Monitoring Report – Yuba County Jail
Second and Third Quarters – 2022
***Hedrick v. Grant,* E. D. Cal. No. 2:76-cv-00162-EFB**
December 2, 2022

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 review of documents covering the second and third quarters of 2022, as well as a monitoring tour conducted by Plaintiffs' counsel and their expert mental health consultant on November 8, 2022.

Plaintiffs' counsel identified several areas of non-compliance during the second and third quarters of 2022. Among the most serious are:

1. Inadequate medical and mental health staffing, including a complete lack of any on-site psychiatrist for multiple weeks;

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

3. Improper placement of class members in restrictive housing because they suffer from mental illness;

4. Inadequate reviews of restrictive housing placements;

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 about the **third** in-custody death at the Jail in the past year, which occurred on November 2, 2022. **The Jail's mortality rate for the past year is more than *seven times* the 2019**

[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.

average for local jails in the United States (the most recent year for which statistics are available).[2]

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.[3] 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.

---

[2] *See* Bureau of Justice Statistics, *Mortality in Local Jails, 2000-2019* (Dec. 1, 2021), *available at* https://bjs.ojp.gov/content/pub/pdf/mlj0019st.pdf. According to this BJS report, the mortality rate for all local jails in the United States was 167 deaths per 100,000 people in 2019, calculated by dividing the total number of deaths by the total average daily population of all local jails in the United States for that year. *Id.* at 1-2. As of December 1, 2022, there were approximately 248 people incarcerated at the Yuba County Jail. Assuming that the average daily population at the Yuba County Jail for the past year was 250 people—a generous assumption, given that the Jail's population has been rising steadily over the past year—the Jail's mortality rate for the period beginning December 1, 2021 and ending December 1, 2022 was **1,200 deaths per 100,000 people**.

[3] Plaintiffs reviewed Defendants' staffing data for weeks beginning April 10, May 22, June 19, July 3, August 13, and September 18, 2022.

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 was severely deficient throughout the review period. The data produced to Plaintiffs' counsel indicates that there was no on-site psychiatrist treating patients at the Jail at any point during the audited weeks, and no telepsychiatrist providing services to class member at the Jail at any point during Q2. Defendants' MFT/LCSWs worked only a small fraction of the required hours in June, July, August, and September. The Jail had no Qualified Mental Health Professional at all on multiple days during each of the audited weeks from June, July, August, and September. This is a gross and unacceptable violation of the ACD and the constitutional rights of the Plaintiff Class.

- Week of April 10, 2022

  LVN – Defendants' LVNs collectively worked a total 16.15 hours on Sunday, April 10; 19.45 hours on Tuesday, April 12; 21.89 hours on Wednesday, April 13; and 17.12 hours on Saturday, April 16. Exhibit C requires that an LVN be working at the Jail 24 hours per day, seven days per week.

  Psychiatry – There was no psychiatrist or telepsychiatrist on duty at any point during this week.

- Week of May 22, 2022

  Psychiatry – There was no psychiatrist or telepsychiatrist on duty at any point during this week.

- Week of June 19, 2022

  LVN – Defendants' LVNs collectively worked a total of 20.92 hours on Wednesday, June 22; 12.75 hours on Thursday, June 23; and 16.8 hours on Friday, June 24. Exhibit C requires LVN coverage 24 hours per day, seven days per week.

  Psychiatry – There was no psychiatrist or telepsychiatrist on duty at any point during this week.

  MFT/LCSW – Defendants' MFT/LCSWs worked a total of 59.71 hours for the week, rather than the required 80 hours, and did not work any hours at all on Saturday, June 25. There was no Qualified Mental Health Professional working at the Jail on this day.

- Week of July 3, 2022

  LVN – Defendants' LVNs collectively worked only 15.29 hours on Monday, July 4, rather than the required 24 hours.

MFT/LCSW – Defendants' MFT/LCSWs collectively worked a total of only 12.62 hours for the week, rather than the required 80 hours, and did not work any hours at all on Sunday, Tuesday, Wednesday, Thursday, Friday, or Saturday. There was no Qualified Mental Health Professional working at the Jail on any of these days.

PA/FNP – Defendants' PA/FNP worked a total of 35.12 hours for the week, rather than the required 40 hours.

Psychiatry – There was no on-site psychiatrist working at the Jail at any point during this week.

- Week of August 14, 2022

LVN – Defendants' LVNs collectively worked only 14.59 hours on Saturday, August 20, rather than the required 24 hours.

Medical Director – Defendants' physician/medical director worked a only 4.5 hours for the week, rather than the required nine hours.

MFT/LCSW – Defendants' MFT/LCSWs collectively worked a total of only 24.75 hours for the week, rather than the required 80 hours, and did not work any hours at all on Sunday, Tuesday, Wednesday, Thursday, or Friday. There was no Qualified Mental Health Professional working at the Jail on any of these days.

