Amended Monitoring Report – Yuba County Jail
Third and Fourth Quarters – 2021
***Hedrick v. Grant*, E. D. Cal. No. 2:76-cv-00162-EFB**
January 5, 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"). Pursuant to the ACD, Plaintiffs' counsel are the court-appointed monitor of Defendants' compliance with the ACD.[1] 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. In a letter dated December 17, 2021, Plaintiffs' counsel requested that Defendants certify by January 10, 2022, that they have implemented all suicide risk-remediation measures recommended in the April 24, 2019 report authored by James Sida (hereafter "Sida Report"). 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 Amended Report[2] is the first of two monitoring reports on Defendants' compliance with the ACD during the second half of 2021. It is based on documents covering the third quarter of 2021, a tour of the Jail on December 13, 2021, and telephonic and in-person interviews with class members conducted between July 2021 and December 2021. A second report will address issues raised in documents from the fourth quarter of 2021, which have not yet been produced to class counsel as of the date of this Amended Report.

Plaintiffs' counsel identified numerous areas of non-compliance during Q3 and Q4 2021. Among the most concerning are:

[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 ("ICE detainees"). It is our understanding that there is one ICE detainee currently detained at the Jail.

[2] In response to information provided by Defendants on January 5, 2022, Plaintiffs have revised a footnote from the original version of this Report that contained an error of fact. Correction of this error does not change any of the Report's substantive findings or conclusions.

1. A severe breakdown of the Jail's mental health system that led to the suicide of a class member in [redacted] on [redacted];

2. A failure to complete certain physical modifications required by the ACD to mitigate the risk of suicide in the Jail;

3. Inadequate and untimely mental health assessments and treatment for class members referred to safety and step-down cells;

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

5. Inadequate medical and mental health staffing;

6. A clear pattern of non-compliance with the grievance procedures required by the ACD;

7. Ongoing refusals to produce documentation relating to compliance with the ACD's sick call provisions and to facilitate confidential phone calls between class members and class counsel.

Many of these deficiencies are not new. We have requested on multiple occasions that Defendants work with us to identify remedies for ongoing violations of the ACD, but instead of engaging in a good-faith discussion Defendants have either refused to acknowledge the problems or have offered frivolous objections and dubious interpretations of the ACD to justify their refusal to fix them. This is unfortunate. If Defendants do not take their obligations under the ACD seriously, further litigation will be necessary to protect class members' rights.

II. CLASS MEMBER SUICIDE

Early on [redacted] a [redacted] class member ("Class Member A") died by an apparent suicide in his cell in [redacted]. Defendants promptly notified Plaintiffs' counsel later the same day and provided us with the class member's medical records and other relevant documents. These documents showed, among other things, that [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

III. FAILURES TO RETROFIT HOUSING UNITS TO MITIGATE THE RISK OF SUICIDE.

Section VI.A of the ACD requires Defendants to "implement" the plan to reduce suicide hazards developed by their own consultant, James Sida. That plan requires, among other things, that Defendants close the "wall gap" between bunks and cell walls so that "bunk edges that abut the cell walls [are] flush against the wall in order to prevent a tie-off point that inmates can use to suffocate themselves by strangulation." Sida Report at 8-9 (April 24, 2019). It also requires that Defendants eliminate other "potential 'tie-off points'" such as "exposed plumbing pipes and grates in the ventilation system." *Id.* at 9.

The information available to us indicates that Defendants' failures to retrofit Class Member A's cell in accordance with the Sida Report likely contributed to his death on [redacted] During our December 13, 2021 monitoring tour of the Jail we examined the cell where Class Member A died and learned that the Jail had completed certain physical modifications to the cells in [redacted] on or around [redacted] days after Class Member A's death. These modifications apparently included, but may not have been limited to, sealing the gap between the bunks and the cell walls.

It is unacceptable that Defendants did not eliminate at least some of the tie-off points in [redacted] earlier. We previously raised the Jail's lack of compliance with certain requirements in the Sida Report in our April 5, 2021 Monitoring Report. *See* April 5, 2021 Rpt. at 9-10. During our May 27, 2021 tour of the Jail we also observed Defendants' limited progress in completing the modifications discussed above and were assured by Defendants that construction would proceed without delay.

