Consent Decree in Mays et al v. County of Sacramento

***First* Monitoring Report of Suicide Prevention Practices**

Submitted by:

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Introduction

The Sacramento County Jail System consists of the Main Jail located in downtown Sacramento and the Rio Cosumnes Correctional Center (RCCC) located in Elk Grove. The Main Jail has a rated capacity for 2,396 inmates, and the RCCC is rated for 2,259 inmates. As of December 7, 2020, the Mail Jail population was 1,780 inmates, whereas the RCCC held 1,421 inmates. The jail system is operated by the Sacramento County Sheriff's Office (SCSO), Medical services are provided to inmates through the County Department of Health Services' Adult Correctional Services (ACH),[1] whereas mental health services are provided to inmates by Jail Psychiatric Services (JPS) through a contractual agreement with the University of California-Davis.

In July 2018, the Plaintiffs (Lorenzo Mays, Ricky Richardson, Jennifer Bothun, Armani Lee, Leertese Beirge, Cody Garland, and other class members) filed a federal class-action lawsuit (*Mays et al v. County of Sacramento*, Case 2:18-cv-02081-TLN-KJN) in the United States District Court, Eastern District of California, alleging constitutional violations for medical and mental health care, suicide prevention, discrimination against people with disabilities, and use of restrictive housing (segregation) in the Sacramento County Jail System. Legal counsel for the parties subsequently negotiated individual remedial plans pertaining to medical care, mental health care, and suicide prevention, and those individual plans were then incorporated into a single global remedial plan within the proposed Consent Decree. It was further agreed that issues pertaining to discrimination against people with disabilities and use of restrictive housing within the jail system would be monitored by Plaintiffs' counsel. The proposed Consent Decree was filed in June 2019 and approved by the federal court on January 13, 2020. Three court-appointed experts (Madeleine LaMarre, Mary Perrien, and Lindsay Hayes) were subsequently assigned to monitor the implementation of the Consent Decree. Exhibit A, located at pages 15 through 119 of the Consent Decree contains the agreed-upon Remedial Plan for *Mays et al v. County of Sacramento*.

In October 2020, the Defendant filed its *First* Status Report which was required pursuant to the Consent Decree to "1) include a description of the steps taken by defendant to implement each provision set forth in the remedial plan; and 2) specifies provisions of the remedial plan which have not yet been implemented. With respect to the provisions of the Remedial Plan not yet implemented, Defendant's Status Report shall (i) describe all steps taken by the Defendant toward implementation; (ii) set forth with as much specificity as possible those factors contributing to non-implementation; and (iii) set forth a projected timeline for anticipated implementation based on the best information available to Defendant" (at pages 3-4). Status reports are required to be submitted to Plaintiffs' counsel and the three court-appointed experts every 180 days.

Monitoring Compliance with the Consent Decree

The Consent Decree offers limited guidance to the court-appointed experts regarding the measurement of compliance with the Remedial Plan, simply stating that the Defendant is in substantial compliance or not in substantial compliance with an individual provision. The term

[1]Various policy documents reviewed by the expert refer to both "Adult Correctional Health" and "Correctional Health Services." The County Department of Health Services is transitioning to "Adult Correctional Health," therefore, that name will be utilized in this report going forward.

"substantial compliance" was not defined. The Consent Decree, however, does state that the "Defendant may, after conferring with Plaintiffs' counsel, request a finding by the Court that the Defendant is in substantial compliance with one or more components of the Remedial Plan and has maintained such substantial compliance for a period of at least 12 months" (at page 11). In an effort to more accurately measure compliance with the provisions of this Consent Decree, as well as to provide guidance to the parties, the court-appointed experts subsequently decided to create a three-tier system for the measurement of compliance. Each of the experts have utilized such a system in prior federal court monitoring assignments. As such, the court-appointed experts agreed to the following definitions for compliance measurement for each of the provisions in this Remedial Plan:

> **Substantial Compliance** indicates that the Defendant has achieved compliance with most or all components of the relevant provision of the Remedial Plan for both the quantitative (e.g., 90% performance measure) and qualitative (e.g., consistent with the larger purpose of the *Decree*) measures. If an individual compliance measure necessitates either a lower or higher percentage to achieve substantial compliance, it will be so noted by the expert. Compliance has been sustained for a period of at least 12 months.
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> **Partial Compliance** indicates that compliance has been achieved on some of the components of the relevant provision of the Remedial Plan, but significant work remains. A minimum requirement is that for each provision, relevant policies and procedures must be compliant with Remedial Plan requirements, contain adequate operational detail for staff to implement the policy, staff trained, and the County has begun implementation of the policy.
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> **Non-Compliance** indicates that most or all of the components of the relevant provision of the Remedial Plan have not yet been addressed and/or have not yet been met.

First Monitoring Report

This expert was appointed to monitor the suicide prevention provisions of the Consent Decree. There are **63** suicide prevention provisions listed under Section VII (pages 41 through 50) of the Remedial Plan.

This report is formatted to present each provision, followed by the provision's current status or rating (substantial, partial, or non-compliance) as determined by the court-appointed expert, a discussion section which provides justification for each rating, recommendations offered to raise each status to substantial compliance, and the evidentiary basis utilized in monitoring each provision. Due to the COVID-19 pandemic, this first monitoring report was completed without the ability to conduct an on-site assessment of suicide prevention practices. This expert, however, is very familiar with the Sacramento County jail system, having conducted several previous assessments, including a subject matter expert review of the jail system in November 2016. That assessment had been requested by the County Counsel's Office for Sacramento County following

the 2015 investigative report by Disability Rights California that became a precursor to the *Mays* lawsuit.

Documents Requested

In June 2020, this expert and mental health expert jointly submitted a suicide prevention and mental health document request to the Defendant. The request included the following:

1) Table of Contents for the Sacramento County Sheriff's Office (SCSO) Policy and Procedure Manual;

2) All current SCSO and Correctional Health policies, procedures, and directives relevant to suicide prevention, mental health services, and detainees/inmates receiving mental health services (e.g., disciplinary, use of force, restrictive housing, tracking);

3) All current Jail Psychiatric Services policies, procedures, and directives relevant to suicide prevention and mental health services;

4) All draft policies, procedures, and directives relevant to suicide prevention, mental health services, and detainees/inmates receiving mental health services (e.g., disciplinary, use of force, restrictive housing, tracking);

5) All current and draft intake screening, health evaluation, mental health assessment, treatment planning and any other forms utilized for the identification of suicide risk and mental illness;

6) Training curriculum regarding pre-service and in-service staff training, as well as curricula, handouts, etc. regarding suicide prevention, mental illness, and mental health services;

7) Draft training curriculum regarding pre-service and in-service staff training, as well as curricula, handouts, etc. regarding suicide prevention, mental illness, and mental health services;

8) Training curriculum (including draft) regarding additional suicide prevention and mental health training provided to custody officers assigned to the Designated Mental Health Units;

9) Training curriculum (including draft) regarding additional training provided to medical and mental health staff regarding development of suicide risk assessments and treatment plans for suicidal inmates specifically and mental health caseload inmates generally;

10) Location of all designated areas utilized to house inmates on suicide precautions and mental health designated units (current and proposed);

11) Policies, procedures, directives (including draft) related to quality assurance and continuous quality improvement in the delivery of mental health services and suicide prevention;

12) Minutes from Suicide Prevention Task Force meetings, as well as any other regularly scheduled multidisciplinary meetings related to suicide prevention, mental health and quality assurance for January 2019 to the present.

13) Documentation of overall staff completion rates for suicide prevention, first aid/CPR, and mental health training presented as follows:

_____ % of all officers received suicide prevention training-2019
_____ % of all medical staff received suicide prevention training-2019
_____ % of all mental health staff received suicide prevention training-2019
_____ % of all officers currently certified in CPR
_____ % of all medical staff currently certified in CPR
_____% of all officers received mental health training-2019
_____% of all medical staff received mental health training-2019
_____% of all mental health staff received mental health training-2019

14) Entire case files (jail, medical, and mental health), investigative reports, and mortality reviews of all inmate suicides from 2019 to present;

15) Total number of serious suicide attempts (incidents resulting in medical treatment and/or hospitalization) for the period of 2019 to present, as well as all documentation of such incidents by the Suicide Prevention Task Force;

16) Listing of inmates on suicide precautions from June 1, 2020 to the present;

17) Listing of current inmates receiving mental health services and level of care;

18) Mental health treatment schedules, to the extent that those exist;

19) Census by facility and designated units within each facility including restrictive housing (please just indicate the date that the census was produced on the document)

20) Current mental health staffing and any proposed additions;

21) Schedule (weekly/monthly/quarterly) of multidisciplinary team meetings attended by the multidisciplinary treatment team for inmates receiving mental health services; and

22) Defendant's *First* Status Report in *Mays v. County of Sacramento*.

A subsequent document request was made by this expert on November 13, 2020 and included updated data on serious suicide attempts, inmates on suicide precautions, and the length of stay of inmates identified as suicidal and placed in safety cells. To date, most these documents have been received.

Documents Received and Reviewed

Sacramento County's *First* Status Report (July 17, 2020)

The following policies:

- SCSO's Policy No. 10/05 - Suicide Prevention Program;
- SCSO Policy No. 4/05 - Use of Safety Cells/ Segregation Cells/Multipurpose Rooms/North Holding #2.
- ACH's Policy No. 1412 - Suicide Prevention 2M-Joint Policy.
- ACH Policy No. 1433 Limitations for Admission to Jail Acute Psychiatric Inpatient Unit.
- ACH's Policy No. 1415 – Patients in Safety Cells.
- JPS's Policies No. 1049 - Suicide Prevention Program, No. 1009 - Suicide Precautions – Acute Inpatient Unit, No. 1010 – Safety Suit Procedures for Inmate-Patients on Acute Inpatient Unit, No. 1011 - Use of Camera Monitors on the Acute Inpatient Unit, No. 1022 – Overview of Staff Responsibilities – Outpatient Department, and No. 1033 - 2M Suicidal Patients.
- JPS Access to Care document, September 2, 2020.
- SCSO Policy No. 10/04 Medical Intake Screening.
- ACH Policy No. 05-05 Intake.

The following training documents and training data:

- "An Overview of Mental Illness for Public Safety Professionals, Identifying Risk in Response to Suicidal Offenders: Refresher Course, Overview of Suicide Prevention Programs, and Supervising People with Mental Illness in Correctional Facilities."

- "Suicide in Corrections," Parts 1-4: "Suicide in Corrections Part 1: Overview of the Problem," "Suicide in Corrections Part 2: Identifying Suicide Risk," "Suicide in Corrections Part 3: Effective Management and Response for Preventing Suicide," and "Suicide in Corrections Part 4: Responding to Suicides."

- A 27-slide PowerPoint presentation entitled "Suicide Prevention Training," as well as other documents including, but not limited to, crisis intervention, mental health, and 5150 certification.

- A 33-slide PowerPoint presentation entitled "Suicide Risk Assessment in Jail," a 56-slide PowerPoint presentation entitled "Suicide Risk Assessment," a 44-slide PowerPoint presentation entitled "Safety Planning Intervention," and a 80-slide PowerPoint presentation entitled "5150 Certification Training."

Medical Intake Screening form.

JPS Mental Health Assessment.

JPS Initial Psychiatric Evaluation form.

JPS Frequency of Service Scale (FOSS).

JPS "Denial of Rights" Sheet for 2P Patients.

MH Suicide Risk Assessment form.

Multiple versions of mental health questions embedded in Medical Intake Screening form.

Meeting minutes from the ACH Safety Committee (September 29, 2020 and July 9, 2020), ACH Quality Improvement Committee (October 27, 2020), and Mental Health Quality Improvement (QIC) Subcommittee (September 26, 2020, June 12, 2020, January 24, 2020, and October 25, 2019), and Suicide Prevention Task Force meeting minutes, March 7, 2019.

Medical chart review of 17 inmate-patients.

Review of SCSO Investigative Report, ACH Incident Report, and Clinical Summary of inmate suicide in August 2019.

ACH Incident Reports for 10 serious suicide attempts from July 19, 2019 thru June 12, 2020.

MH Self-Injury and Hospital Log for Incidents from June 12, 2020 thru October 13, 2020.

Inmates on Suicide Precautions List (Safety Cell and Pre-Admit), August 25, 2020.

2P Pre-Admit List for Sacramento County Jail, August 25, 2020.

2P Acute Inpatient Unit Patient List, August 25, 2020.

"Report on Suicide Prevention Practices Within the Sacramento County Jail System," Lindsay M. Hayes, submitted November 22, 2016.

Checklist for the 'Suicide-Resistant' Design of Correctional Facilities, Lindsay M. Hayes, December 2019.

Stanley, B. and G. Brown (2012), "Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk," *Cognitive and Behavioral Practice*, 19: 256-264.

Plaintiffs' Response to Expert's draft *First* Monitoring Report of Suicide Prevention Practices, received January 5, 2021.

Defendant's Response to Expert's draft *First* Monitoring Report of Suicide Prevention Practices, received January 7, 2021.

Finally, as detailed in this report, there are numerous recommendations calling for either development of, or revision of, policies that address many of the suicide prevention provisions. The Consent Decree was vague regarding the court experts' responsibilities, if any, in the review of draft policies and procedures. Following this expert's request for clarification, Plaintiffs' counsel responded on December 30, 2020 with the following email:

> "As we recently discussed, the parties have agreed to a process in which class counsel (a) conducts an initial review of revised policies, and then (b) (unless circumstances warrant further conferring between the parties first) sends them along to the relevant expert(s) for their review and input. Consistent with the parties' current agreement, we are forwarding to you the mental health-related and suicide prevention-related health care policies that have been recently revised and provided to *Mays* class counsel for review. These are all ACH policies."

The draft policies that were attached to the email of December 30, 2020, as well as any subsequent draft policies received, will be reviewed and critiqued during the second monitoring period.

In addition, the Defendant's *Second* Status Report in *Mays v. County of Sacramento* (January 5, 2021) was received by this expert on January 12, 2021, and will be utilized during the Second Monitoring Report. With regard to status reports, this expert would reiterate (from page 2 of this report) the County's specific Consent Decree responsibilities in such reports:

> "the Defendant shall provide to Plaintiffs' counsel in the court experts a Status Report which (1) shall include a description of the steps taken by Defendant to implement each provision set forth in the Remedial Plan; and (2) specifies provisions of the Remedial Plan which have not yet been implemented. With respect to the provisions of the Remedial Plan not yet implemented, Defendant's Status Report shall (i) describe all steps taken by Defendant toward implementation; (ii) set forth with as much specificity as possible those factors contributing to non-implementation; and (iii) set forth a projected timeline for anticipated implementation based on the best information available to Defendant."

Future status reports should contain the implementation steps and projected timelines as described above.

Conclusion

Given the fact that this is the first monitoring report, it is not surprising that the table below indicates that the Remedial Plan's 63 suicide prevention provisions are in various stages of compliance.

Substantive Area	Total Provisions	Substantial Compliance		Partial Compliance		Non-Compliance	
		#	%	#	%	#	%
Suicide Prevention	63	0	0%	53	84%	10	16%

At the suggestion of counsel for the Plaintiffs and Defendant, this expert would strongly support the strategy of identifying "focus areas" during the Second Monitoring Period that concentrate not only on provisions that are critically important to implementing and sustaining compliance, but are also relatively easy to resolve. Five focus areas are offered as follows:

> First, almost all of the 63 suicide prevention provisions in the Remedial Plan require either development of, or revision to, *suicide prevention policies*. Although challenging to complete in the next few months, policy development should be the primary focus during the Second Monitoring Period.
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> Second, several provisions (B.5, M.2, and N.1 thru 7) address the use of "safety suits" or *smocks*. These provisions could quickly come into substantial compliance if the current utilization of safety smocks in the 2P Acute Inpatient Unit practices are consistently practiced in both the safety cells and SITHU cells.
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> Third, several provisions (C.2, D.1, and K.3) address the requirement for reasonable *privacy and confidentiality* during the intake and assessment processes to identify and manage suicidal inmates. The County should focus on developing immediate, interim measures to ensure such privacy and confidentiality, rather than focusing on preliminary plans for "jail annex" construction or attempting to mitigate the problem by purchasing "white noise" machines.
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> Fourth, several provisions (J.1 thru J.5) address the requirement for the *observation of suicidal inmates*, and each of these can quickly come into substantial compliance through policy revision that includes prohibition of ordering closed-circuit television monitoring.

