Monitoring Report – Yuba County Jail
First and Second Quarters – 2021
***Hedrick v. Grant*, E. D. Cal. No. 2:76-cv-00162-EFB**
October 26, 2021

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"). Pursuant to the ACD, which is attached to this Report as **Exhibit 1,** Plaintiffs' counsel are the court-appointed monitor of Defendants' compliance with the ACD. 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—and that they complete certain architectural modifications by the end of 2021. Defendants' compliance with the provisions in the ACD relating to architectural modifications was discussed in an October 2020 monitoring report and will be reassessed in a future monitoring report.

This Report assesses Defendants' compliance with the ACD during the first and second quarters of 2021. It is based on documents covering the first and second quarters of 2021, a tour of the Jail on May 27, 2021, and telephonic and in-person interviews with class members conducted between January 2021 and July 2021.

Plaintiffs' counsel identified several areas of non-compliance during Q1 and Q2 2021, among which the most concerning are:

1. A failure to follow protocols governing the treatment of new intakes [redacted] which led to the death of a [redacted] class member at the Jail on [redacted]

2. Continued use of step-down cells and administrative segregation as long-term housing for class members with severe mental illness;

3. Continued placement of class members in administrative segregation because of, or in spite of, the class members' severe mental illness;

4. Failure to provide class members with inpatient mental health care when needed;

5. Inadequate medical and mental health staffing;

6. Denial of assistive devices to class members with disabilities based on inappropriate blanket rules rather than a consideration of individual circumstances;

For certain other areas of the ACD, Plaintiffs' counsel have not been provided sufficient information to determine if compliance exists or not. Throughout this Report, Plaintiffs have made requests for information, documents, or action by Defendants. These requests are in bold.

Defendants' inadequate treatment and housing of class members with serious mental illness is particularly troubling and may necessitate litigation to compel Defendants' compliance with the ACD. As class counsel explain in a letter to Defendants dated September 17, 2021, *see* **Exhibit 2**, some class members, whose mental illness is so severe that the Jail staff have concluded that they can only be housed in a safety or step-down cell, have cycled back and forth between those cells and Rideout Memorial Hospital, where they are held for a few hours at most before being returned to a safety or step-down cell at the Jail. Other class members who may or may not need inpatient mental health treatment are held in administrative segregation for prolonged periods of time because of, or in spite of, their severe mental illness. As explained in our September 17 letter, these practices closely resemble the approach to mental health care that was common at the Jail before the ACD and that the ACD was intended to change.

Pursuant to Section XIX of the ACD, Plaintiffs' September 17, 2021 letter requested a written response from Defendants within 30 days. The only written responses Defendants have offered to date are a letter dated October 6, 2021, in which Defendants wrongly suggested that issues relating to mental health care at the Jail are beyond the scope of the ACD, and an October 13, 2021 email in which Defendants wrongly asserted that they "are in strict compliance with the ACD."

Class counsel requests that the parties meet to discuss potential remedies for the additional violations in this Report no later than **November 29, 2021**.

II. DEATH OF CLASS MEMBER

At some point on [redacted], a [redacted]-year-old class member ("Class Member A")[1] died in one of the holding cells in the Jail's booking area. According to the records Defendants have produced to Plaintiffs' counsel, Class Member A was booked into the Jail [redacted] He was "uncooperative and combative" during the booking process and refused an intake health screening around [redacted] that day. At [redacted] jail staff wrote that he was [redacted] Jail staff then [redacted] One of the Jail staff who encountered Class Member A on [redacted] noted that [redacted] Approximately two hours

[1] The identities of specific class members discussed in this report are listed in **Exhibit 3**.

later Class Member A told a Jail staff member that [redacted] The staff member wrote that he or she would "follow up Monday," which was two days later. Jail staff discovered Class Member A unresponsive in his cell around [redacted] An autopsy subsequently determined that Class Member A died of [redacted] The autopsy also confirmed that [redacted]