The urgent need for these modifications also should have been clear to Defendants from multiple suicide attempts during Q3 that involved class members attempting to hang themselves from tie-off points in unmodified cells that are similar or identical to the cell in which Class Member A died. *See, e.g.*, Incident Rpt. No. 82156 (August 30, 2021) (describing suicide attempt involving bed sheet tied to fire sprinkler in class member's E-Pod cell); Incident Rpt. No. 82104 (August 20, 2021) (describing suicide attempt involving bed sheet wrapped around upper bunk in class member's E-Pod cell).

During our December 13, 2021 tour we also observed multiple cells in D-Pod[4] that had not been retrofitted as required by the ACD and the Sida Report. This is just as troubling as Defendants' failure to complete the necessary modifications in [redacted] before Class Member A's suicide. Even after a class member successfully ended his own life by hanging in an unretrofitted cell, Defendants *still* had not completed the required modifications in other celled housing units at the Jail.

As explained in our letter dated December 17, 2021, Defendants must take immediate action to mitigate the risk of suicide in the Jail or face a motion to enforce the ACD.

Please certify that Defendants have completed all remediation measures required by the Sida Report no later than January 10, 2022.

IV. USE OF SAFETY AND STEP-DOWN CELLS AS A SUBSTITUTE FOR ADEQUATE MENTAL HEALTH TREATMENT.

In our recent monitoring reports and correspondence with Defendants, we have repeatedly expressed concern about the rising number of incidents that result in class members being placed in safety and step-down cells at the Jail, as well as the increasing amount of time that class members with severe mental illness are held in these extraordinarily restrictive and non-therapeutic settings. *See, e.g.*, Oct. 26, 2021 Rpt. at 4-8; Letter of Sept. 17, 2021; April 5, 2021 Rpt. at 3-7. These worrisome trends continued during the third quarter of 2021. Although documentation for Q3 shows a modest decline in the number of placements in *safety* cells,[5] the number of placements in *step-down* cells was as high or nearly as high as at any point during the monitoring phase of this case, even though the total Jail population remains approximately one-half of what it was in

[4] In our December 17, 2021 letter we stated that the unmodified cells we observed were located in E-Pod, but after reviewing our tour notes we now believe they were located in D-Pod. Regardless of where the cells were located, it is unacceptable that Defendants had not completed the required modifications.

[5] The safety cell check-sheets produced by Defendants indicate that class members were placed in a safety cell 29 times during Q3 of 2021, down from 43 times in Q2 2021 and 36 times in Q1 2021.

March 2020. The step-down check-sheets produced by Defendants indicate that class members were placed in a step-down cell 89 times during Q3, a substantial increase from the 65 documented step-down placements in Q2 of 2021 and just shy of the 92 step-down placements during Q4 of 2020.

Defendants do appear to have made one change in their use of step-down cells during Q3. Unlike prior quarters, in which multiple class members repeatedly cycled between the Rideout emergency department and the Jail's step-down cells at 5-day intervals, fewer class members were held in a step-down cell for the 120-hour maximum that triggers the ACD's requirement that the class member either be returned to a less restrictive setting in the Jail or be transported to an inpatient facility or hospital emergency room for assessment and treatment.[6] We have repeatedly objected to Defendants' former practice as a violation of numerous provisions of the ACD, including but not limited to the ACD's requirements that Defendants provide adequate mental health care in the Jail, limit the use of administrative segregation and other restrictive housing for class members with serious mental illness, and provide timely access to inpatient mental health care "as needed." *See, e.g.* Oct. 26, 2021 Rpt. at 4-8; Letter of Sept. 17, 2021; April 5, 2021 Rpt. at 3-7.

Unfortunately, Defendants appear to have missed the point of our prior objections. Just as in prior quarters, a small number of class members with severe mental illness appear to be cycling in and out of the Jail's step-down cells one or more times per week—in one case as many as 18 times during Q3 alone. Instead of transporting these class members to Rideout for a superficial mental health evaluation every 120 hours, as they did in the past, Defendants now appear to be cycling these class members between the step-down cells and the Jail's medical cells instead, and doing so at slightly shorter intervals so as to avoid triggering the ACD's requirement that the class members be evaluated at a hospital or inpatient facility after 120 hours in a step-down cell. In short, Defendants' current practice appears to be a deliberate attempt to evade certain requirements in the ACD without making any substantive change to their (unacceptable) practice of housing class members with severe mental illness in highly restrictive and anti-therapeutic settings and failing to provide those class members with adequate mental health care, including but not limited to inpatient mental health treatment at an outside facility.

