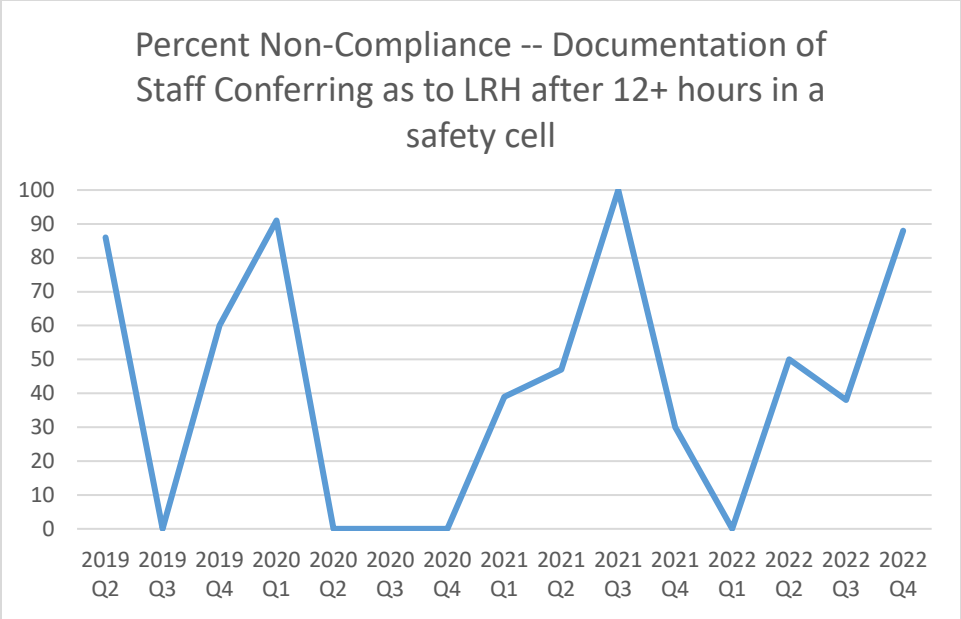


Medical and Mental Health Evaluations

The ACD requires that all class members placed in safety cells be "evaluated at least once every six (6) hours by medical staff and at least once every twelve (12) hours by a Qualified Mental Health Professional." ACD at 41. Defendants were fully compliant with the 6-hour medical evaluation requirement during Q4 and were compliant with the 12-hour mental health evaluation requirement in 34 of the 35 safety cell placements in Q4.

Safety Cell Placement Reviews

By contrast, Defendants were almost entirely *non*-compliant with the ACD's requirement that "[e]very twelve (12) hours, custody, medical, and mental health care staff must review whether it is appropriate to retain an inmate in a safety cell or whether the inmate can be transferred to a less restrictive housing placement." ACD at 42. Of the 16 times that a class member was in a safety cell for longer than twelve hours, mental health staff, medical staff, and custody staff documented that they conferred as to whether it was appropriate to retain the class member in a safety cell in only **two** placements; they did not confer in 14 placements.



Psychiatric Consultations

The ACD prohibits Defendants from placing a class member in a safety cell more than once in a 120-hour period unless they first consult with a psychiatrist regarding the placement. *See* ACD at 42. There were four instances in which a psychiatrist should have been consulted because a class member was placed into a safety cell two or more times within a 120-hour period. The psychiatrist was not consulted for two of those instances.

The ACD also requires on-site mental health staff to consult with a psychiatrist at least once every 24 hours while a class member is housed in a stepdown cell. Of the 52 step-down placements in which staff should have consulted with a psychiatrist for further placement, they either did not do so or they did not do so consecutively in 47 of those placements.

12-Hour Cleanings

The ACD requires that Defendants "clean safety cells at least every twelve (12) hours when occupied, unless it is not possible to do so because of safety concerns." ACD at 43. There were 16 instances in which class members were placed into safety cells for more than 12 hours. Of those instances, all but three contain documentation that the cell was cleaned during the class member's stay.

VII. INADEQUATE SICK-CALL TRIAGE PRACTICES

Section V.B.9 of the Amended Consent Decree requires "daily sick call" for "all inmates requesting medical attention." Pursuant to this section, a Physician's Assistant (PA), Nurse Practitioner (NP), or Registered Nurse (RN) must triage all sick call requests

within 24 hours of submission and determine the urgency of each request. Those requests raising "emergent" issues must be completed "immediately"; those raising "urgent" issues must be completed "within 24 hours"; and those raising "routine" issues must be completed "within 72 hours, unless in the opinion of the PA, NP, or RN that is not medically necessary." Where the PA, NP, or RN concludes that it is not medically necessary for a sick call request to be completed within 72 hours, he or she must note the basis for that conclusion.

Defendants' responsiveness to sick call requests has slowly improved since 2019, and during Q4 only nine of 69 sick calls listed in Defendants' "sick call tracker" were evaluated after more than 72 hours.

As in recent quarters, however, Defendants classified every sick call listed in the tracker produced to Plaintiffs' counsel as "routine," thereby excusing themselves from meeting the 24-hour deadline for evaluating "urgent" requests. Plaintiffs have repeatedly asked Defendants to identify the criteria staff use to identify "urgent" requests, and Defendants have repeatedly failed to respond to this request. At least some of the 69 sick calls listed on Defendants' tracker likely should have been classified as urgent. For example, one class member who complained of a hernia was not evaluated for more than four days, and another who complained of "irregular bleeding" was not evaluated for more than three days.

Please explain what criteria staff use to identify "urgent" requests.

VIII. CONCLUSION

During the fourth quarter of 2022 there was little improvement in Defendants' longstanding non-compliance with key ACD provisions relating to mental health and suicide prevention. Defendants' mental health staffing remains severely deficient, there was little in the way of substantive treatment for class members with the most serious mental illness, and Defendants continued to rely on restrictive housing, including safety and step-down cells, to limit these class members' ability to harm themselves instead of treating their underlying conditions. In addition to these longstanding problems, the documentation reviewed by Plaintiffs' counsel for Q4 revealed additional problems such as improper custodial interference with the minimal mental health treatment class members did receive, as well as serious gaps in the continuity of care for class members who received mental health medication in the community prior to their arrest.

Given the high number of deaths at the Jail over the past two years, Defendants must take proactive steps to safeguard class members' safety and their constitutional rights to adequate medical and mental health care. In addition to bringing the Jail's policies and practices into compliance with all requirements of the ACD, these steps must include, at a minimum, ensuring that proper life-saving equipment is (or continues to be) readily and easily accessible in all locations of the Jail where class members are located;

ensuring that all staff are (and continue to be) properly trained on how to properly respond to emergencies; and identifying and eliminating any remaining suicide risks (even if not previously identified by Defendants' consultants) in areas of the Jail where class members are located.