Based on the records provided to class counsel, it appears that Jail staff failed to adhere to several policies and protocols during the three days Class Member A spent at the Jail before his death. Wellpath[2] Policy [redacted] requires that [redacted] Although Class Member A refused to answer questions during his intake health screening, the RNs who attempted to conduct that screening were aware that [redacted] Yet Class Member A was neither seen by a healthcare practitioner at the Jail nor sent to the emergency room for evaluation, as required by Policy [redacted] Nor does it appear from the records produced to class counsel that Jail staff adhered to [redacted] There is no evidence in these records that staff utilized [redacted] *Id.*

It is also unclear why Jail staff did not respond with greater urgency to Class Member A's report that [redacted] During our May 27, 2021 tour of the Jail class counsel asked a representative from Wellpath what she would do in the event that a person under her care reported [redacted] This individual stated that she would immediately call [redacted] to determine whether [redacted] represented an "emergency." When class counsel subsequently asked what the appropriate course of action would be if the individual was [redacted] the Wellpath representative stated that she would "notify" the Jail physician "at the next MD sick call." Pursuant to Section V.B.9 of the ACD, Defendants are required to provide sick call on a "daily" basis, but on [redacted]

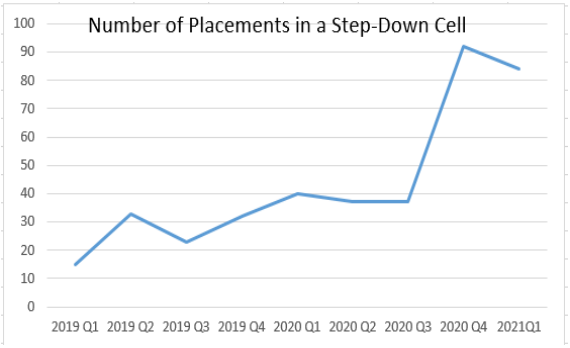
[2] Wellpath is the County's third-party provider of medical and mental health services at the Jail. Effective September 1, 2021, the County extended its contract with Wellpath for one year, at a cost of $411,440.38 per month. *See* **Exhibit 4**.

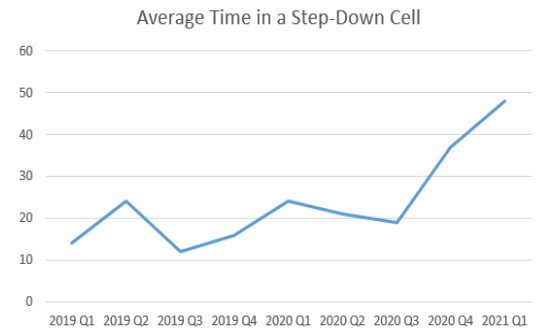
[redacted] Jail staff wrote that they would follow up "on [redacted]"—that is, two days later.

Please explain why Defendants failed to adhere to their own policies relating to [redacted] Please also explain why Defendants did not respond with greater urgency to Class Member A's report that [redacted] Finally, please identify what steps, if any, Defendants are taking to ensure that their policies are followed in the future and that class members with serious medical conditions—including [redacted]—are provided adequate care.

III. CONTINUED USE OF STEP-DOWN CELLS AND ADMINISTRATIVE SEGREGATION AS LONG-TERM HOUSING FOR CLASS MEMBERS WITH SERIOUS MENTAL ILLNESS.

Plaintiffs' counsel previously identified Defendants' use use of step-down cells as long-term housing for certain class members with serious mental illness as a violation of numerous provisions of the ACD. *See* Q3-Q4 2020 Monitoring Report at 3-7; *see also* **Exhibit 2 (**Letter of Sept. 17, 2021). This problem persisted during Q1 and Q2 of 2021, as the number of step-down cell placements remained near an all-time high despite the Jail's reduced population. The average length of time class members were held in step-down cells also continued to increase.[3]





Class Member B, whom Plaintiffs' counsel discussed in the Q3-Q4 2020 monitoring report, continued to be housed in a step-down cell through at least [redacted] During our May 27 tour of the Jail, Class Member B described the nearly seven months he spent in the step-down cell as "more isolating than a SHU."[4] Class Member B

[3] The Y axis in the table labeled "Average Time in a Step-Down Cell" refers to the average number of hours that class members spent in a step-down cell during each quarter since Q1 2019.