Fifth, similar to the proper use of safety smocks, there are several provisions (M.1 thru M.3) that address *property and privileges* afforded to suicidal inmates. These provisions could quickly come into substantial compliance if the current utilization of property and privileges afforded to suicidal patients in the 2P Acute Inpatient Unit were consistently practiced for suicidal patients in both the safety cells and SITHU cells.

Finally, as recommended in response to compliance with Provision R) 5. Quality Assurance and Quality Improvement, given the enormity of responsibility to implement and sustain approximately 63 suicide prevention provisions of this Consent Decree/Remedial Plan, the previously established Suicide Prevention Task Force should be reinstated, or a similar multidisciplinary continuous quality assurance committee created, to *exclusively* focus on ensuring that all suicide prevention provisions are implemented and sustained, including the five focus areas offered above.

CONSENT DECREE/REMEDIAL PLAN

VII. SUICIDE PREVENTION

Provision A) Substantive Provisions	**1. The County recognizes that comprehensive review and restructuring of its suicide assessment, monitoring, and prevention practices are necessary to address the risk of suicide and self-harm attendant to detention in a jail setting.** **2. The County shall establish, in consultation with Plaintiffs' counsel, a new Suicide Prevention Policy that shall be in accordance with the following:**	
Status	**Partial Compliance**	
Discussion	This provision is interpreted as a "catch-all" provision for all suicide prevention-related provisions, therefore, this provision cannot come into substantial compliance until all of the provisions under Suicide Prevention come into substantial compliance. Currently, the Sacramento County Sheriff's Office (SCSO), Adult Correctional Health (ACH), and Jail Psychiatric Services (JPS) all have varying suicide prevention policies. Pursuant to the requirements of the Consent Decree, these policies were in need of varying degrees of revision. Sacramento County's response to this provision, as contained in the *First* Status Report (July 17, 2020), was reported by ACH as "PP 07-04 Suicide Prevention Program (Planning Document) - This is not ready to return for review," and by the SCSO as "Draft policy under review." In conclusion, because the County's suicide prevention policies are currently being revised, as well as the fact that all suicide prevention-related provisions are in varying degrees of compliance, this provision is rated in Partial Compliance.	
Recommendations	1) Finalize all draft suicide prevention policies for the SCSO, ACH, and JPS. 2) Provide all draft suicide prevention policies to expert for review.	
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020) Review of the current suicide prevention policies: SCSO's Policy No. 10/05 - Suicide Prevention Program; ACH's Policy No. 1412 - Suicide Prevention 2M-Joint Policy; and JPS's Policies No. 1049 - Suicide Prevention Program, No. 1009 - Suicide Precautions – Acute Inpatient Unit, No. 1010 – Safety Suit Procedures for Inmate-Patients on Acute Inpatient Unit, No. 1011 - Use of Camera Monitors on the Acute Inpatient Unit, No. 1022 – Overview of Staff Responsibilities – Outpatient Department, and No. 1033 - 2M Suicidal Patients.	

Provision B) 1. Training	**1. The County shall develop, in consultation with Plaintiffs' counsel, a four- to eight-hour pre-service suicide prevention curriculum for new Jail employees (including custody, medical, and mental health staff), to be conducted in person in a classroom or virtual classroom setting, that includes the following topics:** **a) avoiding obstacles (negative attitudes) to suicide prevention; b) prisoner suicide research; c) why facility environments are conducive to suicidal behavior; d) identifying suicide risk despite the denial of risk; e) potential predisposing factors to suicide; f) high-risk suicide periods; g) warning signs and symptoms; h) components of the jail suicide prevention program i) liability issues associated with prisoner suicide; j) crisis intervention.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Training needs are being evaluated against on-going pre-service training." The meaning of this response was unclear. However, the SCSO supplied the following listing of classroom training provided to custody personnel: "jail operations, crisis intervention training (CIT), first-aid/CPR and AED refresher, and principled policing." In addition, numerous on-line courses were either provided or available to custody personnel in the area of mental health and suicide prevention included the following: "An Overview of Mental Illness for Public Safety Professionals, Identifying Risk in Response to Suicidal Offenders: Refresher Course, Overview of Suicide Prevention Programs, Supervising People with Mental Illness in Correctional Facilities, and Suicide in Corrections, Parts 1-4." Although use of on-line training is certainly reasonable during the COVID-19 pandemic, the expert is not an advocate for permanent on-line suicide prevention training because suicide prevention is all about attitude and collaboration, principles that are lost sitting alone in a chair at a computer terminal or laptop. The expert is very familiar with the on-line training course cited above and entitled Suicide in Corrections, Parts 1-4. Produced by Relias Learning, Inc., the 6.75-hour "Suicide in Corrections" course is divided into the following four sections: "Suicide in Corrections Part 1: Overview of the Problem," "Suicide in Corrections Part 2: Identifying Suicide Risk," "Suicide in Corrections Part

	3: Effective Management and Response for Preventing Suicide," and "Suicide in Corrections Part 4: Responding to Suicides." Although review of the Relias training found that the curriculum was quite thorough, it did not include several of the training topic requirements of this provision, including "avoiding obstacles (negative attitudes) to suicide prevention," "identifying suicide risk despite the denial of risk," "components of the jail suicide prevention program," and "liability issues associated with prisoner suicide." Apart from the expert's previous knowledge about the Relias suicide prevention training, the County did not provide any additional information regarding the other training cited above, including training curricula and compliance data for custody personnel. The County did inform the expert that 71 percent of all custody staff received suicide prevention training during 2019, and 63 percent of all custody personnel received mental health training during 2019. The county also stated that 29 officers were scheduled to attend CIT in January 2021. With regard to medical and mental health personnel, ACH provided the expert a 27-slide PowerPoint presentation entitled "Suicide Prevention Training," as well as other documents including, but not limited to, crisis intervention, mental health, and 5150 certification. Although the suicide prevention training PowerPoint slides contained some of the topic requirements of this provision, many topics were missing. ACH informed the expert that 72 percent of all medical staff received suicide prevention training during 2019, and 97 percent of all mental health staff received suicide prevention training during 2019. It was unclear if these percentages included completion of the 27-slide PowerPoint "suicide prevention training" presentation and/or other training topics cited above. Finally, ACH and JPS leadership informed the expert that JPS is in the process of developing a 4- to 8-hour pre-service suicide prevention curriculum to include the 10 topics identified in this provision. The workshops arising out of this curriculum will be instructed by JPS personnel, and all medical and mental health personnel will be required to complete the course. According to SCSO leadership, the SCSO will partner with JPS in delivering the training and all custody personnel will be trained in conjunction with medical and mental health personnel. In conclusion, because the required 4- to 8-hour pre-service suicide prevention curriculum is in the process of being developed, this provision is rated in Partial Compliance.
Recommendations	1) Finalize the draft 4- to 8-hour pre-service suicide prevention curriculum to include the 10 topics identified in this provision. Upon request, the expert's comprehensive jail suicide prevention training curricula entitled *Training*

	Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities can be made available for review in the development of the County's training curricula. 2) Provide the draft pre-service suicide prevention curriculum to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). Various training documents and data. Discussion with SCSO, ACH, and JPS leadership.

Provision B) 2. Training	**The County shall develop, in consultation with Plaintiffs' counsel, a two-hour annual suicide prevention curriculum for all custody, medical, and mental health staff, to be conducted in person in a classroom or virtual classroom setting, that includes:** **a) review of topics (a)-(j) above** **b) review of any changes to the jail suicide prevention program** **c) discussion of recent jail suicides or attempts**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Training needs are being evaluated against on-going in-service training." The meaning of this response was unclear. ACH and JPS leadership informed the expert that JPS is in the process of developing a 2-hour annual suicide prevention curriculum to include the three (3) topics identified in this provision. The workshops arising out of this curriculum will be instructed by JPS personnel, and all medical and mental health personnel will be required to complete the course each year. It was unclear if custody personnel will be involved as participants in the workshops. In conclusion, because the required 2-hour annual suicide prevention curriculum is in the process of being developed, this provision is rated in Partial Compliance.
Recommendations	1) Finalize the draft 2-hour annual suicide prevention curriculum to include the three topics identified in this provision. Upon request, the expert's comprehensive jail suicide prevention training curricula entitled *Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities* can be made available for review in the development of the County's training curricula. 2) Provide the draft annual suicide prevention curriculum to expert for review.

Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). Discussion with SCSO, ACH, and JPS leadership.

Provision B) 3. Training	**Custody officers assigned to Designated Mental Health Units shall receive additional specialized training on suicide prevention and working with prisoners with serious mental illness.**	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "IOP Deputies receive CIT Training." In addition, ACH stated in the same report that "Mental health staff developed and provided training October 2019 for custody staff working in the designated mental health units. Training contain information on recognizing different types of mental illness, interacting with patients with SMI, and mental health policies." Although the provision of CIT training to IOP deputies fulfills a portion of this provision, it was unclear as to the percentage of custody personnel that were trained, as well as no indication whether deputies assigned to the Suicidal Inmate Temporary Housing Unit (SITHU) and 2P Inpatient Unit completed the CIT training. In addition, any further specialized suicide prevention training for these deputies should occur subsequent to the implementation of the revised suicide prevention policies. In conclusion, because training compliance data for custody personnel was not provided, and additional training curricula are being developed, this provision is rated in Partial Compliance.	
Recommendations	1) In the future, any training compliance data for custody personnel should always include: a) the number of custody personnel assigned to the Designated Mental Health Housing Units, and b) the number of custody personnel receiving specialized suicide prevention and mental health training.	
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020).	

Provision B) 4. Training	**All mental health staff, including nurses, clinicians, and psychiatrists, shall receive additional training on how to complete a comprehensive suicide risk assessment and how to develop a reasonable treatment plan that contains specific strategies for reducing future suicidal ideation.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by ACH in the *First* Status Report (July 17, 2020), was: "Suicide Risk Assessment (SRA) Training - Hired a forensic expert to update the SRA training and refine the assessment tool May 2019. Training increased from a four (4) hour training to a seven - eight (7-8) hour training module." JPS leadership informed the expert that all LCSW clinicians have received the SRA training, but nurses and psychiatric staff assigned to the 2P Inpatient Unit have not received the SRA training. Further, it was unclear if psychiatric nurse practitioners assigned to outpatient services had received SRA training. The expert reviewed various training documents pertinent to this provision, including a 33-slide PowerPoint presentation entitled "Suicide Risk Assessment in Jail," a 56-slide PowerPoint presentation entitled "Suicide Risk Assessment," a 44-slide PowerPoint presentation entitled "Safety Planning Intervention," and a 80-slide PowerPoint presentation entitled "5150 Certification Training." In conclusion, because nurses and psychiatric staff assigned to the 2P Inpatient Unit have not received the SRA training, and it was unclear if psychiatric nurse practitioners assigned to outpatient services had received SRA training, this provision is rated in Partial Compliance.
Recommendations	1) In the future, any compliance data for mental health personnel should always include: a) the number of mental health personnel required to receive suicide risk assessment training, and b) the number of mental health personnel receiving suicide risk assessment training. 2) Ensure that all mental health personnel, including LCSW clinicians, psychiatric nurse practitioners assigned to outpatient services, and nursing and psychiatric staff assigned to the 2P Acute Inpatient Unit receive suicide risk assessment training.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). Various training curricula on suicide risk assessment and safety planning. Discussion with JPS leadership.

Provision B) 5. Training	**All mental health staff and custody officers shall be trained on the appropriate use of safety suits, i.e., not to be utilized as a default, not to be used as a tool in behavior management, not to be utilized for patients being observed at 30-minute observations.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Outlined in policy." Although the SCSO's response that the appropriate use of a safety suit ("smock") for suicidal inmates was "outlined in policy," review of SCSO's current suicide prevention policy (No. 10/05 - Suicide Prevention Program) indicated that the issue was not discussed. The appropriate use of smocks in the 2P Acute Inpatient Unit was adequately described in JPS Policy No. 1010 – Safety Suit Procedures for Inmate-Patients on Acute Inpatient Unit. As described later in this report, this expert reviewed multiple medical charts of inmate-patients placed on suicide precautions. *The review determined that all inmates placed on suicide precautions and housed on an outpatient basis in either the SITHU or safety cells were clothed in safety smocks for the entire duration of their suicide precautions.* As such, use of safety smocks was not individualized on a case-by-case basis. Contrary to this provision, safety smocks "were utilized as a default." The review also found that patients admitted to the 2P-Acute Inpatient Unit were almost always changed from a safety smock to their uniform within 24 hours of admittance. With that said, and as described later in this report, the expert reviewed the medical charts of at least two patients that were on suicide precautions in the 2P-Acute Inpatient Unit and were clothed in safety smocks and ordered to be observed at 30-minute intervals. In Case No. 1, the patient was admitted into the 2P Unit on October 13, 2020 after initially being placed on suicide precautions on an outpatient basis. Although initially clothed in a smock, the patient was given his clothing shortly after admission, but remained on observation at 15-minute intervals. The following day, the observation was downgraded to 30-minute intervals, but following several days of recurring suicidal ideation, he was placed back into a safety smock but remained on 30-minute intervals. During the next week, the patient continued to voice suicidal ideation, was interchangeably clothed in either a smock or uniform, but remained on 30-minute intervals. In Case No. 2, the inmate was booked into the Main Jail on June 8, 2020 and voiced suicidal ideation. He had placed a knife to his throat during arrest. He was initially placed on suicide precautions, but cleared two days later on July 10. Later that same day, the inmate began banging his head against a wall and

	voicing suicidal ideation. He was placed on suicide precautions and admitted into the 2P Unit in a safety smock and observation at 15-minute intervals. The following day (June 13), the patient remained in the smock, but his observation was downgraded to 30-minute intervals, with a nursing note stating that the patient would "remain on camera, in safety suit, and every 30 minutes safety checks." In conclusion, safety smocks continue to be utilized as the default for suicidal inmates housed in outpatient settings. Corrective action through policy revision has not occurred to date. Although JPS has an adequate policy regarding utilization of safety smocks in the 2P Acute Inpatient Unit, as well as a practice of exchanging safety smocks to uniforms within 24 hours of admittance in most cases, there were several cases reviewed by the expert in which 2P Unit patients were clothed in safety smocks and observed that 30-minute intervals. This provision is rated in Partial Compliance.
Recommendations	1) Revise SCSO and ACH/JPS suicide prevention policies to ensure they are consistent with the requirements of this provision regarding appropriate use of safety smocks. 2) Provide verification that all mental health and custody personnel have been trained regarding the new policy.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program. JPS Policy No. 1010 – Safety Suit Procedures for Inmate-Patients on Acute Inpatient Unit. Medical chart review.

Provision B) 6. Training	**The County shall ensure that all staff are trained in the new Suicide Prevention Policy.**
Status	**Non-Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First Status Report* (July 17, 2020), was "Draft policy under review." The County has not yet revised their suicide prevention policies, therefore, they have not had an opportunity to train all staff on the new policy. This provision is in Non-Compliance.
Recommendations	1) Revise the SCSO and ACH/JPS suicide prevention policies. 2) Provide the draft suicide prevention policies to expert for review. 3) Provide verification that all custody, medical, and mental health personnel have been trained on the revised suicide prevention policies.

Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). Review of the current suicide prevention policies: SCSO's Policy No. 10/05 - Suicide Prevention Program; ACH's Policy No. 1412 - Suicide Prevention 2M-Joint Policy; and JPS's Policies No. 1049 - Suicide Prevention Program, No. 1009 - Suicide Precautions – Acute Inpatient Unit, No. 1010 – Safety Suit Procedures for Inmate-Patients on Acute Inpatient Unit, No. 1011 - Use of Camera Monitors on the Acute Inpatient Unit, No. 1022 – Overview of Staff Responsibilities – Outpatient Department, and No. 1033 - 2M Suicidal Patients. Discussion with SCSO, ACH and JPS leadership.