Psychiatry – There was no on-site psychiatrist working at the Jail at any point during this week.

- Week of September 18, 2022

LVN – Defendants' LVNs collectively worked only 12.14 hours on Monday, September 18; 17.67 hours on Tuesday, September 20; 21.35 hours on Wednesday, September 21; 13.22 hours on Friday, September 23; and 17.25 hours on Saturday, September 24. Exhibit C requires LVN coverage 24 hours per day, seven days per week.

MFT/LCSW – Defendants' MFT/LCSWs collectively worked only 51.55 hours for the week, rather than the required 80 hours, and did not work any hours at all on Tuesday, Wednesday, or Thursday. There was no Qualified Mental Health Professional working at the Jail on any of these days.

Psychiatry – There was no on-site psychiatrist working at the Jail at any point during this week.

During our November 8 tour of the Jail, Defendants stated that they had recently hired two additional MFT/LCSWs in response to the MFT/LCSW deficiencies identified

above. ***Have these MFT/LCSWs started work yet? If not, when are they scheduled to begin working at the Jail?***

Wellpath representatives also suggested during the tour 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.***

III. MISUSE OR OVERUSE OF RESTRICTIVE HOUSING

A. Improper Placements in Administrative Segregation

Despite Plaintiffs' multiple objections in prior monitoring reports and in various other communications with Defendants, the Jail continues to house people in administrative segregation, medical cells, and other forms of restrictive housing without adequate justification. In some cases, Defendants house people in segregation solely because of their mental illness. *See, e.g.*, Incident 84349 (July 3, 2022) (class member housed in ad seg due to "bizarre behavior" such as pacing while talking to herself); Incident 84366 (July 5, 2022) (class member housed in ad seg because he "is known to have mental health issues" and is "unpredictable"); Incident 84375 (July 6, 2022) (class member housed in ad seg because she "refused to answer many questions" and may have been delusional and/or suffering from hallucinations); Incident 84489 (July 20, 2022) (class member housed in ad seg because she "was saying weird things" and was threatened by another inmate). During our November 8 monitoring tour of the Jail, [redacted] also reported that he had received inpatient mental health care shortly before being booked into the Jail[4] and that Defendants had been housing him in administrative segregation for more than a month without any explanation whatsoever.

These actions clearly violate Section IX of the ACD, which states that "Defendants shall not house inmates with serious mental illness in Administrative Segregation…or the medical cells unless those inmates demonstrate a current threat to Jail security, inmate safety, or officer safety, as documented by custody staff," and that "[i]nmates shall not be housed in Administrative Segregation solely because they have a mental illness." ACD at 53-54. While we recognize that some of these individuals may have been at risk of victimization in a general population setting, ***Defendants must***

[4] The class member's intake screening form indicates that he reported this to staff at the Jail as well. *See* Defs' September 2022 Intake Screening Forms at p. 915.

develop alternative, less restrictive housing options for such persons rather than housing them in segregation indefinitely.[5]

B. Untimely Documentation of Reasons for Placement in Administrative Segregation

The ACD requires that placements in administrative segregation be "based on a written report providing an explanation of the facts and circumstances requiring the segregation," and that this report be "written as soon as possible and in no case later than forty-eight (48) hours after the initiation of the assignment to administrative segregation." ACD at 53. In at least one instance during the review period, Defendants failed to document the reason(s) for placing a class member in administrative segregation until well after the 48-hour deadline had lapsed. *See* Incident 84351 (July 3, 2022) (noting lack of documentation for segregation term that began approximately one month earlier).[6]

C. Inadequate Consideration of Class Members' Fitness to Return to General Population

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.

During our November 8 tour of the Jail, Defendants provided us with several "classification review" and "adseg review" forms for two class members. These forms suggest that Defendants are conducting the reviews in a timely fashion, but that classification officers do not always consider relevant factors or consult with medical and mental health staff, as required. Some of these reviews offered no reason at all for continuing to house the person in segregation. Others relied on conclusory assertions about the class member's character or cite minor disciplinary violations or even the person's hygiene as a basis for continuing to house the person in segregation. Such

---

[5] *See* Letter from Gay C. Grunfeld to Defendants re: Overuse of Restrictive Housing for People with Serious Mental Illness, Sept. 17, 2021 (proposing that Defendants create a specialized mental health unit where class members are provided a higher level of mental health care in a properly therapeutic setting).

[6] In several other instances, officers noted that there was no documentation of the reasons for a segregation placement, but the documentation available to Plaintiffs' counsel does not indicate when these segregation terms began. *See, e.g.*, Incidents 84366, 84367, and 84374 (July 5, 2022).

reviews do not indicate the required effort on Defendants' part to "limit the placement of inmates in Segregated Housing for prolonged periods of time." ACD at 55. To the extent the decisions to continue housing the class members in segregation were premised on minor disciplinary violations, moreover, they also violate the ACD's limitations on what types of punishment may be imposed for such violations. *See* ACD at 48-49.