[4] The term SHU is an acronym for "Security Housing Unit," which are punitive segregation units used by the California Department of Corrections and Rehabilitation

also reported that he had been refused inpatient care at Sutter-Yuba Behavioral Health due to the nature of his criminal charges. [redacted][5]

Class Member D, also discussed in the Q3-Q4 2020 monitoring report, was placed in a safety or step-down cell on 24 separate occasions during the review period. When Class Member D was not in a step-down cell, Defendants generally housed him in administrative segregation. The long duration of Class Member D's confinement in restrictive housing may have exacerbated his preexisting mental illness. According to Class Member D's medical records, he [redacted]

Class Member G was placed in a safety or step-down cell at least eight times during the review period. Class Member G was housed in administrative segregation when he was not housed in a step-down cell, and his prolonged confinement in restrictive housing may have exacerbated his preexisting mental illness. *See* Incident 81045 [redacted] (describing Class Member G's [redacted]); Incident 81217 [redacted] (same).

Class Member K was placed in a safety or step-down cell at least five times during [redacted] alone. In response to an inquiry from Plaintiffs' counsel in [redacted], Defendants stated that Class Member K's "normal housing assignment is in a Medical Cell" due to his need for [redacted], but that from [redacted] through [redacted] he had been housed in a safety or step-down cell. It appears that Class Member K was sent to Rideout for mental health evaluations at least four times during Q2 but was not admitted for inpatient mental health care on any of these occasions. On [redacted] Class Member K was [redacted]

(CDCR) to house certain individuals convicted of criminal offenses and/or disciplinary infractions occurring within the state prison system.

[5] Defendants have produced medical records for Class Member B from Rideout and certain medical records from the Jail reflecting care that was provided to Class Member B prior to March 2020. Despite numerous requests, class counsel have not been provided with any records related to the care Class Member B received at the Jail between March 2020 and May 2021. This refusal to provide class counsel with the requested records violates Section XV of the ACD and the parties stipulated order governing the production of class member medical records that was entered by the Court on May 17, 2021. *See* Dkt. No. 265.

[redacted]

IV. CONTINUED PLACEMENT OF CLASS MEMBERS IN ADMINISTRATIVE SEGREGATION BECAUSE OF, OR IN SPITE OF, THE CLASS MEMBERS' SEVERE MENTAL ILLNESS

Section IX of the ACD states that "[i]nmates shall not be housed in Administrative Segregation solely because they have a mental illness." Section VI.B further requires Defendants to "limit the use of Segregated Housing, including Administrative Segregation and safety cells, for inmates with serious mental illness or who present a serious suicide risk."

Plaintiffs' counsel previously found that Defendants regularly housed class members in administrative segregation because of their mental illness, but that in Q4 2020 Defendants either ended this practice or stopped documenting it on incident reports, as they had previously done. *See* Q3-Q4 Monitoring Report at 17. Plaintiffs requested that Defendants identify any changes in policy in this area and that Defendants explain where and under what conditions Defendants would be housing class members with serious mental illness in the future. *Id.* In their response to Plaintiffs' monitoring report, Defendants maintained that all placements were appropriate and there were unidentified "issues related to documentation" that Defendants had corrected. *See* Defs.' July 7, 2021 Response at 14-15. In their October 13, 2021 response to Plaintiffs' September 17 letter objecting to Defendants' housing of people with serious mental illness in overly restrictive settings, Defendants again maintained that they "are in strict compliance with the ACD."