Provision C) 1. Nursing Intake Screening	**Intake screening for suicide risk will take place at the booking screening and prior to a housing assignment. If clinically indicated, JPS will then perform an additional clinical assessment after the inmate is placed in a housing assignment.**	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by either the SCSO or ACH in the *First* Status Report (July 17, 2020), was omitted. Both the SCSO's Policy No. 10/04 Medical Intake Screening and ACH's Policy No. 05-05 Intake provided only vague reference to intake screening for suicide risk. JPS's Policy No. 1049 Suicide Prevention Program provided little guidance on the issue, simply stating that "All inmates booked into the Main Jail and RCCC will have an intake screening completed by CHS staff which includes questions related to suicidal risk factors. Inmates who screened positive for suicide risk factors and/or other psychiatric concerns will be referred to JPS." Review of multiple medical charts by this expert indicated that nursing personnel consistently completed the Intake Screening Form at booking and prior to an inmate's housing assignment. In addition, the chart review found that JPS clinicians consistently completed a clinical assessment (suicide risk assessment) for those inmates referred from intake nurses. However, as detailed in a subsequent provision of this report, there were inconsistent practices regarding 1) inclusion of required suicide risk questions on the intake screening form and 2) nursing staff asking all of the required suicide risk questions during the process. This provision is in Partial Compliance.	
Recommendations	1) SCSO's Policy No. 10/04 Medical Intake Screening, ACH's Policy No. 05-05 Intake, and JPS's Policy No. 1049 Suicide Prevention Program should be revised to provide an adequate description of the requirement for suicide risk inquiry during the intake screening process, as well as requirement for clinical assessment by JPS when appropriate in prior to housing assignment. 2) Provide the draft intake screening policies to expert for review.	

Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/04 Medical Intake Screening. ACH Policy No. 05-05 Intake. JPS Policy No. 1049 Suicide Prevention Program. Medical chart review.

Provision C) **2. Nursing Intake Screening**	**All nursing intake screening shall be conducted in an area that provides reasonable sound privacy and confidentiality. If a custody officer is present, the officer should be positioned in a place that allows for observation of the prisoner but maintains sound privacy, unless there is a clearly identified security or safety risk.**
Status	**Non-Compliance**
Discussion	Sacramento County's response to this provision, as authored by either the SCSO or ACH in the *First* Status Report (July 17, 2020), was omitted. Current SCSO and ACH policies do not address privacy and confidentiality during the intake screening process, nor do current practices reflect compliance with this provision. This expert was informed that the issue of reasonable sound privacy and confidentiality in the booking area at the Main Jail has remained unchanged since my on-site assessment conducted in September 2016. At that time, practices were that nursing staff was assigned to the booking area 24 hours a day to conduct intake screening, with up to three stations located side-by-side in a Nurse's Office. Nurses were only separated by small partitions. If all three stations were fully operational, three nurses were completing intake screening on three detainees. Each detainee was separated by only a few feet. Each detainee was also accompanied by at least one arresting officer who was stationed within arms' length of the detainee. Due to the occurrence of multiple intake screenings at the same time, involving multiple nurses, detainees, and arresting officers, confidentiality was severely compromised. It should be noted that the shield of privacy and confidentiality extends not only between inmate and inmate, but inmate and non-health care personnel (e.g., custody staff). This expert was informed that, apart from preliminary plans for a "jail annex" which would include a new booking and processing area, or purchasing "white noise" equipment in an attempt to mitigate the problem, current practices remain the same, and the County does not have any interim remedies to address the requirement for reasonable sound privacy and confidentiality during the intake screening process. As such, this provision is in Non-Compliance.
Recommendations	1) Aside from planning a Jail Annex to create a new booking and processing area, the County should develop a remedial plan that addresses, or at least

	attempts to mitigate, the lack of privacy and confidentiality during the intake screening process.
Evidentiary Basis	The expert's "Report on Suicide Prevention Practices Within the Sacramento County Jail System," submitted November 22, 2016. Discussion with SCSO, ACH, and JPS leadership.

Provision C) 3. Nursing Intake Screening	**The County shall revise its nursing intake assessment procedures and screening forms to ensure timely identification of acute and high-risk mental health conditions, consistent with the recommendations made by Lindsay Hayes. Intake screening, as documented on screening forms, shall include:** **a) Review of suicide risk notifications in relevant medical, mental health, and custody records, including as to prior suicide attempts, self-harm, and/or mental health needs;** **b) Any prior suicidal ideation or attempts, self-harm, mental health treatment, or hospitalization;** **c) Current suicidal ideation, threat, or plan, or feelings of helplessness and/or hopelessness;** **d) Other relevant suicide risk factors, such as:** **i. Recent significant loss (job, relationship, death of family member/close friend);** **ii. History of suicidal behavior by family member/close friend;** **iii. Upcoming court appearances;** **e) Transporting officer's impressions about risk.**	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by either the SCSO or ACH in the *First* Status Report (July 17, 2020), was omitted. This expert reviewed multiple medical charts of inmates booked into the Main Jail and found a variety of practices. First, it appeared that there were at least two versions of mental health questions contained within the intake screening form embedded into Centricity, the Jail System's electronic medical record. For example, the intake nurse could populate mental health questions contained in either Version 1 or Version 2, or simply select mental health questions to ask detainee: **<u>Version 1</u>** Mental Health Are you an ALTA regional client? Do you have a Conservator? Do you have mental health diagnosis? Are you currently thinking of hurting yourself?	

	Are you currently thinking of killing yourself? Have you attempted suicide within the *last two weeks*? Has a family member or close friend committed suicide within the *last two weeks*? Are you currently thinking of hurting someone else? Are you currently thinking of killing someone else? **Version 2** Mental Health Issues Mental Illness? Outpatient psychiatric care or MH Program/Clinic care? Mental Health Hospitalization? Have you ever thought about or tried to hurt or kill yourself? Has a parent, spouse or other close relative or friend committed suicide? Are you thinking about hurting/killing yourself now? Has there been a recent change in your support system? Have you ever experienced abuse? Have you ever been a victim of a violent crime? Do you have a history of violent behavior? Although it was unclear when either of these versions of mental health questions were embedded into Centricity, as indicated in **Version 1** above, questions regarding prior suicide attempts and suicides of either a family member or close friend was limited to the "last two weeks." Suicide risk inquiry during the intake screening process is designed to be all-inclusive rather than limit inquiry to specific time durations. Because prior suicide attempts are one the most significant risk factors for suicide, it is critically important not to restrict the inquiry. The medical chart review also found that intake nurses occasionally did not ask all of the mental health questions in either **Version 1** or **Version 2**, and simply limited the inquiry to: "Are you thinking of about hurting/killing yourself now?" It was noteworthy that this expert encountered similar problems of complete suicide risk inquiry during the prior assessment in September 2016. Further, although observations of the arresting/transporting officer are also embedded in Centricity, and include a suicide risk question ("Are you currently suicidal or do you feel like hurting yourself or someone else?), such inquiry was not always contained on the intake screening forms reviewed by the expert during the medical chart review. In conclusion, despite the finding of multiple deficiencies regarding consistent suicide risk inquiry during the intake screen process, basic inquiry/questioning was found, therefore, this provision is in Partial Compliance.

Recommendations	1) ACH should delete all prior versions of the mental health and suicide risk inquiry questions from the intake screening form that is embedded in Centricity and replace it with the following Suicide Risk inquiries: **Independent Verification from Nurse** • Was the inmate a suicide risk (either on suicide precautions or attempted suicide) or received mental health services [note Frequency of Service Scale (FOSS) during any prior confinement within this facility? (check active and inactive Problem List in Centricity) • Does the arresting and/or transporting officer have any information (e.g., from observed behavior, documentation from arresting agency, hospital, court/probation officials, conversation with family member, etc.) that indicates the inmate is a suicide risk now? **Observations/Responses Directed at Detainee** • Have you ever attempted suicide? If so, describe. • Have you ever considered suicide? If so, describe. • Are you now or have you ever been received either outpatient or inpatient mental health treatment? If so, describe. • Have you recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)? If so, describe. • Has a family member/close friend ever attempted or committed suicide? If so, describe. • Do you feel there is nothing to look forward to in the immediate future (expressing helplessness and/or hopelessness)? If so, describe. • Do you have an up-coming court hearing that you are particularly concerned about? If so, describe. • Are you thinking of hurting and/or killing yourself? If so, do you have a plan? Describe. 2) SCSO Policy No. 10/04 Medical Intake Screening and ACH Policy No. 05-05 Intake should be revised to provide an adequate description of the requirement for suicide risk inquiry during the intake screening process, as well specifically listing the above questions/inquiry in the policies. 3) Provide the draft intake screening policies to expert for review.

	4) All of the suicide risk inquiry questions should be embedded into Centricity in a manner in which the questions cannot be deleted and/or avoided, i.e., each question must be answered before moving onto the next question. 5)Nursing personnel responsible for intake screening shall be trained on the revised intake screening policy, as well as the new suicide risk questions. 6) Verification of nursing training should be provided to the expert.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/04 Medical Intake Screening. ACH Policy No. 05-05 Intake. Medical chart review. Multiple versions of mental health questions embedded in Intake Screening Form.

Provision C) 4. Nursing Intake Screening	**Regardless of the prisoner's behavior or answers given during intake screening, a mental health referral shall always be initiated if there is a documented history related to suicide or self-harm, including during a prior incarceration.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by either the SCSO or ACH in the *First* Status Report (July 17, 2020), was omitted. The Problem List embedded within Centricity allows for the storage of information regarding an inmate's current and prior medical and mental health history. The Problem List was had both an active (highlighted) and inactive view (shaded). Review of various multiple charts indicated that many inmates had both active and inactive mental health problems, including notations for Frequency of Service Scale (FOSS), serious mental illness, suicide attempt, 2P pre-admit, etc. Of note, the designation for "2P pre-admit" was an indication that the inmate had been placed on suicide precautions and was awaiting placement in the Acute Inpatient Unit. As noted in the provision above (C) 3., there is a requirement for nursing staff to "Review of suicide risk notifications in relevant medical, mental health, and custody records, including as to prior suicide attempts, self-harm, and/or mental health needs." Review of various medical charts found that intake nurses were not consistently creating orders for mental health referrals when in-coming detainees presented with FOSS levels, 2P pre-admit, suicide attempt, serious mental illness, etc. The vast majority of mental health referrals generated by intake nurses appeared to be driven by current self-reported information from the detainee, rather than also including prior information available from the Problem List. As such, this provision is in Partial Compliance.
Recommendations	1) SCSO Policy No. 10/04 Medical Intake Screening and ACH Policy No. 05-05 Intake should be revised to include the requirement that intake nurses shall

	create orders for mental health referrals when an in-coming detainee's Problem List includes FOSS levels, 2P pre-admit, suicide attempt, serious mental illness, etc. 2) Provide the draft intake screening policies to expert for review. 3) Nursing personnel responsible for intake screening shall be trained on the revised intake screening policy. 4) Verification of nursing training should be provided to the expert.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/04 Medical Intake Screening. ACH Policy No. 05-05 Intake. Medical chart review.

Provision C) 5. Nursing Intake Screening	**The County shall develop and implement a written policy and procedure for referrals to mental health by intake staff. The policy shall correspond with the triage system and timeframes set forth in the Mental Health Remedial Plan.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by either the SCSO or JPS in the *First* Status Report (July 17, 2020), was omitted. Neither the SCSO Policy No. 10/04 Medical Intake Screening or ACH Policy No. 05-05 Intake addresses this provision; whereas JPS Policy No. 1022 - Overview of Staff Responsibilities – Outpatient Department states that "Triage involves screening to: 1) identify mental illness; 2) identify suicide risk; 3) identify if ongoing mental health treatment is needed; 4) divert the referral to more appropriate services such as detoxification, Correctional Health Services, custody and jail social workers." The policy includes three levels of triage, but does not assign specific time frames to these triage levels. In addition, JPS provided this expert with an Access to Care document that lists several mental health responsibilities rising from medical referrals. For example: • Health Service Request is prioritized according to emergent (ASAP to within 6 hours), urgent (within 36 hours) and routine (within 2 weeks); • Initial Psychiatric Evaluation is prioritized according to emergent (within 24 hours), urgent (within 72 hours), and routine (within two weeks); • Initial Mental Health Assessment is prioritized according to emergent (ASAP to within 6 hours), urgent (within 36 hours), and routine (within 2 weeks); and

	• Discharge From the Acute Inpatient Unit or From Suicide Precautions is listed as within 24 hours of discharge, 72 hours of discharge, and 7 days of discharge. As this provision does not specifically address the identification of suicidal inmates, the expert would defer to the mental health expert in this Consent Decree regarding the reasonableness of the above-described mental health triage timeframes. In conclusion, because this provision requires creation of policies and procedures regarding timely mental health referrals for inmates identified as possibly in need of mental health services (excluding suicide prevention), and such policies and procedures are currently lacking, this provision is in Partial Compliance.
Recommendations	1) In collaboration with the mental health expert, develop and implement a written policy and procedure for mental health referrals by intake staff. The policy shall correspond with the triage system timeframes set forth in the Mental Health Remedial Plan.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/04 Medical Intake Screening. ACH Policy No. 05-05 Intake. JPS Policy No. 1022 - Overview of Staff Responsibilities - Outpatient Department. JPS Access to Care document, September 2, 2020. Medical chart review.

Provision C) 6. Nursing Intake Screening	**Any prisoner expressing current suicidal ideation and/or current suicidal/self-injurious behavior shall be designated as an emergent referral and immediately referred to mental health staff.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by either the SCSO or ACH in the *First* Status Report (July 17, 2020), was omitted. Neither the SCSO Policy No. 10/04 Medical Intake Screening or ACH Policy No. 05-05 Intake addresses this provision; whereas JPS Policy No. 1022 - Overview of Staff Responsibilities – Outpatient Department states that "Triage involves screening to: 1) identify mental illness; 2) identify suicide risk; 3) identify if ongoing mental health treatment is needed; 4) divert the referral to more appropriate services such as detoxification, Correctional Health Services, custody and jail social workers." The policy includes three levels of triage, but does not assign specific time frames to these triage levels.

	In addition, JPS provided this expert with an Access to Care document that lists several mental health responsibilities rising from medical referrals, but does not specifically address mental health triage and time frames for responding to the identification of suicidal inmates at intake. It would be this expert's opinion that a detainee identified at intake (for any time during confinement) as a possible current risk for suicide should be seen by a JPS clinician on an emergent basis, i.e., immediately or within four (4) hours, as well as under constant observation until assessment; whereas a detainee identified at intake with a prior history of suicidal behavior should be seen by a JPS clinician on an urgent basis, i.e., within 24 hours. Review of various medical charts found that JPS clinicians consistently responded to emergent mental health referrals for inmates currently at risk for suicide, although it was unclear from the record whether the response time was always within 4 hours. In conclusion, because this provision requires creation of policies and procedures regarding timely mental health referrals for inmates presenting with either a current risk or prior history of suicidal behavior from intake nurses, and such policies and procedures are currently lacking, this provision is in Partial Compliance.
Recommendations	1) The following language should be added to the policy and procedure for mental health referrals by intake staff that is required by another provision (C) 5.): "a detainee identified at intake (for any time during confinement) as a possible current risk for suicide should be seen by a JPS clinician on an emergent basis, i.e., immediately or within four (4) hours, as well as under constant observation until assessment; whereas a detainee identified at intake with a prior history of suicidal behavior should be seen by a JPS clinician on an urgent basis, i.e., within 24 hours."
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/04 Medical Intake Screening. ACH Policy No. 05-05 Intake. JPS Policy No. 1022 - Overview of Staff Responsibilities - Outpatient Department. JPS Access to Care document, September 2, 2020. Medical chart review.