On November 9, 2022, Plaintiffs requested similar classification review documents for several more class members to assess whether the reviews discussed above are representative. As of the date of this Report, Defendants have not produced the requested documentation.

IV. SAFETY AND STEPDOWN CELLS

A. Improper Use of Stepdown Cells as a Substitute For Inpatient 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. *See, e.g.*, Incident Rpt. No. 84389 (July 7, 2022, and supplements through August 16, 2022) (describing a class member's housing in stepdown cell from early July through at least mid-August, interrupted only by brief visits to Rideout every five days).

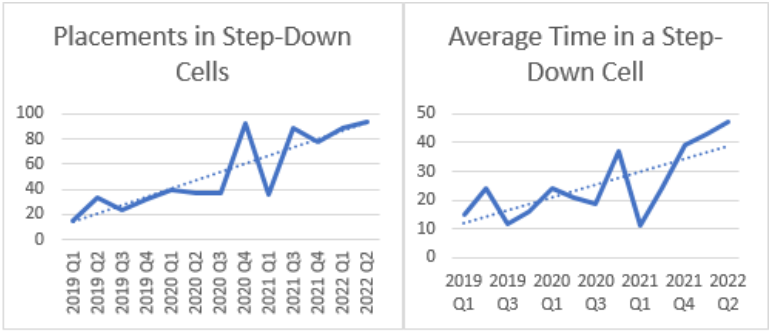
As we have noted in prior monitoring reports and in prior communications with Defendants, there is substantial overlap in the criteria for housing a person in a stepdown cell and for placement in an inpatient mental health facility. Yet few if any of the individuals housed in Defendants' stepdown cell for extended periods of time are admitted for inpatient care at Rideout and/or Sutter-Yuba Behavioral Health. In one case during the review period, a class member who had been repeatedly housed in a stepdown cell was returned to the Jail and placed in a stepdown cell again less than one day after he nearly succeeded in hanging himself from the upper-tier railing in D-Pod. *See* Incident 84502 (July 21, 2022) (noting that class member lost consciousness during the suicide attempt); Incident 84503 (July 22, 2022) (noting that the class member was returned to the Jail from Rideout and placed in a stepdown cell on the day after his suicide attempt).

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.[7]

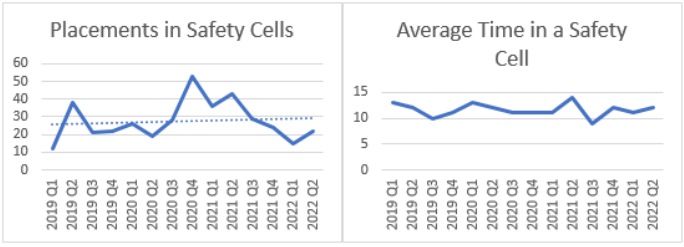
B. Increasing Number and Length of Stepdown Cell Placements

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. This trend appears to have accelerated in or around the fourth quarter of 2020. This is particularly notable in light of the dramatic reduction in the Jail's average daily population since 2020.[8] While we do not object to the use of stepdown cells when needed, as noted in subsection III.D above we are concerned that Defendants are using stepdown cells as a substitute for adequate treatment of class members' underlying mental health conditions.[9]



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

[8] Defendants' use of safety cells, by contrast, has remained fairly consistent during this period:



[9] 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. ***How many class members are currently participating in the Jail-Based Competency Treatment and Early Access and Stabilization programs described during the tour? How many have participated since these programs became available at the Jail? Are there any limits on who can participate (e.g., limits based on security classification or housing location within the Jail)?***

C. 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 Q2.[10]

The ACD states 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. For the first time since the monitoring phase of this case began in 2019, Defendants were in full compliance with this requirement during the second quarter of 2022.

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' compliance with this requirement improved in Q2; they failed to document a timely suicide risk assessment in only 2 of 22 safety-cell placements.

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 did not comply with the 6-hour medical evaluation requirement on three occasions in Q2. Defendants did not comply with the 12-hour QMHP evaluation requirement twice in Q2.

The ACD further requires 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. Defendants did not document the required conference in six of the twelve instances during Q2 when a class member was held in a safety cell for more than twelve hours.

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. Defendants did not document the required consultation in

[10] Due to a scanning error in Defendants' Q3 document production, Plaintiffs were unable to calculate Defendants' compliance with any of the requirements in this section for Q3. Plaintiffs requested that Defendants re-scan and provide the relevant Q3 documents on November 22, 2022, but had not received the requested documents as of the date of this Report. Plaintiffs' counsel will send a follow-up letter evaluating Defendants' compliance with these provisions during Q3 once we receive the requested documents.

any of the three instances during Q2 in which a class member was placed in a safety cell for the second time in a 120-hour period.