During Q1 and Q2 of 2021, however, Defendants continued to cite class members' mental illness as the basis for their placement in administrative segregation. *See, e.g.*, Incident 80964 [redacted] (class member placed in ad-seg "due to statements of having issues with a lot of people and other mental health issues"); Incident 81284 [redacted] (class member placed in ad-seg because he "has mental health issues and tends to talk to himself and he refused to answer the classification questions"); Incident 81640 [redacted] (same). This is a clear violation of Section IX of the ACD. It also violates the ADA. *See* 28 C.F.R. § 35.130(d) (requiring public entities to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities"); *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 597 (1999) ("[u]njustified isolation … is properly regarded as discrimination based on disability").

During our May 27, 2021 tour of the Jail, we also observed numerous class members housed in segregation in A-Pod who appeared to be floridly psychotic. Regardless of whether mental illness was the sole reason for these individuals' placement in A-Pod, the Jail's practice of housing such class members in segregation rather than a

specialized mental health unit or other less-restrictive setting places them at a substantial risk of serious harm. *See, e.g., Coleman v. Brown*, 28 F. Supp. 3d 1068, 1099 (E.D. Cal. 2014) ("[P]lacement of seriously mentally ill inmates in the harsh, restrictive, and non-therapeutic conditions of California's administrative segregation units for non-disciplinary reasons for more than a minimal period … violates the Eighth Amendment."); *Hernandez v. County of Monterey*, 110 F. Supp. 3d 929, 947-48 (N.D. Cal. 2015) (granting preliminary injunction based on evidence that, among other things, "Defendants house the inmates with the most serious mental illness and who are most clinically unstable in segregation units *because* of their mental illness"). As we explained in our letter of September 17, 2021, Defendants must immediately cease their practice of holding mentally ill class members in restrictive housing for prolonged periods of time and comply with the ACD's requirement that people with serious mental illness be housed in segregation only as a last resort. *See* ACD § IX.

As noted above and in our September 17, 2021 letter, *see* **Exhibit 2**, this approach to mental health treatment prevailed at the Jail before the ACD, and improving the care provided to class members in these circumstances represents one of the core purposes of the ACD. Following a recent phone call with class counsel, Defendants provided class counsel with a copy of a design-build contract that the Yuba County Board of Supervisors conditionally awarded to Sletten Companies / Arrington Watkins Architects in March 2021 for the construction of the new medical and mental health facility that Defendants received state funding to construct in 2015. *See* **Exhibit 5** This contract appears to require that the facility be completed no later than June 2, 2023. During our May 27, 2021 tour of the Jail, however, Captain Garza indicated that the facility likely would not be complete before 2024.

Please provide us with an update on the progress of the new facility. Please also explain what Defendants will do in the interim to ensure that class members with severe mental illness are not housed in overly restrictive settings, in violation of the ACD. Finally, please identify where in the Jail each of the class members listed in* Exhibit 6 *have been housed since they were booked into the facility.

V. LACK OF INPATIENT MENTAL HEALTH CARE

The ACD requires Defendants to "ensure that inmates are provided timely access to inpatient and outpatient mental health care as needed." ACD § V.B.6. In the same section, the ACD also requires Defendants to transfer "[i]nmates requiring services beyond the on-site capability of the Jail" to "appropriate off-site providers." *Id.* The ACD further requires Defendants to document "all steps taken to expeditiously transfer" these class members. *Id.* § VI.B.

During the review period, Defendants sent a class member to Rideout's emergency department on a so-called "5150 hold" at least 35 times. As far as we can tell, *none* of

the 35 individuals whom Defendants sent to Rideout on a "5150 hold"[6] were admitted for inpatient mental health treatment, and only two spent more than a few hours at Rideout: one for two days and the other for three days.

In their response to similar findings in Plaintiffs' previous monitoring report, Defendants stated, *inter alia*, that "inpatient placements are simply not available and waits for such placement can be extremely long." Defs.' July 7 Response at 7. Some medical records from Rideout, such as those for Class Member B, further indicate that certain class members' security classifications may be resulting in them being refused inpatient treatment based on non-clinical factors.