Provision D) 1. Post-Intake Mental Health Assessment Procedures	**All mental health assessments shall be conducted in an area that provides reasonable sound privacy and confidentiality. If a custody officer is present, the officer should be positioned in a place that allows for observation of the prisoner but maintains sound privacy, unless there is a clearly identified security or safety risk.**
Status	**Non-Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Booking area interview room modified for psychiatric use." The expert determined that current SCSO and ACH/JPS policies do not address privacy and confidentiality during the assessment of suicide risk. In addition, this expert was informed that an existing attorney booth in the Main Jail's booking area had been designated and modified for exclusive use by JPS clinicians when they are assessing inmates at risk for suicide. The booth has a solid glass barrier that separates the clinician from the inmate, thus providing full security. However, this expert was provided conflicting reports as to whether or not the door to the attorney booth remained open or closed during the assessment. Although custody leadership informed the experts that the practice was to keep the door closed at all times, with the deputy providing visual observation through the door's window, other custody leadership informed the mental health expert that the practice was for the door to remain open. Allowing the door to remain open would not only defeat the purpose of designating the booth for JPS clinical use, but severely compromise privacy and confidentiality. The expert will attempt to verify existing practices during the next on-site monitoring assessment. With regard to suicide risk assessments conducted outside of booking and in other areas of the Main Jail, the expert was informed that both classroom and dayroom areas on each housing floor can be utilized, but are often not available. Although a classroom on 3-West was previously designated for the Intensive Outpatient Program (IOP), a similar designation for a private area in which to assess suicidal inmates has not been made. As such, both custody and JPS leadership conceded that privacy and confidentiality was not always made available for the assessment of suicidal inmates. As found during the review of multiple medical charts of inmates placed on suicide precautions and subsequently assessed by JPS clinicians, *the assessments are consistently performed cell-side and there was no indication that any suicidal inmate was assessed either in the converted attorney both in booking or in a classroom/dayroom area of any housing unit at the Main Jail.* Ironically, following discharge from suicide precautions and referral into the IOP, the expert did find examples of inmates being seen by JPS clinicians in a classroom as part of the initial assessment into the program.

	In conclusion, the lack of privacy and confidentiality during the assessment of suicide risk is a significant impediment to the County's ability to provide a reasonable suicide prevention program. Based upon current practices, as well as lack of a policy to address the issue, this provision is in Non-Compliance.
Recommendations	1) Unless exigent circumstances exist and are documented on a case-by-case basis, any inmate identified as suicidal should be given an opportunity for assessment outside of their cell. This includes initial assessments, daily on-going assessments, discharge assessments, and scheduled follow-up. 2) JPS clinicians conducting initial and on-going assessments of inmates on suicide precautions should continue to document the location of the assessment in the medical chart and, if the assessment was conducted cell-side, the reason why privacy and confidentiality were not provided. 3) Unless there is a clearly identified security or safety risk, the designated JPS booth in the booking area of the main jail should be routinely utilized for the assessment of suicidal inmates, to include those inmates housed in the booking area's safety cells, sobering cell, and segregation cell. In addition, unless exigent circumstances exist and are documented on a case-by-case basis, the door to the JPS both should remain closed at all times. 4) A designated room(s) or areas outside of the Main Jail's booking area that can provide privacy and confidentiality should be designated and routinely utilized for the assessment of suicidal inmates. 5) The SCSO and ACH/JPS suicide prevention policies should be revised to include inadequate description of the requirement for privacy and confidentiality during the assessment of suicidal inmates. 6) Provide the draft suicide prevention policies to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). Review of the current suicide prevention policies: SCSO's Policy No. 10/05 - Suicide Prevention Program; ACH's Policy No. 1412 - Suicide Prevention 2M-Joint Policy; and JPS's Policies No. 1049 - Suicide Prevention Program, No. 1009 - Suicide Precautions – Acute Inpatient Unit, No. 1010 – Safety Suit Procedures for Inmate-Patients on Acute Inpatient Unit, No. 1011 - Use of Camera Monitors on the Acute Inpatient Unit, No. 1022 – Overview of Staff Responsibilities – Outpatient Department, and No. 1033 - 2M Suicidal Patients. Discussion with SCSO, ACH and JPS leadership. Medical chart review.

Provision D) 2. Post-Intake Mental Health Assessment Procedures	**Mental health staff shall conduct assessments within the timeframes defined in the mental health referral triage system.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by either the SCSO or ACH in the *First* Status Report (July 17, 2020), was omitted. As previously stated, JPS provided this expert with an Access to Care document that listed the mental health triage system and time frames for response. As this provision is similar to Provision C) 5. Nursing Intake Screening above and is not specifically address suicidal inmates, the expert would defer to the mental health expert in this Consent Decree regarding the reasonableness of the above-described mental health triage timeframes for initial mental health assessments. In conclusion, because this provision requires creation of policies and procedures regarding timely mental health referrals for inmates identified as possibly in need of mental health services (excluding suicide prevention), and such policies and procedures are currently lacking, this provision is in Partial Compliance.
Recommendations	1) In collaboration with the mental health expert, develop and implement a written policy and procedure regarding timeframe for completion of initial mental health assessments.
Evidentiary Basis	JPS Policy No. 1022 - Overview of Staff Responsibilities - Outpatient Department. JPS Access to Care document, September 2, 2020.

Provision D) 3. Post-Intake Mental Health Assessment Procedures	**The County shall revise its mental health assessment procedures and related forms to ensure identification of historical and current patient mental health and suicide risk information, consistent with the recommendations of the subject matter expert.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by either the SCSO or ACH in the *First* Status Report (July 17, 2020), was omitted. The JPS Mental Health Assessment is embedded within Centricity and contains the following domains: Background and Legal Information, Personal History, Medical Information and Significant Health Issues, Substance Abuse History, Mental Health Treatment History, Medication Verification, Mental Status

	Examination, DSM-V Diagnoses, and Preliminary Treatment Plan. In addition, the JPS Initial Psychiatric Evaluation is also embedded within Centricity and contains the following domains: Current Psychotropic Medication, Mental Status Examination, DSM-V Diagnoses, and brief Suicide Ideation inquiry. The Mental Health Assessment and Initial Psychiatric Evaluation forms should not be primarily utilized for the assessment of suicide risk. In sum, critique of the utility of the current JPS Mental Health Assessment and JPS Initial Psychiatric Evaluation forms are deferred to the mental health expert in the Consent Decree. This provision is in Partial Compliance because JPS does not currently have a policy and procedure that addresses the provision.
Recommendations	None
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). JPS Mental Health Assessment form. JPS Initial Psychiatric Evaluation form.

Provision E) 1. Responses to Identification of Suicide Risk or Need for Higher Level of Care	**When a prisoner is identified as at risk for suicide and placed by custody staff in a safety cell, on suicide precautions, and/or in a safety suit, mental health staff shall be contacted immediately. A qualified mental health professional, or other appropriately trained medical staff in consultation with mental health staff, shall complete a confidential in-person suicide risk assessment as soon as possible, consistent with the "must-see" referral timeline.**	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current custody practice." Following the medical chart review, this expert determine that portions of this provision were currently being practiced. Inmates identified as suicidal are often placed on suicide precautions in a safety cell and always clothed in a safety smock. JPS is immediately notified and seemingly responds in a timely manner. As stated earlier in this report, JPS clinicians consistently responded to emergent mental health referrals for inmates currently at risk for suicide, although it was unclear from the record whether the response time was always within the recommended four (4) hours. Finally, as also reported earlier in this report, inmates identified as potentially suicidal are not provided reasonable privacy and confidentiality during the suicide risk assessment process. In conclusion, because the SCSO and ACH/JPS suicide prevention policies have not been revised to incorporate the requirements of this provision, as well as the fact that inmates identified as potentially suicidal are not provided	

	reasonable privacy and confidentiality during the assessment process, this provision is in Partial Compliance.
Recommendations	1) Revise the SCSO and ACH/JPS suicide prevention policies to incorporate the requirements of this provision. 2) Provide the draft suicide prevention policies to expert for review. 3) Create a corrective action plan that resolves issues of reasonable privacy and confidentiality during the assessment of suicide risk.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program and Policy No. 4/05 - Use of Safety Cells/Segregation Cells/Multipurpose Rooms/North Holding No. 2. ACH Policy No. 1412 - Suicide Prevention 2M-Joint Policy. JPS Policies No. 1049 - Suicide Prevention Program, No. 1009 - Suicide Precautions – Acute Inpatient Unit, No. 1010 – Safety Suit Procedures for Inmate-Patients on Acute Inpatient Unit, No. 1011 - Use of Camera Monitors on the Acute Inpatient Unit, No. 1022 – Overview of Staff Responsibilities – Outpatient Department, and No. 1033 - 2M Suicidal Patients. Medical chart review.

Provision E) 2. Responses to Identification of Suicide Risk or Need for Higher Level of Care	**Consistent with current RCCC policy, if there is no mental health staff on site at RCCC at the time that an emergent mental health need is identified, the prisoner shall be transported to the Main Jail for emergency evaluation within two hours of the initial report.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current practice. Development of procedures for use of suicide-resistant cells at RCCC to limit transport to only the most acute patients." According to the County's response, as well as SCSO policy and review of various medical charts, an inmate identified as suicidal at RCCC is initially seen by a JPS clinician (during regular business hours) and provided with a suicide risk assessment. If the assessment indicates the need for further suicide precautions, the inmate is transported to the Main Jail. If a JSP clinician is not available, the inmate is initially housed in the Safety Cell or North Holding No. 2 Cell and then immediately transported to the Main Jail within two hours.

	In conclusion, because the SCSO and ACH/JPS suicide prevention policies have not been revised incorporate the requirements of this provision, this provision is in Partial Compliance.
Recommendations	1) Revise the SCSO and ACH/JPS suicide prevention policies to incorporate the requirements of this provision. 2) Provide the draft suicide prevention policies to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program and Policy No. 4/05 - Use of Safety Cells/Segregation Cells/Multipurpose Rooms/North Holding No. 2. ACH Policy No. 1412 - Suicide Prevention 2M-Joint Policy. JPS Policy No. 1049 - Suicide Prevention Program. Medical chart review.

Provision E) 3. Responses to Identification of Suicide Risk or Need for Higher Level of Care Provision	**The County shall revise its JPS suicide risk assessment procedures and forms in consultation with Plaintiffs. The County shall ensure that its JPS suicide risk assessment process, policies, and procedures consider and document the following:** **a) Review of suicide risk notifications and records from any previous incarcerations at the Jail, including records pertaining to suicide attempts, self-harm, and/or mental health needs;** **b) Other prior suicide ideation or attempts, self-harm, mental health treatment or hospitalization;** **c) Current suicidal ideation, threat, or plan, or feelings of helplessness and/or hopelessness;** **d) Suicide risk factors and protective factors, such as:** **i. Recent significant loss (job, relationship, death of family member/close friend);** **ii. History of suicidal behavior by family member/close friend;** **iii. Upcoming court appearances;** **e) Transporting officer's impressions about risk;** **f) Suicide precautions, including level of observation.**	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by either the SCSO or ACH in the *First* Status Report (July 17, 2020), was omitted. Although there are no current policies that address the utilization of a suicide risk assessment form, based upon review of various medical charts, it would appear that JPS has developed a Suicide Risk Assessment form that is completed by outpatient clinicians whenever an inmate is identified at risk for suicide. If the inmate is placed on suicide precautions, a follow-up Suicide Risk	

	Assessment form is subsequently completed upon a determination that the inmate can be discharged from suicide precautions. Of note, if a patient is placed in the 2P Acute Inpatient Unit, a suicide risk assessment is not completed by either nursing or psychiatry staff. Rather, current practices are for a JPS outpatient clinician to complete the SRA. According to JPS leadership, there are preliminary plans to assign an LCSW clinician to the 2P Unit to complete suicide risk assessments in the future. The current JPS Suicide Risk Assessment template is embedded within Centricity and contains the following inquiry: In the last 72 hours were there any of these warning signs present? (IS-PATH-WARM: Ideation, Substance Abuse, Purposelessness, Anxiety, Trapped, Hopelessness, Withdrawal, Anger, Recklessness, Mood Changes) (Questions 1 thru 8 require "Yes" or "No" response) 1) Have you ever wished you were dead or wish you could go to sleep and not wake up the past month? 2) Have you had thoughts of actually killing yourself? 3) Have you been thinking about how you might kill yourself? 4) Have you had these thoughts and some intention of acting on them? 5) Have you worked out the details of how you might kill yourself? 6) Has there been a time when you started to do something to try to end your life, stopped yourself before you actually did anything? 7) Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)? 8) Have you ever attempted suicide? 9) Reported level of suicidal intent? 10) Primary method of planned suicide? 11) Inmates report of a suicide plan? Listing of Chronic Risk Factors (family history of suicide, history of emotional, physical or sexual abuse, history of mental illness, other medical illnesses, chronic pain problem, history of poor impulse control, history of violence, history of substance abuse, long or life sentence, first jail term, sex offender, history of suicide attempts) Listing of Acute Risk Factors (within the past three months) Detainment (safety concerns, single cell placement, first week of detainment, recent accumulation of disciplinary infractions, recent adverse change in housing, unable to adjust to the deprivations of confinement) Mental Health (recent discharge from inpatient psychiatric unit, current symptoms of mental illness, current substance of substance use or active detoxification, current or recent violence)

	Psychological (recent negative staff interactions, acute shame, guilt, or feeling disgraced due to the attainment, hopelessness about legal situation) Social (un-convicted, recent bad news from court, home, feels abandoned/rejected as a result of detainment, acute fears of social/occupational/financial consequences of detainment, recent trauma) Medical (recent serious medical diagnosis, evidence of medication hoarding) Protective Factors (Family support, religious/spiritual/cultural beliefs, interpersonal social support, future orientation or plans for the future, exercises regularly, positive coping/conflict resolution skills, children at home, spousal/partner support, insight into problems, job or school assignment, active and motivated in psych treatment, sense of optimism, self-efficacy.) Estimate of Risk (chronic and acute risk; low, moderate, high) Safety and Risk Reduction Plan (short-term, long-term) The JPS Suicide Risk Assessment (SRA) template is very comprehensive and exceeds the requirements of this provision. However, review of various medical charts found that JPS clinicians did not consistently complete all of the required domains on the form. For example, this expert reviewed SRAs of four patients (Case No. 1 on September 27, 2020, Case No. 2 on June 9, 2020, Case No. 3 on August 26, 2020, and Case No. 4 on October 10, 2020) by four different JPS clinicians and found various degrees of completion. Case No. 1 contained only one error, whereas the other three cases contained numerous deficiencies in failing to notate "yes" or "no" responses to required questions (No. 1 thru 8); chronic, acute, and protective factors; and medical issues. In conclusion, although there are no current policies that address the utilization of a suicide risk assessment form, the SRA developed by JPS is very comprehensive. The medical chart review found a few deficiencies in its use. This provision is in Partial Compliance.
Recommendations	1) Revise the SCSO and ACH/JPS suicide prevention policies to incorporate the requirements for completion of suicide risk assessments. 2) Provide the draft suicide prevention policies to expert for review. 3) In order to comply with the requirement of this provision to "Review of suicide risk notifications and records from any previous incarcerations at the Jail, including records pertaining to suicide attempts, self-harm, and/or mental health needs," JPS clinicians should be instructed to review the inmate's Problem List to determine if it includes FOSS levels, 2P pre-admit, suicide attempt, serious mental illness, etc. notations from previous confinements.

	3) Provide training to JPS clinicians regarding full completion of SRA forms, including review of the Problem List, and provide verification of such training to the expert.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program. ACH Policy No. 1412 - Suicide Prevention 2M-Joint Policy. JPS Policy No. 1049 - Suicide Prevention Program. JPS Suicide Risk Assessment form. Medical chart review.

Provision E) 4. Responses to Identification of Suicide Risk or Need for Higher Level of Care	**The County shall ensure that the meal service schedule or other custody-related activities cause no delay in the completion of suicide risk assessments for prisoners.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current practice." Review of the SCSO and ACH/JPS suicide prevention policies found that they did not include language to require custody-related activities (including meal service schedule) shall not delay completion of the suicide risk assessment process. However, review of various medical charts did not indicate any impediments to the timely completion of Suicide Risk Assessments. In conclusion, because the SCSO and ACH/JPS suicide prevention policies have not been revised to incorporate the requirements of this provision, this provision is in Partial Compliance.
Recommendations	1) Revise the SCSO and ACH/JPS suicide prevention policies to incorporate the requirement of this provision. 2) Provide the draft suicide prevention policies to expert for review.
Evidentiary Basis	Sacramento County's *First Status Report* (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program and Policy No. 4/05 - Use of Safety Cells/Segregation Cells/Multipurpose Rooms/North Holding No. 2. ACH Policy No. 1412 - Suicide Prevention 2M-Joint Policy. JPS Policy No. 1049 - Suicide Prevention Program. Medical chart review.