Class Member B, for example, was placed in a step-down cell at least 18 times during Q3. Between these frequent step-down placements, Class Member B appears to have been housed either in the Jail's medical cells or in administrative segregation. Each

[6] Section VI.D requires that class members who have been housed in a combination of safety and/or step-down cells for 120 hours be either "returned to a setting in the Jail that is less restrictive than the step-down cell" or "transferred to an inpatient mental health facility or to a hospital emergency room for assessment and care."

of Class Member B's step-down cell placements appears to have been triggered by him reporting [redacted] *See, e.g.*, Incident Rpt. No. 81873 (July 20, 2021); Incident Rpt. No. 81965 (August 2, 2021); Incident Rpt. No. 82003 (August 6, 2021); Incident Rpt. No. 82034 (August 10, 2021); Incident Rpt. No. 82041 (August 11, 2021); Incident Rpt. No. 82093 (August 19, 2021); Incident Rpt. No. 82193 (Sept. 4, 2021); Incident Rpt. No. 82203 (Sept. 7, 2021); Incident Rpts. Nos. 82224 and 82228 (Sept. 10, 2021); Incident Rpt. No. 82238 (Sept. 12, 2021); Incident Rpt. No. 82281 (Sept. 24, 2021); Incident Rpt. No. 82285 (Sept. 25, 2021). While Class Member B does appear to have been prone to violent and confrontational behavior in some instances, Defendants do not appear to have treated this behavior as a symptom of Class Member B's mental illness requiring anything beyond an aggressive and sometimes violent response. *See, e.g.*, Incident Rpt. No. 82319 (Sept. 20, 2021) (describing an incident in which custodial staff escalated a verbal confrontation with Class Member B and then conducted a controlled use of force that culminated in their use of a taser to subdue him, without any apparent consultation with mental health staff or consideration of the relationship between his behavior and his mental illness). Neither the ACD nor the U.S. Constitution permits Defendants to effectively ignore class members' needs for intensive mental health treatment and trap them in a cycle of misbehavior, violence, and disciplinary isolation. *See, e.g.*, *Coleman v. Wilson*, 912 F. Supp. 1282, 1321-23 (E.D. Cal. 1995); *Coleman v. Brown*, 28 F. Supp. 3d 1068, 1078-87 (E.D. Cal. 2014).[7] It is not enough for Defendants to simply prevent these individuals from harming themselves by moving them to a step-down or safety cell whenever their condition deteriorates. Both the Constitution and the ACD require more.

V. INADEQUATE AND UNTIMELY MEDICAL AND MENTAL HEALTH ASSESSMENTS FOR CLASS MEMBERS HOUSED IN SAFETY AND STEP-DOWN CELLS.

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. 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

[7] Defendants' actions in this instance also appear to have conflicted with Jail policy E-132 ("Use of Force"), which requires "confrontation avoidance"—including but not limited to consultation with "appropriate medical or mental health staff"—before resorting to "calculated" uses of force. ***Please produce a copy of the video recording required by Policy E-132(E)(1), as well as any other video footage of the incident described in Incident Rpt. No. 82319.***

of safety cell placement." ACD at 40-41. Defendants remain non-compliant with these requirements. **Defendants' safety-cell check sheets do not document a suicide risk assessment for 19 of the 29 safety-cell placements during Q3.** In five of the 29 safety cell placements during Q3, the check-sheets do not document the required medical assessment.

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 any of the three instances during Q3 in which a class member was housed in a safety cell for more than 12 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 documented the required consultation in only one out of the ten (10%) of the instances during Q3 in which a class member was placed in a safety cell two or more times in a 120-hour period.**

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	

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. We then compared the information in these tables to the requirements in Exhibit C to the ACD.

Defendants were non-compliant with many of their staffing obligations during the review period. Indeed, Defendants' compliance with their staffing obligations significantly worsened over the course of this period.

Psychiatry – Defendants did not comply with their psychiatry staffing obligations during the third quarter of 2021. 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 document any telepsychiatry coverage during any of the weeks under review. During the weeks of July 11 and September 19, 2021, the Jail's on-site psychiatrist worked a total of 21 hours at the Jail, rather than the required 24 hours (including telepsychiatry coverage). During the week of August 15, 2021, the Jail's on-site psychiatrist worked at the Jail for only 18 hours instead of the required 24 hours. Although this represents an improvement from the first two quarters of 2021, when there was no psychiatry coverage at the Jail whatsoever during half of the weeks under review, Defendants remained non-compliant with their psychiatry staffing obligations in each of the three weeks reviewed for Q3.