The ACD does not absolve Defendants of their responsibility to provide adequate inpatient mental health care to class members who need it simply because Rideout lacks space or refuses to admit patients for other non-clinical factors. Defendants have not provided any documentation of their efforts, if any, to secure inpatient mental health treatment at locations other than Rideout.

Please explain what Defendants are doing to make inpatient mental health care available to class members who need it.

VI. 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	

[6] California Welfare & Institutions Code § 5150 states, in relevant part, that a peace officer, upon a showing of probable cause, may take a person into custody for evaluation and treatment for up to 72 hours for "assessment, evaluation, and crisis intervention."

To verify compliance with this staffing plan, Plaintiffs' counsel reviewed the staffing data included in Defendants' third and fourth quarterly productions for one randomly chosen week in each month of the review period. Using this data, Plaintiffs' counsel compiled tables of the daily hours worked for each employee during the week at issue. These tables are attached to this report as **Exhibit 7**.[7] We then compared the information in these tables to the requirements in Exhibit C to the ACD. Squares highlighted in yellow indicate that Defendants' employees worked fewer hours on that day than Exhibit C requires for the position at issue.

As shown in the table below, Defendants' were non-compliant with many of their staffing obligations during Q1 and Q2 2021. Indeed, Defendants' compliance with their staffing obligations significantly worsened over the course of the review period.

	Q1 2021			Q2 2021		
	1/24-1/30	2/7-2/13	3/7-3/13	4/18-4/24	5/16-5/22	6/13-6/19
Clerks	X	X	X		X	X
HSA/RN			X	X		X
LVN			X	X		X
Medical Director						X
MFT/LCSW			X	X	X	X
PA/FNP						
Psychiatrist/Telepsych			X	X	X	
RN			X			

Psychiatry – The ACD requires that a psychiatrist work on-site at the Jail at least eight hours per week. The Jail also requires that sixteen additional hours of psychiatry coverage be provided by either a telepsychiatrist or an on-site psychiatrist. Defendants did not have *any psychiatry coverage whatsoever* during the weeks of March 7, April 18, and May 16. This is unacceptable, particularly in light of Defendants' practice of housing class members with severe mental illness in restrictive housing for prolonged periods of time.

[7] The data provided to Plaintiffs' counsel lists the number of hours each employee worked on a given day but does not indicate the time of day the employee was on-site at the Jail. As a result, Plaintiffs' counsel were able to determine whether the total number of required hours for each position was satisfied on a given day, but not whether, for example, the 24 LVN hours worked on that day were appropriately spread between first, second, and third shifts so that an LVN was on site 24 hours per day.

HSA – During the week of March 7, the HSA worked only 13.5 hours rather than the required 40 hours.

LVN – The ACD requires that Defendants have an LVN on-site at the Jail 24 hours per day, seven days per week. Several of the weeks Plaintiffs' counsel reviewed, however, included days when Defendants' LVNs did not collectively work at least 24 hours. On March 10 and 11, for example, Defendants' LVNs worked a total of 12.5 and 11.25 hours, respectively. On April 21, 22, 23, and 24, Defendants' LVNs worked 15.9 hours, 8.18 hours, 15.5 hours, and 4.82 hours, respectively. Although Defendants' LVN staffing improved in May and June, there was an LVN on site for only 12.83 hours on June 19.

MFT/LCSW – The ACD requires that an MFT/LCSW work at the Jail for at least 8 hours per day on Sundays, Mondays, Tuesdays, and Saturdays, and that two MFT/LCSWs work a combined total of 16 hours at the Jail each Wednesday, Thursday, and Friday. On Saturday, March 13, however, Defendants' MFT/LCSWs worked a total of only 2 hours at the Jail. MFT/LCSW staffing deteriorated further in April, when Defendants were compliant on only 3 of 7 days in the audited week. In May there was no MFT/LCSW on-site at all on one day during the audited week, and on another day the MFT/LCSW was on-site for only 2.17 hours. During the week of June 13 there was no MFT/LCSW on-site on either Friday or Saturday.