Provision F) **1. Housing of Inmates on Suicide Precautions**	**The County's policy and procedures shall direct that prisoners, including those identified as being at risk for suicide, be treated in the least restrictive setting appropriate to their individual clinical and safety needs.**
Status	**Non-Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Policy forthcoming. Current post orders and practice indicate least restrictive housing for suicidal inmates." Any "current post orders" cited above were not provided to this expert. Review of the SCSO and ACH/JPS suicide prevention policies found that they did not include language to require that inmates on suicide precautions "be treated in the least restrictive setting appropriate to their individual clinical and safety needs." In addition, review of various medical charts indicated that many inmates placed on suicide precautions were initially housed in safety cells or sobering/segregation cells located in the Main Jail's booking area and clothed in safety smocks. Safety cells were clearly utilized as the initial default setting for many suicidal inmates. In conclusion, because current post orders were not provided, SCSO and ACH/JPS suicide prevention policies have not been revised to incorporate the requirements of this provision, and current practices indicated that many inmates placed on suicide precautions were initially placed in safety cells and clothed in safety smocks, this provision is in Non-Compliance.
Recommendations	1) Revise the SCSO and ACH/JPS suicide prevention policies (including SCSO Policy No. 4/05 - Use of Safety Cells/Segregation Cells/Multipurpose Rooms/North Holding No. 2.) to incorporate the requirement that inmates on suicide precautions "be treated in the least restrictive setting appropriate to their individual clinical and safety needs." The policies should specifically state that safety cells should not be the default setting for inmates initially placed on suicide precautions. 2) Provide the draft suicide prevention policies to expert for review.
Evidentiary Basis	Sacramento County's *First Status Report* (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program and Policy No. 4/05 - Use of Safety Cells/Segregation Cells/Multipurpose Rooms/North Holding No. 2. ACH Policy No. 1412 - Suicide Prevention 2M-Joint Policy. JPS Policy No. 1049 - Suicide Prevention Program. Medical Chart review.

Provision G) 1. Inpatient Placement	**The County shall ensure that prisoners who require psychiatric inpatient care as clinically indicated are placed in the 2P unit within 24 hours of identification, absent exceptional circumstances. In all cases, the provision of clinically indicated treatment to any prisoner requiring inpatient level of care shall be initiated within 24 hours.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Jail Annex planning." This response was unclear and could be interpreted to mean that future Jail Annex construction would include expansion of the 2P Acute Inpatient Unit. Further explanation is necessary. Both ACH Policy No. 1433 Limitations for Admission to Jail Acute Psychiatric Inpatient Unit and JPS Policy No. 1009 Suicide Precautions - Acute Inpatient Unit do not specifically address admission criteria that is consistent with this provision. The medical chart review of inmates placed on suicide precautions found that all cases resulted in an automatic order for 2P pre-admit. In practice, not all inmates placed on suicide precautions were eventually placed in the 2P Acute Inpatient Unit. In fact, only a small percentage of suicidal inmates are housed on the 2P Unit. Rather, most of these inmates are initially housed in a safety cell and then transferred to the Suicidal Inmate Temporary Housing Unit (SITHU), located in 3-West Unit, lower 300 pod, cells 302 – 310 for male inmates or 3-West Unit lower 100 pod, cells 101 – 1044 for female inmates. Most inmates remain on suicide precautions in the SITHU for several days or longer, while still maintaining a pending 2P pre-admit order. Eventually, the issue is resolved and the 2P Pre-Admit order is withdrawn. It would be the expert's opinion that not all inmates presenting with suicidal ideation and subsequently placed on suicide precautions meet the criteria for a 5150 order and placement on the 2P Acute Inpatient Unit. Such clinical judgment is deferred to the mental health expert in the Consent Decree. This provision is in Partial Compliance.
Recommendations	1) Determine the specific criteria for admittance into the 2P Acute Inpatient Unit, to include the scope of "danger to self" behavior. 2) Revise ACH Policy No. 1433 Limitations for Admission to Jail Acute Psychiatric Inpatient Unit, JPS Policy No. 1009 Suicide Precautions - Acute Inpatient Unit, and/or other policies to ensure that they are compliant with the requirements of this provision. 3) Provide the draft policies to expert for review.

Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). ACH Policy No. 1433 Limitations for Admission to Jail Acute Psychiatric Inpatient Unit. JPS Policy No. 1009 Suicide Precautions - Acute Inpatient Unit.

Provision H) 1. Temporary Suicide Precautions	**No prisoner shall be housed in a safety cell, segregation holding cell, or other Temporary Suicide Precautions Housing for more than six (6) hours. If mental health or medical staff determine it to be clinically appropriate based on detoxification-related needs, this time limit may be extended to no more than eight (8) hours. If exceptional circumstances prevent transfer within these timelines, those circumstances shall be documented, and transfer shall occur as soon as possible. This does not preclude the housing of a prisoner in the IOP unit if clinically indicated.**	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Jail Annex planning." This response was unclear and could be interpreted to mean that future Jail Annex construction would exclude additional "Temporary Suicide Precautions Housing" cells. Further explanation is necessary. Currently, there are 4 safety cells located in the Main Jail: 2 in the male booking area, 1 in the female building area, and 1 in the 2P Acute Inpatient Unit. In addition, there is 1 safety cell and 1 holding cell (North Holding No. 2) located at RCCC. There are 6 segregation cells in the Main Jail's booking area, as well as at least 1 sobering cell. Although the safety cells are prioritized to temporarily house suicidal inmates, any of the remaining segregation, holding, and sobering cells could be designated as Temporary Suicide Precautions Housing. For purposes of this monitoring, the expert interprets the term "Temporary Suicide Precautions Housing" to exclude the Suicidal Inmate Temporary Housing Unit (SITHU) on 3-West Unit because suicidal inmates may be clinically appropriate for placement in the SITHU while awaiting a determination for inpatient hospitalization. For example, this provision does allow for the "the housing of a prisoner in the IOP unit if clinically indicated." As such, length of stay in the SITHU should not be limited to six (6) hours. In addition, the expert interprets "Temporary Suicide Precautions Housing" to include the Main Jail's "sobering cell" (not currently included in the Consent Decree definition) because of the provision's allowance for utilizing such cells for "detoxification-related needs." Clarification and/or confirmation from the parties was required regarding the above issues. In early January 2020, counsel for both parties confirmed this expert's interpretation of the Consent Decree whereby the SITHU is exempt	

	from this provision because it is not a temporary suicide precautions housing unit, and the Main Jail's sobering cell is considered temporary suicide precautions housing and, therefore, limited to a six-hour length of stay that can be extended to no more than eight (8) hours based on detoxification-related needs. The expert was informed by both custody and JPS leadership that, although the goal is to remove a suicidal inmate from the safety or other temporary holding cells as soon as possible and there is a belief that the vast majority of the inmates are released from these cells within six (6) hours, despite the expert's multiple requests for length of stay data, there is no verification for such an assertion. In addition, according to custody leadership, whenever the length of stay in safety cells exceeds the 6-hour limit, it is normally because of the lack of available cells in the SITHU. The expert was subsequently informed that length of stay data for safety and segregation cells can be generated from the "PF-10 Report" of the SCSO's inmate management system. In conclusion, because the current SCSO and ACH safety cell use policies do not address the requirements of this provision, and length of stay data regarding safety cells and other temporary holding cells utilized for the housing of suicidal inmates was not generated to verify the 6-hour limit, this provision is in Partial Compliance.
Recommendations	1) Revise all SCSO and ACH/JPS suicide prevention and safety cell use policies to include language that prohibits use of safety cells, sobering cells, and segregation holding cells for more than six (6) hours except for exceptional circumstances. 2) Provide all draft policies to expert for review. 3) Provide a "PF-10 Report" for the length of stay within safety cells, sobering cells, segregation cells, and any other holding cells utilized for the temporary housing of suicidal inmates to the expert on a monthly basis.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 4/05 - Use of Safety Cells/ Segregation Cells/Multipurpose Rooms/North Holding #2. ACH Policy No. 1415 – Patients in Safety Cells. Discussion with counsel for both parties.

Provision H) 2. Temporary Suicide Precautions	**The County shall ensure, including by revising written policies and procedures where necessary, the timely and adequate completion of medical assessments for prisoners in need of suicide precautions, as required under Operations Order 4/05 (i.e., within 12 hours of placement of the next daily sick call, whichever is earliest, and then every 24 hours thereafter).**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current practice." The current SCSO Policy No. 4/05 - Use of Safety Cells/ Segregation Cells/Multipurpose Rooms/North Holding No. 2 states: "A medical assessment shall be completed within twelve (12) hours of placement or the next daily sick call, whichever is earliest. The prisoner must be medically cleared for continued retention every 24 hours thereafter." Because this policy is specific to safety cells and other temporary housing cells that cannot house inmates beyond six (6) hours, the requirement for the medical assessment for inmates on suicide precautions within 12 hours of placement and then every 24 hours thereafter needs to be incorporated in the SCSO and ACH/JPS suicide prevention policies. This expert reviewed multiple medical charts of inmates housed on suicide precautions. The review found that nursing staff almost always provided timely medical assessments (documented as SOAP notes in Centricity) within 12 hours of placement and then every 24 hours during the entirety of an inmate's placement on suicide precautions. There were few examples of nursing staff unable to complete daily rounds of inmates on suicide precautions due to "custody staff availability." In conclusion, because the medical assessment for inmates on suicide precautions within 12 hours of placement and then every 24 hours thereafter needs to be incorporated in the SCSO and ACH/JPS suicide prevention policies, this provision is in Partial Compliance.
Recommendations	1) Revise all SCSO and ACH/JPS suicide prevention policies to incorporate the requirement that medical assessments for inmates on suicide precautions should occur within 12 hours of placement and then every 24 hours thereafter. 2) Provide all draft policies to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program and Policy No. 4/05 - Use of Safety Cells/Segregation Cells/Multipurpose Rooms/North Holding No. 2. ACH Policy No. 1412 - Suicide Prevention 2M-Joint Policy. JPS Policy No. 1049 - Suicide Prevention Program. Medical Chart review.

Provision H) 3. Temporary Suicide Precautions	**The County shall ensure that any cell used for holding prisoners on suicide precautions is clean prior to the placement of a new prisoner, as well as cleaned on a normal cleaning schedule.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Will add language to policy under review." This expert did not have an opportunity to inspect Temporary Suicide Precautions Housing, SITHU, or 2P Acute Inpatient Unit cells during the current monitoring period to ensure they were clean prior to the placement. Such inspection shall occur during the next monitoring period. In conclusion, pending inspection of all cells utilized for the housing of inmates on suicide precautions, as well as revision of current suicide prevention policies to include the required language of this provision, this provision is in Partial Compliance.
Recommendations	1) Revise all SCSO and ACH/JPS suicide prevention policies to incorporate the requirement that all cells utilized for the housing of suicidal inmates are to be cleaned prior to the placement, as well as cleaned on a normal cleaning schedule. 2) Provide all draft policies to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program and Policy No. 4/05 - Use of Safety Cells/Segregation Cells/Multipurpose Rooms/North Holding No. 2. ACH Policy No. 1412 - Suicide Prevention 2M-Joint Policy. JPS Policy No. 1049 - Suicide Prevention Program.

Provision H) 4. Temporary Suicide Precautions	**The County shall create and implement a written policy ensuring adequate frequency for meals, fluids, hygiene, showers, prescribed medications, and toileting when a prisoner is in cell used for holding prisoners on suicide precautions**.
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current practice. Will add language to policy under review."

	Review of all current SCSO and ACH/JPS suicide prevention policies, including SCSO Policy No. 4/05 - Use of Safety Cells/Segregation Cells/Multipurpose Rooms/North Holding No. 2. found that they did not include the requirement regarding adequate frequency for meals, fluids, hygiene, showers, prescribed medications, and toileting for inmates on suicide precautions. In fact, inmates housed in safety cells were not offered showers, were required to request hydration, and could only defecate into a floor grate. This provision is in Partial Compliance.
Recommendations	1) Revise all SCSO and ACH/JPS suicide prevention policies to incorporate the requirement regarding adequate frequency for meals, fluids, hygiene, showers, prescribed medications, and toileting for inmates on suicide precautions. 2) Provide all draft policies to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program and Policy No. 4/05 - Use of Safety Cells/Segregation Cells/Multipurpose Rooms/North Holding No. 2. ACH Policy No. 1412 - Suicide Prevention 2M-Joint Policy. JPS Policy No. 1049 - Suicide Prevention Program. Medical chart review.

Provision H) 5. Temporary Suicide Precautions	**Inmates on suicide precautions shall not automatically be on lockdown and should be allowed dayroom or out-of-cell access consistent with security and clinical judgments.**
Status	**Non-Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current practice." Contrary to the County's response, this expert's medical chart review saw no evidence that inmates on suicide precautions in either the safety cells or SITHU cells were allowed any out-of-cell access, including dayroom. In practice, all inmates on suicide precautions were are locked down. Both custody and JPS leadership acknowledged the current practice. The expert also sensed that custody supervisors were driving the management of inmates on suicide precautions, rather than the Consent Decree requirement that "Qualified mental health professionals shall have the primary responsibility to determine, based on clinical judgment and on a case-by-case basis in consultation with custody staff." This provision is similar to Provision "M) 1. Property and Privileges," and will be discussed in more detail in that provision.

	In conclusion, because there are no current SCSO and ACH/JPS policies that address this requirement and, contrary to the County's response, all inmates on suicide precautions in either the safety cells or SITHU cells are locked down and have no out-of-cell access, this provision is in Non-Compliance.
Recommendations	1) Revise all SCSO and ACH/JPS suicide prevention policies to include language that suicidal inmates will not automatically be on lockdown and should be allowed dayroom or out-of-cell activities as determined by JPS clinicians in consultation with custody personnel. 2) Provide all draft policies to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program and Policy No. 4/05 - Use of Safety Cells/Segregation Cells/Multipurpose Rooms/North Holding No. 2. ACH Policy No. 1412 - Suicide Prevention 2M-Joint Policy. JPS Policy No. 1049 - Suicide Prevention Program. Discussion with SCSO and JPS leadership. Medical chart review.

Provision H) **6. Temporary Suicide Precautions**	**The classrooms or multipurpose rooms adjacent to the housing units in the Main Jail are designed for, and should be made available for, prisoner programs and treatment. Absent an emergency, the County shall not use the classrooms and multipurpose rooms to hold prisoners pending a mental health evaluation or on suicide precautions. Where such emergency occurs, the County shall document the reasons for retention and move the prisoner, within six (6) hours, to the inpatient unit or other appropriate housing location for continued observation, evaluation, and treatment.**	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Multi-purpose rooms are no longer used for holding suicide precaution, or mental health evaluation inmates. Written directives to staff document acceptable practice for at-risk patients, without the use of MPRs. There is currently a zero-use policy, not even as a last resort." This expert did not any evidence in the medical chart reviews that multi-purpose rooms, including classrooms, were currently utilized for even the temporary housing of inmates on suicide precautions. In addition, both SCSO and JPS leadership also informed this expert that multi-purpose rooms/classrooms were no longer utilized for that purpose. This provision is in Partial Compliance only because the existing SCSO Policy No. 4/05 - Use of	

	Safety Cells/Segregation Cells/Multipurpose Rooms/North Holding No. 2. needs to be revised to eliminate reference to multi-purpose rooms.
Recommendations	1) SCSO Policy No. 4/05 - Use of Safety Cells/Segregation Cells/Multipurpose Rooms/North Holding No. 2. should be revised to delete reference to multi-purpose rooms, including classrooms, as acceptable locations for the housing of suicidal inmates. 2) Provide all draft policies to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 4/05 - Use of Safety Cells/ Segregation Cells/Multipurpose Rooms/North Holding #2. ACH Policy No. 1415 – Patients in Safety Cells. Discussion with SCSO and JPS leadership. Medical chart review.