Plaintiffs' counsel has not yet received staffing data for the fourth quarter of 2021. During our December 13, 2021 tour of the Jail, however, Defendants conceded that the psychiatrist previously assigned to the Jail had quit at some point during the fall of 2021, and that there was no psychiatrist working at the Jail during the week of [redacted] As a result of this breach of Defendants' psychiatry staffing obligations, [redacted]

MFT/LCSW – Defendants' MFT/LCSW staffing was severely deficient in each of the weeks under review during Q3. 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. Between Wednesday, July 14 and Friday, July 16, however, **Defendants' MFT/LCSWs worked only 4.17 of the 48 total hours required for those days under the ACD**. Defendants' staffing data for August and September shows nearly identical deficiencies between Wednesday, August 18 and Thursday, August 20, and an even worse deficiency between Wednesday, September 22 and Saturday, September 25, when **Defendants' MFT/LCSW worked only 4.34 of the 56 hours required by the ACD**.

Clerks – During the week of July 11, 2021, Defendants' clerks worked only 16 of the 56 hours required by the ACD.

HSA – During the week of September 19, 2021, Defendants' HSA did not work any of the 40 hours required by the ACD.

VII. SICK CALL / REFUSAL TO PROVIDE NECESSARY INFORMATION

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 in recent quarters but Defendants' ongoing refusal to provide Plaintiffs' counsel with information to which we are entitled under the ACD has made it impossible to determine whether this pattern has continued during Q3 or whether the timeliness of Defendants' responses to sick call requests has worsened. The data in Defendants' Q3 "sick call tracking tool" suggests that they are compliant with certain requirements in the ACD, but this tool does not include critical information about the subject matter of each sick call request. As

Plaintiffs' counsel explained to Defendants in emails dated November 8 and 18, 2021, this information is necessary to determine whether Defendants are properly classifying sick call slips as routine, urgent, or emergent—and thus whether Defendants were required to respond to the sick call within the 24 hours required for urgent requests or the 72 hours required for routine sick calls. As of the date of this Report, Defendants continue to refuse Plaintiffs' request for these documents.

This refusal to provide necessary information that Defendants previously produced on a quarterly basis is itself a serious violation of the ACD, which requires that Defendants provide class counsel with "[a]ll records and documents which relate to compliance with this Amended Consent Decree, including records and documents maintained or generated by or in the possession of the Jails' contracted medical and mental health provider…upon request by Class Counsel." ACD at 62-63.

Plaintiffs again 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 Section XV and Exhibit G to the ACD. Failure to meet and confer meaningfully on these issues within 30 days will result in a motion to enforce.

VIII. FAILURES TO ADHERE TO REQUIRED GRIEVANCE PROCEDURES

Section X.B of the Amended Consent Decree states that "[a]ny inmate may file a grievance" by submitting a form "provided for that purpose." Section X.A.2 of the Amended Consent Decree states that "[a] grievance can be any complaint regarding Jail conditions, procedures, food, failure to accommodate disabilities, or compliance with any portion of this Amended Consent Decree."[8]

[8] Upon submission of a grievance form, a Jail Supervisor must investigate and attempt to resolve the grievance within 48 hours. If the grievant signs a form indicating that he or she is satisfied with the proposed resolution, "the grievance shall proceed no further." If the grievant does not sign this form and/or otherwise indicates that he or she is not satisfied with the proposed resolution, the Jail Commander must conduct a grievance hearing "within seventy-two (72) hours of receipt of the grievance." The Commander must then provide the grievant with "a written disposition … within seventy-two (72) hours of the completion of the hearing." The grievant may appeal the Jail Commander's disposition so long as he files the appropriate paperwork within seven days of receiving that disposition, ACD § X.C. "If a grievance concerns an allegation of a violation of a Sheriff's Department policy or state or federal law by an employee of the Jail," the grievance must be referred to the Professional Standards Unit of the Sheriff's Department for investigation by Internal Affairs. *Id.* § X.A.2.