RN – The ACD requires that Defendants have at least one RN on site at the Jail 24 hours per day—not including the HSA/RN who must be onsite each weekday for at least 8 hours—except for Tuesdays and Thursdays, when there must be at least one RN on site (again, not including the HSA/RN) for at least 16 hours per day. Defendants' RN staffing was compliant for all but one of the audited days during the review period, when RNs collectively worked only 23.15 hours.

VII. DENIAL OF DISABILITY ACCOMMODATIONS BASED ON INAPPROPRIATE BLANKET RULES AND WITHOUT INTERACTIVE PROCESS.

Section V.D of the Amended Consent Decree requires that the Jail adhere to the Americans with Disabilities Act (ADA) and all other applicable federal and state laws, regulations, and guidelines. Section V.D.3 of the ACD requires Defendants to "offer reasonable accommodations to inmates with disabilities necessary to provide access to all programs, services and activities offered to other inmates[.]" ACD at 37. Furthermore, "[i]f there is a question regarding the ability of the Jail to provide an accommodation, Defendants shall conduct an interactive process to determine whether a reasonable accommodation can afford an inmate with a disability the ability to participate in a program, service, or activity." *Id.*

Class Member H reported to class counsel in [redacted] that the Jail had refused to provide her with a solid back brace that her doctor had prescribed for [redacted] Although the Jail did eventually provide Class Member H with a soft lower-back brace, Class Member H reported that this device did not provide her with adequate support because it lacked a hard plate extending the full length of her back. Without this support, Class Member H reported that she regularly missed Jail activities such as meals and yard because getting up from her bed caused her significant pain. Class Member H further reported that she had been provided with a proper brace before she was incarcerated, and that that brace made it feasible for her to participate in normal daily activities. Class Member H's medical records confirmed that [redacted]

When Plaintiffs' counsel brought Class Member H's complaint to Defendants' attention in [redacted] Defendants stated that Class Member H "was provided with a brace which meets her needs" but provided no details to support this conclusory assertion. Defendants also cited "custody requirements for safety purposes" as a basis for denying Class Member H the brace she had requested and explained that "items which are made from metal, plastic, or other rigid materials are not allowed within the facility." *Id.*[8] Such a sweeping rule violates the ADA, as it categorically precludes necessary assistive devices. *See, e.g.*, *Armstrong v. Brown*, 857 F. Supp. 2d 919, 932 (N.D. Cal. 2012) (ADA violation premised on, among other things, Yuba County Jail's refusal to provide inmate with wheelchair). Defendants' vague, conclusory invocation of their interest in preserving jail security does not absolve them of their obligation to provide reasonable accommodations to class members, including but not limited to Class Member H. *See generally Armstrong v. Davis*, 275 F.3d 849, 874 (9th Cir. 2001) (prison authorities "cannot avoid court scrutiny [of their compliance with ADA obligations] by reflexive, rote assertions" of penological interests); *Pierce v. County of Orange*, 526 F.3d 1190, 1211 (9th Cir. 2008) ("The district court should not have blindly deferred to the County's bare invocation of security concerns."); 28 C.F.R. § 35.130(h) (requiring that public entities "ensure that [their] safety requirements are based on *actual risks, not on mere speculation*, stereotypes, or generalizations") (emphasis added).

Moreover, Defendants did not identify any evidence suggesting that they had attempted to engage in an interactive process with Class Member H to identify an

[8] Defendants also incorrectly asserted that Class Member H had not requested an accommodation until March 8, 2021, even though she had submitted multiple requests beginning on January 5, 2021.

alternative accommodation that would enable her to participate in Jail activities and programs. *See* ACD § V.D.3; *Vinson v. Thomas*, 288 F.3d 1145, 1154 (9th Cir. 2002) ("[O]nce the need for accommodation has been established, there is a mandatory obligation to engage in an informal interactive process to clarify what the individual needs and identify the appropriate accommodation.") (quotation marks and citations omitted). Defendants' provision of a soft brace was not sufficient to discharge their obligations under the ACD, because Class Member H notified them multiple times after she had received the soft brace that she was still effectively excluded from Jail activities because of her back pain.