Provision I) 1. Suicide Hazards in High-Risk Housing Locations	**The County shall not place prisoners identified as being at risk for suicide or self-harm, or for prisoners requiring IOP level of care, in settings that are not suicide-resistant as consistent with Lindsay Hayes's "Checklist for the 'Suicide-Resistant' Design of Correctional Facilities."**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current practice." This expert did not have an opportunity to inspect Temporary Suicide Precautions Housing, SITHU, or 2P Acute Inpatient Unit cells during the current monitoring period to ensure they were "suicide-resistant." Such inspection shall occur during the next monitoring period. This provision is in Partial Compliance.
Recommendations	1) Revise SCSO Policy No. 4/05 - Use of Safety Cells/Segregation Cells/Multipurpose Rooms/North Holding No. 2. to delete reference to multi-purpose rooms, including classrooms, as acceptable locations for the housing of suicidal inmates. 2) Provide all draft policies to expert for review. 3) Although not on suicide precautions at the time of his suicide in the Main Jail in August 2019, the inmate utilized a fire sprinkler in the ceiling of the cell as the anchoring point to the hanging. The SCSO should reinspect all cells utilized for suicide precautions to ensure that the fire sprinklers our tamper-resistant and suicide resistant.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program and Policy No. 4/05 - Use of Safety Cells/Segregation Cells/Multipurpose Rooms/North Holding No. 2.

	ACH Policy No. 1412 - Suicide Prevention 2M-Joint Policy. JPS Policy No. 1049 - Suicide Prevention Program. Checklist for the 'Suicide-Resistant' Design of Correctional Facilities, Lindsay M. Hayes, December 2019.

Provision I) 2. Suicide Hazards in High-Risk Housing Locations	**Cells with structural blind spots shall not be used for suicide precaution.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current practice." This expert did not have an opportunity to inspect Temporary Suicide Precautions Housing, SITHU, or 2P Acute Inpatient Unit cells during the current monitoring period to ensure they were no structural blind spots in cells utilized to house suicidal inmates. This provision is in Partial Compliance.
Recommendations	None
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020).

Provision J) 1. Supervision/ Monitoring of Suicidal Inmates	**The County shall ensure adequate visibility and supervision of prisoners on suicide precautions.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current practice." This expert did not have an opportunity to inspect Temporary Suicide Precautions Housing, SITHU, or 2P Acute Inpatient Unit cells during the current monitoring period to ensure adequate visibility and supervision of inmates on suicide precautions. This provision is in Partial Compliance.
Recommendations	None
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020).

Provision J) 2. Supervision/ Monitoring of Suicidal Inmates	**The County shall not cover cell windows with magnetic flaps or any other visual barrier preventing visibility into any cell that is housing a prisoner on suicide precautions or awaiting an inpatient bed, unless there is a specific security need and then for only a period of time necessary to address such security need.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current practice." This expert did not have an opportunity to inspect Temporary Suicide Precautions Housing, SITHU, or 2P Acute Inpatient Unit cells during the current monitoring period to ensure that cell windows were not covered with magnetic flaps or any other visual barriers when inmates are on suicide precautions. This provision is in Partial Compliance.
Recommendations	None
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020).

Provision J) 3. Supervision/ Monitoring of Suicidal Inmates	**The County shall revise its policies regarding the monitoring of prisoners on suicide precautions to provide for at least the following two defined levels of observation:** **a) <u>Close observation</u> shall be used for prisoners who are not actively suicidal but express suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) or have a recent prior history of self-destructive behavior. Close observation shall also be used for prisoners who deny suicidal ideation or do not threaten suicide but are engaging in other concerning behaviors indicating the potential for self-injury. Staff shall observe the prisoner at staggered intervals not to exceed every 15 minutes and shall document the observation as it occurs.** **b) <u>Constant observation</u> shall be used for prisoners who are actively suicidal, either threatening or engaging in self-injury, and considered a high risk for suicide. An assigned staff member shall observe the prisoner on a continuous, uninterrupted basis. The observation should be documented at 15-minute intervals. Staff should be**

	physically stationed outside of the prisoner's cell to permit continuous, uninterrupted observation.
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by CHS in the *First* Status Report (July 17, 2020), was: 1) "Close (direct) observation - Requirements are being met for patients who are not actively suicidal but express suicidal ideation as well as for patients who deny suicidal ideation or do not threaten suicide but are engaging in other concerning behaviors indicating the potential for self-injury; and 2) Constant Observation - Requirements are met for Suicidal Inmate Temporary Housing Unit (SITHU). This currently houses male patients only. An additional area is pending for female patients "Current custody practice." In addition, Sacramento County's response to this provision, as authored by the SCSO in the same report, was "Language of 'direct observation' was used in other areas. This should be amended. Policy under review contains this language" for close observation. With regard to constant observation, the SCSO reported that "This type of monitoring occurs in the SITHU or 2P level of care currently." The County's response was partially non-responsive. This provision includes not only the requirement for two levels of observation of suicidal inmates, but the identified behavior that necessitates each level of observation. Although several SCSO and ACH/JPS suicide prevention policies reference both close observation and constant observation, they do not include the displayed behavior that necessitates one level of observation versus the other level. In addition, the SCSO suicide prevention policies, namely SCSO Policy No. 10/05 - Suicide Prevention Program and Policy No. 4/05 - Use of Safety Cells/Segregation Cells/Multipurpose Rooms/North Holding No. 2., utilize the observation phrase "twice every thirty (30) minutes." Although such a term might be compliant with Title 15, it is not compliant with the requirement of this Consent Decree which requires close observation at staggered intervals that does not exceed every 15 minutes. Observational checks that occur twice every 30 minutes could exceed 15 minutes (e.g., 20 and 10 minutes). In conclusion, this provision is in Partial Compliance.
Recommendations	1) Revise SCSO and ACH/JPS suicide prevention policies to ensure that they contain the exact definitions of both Close Observation and Constant Observation as provided in this provision. 2) Provide all draft policies to expert for review. 3) Revise suicide prevention policies should not include the phrase "twice every thirty (30) minutes."

Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020) Review of the current suicide prevention policies: SCSO Policy No. 10/05 - Suicide Prevention Program; ACH Policy No. 1412 - Suicide Prevention 2M-Joint Policy; and JPS Policies No. 1049 - Suicide Prevention Program, No. 1009 - Suicide Precautions – Acute Inpatient Unit, No. 1010 – Safety Suit Procedures for Inmate-Patients on Acute Inpatient Unit, No. 1011 - Use of Camera Monitors on the Acute Inpatient Unit, No. 1022 – Overview of Staff Responsibilities – Outpatient Department, and No. 1033 - 2M Suicidal Patients.

Provision J) 4. Supervision/ Monitoring of Suicidal Inmates	**For any prisoner requiring suicide precautions, a qualified mental health professional shall assess, determine, and document the clinically appropriate level of monitoring based on the prisoner's individual circumstances. Placement in a safety cell shall not serve as a substitute for the clinically determined level of monitoring.**	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current practice." As previously indicated, this expert found during the medical chart review that when an inmate is identified as suicidal and placed on suicide precautions, they are often initially housed in a safety cell. This is the normal default mechanism utilized by custody staff prior to assessment by a JPS clinician. In addition, a JPS clinician could continue the safety cell placement following assessment, often because a SITHU cell might not be available. Therefore, there is rarely a clinical justification for safety cell placement, and the placement is simply done by default. This provision is in Partial Compliance.	
Recommendations	1) Revise all SCSO and ACH/JPS suicide prevention and safety cell policies to include language that suicidal inmates will be placed in the most clinically appropriate setting and placement in a safety cell shall not serve as a substitute for such a clinical determination. 2) Provide all draft policies to expert for review.	
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program and Policy No. 4/05 - Use of Safety Cells/Segregation Cells/Multipurpose Rooms/North Holding No. 2. ACH Policy No. 1412 - Suicide Prevention 2M-Joint Policy. JPS Policy No. 1049 - Suicide Prevention Program. Medical chart review.	

Provision J) 5. Supervision/ Monitoring of Suicidal Inmates	**Video monitoring of prisoners on suicide precaution shall not serve as a substitute for Close or Constant observation.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current practice." Closed-circuit television (CCTV) monitoring is only available in the 2P Acute Inpatient Unit. According to JPS leadership, nursing personnel assigned to the unit are not assigned exclusively to monitor the CCTV. Therefore, 2P Unit patients are not expected to be continuously monitored by the CCTV. The SCSO Policy No. 10/05 - Suicide Prevention Program appropriately states that "video systems may be used to supplement observations of the prisoner, but they are not substitutes for direct visual observation." In addition, JPS No. 1011 - Use of Camera Monitors on the Acute Inpatient Unit states that "Camera monitors will not be used in place of Q-15 minute checks, and staff will continue to maintain direct inmate patient contact." Despite the unequivocal language in both these policies the medical chart review found inappropriate use of CCTV in the 2P Acute Inpatient Unit. For example, in Case No. 1, a psychiatric provider wrote in the Initial Psychiatric Evaluation on October 14, 2020 that "patient also has a high risk for suicide given extensive history of past, multiple attempts, and current unpredictable behavior. Therefore, we will continue the camera and Q-30 checks." On October 20, the order was renewed for CCTV, safety smock, and Q-30-minute checks after the patient again threatened suicide by stating "I want to die." In Case No. 2, there were orders on multiple days (e.g., June 13, 2020 and June 14, 2020) for the suicidal patient which included CCTV, safety smock and Q-30-minute observation. The following week on June 20, the patient was observed banging his head on the wall and cell door, and the subsequent order was to restart CCTV surveillance, but not an increase of observation to 15-minute checks. In sum, if a patient is on suicide precautions and clothed in a safety smock, they are required to be observed at either 15-minute intervals or constant observation, not simply CCTV. Observation that 30-minute intervals is prohibited for suicidal patients. An order for a safety smock is an indication that the patient is a suicide risk, therefore, there cannot be in order for only CCTV without either constant observation or Q-15 checks. In conclusion, the easiest solution to resolving the issue of psychiatric providers writing daily orders for CCTV surveillance of suicidal patients is to simply prohibit the practice of requiring orders for CCTV surveillance. This provision is in Partial Compliance.

Recommendations	1) Revised SCSO and ACH/JPS suicide prevention policies should include the appropriate language that specify orders for observation of suicidal inmate-patients be limited to either constant direct observation or direct observation at staggered intervals not exceeding every 15 minutes. Orders for CCTV monitoring are prohibited. 2) Provide all draft policies to expert for review.
Evidentiary Basis	Sacramento County's First Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program. JPS Policy No. 1011 - Use of Camera Monitors on the Acute Inpatient Unit. Discussion with JPS leadership. Medical chart review.

Provision K) 1. Treatment of Inmates Identified as at Risk of Suicide	**Qualified mental health professionals shall develop an individualized treatment plan and/or behavior management plan for every prisoner that mental health staff assesses as being a suicide risk.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by either the SCSO or CHS in the *First* Status Report (July 17, 2020), was omitted. This provision is duplicative to "Provision P) 2. Treatment of Inmates Identified at Risk of Suicide." There are no current SCSO or ACH/JPS suicide prevention policies that adequately address the requirement for a treatment plan/behavioral management plan for inmates on suicide precautions. As explained in more detail below in Provision P) 2., ACH introduced a new treatment planning program in January 2020 entitled "Safety Planning Intervention (SPI). Outpatient and IOP clinicians were initially trained, with 2P Unit and Jail Based Competency Treatment (JBCT) program staff scheduled to be trained in the future. Finally, a "MH Suicide Safety Plan" template has been embedded in Centricity based upon the SPI model, and the JPS Suicide Risk Assessment template contains a domain for "Safety and Risk Reduction plan." Following review was several medical charts, the quality of safety planning will be discussed in more detail in Provision P) 2. below. In conclusion, this provision is in Partial Compliance.
Recommendations	1) Revised SCSO and ACH/JPS suicide prevention policies should include the appropriate language regarding safety planning for inmates on suicide precautions. The language should include the following: "The treatment/safety plan shall describe signs, symptoms, and circumstances in which the risk for

	suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient or staff can take if suicidal thoughts do occur." 2) Provide all draft policies to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program. ACH Policy No. 1412 - Suicide Prevention 2M-Joint Policy. JPS Policy No. 1049 - Suicide Prevention Program.

Provision K) 2. Treatment of Inmates Identified as at Risk of Suicide	**Treatment plans shall be designed to reduce suicide risk and shall contain individualized goals and interventions. Treatment plans shall be reviewed following discharge from suicide precautions and updated as clinically indicated.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by either the SCSO or CHS in the *First* Status Report (July 17, 2020), was omitted. This provision is also duplicative to "Provision P) 2. Treatment of Inmates Identified at Risk of Suicide," as well as Provision K) 1. above. The only difference is that this provision requires that the treatment/safety plan be "updated as clinically indicated." There are no current SCSO or ACH/JPS suicide prevention policies that adequately address the requirement for a treatment plan/behavioral management plan for inmates on suicide precautions. In conclusion, this provision is in Partial Compliance.
Recommendations	1) Revised SCSO and ACH/JPS suicide prevention policies should include the appropriate language regarding safety planning for inmates on suicide precautions. The language should include the following: "The treatment/safety plan shall describe signs, symptoms, and circumstances in which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient or staff can take if suicidal thoughts do occur. The plan should be updated as clinically indicated." 2) Provide all draft policies to expert for review.
Evidentiary Basis	Sacramento County's First Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program. ACH Policy No. 1412 - Suicide Prevention 2M-Joint Policy. JPS Policy No. 1049 - Suicide Prevention Program.

Provision K) 3. Treatment of Inmates Identified as at Risk of Suicide	**All assessments, treatment, and other clinical encounters shall occur in an area that provides reasonable sound privacy and confidentiality. If a custody officer is present, the officer should be positioned in a place that allows for observation of the prisoner but maintains sound privacy, unless there is a clearly identified security or safety risk.**
Status	**Non-Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Jail Annex planning. However, we have attempted to maximize our ability to follow this plan to the best of our ability." This provision is duplicative of "Provision D) 1. Post-Intake Mental Health Assessment procedures." As previously indicated, current SCSO and ACH/JPS policies do not address privacy and confidentiality during the assessment of suicide risk. In addition, this expert was informed that an existing attorney booth in the Main Jail's booking area had been designated and modified for exclusive use by JPS clinicians when they are assessing inmates at risk for suicide. The booth has a solid glass barrier that separates the clinician from the inmate, thus providing full security. However, this expert was provided conflicting reports as to whether or not the door to the attorney booth remained open or closed during the assessment. Although custody leadership informed the experts that the door was closed at all times, with the deputy providing visual observation through the door's window, other custody leadership informed the mental health expert that the practice was for the door to remain open. Allowing the door to remain open would not only defeat the purpose of designating the booth for JPS clinical use, but severely compromise privacy and confidentiality. This expert will attempt to verify existing practices during the next on-site monitoring assessment. With regard to suicide risk assessments conducted outside of booking and in other areas of the Main Jail, this expert was informed that both classroom and dayroom areas on each housing floor can be utilized, but are often not available. Although a classroom on 3-West was previously designated for the Intensive Outpatient Program (IOP), a similar designation for a private area in which to assess suicidal inmates has not been made. As such, both custody and JPS leadership conceded that privacy and confidentiality was not always made available for the assessment of suicidal inmates. As found during the review of multiple medical charts of inmates placed on suicide precautions and subsequently assessed by JPS clinicians, *the assessments are consistently performed cell-side and there was no indication that any suicidal inmate was assessed either in the converted attorney both in*

	booking or in a classroom/dayroom area of any housing unit at the Main Jail. Ironically, following discharge from suicide precautions and referral into the IOP, this expert did find examples of inmates being seen by JPS clinicians in a classroom as part of the initial assessment into the program. In conclusion, the lack of privacy and confidentiality during the assessment of suicide risk is a significant impediment to the County's ability to provide a reasonable suicide prevention program. Based upon current practices, as well as lack of a policy to address the issue, this provision is in Non-Compliance.
Recommendations	1) Unless exigent circumstances exist and are documented on a case-by-case basis, any inmate identified as suicidal should be given an opportunity for assessment outside of their cell. This includes initial assessments, daily on-going assessments, discharge assessments, and scheduled follow-up. 2) JPS clinicians conducting initial and on-going assessments of inmates on suicide precautions should continue to document the location of the assessment in the medical chart and, if the assessment was conducted cell-side, the reason why privacy and confidentiality were not provided. 3) Unless there is a clearly identified security or safety risk, the designated JPS booth in the booking area of the main jail should be routinely utilized for the assessment of suicidal inmates, to include those inmates housed in the booking area's safety cells, sobering cell, and segregation cell. In addition, unless exigent circumstances exist and are documented on a case-by-case basis, the door to the JPS both should remain closed at all times. 4) A designated room(s) or areas outside of the Main Jail's booking area that can provide privacy and confidentiality should be designated and routinely utilized for the assessment of suicidal inmates. 5) The SCSO and ACH/JPS suicide prevention policies should be revised to include inadequate description of the requirement for privacy and confidentiality during the assessment of suicidal inmates. 6) Provide the draft suicide prevention policies to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). Review of the current suicide prevention policies: SCSO Policy No. 10/05 - Suicide Prevention Program; ACH Policy No. 1412 - Suicide Prevention 2M-Joint Policy; and JPS Policies No. 1049 - Suicide Prevention Program, No. 1009 - Suicide Precautions – Acute Inpatient Unit, No. 1010 – Safety Suit Procedures for Inmate-Patients on Acute Inpatient Unit, No. 1011 - Use of Camera Monitors on the Acute Inpatient Unit, No. 1022 – Overview of Staff Responsibilities – Outpatient Department, and No. 1033 - 2M Suicidal Patients. Discussion with SCSO, ACH and JPS leadership. Medical chart review.