Despite the breadth of allowable grievances under the ACD, we received numerous complaints during our December 13, 2021 tour of the Jail relating to Defendants' practice of informally dismissing grievances as "non-grievable" based on their subject matter. One class member, for example, reported that he had filed multiple grievances about what he believed to be Defendants' improper calculation of the milestone credits to which he was entitled, but each of these grievances had been returned to him as "not grievable." Another class member reported that he had filed a grievance relating to the Jail's implementation of its quarantine procedure for new intakes, which had similarly been returned to him as "non-grievable." In one particularly egregious example, a class member reported that he had suffered severe burns on his arm from a hot water spigot in A Pod and had subsequently grieved the lack of any warning that the spigot releases scalding hot water. This class member showed Plaintiffs' counsel the burn he suffered and a copy of the grievance he had submitted, which had been returned to him by a custody officer with the words "non-grievable" written on it.

None of these class members were even provided with an opportunity to request a hearing on their grievance, let alone the actual hearing to which they are entitled. Instead, their common experience indicates that there is a widespread practice among Jail staff of simply ignoring grievances without following any of the detailed procedures outlined in Section X to the ACD. It appears likely that this practice has the additional effect of concealing class member complaints that would otherwise be disclosed to class counsel in Defendants' quarterly document productions.

During the December 13, 2021 tour, Captain Garza told us that the Jail would begin using a new grievance form that will create a copy for the class member to retain. It is our understanding that the new grievance form will be implemented in early 2022, "when the old forms run out." Captain Garza indicated that the grievance procedure in the Jail Handbook will be revised to reflect the use of the new form. We view this as a positive development that will allow class members to track their grievances.

Defendants must immediately cease their practice of ignoring grievances they deem "non-grievable," as it reflects a breach of their obligations under Section X of the ACD. Please train staff on their obligations to follow the grievance procedures in the ACD and provide documentation of all staff members' participation in these trainings. Finally, please notify us when the Jail begins using the new grievance forms, and please provide us with a sample of the new form and the updated Jail Handbook.

IX. REFUSAL TO FACILITATE CONFIDENTIAL PHONE CALLS WITH CLASS MEMBERS

Defendants have taken the position that the ACD does not require them to facilitate confidential phone calls between class members and class counsel. Defendants reiterated this position during our December 13, 2021 tour of the Jail.

While we appreciate Defendants' willingness to promptly inform class members that we would like to speak with them, Defendants must inform these class members that we have requested to speak with them confidentially, and Defendants must make it possible for these class members to call us on a confidential telephone line in a confidential setting. *See Walker v. Cal. Dep't of Corrections*, 2018 WL 1071157, at *10 (E.D. Cal. Feb. 26, 2018) ("The right of access to the courts has been found to encompass the right to talk in person and on the telephone with counsel in a private setting."). All people incarcerated at the Yuba County Jail are our clients and they have a right to speak to us confidentially with the full protection of the attorney client privilege.

Defendants' unwillingness to arrange for confidential legal calls is inconsistent with their obligations under the First and Fourteenth Amendments. *See Walker*, 2018 WL 1071157, at *10. It is also inconsistent with Defendants' obligations under the ACD to facilitate legal calls with "out-of-town attorneys," ACD at 61, and to "take all necessary steps to make the monitoring as cost efficient as possible," *id.* at 67.

When we have raised concerns about non-confidential calls in the past, Defendants have suggested that we conduct in-person interviews at the Jail instead. But in-person interviews are not an adequate substitute due to the time and expense involved in regular travel from San Francisco to Marysville. This is especially true in light of the monitoring cap of $115,000 per year that Yuba County insisted be part of the ACD. *See* ACD at 67. Frequent in-person visits would also place class members at risk by increasing the likelihood of another COVID-19 outbreak at the Jail. Finally, we are concerned that even in-person interviews at the Jail may not provide the necessary confidentiality. We observed during our December 13 tour of the Jail that conversations in Defendants' purportedly confidential visiting booths are easily audible from adjacent booths.

In the future, please ensure that Jail staff allow class members whom we ask to speak with to call us on a confidential phone line in a confidential setting.

X. CONCLUSION

We have previously requested that Defendants meet and confer to discuss these and other areas of non-compliance with the ACD. With the exception of a single phone call in June 2021, Defendants have declined to discuss any of these problems with class counsel in a substantive manner. Instead, Defendants have either refused to acknowledge the problems or have offered frivolous objections and dubious interpretations of the ACD to justify their refusal to fix them. This leaves Plaintiffs with little choice but to prepare a motion to enforce the ACD.