VIII. UNREASONABLE DELAYS IN PROVIDING SPECIALTY CARE

Section IV.A.10 of the Amended Consent Decree requires Defendants to provide class members with treatment from private medical and mental health specialists "as needed." Section V.B.9 further states that a healthcare professional who "believes that tests, evaluation, or treatment by a specialist is medically indicated" must "fill out a referral slip indicating the maximum time which can elapse before the test, evaluation, or treatment." Defendants must also "insure that the inmate is transferred to the proper person or facility within the specified time interval."

During a previous Jail tour Defendants admitted the existence of "systemic" problems in obtaining specialty care for class members. *See* 2019 Q3-Q4 Monitoring Report at 5. Defendants subsequently explained that "[i]t is not uncommon for community providers to cancel or reschedule our patients' appointments without any prior notice." Defs' May 22, 2020 Response at 3-4.

Evidence suggests, however, that Wellpath itself may be responsible for at least some of these delays. During our May 27, 2021 tour of the Jail we spoke with Class Member I, who reported long delays in receiving [redacted]. When class counsel asked Defendants' medical staff about the lack of progress in obtaining [redacted], one staff member stated that she and others submitted multiple referrals for Class Member I's [redacted] but that Wellpath "sat on" the referrals for approximately six months. Class Member I's medical records appear to confirm this. Those records indicate that [redacted] The [redacted] referral was finally approved by Wellpath on or around [redacted] and Class Member I received the [redacted] at [redacted] on or around [redacted]—approximately six months after it was first ordered by Class Member I's physician.

Plaintiffs' counsel asked counsel for Wellpath to explain this delay during the tour itself and in multiple follow-up emails. Neither Wellpath nor the County has provided an explanation.

IX. SICK CALL

A. Relevant Provisions of Amended Consent Decree and Sick Call Process at Jail

Prompt access to medical care has never been more important, given the global pandemic. 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.

Section V.B.9 further provides that Defendants must "develop and implement a process to track and assess the timeliness of providing sick call services," "review and assess that information on a quarterly basis, at minimum," and "produce the results of the review and assessment of the sick call process."

Defendants' current process for class members to request medical care involves the use of sick call slips. Sick call slips are available upon request from medical staff, who, according to Defendants, are present in each housing unit at least four times per day in order to distribute medication. Class members submit completed sick call slips by giving them to medical staff when medical staff enter the housing units. Sick call slips are required to be triaged by nursing staff within 24 hours, *see* ACD § V.B.9. During Plaintiffs' January 27, 2020 tour of the Jail, Defendants' contracted medical provider Wellpath stated to Plaintiffs' counsel that sick call slips typically are triaged by no later than the end of the 12-hour nursing shift during which the sick call slip is submitted.

B. Sick Call Timelines

Defendants' compliance with sick call timelines has slowly improved over time. For the first and second quarters of 2021, the data provided by Defendants suggests that they are largely compliant.

According to Defendants' data, there were 306 sick calls during Q1 all of which were classified as "routine." All but five of the 306 sick calls were addressed within

72 hours. For Q2, Defendants' data shows 291 sick calls, 287 of which were deemed routine. All the routine sick calls in Defendants' Q2 data were seen within 72 hours, and all urgent sick calls were seen within 24 hours.

Flaws in Defendants' "sick call tracking tool," however, call the reliability of this data into question. A review of class member medical records suggests that the tracking tool does not include all class member sick call requests. Class Member J's medical records, for example, show an *emergent* medical sick call request on [redacted]. This request does not appear in the tracker, as far as we can tell, even though the tracker includes other sick calls from [redacted] Even if this sick call does appear in the tracker, moreover, it means that Defendants mislabeled an emergent request as a routine request, thereby extending their own deadline to respond by 72 hours. Plaintiffs' counsel do not know how many such sick calls have been omitted from Defendants' data.