Provision L) 1. Conditions for Individual Inmates on Suicide Precautions	**The County's Suicide Prevention Policy shall set forth clear and internally consistent procedures regarding decisional authority for determining the conditions for individual inmates on suicide precautions. Mental health staff shall have primary authority, consistent with individualized classification and security needs, with respect to the following:**
Status	**Partial Compliance**
Discussion	This provision is interpreted as a "catch-all" provision for these subsequent provisions: M. Property and Privileges, N. Use of Safety Suits, and O. Beds and Bedding, therefore, this provision cannot come into substantial compliance until the suicide prevention policies are revised, and all three of these subsequent provisions come into substantial compliance. Review of the current SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program found that they were not consistent with this provision and were in need of revision. As previously stated, the expert also sensed that custody supervisors were driving the management of inmates on suicide precautions, rather than the Consent Decree requirement that JPS clinicians "shall have primary authority." This provision is in Partial Compliance.
Recommendations	1) Revise all SCSO and ACH/JPS suicide prevention policies to include language that the management of suicidal inmates and suicide precautions should be primarily determined by JPS clinicians in consultation with custody personnel. 2) Provide all draft policies to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program. Medical chart review.

Provision M) 1. Property and Privileges	**Qualified mental health professionals shall have the primary responsibility to determine, based on clinical judgment and on a case-by-case basis in consultation with custody staff, depending on suicide risk, the removal and/or return of routine privileges (e.g., visits, telephone calls, recreation) that are otherwise within the limitations of a prisoner's classification security level. Any removal of privileges shall be documented with clinical justification in the prisoner's medical/mental health record and reviewed on a regular basis.**
Status	**Non-Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current practice." The ACH response in the same report stated: "MH staff in consultation with custody determine limitation, removal, and return of patient clothing, property, and/or routine privileges (e.g., visits, telephone calls, recreation) based on the patient's current functioning and ability to maintain safety. Procedures and staff training are being developed for outpatient programs and patients pending admission to the acute inpatient unit. This area is currently partially compliant." Contrary to the County's response, medical chart review of various inmates placed on suicide precautions in either safety cells or the SITHU cells found that all were denied any routine privileges, such as visits, telephone calls, or any out-of-cell activity. Most inmates on suicide precautions either did not receive a shower or rarely received the shower. For example, in Case No. 5, the inmate was on suicide precautions on August 23, 2020 and denied suicidal ideation, stating "I can't go to court if I am here (SITHU)." An SRA was subsequently completed and he was discharged from suicide precautions. However, the inmate was placed back onto suicidal precautions the following day (August 24) and told by a JPS clinician a few days later on August 27 that he had "no access to commissary/phone card" while on suicide precautions. In Case No. 6, the inmate on suicide precautions told the clinician on August 26 "I just persuaded the last one (another clinician) to clear me cause it's my grandma's birthday. I wanted to call my grandma and tell her happy birthday. Then I came back" on suicide precautions. The inmate was subsequently released from custody and rebooked into the Main Jail and placed on suicide precautions on October 16, 2020. He was seen by a clinician on a daily basis on suicide precautions and then denied any suicidal ideation on October 19 because he "wants to go to court today." He was cleared following completion of a suicide risk of assessment. Finally, in Case No. 7, the clinician informed an inmate on suicide precautions on July 4 that he "could not go to court on suicide watch." He was subsequently discharged from suicide precautions, but reinstated the following week on July 13 whereupon the clinician wrote a progress note stating that the inmate "wants to speak to medical and get clearance for shower, wants to speak to sergeant to get clearance for phone." While on suicide precautions on August 30, 2020, the

	inmate was again denied a request to call his mother despite the fact she was listed as a "protective factor" in his safety plan. Both custody and JPS leadership confirmed the expert's medical chart review findings of the denial of all routine privileges. One of the many concerns demonstrated in these cases is the possibility of a suicidal inmate denying that they are suicidal simply because they would like to take a shower, have a telephone call, get out-of-cell access, or go to court. The blanket denial of such routine privileges was very problematic. This provision is in Non-Compliance.
Recommendations	1) Revise all SCSO and ACH/JPS suicide prevention policies to include language that inquiring that JPS clinicians shall have the primary responsibility to determine, based on clinical judgment and on a case-by-case basis in consultation with custody staff, depending on suicide risk, the removal and/or return of routine privileges (e.g., visits, telephone calls, recreation) that are otherwise within the limitations of an inmate's classification security level. Any removal of privileges shall be documented with clinical justification in the medical chart. In addition, all inmates on suicide precautions should be allowed to attend any court hearing unless the clinician, based upon their clinical judgment and in consultation with security staff, determines that transportation to court would adversely affect to the inmate. 2) Provide all draft policies to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program. Medical chart review. Discussion with SCSO and JPS leadership.

Provision M) 2. Property and Privileges	**Qualified mental health professionals shall have the primary responsibility to determine, based on clinical judgment and on a case-by-case basis in consultation with custody staff depending on suicide risk, the removal and/or return of a prisoner's <u>clothing and possessions</u> (e.g., books, slippers/sandals, eyeglasses) that are otherwise within the limitations of a prisoner's classification security level. The removal of property shall be documented with clinical justification in the prisoner's medical/mental health record and reviewed on a regular basis.**	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current practice." The ACH response in the same report stated: "MH staff in consultation with custody determine limitation, removal, and return of patient clothing, property, and/or routine privileges (e.g., visits, telephone calls, recreation) based on the patient's current functioning and ability to maintain safety. Procedures and staff training	

	are being developed for outpatient programs and patients pending admission to the acute inpatient unit. This area is currently partially compliant." Contrary to the County's response, medical chart review of various inmates placed on suicide precautions in either safety cells or the SITHU cells found that all were all placed in safety smocks and were never given their uniform or any other possessions until their discharge from suicide precautions. As such, the default was issuance of safety smocks as directed by custody personnel. In stark contrast to housing of suicidal inmates in either safety cells or the SITHU cells, inmate-patients admitted into the 2P Acute Inpatient Unit are treated very differently. The medical chart review found that when an inmate is admitted into the 2P Unit on suicide precautions and initially clothed in a smock, their uniform is generally returned to them within 24 hours. In addition, psychiatric providers into the 2P Unit follow a "Denial of Rights" (DOR) protocol that works as follows on a case-by-case basis: DOR1: Standard inmate clothing DOR2: Personal items (including toothbrush, deodorant etc.) DOR5: Personal visits (visits with attorneys are never limited but may need to occur at cell-side) DOR7: Writing utensils (pencils) DOR10: Placement in restraints For example, in Case No. 8, the inmate was booked into the Main Jail on January 29, 2020 as a transfer from another county. He self-reported anxiety, bipolar and schizophrenic disorders, several prior suicide attempts, and psychiatric hospitalization in 2017. He was placed on the JPS caseload, began receiving his psychotropic medication on January 31, and was seen periodically by a JPS clinician for the next two months. On March 31, 2020, the inmate self-reported both suicidal ideation and a suicide attempt to staff (he tied a t-shirt around his neck with no injury), and was seen by a clinician who completed an SRA. He was placed on suicide precautions and housed in a safety cell in a safety smock. The inmate was seen by a clinician the following day (April 1) and discharged from suicide precautions. He was not seen for follow-up until six days later on April 7. A few weeks later on April 30, the inmate expressed suicidal ideation, and then recanted during the clinician's completion of an SRA. A few days later on May 3, he again expressed suicidal ideation and reported a suicide attempt by drug overdose. The inmate was sent out to the hospital for examination and, upon return on May 4, was placed in the 2P Acute Inpatient Unit. He was initially clothed in a safety smock with observation at 15-minute intervals, as well as closed-circuit television monitoring (CCTV). Although the inmate was not seen by a provider the following day (May 5), an order for discontinuation of the smock and issuance of a book and playing cards was

	received by nursing staff. The inmate was seen for an Initial Psychiatric Evaluation the following day (May 6) and the provider ordered that observation be reduced to 30-minute intervals, with continued CCTV monitoring. The following day (May 7), CCTV was discontinued and the inmate was discharged from the 2P Unit on May 8 following completion of an SRA by an out-patient JPS clinician. When informed that he was going to be transferred to RCCC, the initially threatened suicide and remained on the 2P Unit until May 12. He was seen for follow-up assessment at 24 hours (May 13), 72 hours (May 15), and five-day (May 17) intervals, and then scene periodically the next few weeks. On both June 5 and June 9, the inmate expressed suicidal ideation, then recanted during completion of the SRAs, and was not placed on suicide precautions. According to an incident report, he placed a "ligature around neck while housed in IOP. Custody intervened and had to deploy Taser to obtain compliance" on June 12, 2020. The inmate was transferred to a local hospital for treatment and returned to the jail the following day (June 13) and placed on suicide precautions and the 2P Pre-Admit list. He was again admitted into the 2P Unit on June 15 and placed on suicide precautions in a safety smock. An Initial Psychiatric Evaluation was completed on June 15, and he was seen daily by nursing staff. On June 16, the inmate was issued his clothes and a book, and observation was reduced to 30-minute checks, as well as CCTV. He was discharged from the 2P Unit the following day (June 17) after the SRA was completed by an out-patient clinician. The inmate was seen for follow-up assessment at 24 hours (June 18), 72 hours (June 20), and five-day (June 22) intervals. In sum, Case No. 8 involved an inmate on suicide precautions in both 2P Unit and non-2P Unit, but he only received his clothing and access to other possessions (such as books) when he was in the 2P Unit, only clothed in a safety smock when confined in a safety cell or SITHU cell, and only had an order for follow-up assessments (at 24 hours, 72 hours, and five-day intervals) when he was on the 2P Unit. In addition, for reasons that were unclear from available documentation, the inmate was tasered following a suicide attempt on June 12, 2020. In conclusion, this provision is in Partial Compliance primarily because of the stark contrast between safety smock and possessions use in out-patient units versus the 2P Unit within the Main Jail.
Recommendations	1) Revise all SCSO and ACH/JPS suicide prevention policies to include language that inquiring that JPS clinicians shall have the primary responsibility to determine, based on clinical judgment and on a case-by-case basis in consultation with custody staff, depending on suicide risk, the removal and/or return of clothing and possessions (e.g., books, slippers/sandals, eyeglasses) that are otherwise within the limitations of an inmate's classification security level. Any removal of clothing and possessions shall be documented with clinical justification in the medical chart.

	2) Provide all draft policies to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program. Medical chart review. Discussion with SCSO and JPS leadership.

Provision M) 3. Property and Privileges	**Cancellation of privileges should be avoided whenever possible and utilized only as a last resort.**
Status	**Non-Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current practice." This provision is duplicative with "Provision M) 1. Property and Privileges." As stated above, the blanket denial of such routine privileges as taking a shower, having a telephone call, getting out-of-cell access, or going to court without the utilization of any clinical judgment is very problematic. This provision is in Non-Compliance.
Recommendations	See above.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program. Medical chart review. Discussion with SCSO and JPS leadership.

Provision N) 1. Use of Safety Suits	**Decisions about the use of a safety suit (smock) or removal of normal clothing will be under mental health staff's authority, based on individualized clinical judgment along with input from custody staff.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current practice."

	This provision is duplicative with "Provision M) 2. Property and Privileges" above. It is in Partial-Compliance primarily because of the stark contrast between safety smock use in outpatient units versus the 2P Unit within the Main Jail.
Recommendations	See above.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program. Medical chart review. Discussion with SCSO and JPS leadership.

Provision N) 2. Use of Safety Suits	**Custody staff may only temporarily place an inmate in a safety suit based on an identified risk of suicide by hanging until the qualified mental health professional's evaluation, to be completed within the "must see" referral timeline. Upon completion of the mental health evaluation, the mental health professional will determine whether to continue or discontinue use of the safety suit.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Policy under review." This provision is duplicative with "Provision M) 2. Property and Privileges" above. It is in Partial-Compliance primarily because of the stark contrast between safety smock use in outpatient units versus the 2P Unit within the Main Jail. Use of safety smocks for suicidal inmates housed in safety cells and the SITHU cells are not "temporary," rather are maintained throughout and inmate's placement on suicide precautions.
Recommendations	See above.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program. Medical chart review. Discussion with SCSO and JPS leadership.

Provision N) 3. Use of Safety Suits	**If an inmate's clothing is removed, the inmate shall be issued a safety suit and safety blanket.**	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current practice." Although SCSO and ACH/JPS suicide prevention policies need to be revised, the medical chart review did not find any instances in which an inmate on suicide precautions in the safety cells or SITHU was not provided a safety smock and safety blanket. This provision is in Partial Compliance only because suicide prevention policies need to be revised.	
Recommendations	See above.	
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program. Medical chart review. Discussion with SCSO and JPS leadership.	

Provision N) 4. Use of Safety Suits	**As soon as clinically appropriate, the provision of regular clothing shall be restored. The goal shall be to return full clothing to the inmate prior to discharge from suicide precautions.**	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current practice." This provision is duplicative with "Provision M) 2. Property and Privileges." As noted above, suicidal inmates housed in either safety cells or the SITHU cells are always closed in safety smocks, whereas patient is admitted to the 2P Acute Inpatient Unit might initially be clothed in a smock, but their uniform is generally returned to them within 24 hours. This provision is in Partial Compliance.	
Recommendations	See above.	

Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program. Medical chart review. Discussion with SCSO and JPS leadership.

Provision N) 5. Use of Safety Suits	**A qualified mental health professional shall conduct daily assessments of any prisoner in a safety suit and document reasons for continued use when clinically indicated.**	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by ACH in the *First* Status Report (July 17, 2020), was "MH staff assess patients in safety suits every 24 hours but a policy is not yet formalized. Staff will draft a policy for out-patient staff." This provision is duplicative with "Provision M) 2. Property and Privileges." As noted above, suicidal inmates housed in either safety cells or the SITHU cells are always clothed in safety smocks, whereas patients admitted to the 2P Acute Inpatient Unit might initially be clothed in a smock, but their uniform is generally returned to them within 24 hours. This provision is in Partial Compliance.	
Recommendations	See above.	
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program. Medical chart review. Discussion with SCSO and JPS leadership.	

Provision N) 6. Use of Safety Suits	**If a qualified mental health professional determines that 30-minute (or less frequent) observations are warranted for a prisoner, safety suits shall not be used on that prisoner.**	
Status	**Non-Compliance**	

Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "This causes some confusion to address. County requests discussion on the exact meaning of this provision." This expert would agree that a portion of this provision is confusing, i.e., reference to the phrase "or less frequent" than 30-minute observation. This expert interprets the provision to mean that, if a qualified mental health professional recommends that an inmate be placed on a 30-minute observation level or greater (e.g., 60 minutes), the inmate was assessed as not being suicidal and, therefore, should not also be issued a safety smock. In other words, safety smocks are only authorized for suicidal inmates, and suicidal inmates can never be placed on 30-minute observation. Following discussion with counsel of the parties, the above interpretation by this expert was correct, i.e., a safety smock can never be authorized for an inmate that a clinician has recommended 30-minute or greater observation level. Safety smocks can only be authorized on a case-by-case basis for those suicidal inmates that require either constant observation or observation at staggered 15-minute intervals. As noted above, the chart review found several examples (Case No. 1, Case No. 2, and Case No. 5) of *patients in the 2P Unit that were clothed in safety smocks and ordered to be observed at 30-minute intervals, often with an order for closed circuit television (CCTV). Therefore, although the provider believed the patient to be a continued risk of suicide that justified being clothed in only a smock, they inexplicitly ordered a level of observation (30-minute intervals) for a non-suicidal patient. In addition, the CCTV order was troubling because it suggested the provider was using it as a substitute for physical observation of a suicidal patient. Such a practice is very problematic*. This provision is in Non-Compliance.
Recommendations	1) Revise all SCSO and ACH/JPS suicide prevention policies to include language indicating that if a JPS clinician determines an inmate requires 30-minute observation that inmate cannot be clothed in a safety smock. Likewise, if a clinician determines that a suicidal inmate requires a safety smock, they must be observed on either constant observation or close observation. 2) Provide all draft policies to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program. Medical chart review. Discussion with SCSO and JPS leadership.