V. 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' compliance with sick call timelines has slowly improved since 2019, and during Q2 and Q3 all but four percent of the sick calls listed in Defendants' "sick call tracker" were evaluated within 72 hours. At least part of this improvement, however, is likely related to what is apparently Defendants' practice of labeling *all* sick call requests "routine."[11] ***Please confirm that Defendants' sick call tracking sheets include all sick call requests from the required dates. Please also explain what criteria staff use to identify "urgent" requests.***

During our November 8 tour, moreover, multiple class members also reported multi-week delays between their submission of a sick call slip and their evaluation by medical staff. On November 9, 2022 we requested that Defendants provide us with medical records for certain individuals so that we can verify their reports, as well as the other documents described in **Exhibit A** hereto. As of the date of this Monitoring Report, we have not yet received these records from Defendants.

VI. GRIEVANCES

During a prior Jail tour on December 13, 2021, Captain Garza reported that the Jail would begin providing class members with a new grievance form in 2022 that would automatically create a carbon copy for the class member to retain. The completed "Grievance Procedure Forms" that Defendants included in their Q3 2022 document production appear to be identical to the forms Defendants included in prior years. ***Has the Jail begun using the new forms referenced by Captain Garza during the December 13, 2021 monitoring tour?***

[11] Every single request was labeled "routine" in Defendants' sick call tracking sheets for both Q2 and Q3 2022.

In August 2022, Yuba County contracted with the U.S. Marshals Service to detain federal pre-trial detainees who have pending criminal charges in Sacramento. ***Please confirm that the Jail complies with the provisions in the Federal Performance Based Detentions Standards (FPBDS) requiring 3-part triplicate grievance forms that allow class members to retain a copy of filed grievances and the Jail's response(s) to those grievances***. *See* FPBDS §§ G.10.2, G.10.8.

As in past monitoring periods, we continue to receive anecdotal reports of class members being denied access to grievance forms. Any such denials violate Section X.B of the ACD, which requires that Defendants permit "[a]ny inmate [to] file a grievance" by submitting a form "provided for that purpose." Such denials would also appear to violate Sections G.10.3 and G.10.4 of the FPBDS, which require that "prisoners have unfettered access to grievance forms" without depending on staff to provide them.

VII. THIRD DEATH IN CUSTODY SINCE DECEMBER 1, 2021

On November 2, 2022 a 30-year-old class member died in Defendants' custody as a result of a Fentanyl overdose. This was the third death at the Yuba County Jail in the past year. As noted in the introduction to this Report, **the Jail's mortality rate for the past year is <u>more than seven times the national average</u>**.

Although Defendants provided Plaintiffs' counsel with the class member's medical records, [redacted] During our November 8 tour of the Jail, Defendants refused to provide further information because their "investigation" of the death was ongoing. Defendants similarly refused to provide any information on the nature of the investigation. To date, Defendants also have not provided reports for the other two in-custody deaths over the past year. These refusals to provide information violate Section XV of the ACD, which states that "[a]ll records and documents which relate to compliance with this Amended Consent Decree…shall be kept by the Jail and made available within a reasonable time upon request by Class Counsel." ACD at 62-63.

The decedent's medical records show that [redacted] On November 9, 2022, we requested that Defendants provide video footage of [redacted] where we understand the incident occurred. As of the date of this Report Defendants have not yet provided the requested video footage. Plaintiffs will continue to investigate the November 2 death and may comment further once we receive the requested footage and/or other information about the death. ***Defendants must promptly provide the requested video footage and all other information requested on November 9, 2022, as well as any and all reports on the other two in-custody deaths at the Jail since December 1, 2021.***

When we asked Defendants to describe the measures they use to prevent illicit drugs from being smuggled into the facility, Defendants explained that they primarily

rely on [redacted] Defendants further stated that [redacted] When Plaintiffs' counsel asked about measures to deter staff from bringing drugs into the facility, Defendants stated that they would not consider additional measures beyond their current system of subjecting new hires to background checks. However, certain media reports published on December 1, 2022 quote Defendants as stating that "they'll be using a new body scanner *for every person entering the jail* starting early 2023" (emphasis added). ***Please clarify whether this requirement will apply to staff working in the Jail, which we recommend.***

VIII. CONCLUSION

Given the astronomical death rate at the Jail over the past year, 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.

Pursuant to Section XIX of the ACD, Plaintiffs request that Defendants meet and confer with them no later than **January 6, 2023** to discuss potential remedies for the multiple violations of the ACD and the U.S. Constitution discussed in this report. We look forward to working with Defendants in the coming months to improve the unacceptably dangerous conditions at the Jail.