Plaintiffs request that Defendants return to their earlier practice of providing both the sick call tracking tool and the sick call "logs" generated by Defendants' medical records system, as required by Exhibit G to the ACD.

X. EDUCATION AND VOCATIONAL TRAINING

Section XIII of the ACD requires Defendants to develop detailed plans for an education and vocational training program that includes, at minimum, "high school courses leading to a high school degree or its equivalent"; "life skills and/or drug/alcohol recovery; vocational training"; and "utilization of outside instructors and county personnel as instructors, where feasible and appropriate." Section XIII further requires that Defendants make "a good faith effort" to incorporate in their education and vocational training program any available resources and suggestions from the Yuba Community College District, the Marysville Joint Unified School District, Gateways Projects, Inc., and the Board of State and Community Corrections.

It is our understanding that Defendants cancelled all in-person educational and vocational training activities during the COVID-19 pandemic and began providing class members with certain activities on digital tablets instead.

What is the status of on-site educational and vocational programming at the Jail? When do Defendants anticipate resuming in-person programming? What efforts have Defendants made since our April 2021 monitoring report to incorporate resources and suggestions from the Yuba Community College District, the Marysville Joint Unified School District, Gateways Projects, Inc., and the Board of State and Community Corrections?

XI. COVID-19 PREPAREDNESS

A. Outbreak

An outbreak of COVID-19 occurred at the Jail in August and September 2021. Defendants met with Plaintiffs' counsel on August 25 to discuss the outbreak and their plans for containing it. It is Plaintiffs' understanding that the outbreak has been contained, that a total of 37 class members tested positive for the coronavirus, and that none of these 37 class members required hospitalization. If this is still the case, we commend Defendants for their successful efforts to contain the outbreak.

B. Vaccinations

Defendants have been offering the J&J COVID-19 vaccine to all class members since late March 2021. During the May 27 tour of the Jail, we objected to a County policy that resulted in class members having to wait to receive the vaccine until a critical mass of other incarcerated people were also waiting, so as to avoid "wasting" any doses in the County's vaccine stockpile. It is our understanding that this policy is no longer in place, and that any class member who wishes to receive the COVID-19 vaccine will be vaccinated without unreasonable delay. It is also our understanding that Defendants have implemented a $50 incentive program to encourage class members to accept the vaccine.

While we commend Defendants for their recent efforts to vaccinate class members, we remain concerned about the lack of a staff vaccination requirement (or even an incentive).

We request that Defendants implement a vaccine mandate for all Jail staff as soon as possible. Please also provide us with updated figures for the number and percentage of class members and Jail staff who have received the vaccine.

C. Testing

During the COVID-19 outbreak at the Jail in August and September, Defendants dramatically increased the frequency with which they test class members for coronavirus infection.

What is the Jail's current testing protocol? How often are class members being tested? How often are staff being tested?

D. Overall Jail Population

According to the Jail's online inmate locator, the current Jail population is 195—less than half of its pre-pandemic population of more than 400. It is our understanding that there are now only 2 ICE detainees remaining at the Jail. We commend Defendants for their efforts to maintain the reduced Jail population during the pandemic, and we hope

that Defendants will continue to take affirmative steps to limit the Jail population in the months and years ahead. Overcrowding not only increases the risk of an outbreak of communicable disease like COVID-19, but it also hinders Defendants' ability to comply with numerous other provisions of the ACD, ranging from timely responses to requests for medical care to appropriate care and treatment for class members with mental illness. *See Brown v. Plata*, 563 U.S. 493 (2011).

Please provide an update on what steps Defendants intend to take to limit crowding within the Jail in the months and years ahead. What is the current plan for admitting ICE detainees in the future?

XII. CONCLUSION

Pursuant to Section XIX of the ACD, Plaintiffs request that Defendants meet and confer with them no later than **Monday, November 29, 2021** to discuss potential remedies for the violations discussed in this report. Failure to identify and discuss potential remedies with Plaintiffs' counsel may necessitate an enforcement motion.