Provision N) 7. Use of Safety Suits	**Safety suits shall not be used as a tool for behavior management or punishment.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current practice." Although this expert did not find any evidence from the medical chart review that safety smocks were being utilized as a tool for behavior management or punishment, the use of safety smocks as a default for all inmates housed in safety cells and SITHU cells could certainly be interpreted by an inmate and others as a punitive management tool to deter perceived manipulative and/or attention-seeking behavior. In conclusion, because current SCSO and ACH/JPS suicide prevention policies do not address this issue, this provision is in Partial Compliance.
Recommendations	1) Revise all SCSO and ACH/JPS suicide prevention policies to include language indicating that use of safety smocks will be determined has clinically appropriate on a case-by-case basis, and they shall not be utilized punitively or as a behavior management tool for inmates perceived to be manipulative and/or displaying attention-seeking behavior. 2) Provide all draft policies to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program. Medical chart review.

Provision O) 1. Beds and Bedding	**All prisoners housed for more than four hours on suicide precautions and/or in an inpatient placement shall be provided with an appropriate bed, mattress, and bedding unless the prisoner uses these items in ways for which they were not intended (e.g., tampering or obstructing visibility into the cell). Such a determination shall be documented and shall be reviewed on a regular basis.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Attempting to meet this criteria

	through use of suicide-resistant cells, and an emphasis on removal from booking housing as soon as practical." This expert found that there was a slight inconsistency with this provision compared to "Provision H) 1. Temporary Suicide Precautions," which restricts safety cell placement to no more than six (6) hours. In contrast, this provision requires a suicidal inmate to be housed with a bed, mattress, and bedding after four (4) hours. Following discussion with the parties, this expert will interpret this provision as requiring the provision of a bed, mattress, and bedding after four (4) hours, with the County responsible for the provision of a temporary suicide-resistant bed, commonly referred to as a "stack-a-bunk," and mattress. In conclusion, because current SCSO and ACH/JPS suicide prevention policies do not address this issue, this provision is in Partial Compliance.
Recommendations	1) Revise all SCSO and ACH/JPS suicide prevention policies to include language indicating that any inmate placed on suicide precautions for more than four hours shall be provided with an appropriate bed, mattress, and bedding unless the inmate uses these items in ways for which they were not intended (e.g., tampering or obstructing visibility into the cell). Such a determination shall be documented and shall be reviewed on a regular basis. 2) Provide all draft policies to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program.

Provision P) 1. Discharge from Suicide Precautions	**A qualified mental health professional shall complete and document a suicide risk assessment prior to discharging a prisoner from suicide precautions in order to ensure that the discharge is appropriate and that appropriate treatment and safety planning is completed.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current custody practice." Such a response was incorrect because this provision is specific to JPS policies and practices. Although SCSO and ACH/JPS suicide prevention policies need to be revised in order to better address the requirement that all inmates discharged from suicide precautions should have a suicide risk assessment and safety plan completed, the medical chart review indicated that SRAs were completed for all inmates discharged from suicide precautions. As previously indicated, discharge SRAs for patients assigned to the 2P Acute Inpatient Unit were completed by JSA out-patient clinicians at the end of such placement.

Recommendations	1) Revise all SCSO and ACH/JPS suicide prevention policies to include language requiring that all inmates discharged from suicide precautions should have a suicide risk assessment and safety plan completed. 2) Inmates placed on suicide precautions by either custody or medical personnel and subsequently discharged from suicide precautions by a JPS clinician within 24 hours after finding that the placement was inadvertent (e.g., the inmate was intoxicated when he initially expressed suicidal ideation and is now stable, the inmate expressed suicidal ideation out of frustration or to get other needs met, etc.) might not need a safety plan. However, if the JPS clinicians initial suicide risk assessment determines that continued suicidal courses are appropriate, then a safety plan should always be completed. Counsel for the parties are in agreement to this stipulation and the suicide prevention policies should be revised accordingly. 2) Provide all draft policies to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program. Medical chart review.

Provision P) 2. Discharge from Suicide Precautions	**Treatment plans shall be written for all prisoners discharged from suicide precautions. The treatment plan shall describe signs, symptoms, and circumstances in which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient or staff can take if suicidal thoughts do occur.**	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by either the SCSO or ACH in the *First* Status Report (July 17, 2020), was omitted. However, ACH did state: "Safety Planning Intervention (SPI) - Began training all mental health staff in the use of SPI January 2020. All out-patient and intensive out-patient staff have been trained. Training for staff in the acute in-patient unit and Jail Based Competency Treatment (JBCT) program is in process." As required by this provision, safety planning includes a specific strategy that describes signs, symptoms, and the circumstances in which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient and clinician can take if suicidal thoughts do occur. Safety planning to reduce suicide risk is challenging, and requires motivation by both the clinician and inmate. It would appear that JPS has recently implemented a safety plan model entitled Safety Planning Intervention (SPI). This expert is very familiar with SPI model.	

	SPI is intended to provide a prioritized and specific set of coping strategies and sources of support that suicidal patients could utilize should suicidal thoughts reemerge. Comprising seven steps, SPI was originally developed to be utilized in settings where emergency services or acute care services were provided, such as emergency rooms and crisis hotlines. This expert is not aware of any other state or local correctional agency that currently utilizes SPI. Although initiated by the California Department of Corrections and Rehabilitation 2019, the SPI model has not been successful there and is currently being replaced. The medical chart review found that JPS clinicians were struggling to complete adequate safety planning for suicidal inmates. The following two attempts at safety planning exemplified the problem. Both inmates had extensive histories of suicidal and self-injurious behavior, and both were on and off suicide precautions during most of their Main Jail confinement: **Case No. 1** Step 1 (Warning Signs): "war in my head" Step 2 (Internal Coping Strategies): "color, read" Step 3 (People and Social Settings that Provide Distraction): "no one" Step 4 (People to Ask for Help): "JPS, custody" Step 5 (Professionals to Contact): "any staff member" Step 6 (Means Safety - Making the Environment Safe): "playing cards" Step 7 (Reasons to Live): "cooking, I make pies, tacos, pasta" **Case No. 2** Step 1 (Warning Signs): "hit myself" Step 2 (Internal Coping Strategies): "pacing, smoke weed" Step 3 (People and Social Settings that Provide Distraction: "family" Step 4 (People to Ask for Help): "JPS, custody" Step 5 (Professionals to Contact): "any staff member" Step 6 (Means Safety - Making the Environment Safe): no response Step 7 (Reasons to Live): "$1 million dollar house, Rolls Royce, $1 million dollar boat" Within the SPI template there are examples of each Step. For example, Step 2 involves developing "Internal Coping Strategies - Things I can do to take my mind off my problems without contacting another person, such as relaxation skills, reading, exercise, draw/write." The challenge is because the County's suicide precautions are so restrictive, and inmates are prohibited from any out-of-cell activity and possessions, they cannot easily recreate, "playing cards," read a book, or write in a journal as an effective coping strategy in reducing suicidal ideation. In addition, a possible coping strategy of support from family is adversely affected when they are prohibited from using the telephone or having visits.

	An additional deficiency is that development of these safety plans is not collaborative between the patient and clinician. For example, instead of assisting the patient in verbalizing reasonable and practical coping skills that can be utilized in a jail environment to reduce suicidal ideation, clinicians are simply instructed to list, without correction, the patient's exact words, such as "smoke weed" as a coping mechanism. Finally, the narrative in the safety plans simply failed to address the specific requirement of this provision which is development of "a specific strategy that describes signs, symptoms, and the circumstances in which the risk for suicide was likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient and clinician could take if suicidal thoughts reoccurred. In conclusion, JPS clinicians will continue to struggle with development of adequate safety plans unless the process is collaborative between the patient and the clinician, and suicide prevention policies are revised to allow clinicians to utilize their clinical judgment in granting routine privileges that can act as coping skills in reducing suicidal ideation. And as noted above in Case No. 8, inmate-patients in the 2P Unit do not receive safety planning until they are discharged from the placement. This is also problematic. This provision is in Partial Compliance.
Recommendations	1) Revise all SCSO and ACH/JPS suicide prevention policies to allow clinicians to utilize their clinical judgment in granting routine privileges that can act as coping skills in reducing suicidal ideation, and include specific language stating that required treatment/safety plans "shall describe signs, symptoms, and circumstances in which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the patient or staff can take if suicidal thoughts do occur." 2) Provide all draft policies to expert for review. 3) Instruct JPS clinicians that the development of a safety plan is a collaborative process, and not simply listing, without correction, the patient's exact sometimes, irrational or impractical, words.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program. Medical chart review. Stanley, B. and G. Brown (2012), "Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk," *Cognitive and Behavioral Practice*, 19: 256-264.

Provision P) 3. Discharge from Suicide Precautions	**Qualified mental health professionals shall provide clinical input regarding clinically appropriate housing placement (e.g., whether isolation is contraindicated for the prisoner) upon discharge. Custody and classification shall consider such clinical input in determining post-discharge placement and conditions of confinement. Once clinically discharged from suicide precautions, the prisoner shall be promptly transferred to appropriate housing.**	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current custody practice." Although current SCSO and ACH/JPS suicide prevention policies do not address this provision, both custody and JPS leadership informed this expert that clinicians do work collaboratively with custody personnel in the placement of inmates following their discharge from suicide precautions. The medical chart review did not provide any evidence to the contrary. This provision is in Partial Compliance because the suicide prevention policies have not been revised to reflect the appropriate language.	
Recommendations	1) Revise all SCSO and ACH/JPS suicide prevention policies to include language that allows clinicians to provide clinical input regarding clinically appropriate housing placement for inmates following their discharge from suicide precautions. 2) Provide all draft policies to expert for review.	
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program. Medical chart review.	

Provision P) 4. Discharge from Suicide Precautions	**Prisoners discharged from suicide precautions shall remain on the mental health caseload and receive regularly scheduled clinical assessments and contacts. Unless a prisoner's individual circumstances direct otherwise, a qualified mental health professional shall provide follow-up assessment and clinical contacts within 24 hours of discharge, again within 72 hours of discharge, again within one week of discharge.**	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by ACH in the First Status Report (July 17, 2020), was "MH staff complete and document a suicide risk assessment prior to discharge from suicide precautions. Patients discharged from the acute unit are seen within 24 hours, 72 hours, and then within one week of discharge (implementation March 2020)."	

	Medical chart review (e.g., Case No. 1, Case No. 2, Case No. 5, and Case No. 8) confirmed that psychiatric providers who discharged patients from the 2P Acute Inpatient Unit did create orders requiring follow-ups assessments for 24 hours, 72 hours, and then one week. The assessments were subsequently performed by JPS outpatient clinicians. However, the medical chart review (e.g., Case No. 6, Case No. 7, Case No. Case No. 8, and Case No. 9) also indicated that inmates discharged from suicide precautions in the out-patient setting, such as safety cells and the SITHU, did not receive scheduled follow-up at 24 hours, 72 hours, and one week intervals, despite the fact that they might have been on suicide precautions for several days or a few weeks. JPS leadership informed the expert that they were not adequately staffed to provide such scheduled follow-up. This practice is problematic because the vast majority of inmates that are subsequently discharged from suicide precautions are in an out-patient setting (safety cell or SITHU), not the 2P Unit. It is noteworthy that this provision also includes some discretion that scheduled follow-up might not the required for every inmate discharged from suicide precautions, i.e., "Unless a prisoner's individual circumstances direct otherwise." Such narrative is interpreted by the expert to me that there might be occasions, e.g., in which an inmate was placed on suicide precautions by either custody or medical personnel and subsequently discharged from suicide precautions by a JPS clinician within 24 hours after finding that the placement was inadvertent (e.g., the inmate was intoxicated when he initially expressed suicidal ideation and is now stable, the inmate expressed suicidal ideation out of frustration or to get other needs met, etc.) might not need scheduled follow-up at 24 hours, 72 hours, and one week intervals. However, similar to safety planning, if the JPS clinician's initial suicide risk assessment determines that *continued* suicide precautions beyond 24 hours is appropriate, then the scheduled follow-up should always occur. In conclusion, because current suicide prevention policies do not contain the requirements of this provision, as well as the fact that scheduled follow-up at 24 hours, 72 hours, and one week intervals was not provided to most of the inmates discharged from suicide precautions from non-2P Unit settings, this provision is in Partial Compliance.
Recommendations	1) Revise all SCSO and ACH/JPS suicide prevention policies to include the requirement that, unless an inmate's individual circumstances direct otherwise, a JPS clinician shall provide follow-up assessment within 24 hours, 72 hours, and one week of discharge from suicide precautions. 2) The revised suicide prevention policies should provide a description/examples of "unless an inmate's individual circumstances direct otherwise." 3) The County should consult with JPS to determine if additional staff are necessary to ensure compliance with this and other provisions.

	4) Provide all draft policies to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program. Medical chart review.

Provision Q) 1. Emergency Response	**The County shall keep an emergency response bag that includes appropriate equipment, including a first aid kit, CPR mask or Ambu bag, and emergency rescue tool in close proximity to all housing units. All custodial and medical staff be trained on the location of this emergency response bag and shall receive regular training on emergency response procedures, including how to use appropriate equipment.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Many of these items are stored on, or within very close proximity of the housing locations. Nursing staff responded to man-down situations bring the required equipment." Irrespective of whether nursing staff respond with emergency medical equipment, this provision specifically requires that an emergency response bag (including a first aid kit, CPR mask or Ambu bag, and emergency rescue tool) be located in close proximity to all housing units. This provision also requires that both custody and medical staff be trained on emergency response procedures, including how to use the equipment. Compliance with this provision requires revision of the current SCSO policy (No. 10/05-Suicide Prevention Program) to include reference to the above emergency response bag equipment, as well as verified training data. The expert will inspect the current location of the emergency response bag during an upcoming monitoring assessment. This provision is in Partial Compliance.
Recommendations	1) Revise all SCSO and ACH/JPS suicide prevention or other appropriate policies to include the requirement that an emergency response bag should be located in close proximity to all housing units, and that both custody and medical personnel are trained on its location in use. 2) Provide all draft policies to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program.

Provision Q) 2. Emergency Response	**All custody and medical staff shall be trained in first aid and CPR.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current Custody practice." Training data provided to this expert indicated that 100 percent of medical staff were currently certified in CPR, and only 72 percent of custody personnel currently certified in CPR. This provision is in Partial Compliance.
Recommendations	1) Ensure that both medical and custody personnel are at least 90% compliant with CPR certification.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO and ACH training data.

Provision Q) 3. Emergency Response	**It shall be the policy of the County that any staff who discovers an inmate attempting suicide shall immediately respond, survey the scene to ensure the emergency is genuine, and alert other staff to call for medical personnel. Trained staff shall begin to administer standard first aid and/or CPR, as appropriate.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current practice." This expert reviewed both the investigative report and medical chart of Case No. 10. The review indicated that both custody and medical personnel responded appropriately and consistent with all current policies and procedures. In addition, this expert reviewed the medical charts of several inmates who attempted suicide and were subsequently transported to a local hospital for precautionary treatment during the last six (6) months. This review also found that both custody and medical personnel responded appropriately to the emergency medical response in each case. This provision is only in Partial Compliance because the appropriate policies need to be revised.
Recommendations	1) Revise all SCSO and ACH/JPS suicide prevention or other appropriate policies to include the requirement that any staff who discovers an inmate attempting suicide shall immediately respond, survey the scene to ensure the emergency is genuine, and alert other staff to call for medical personnel. Trained staff shall begin to administer standard first aid and/or CPR, as appropriate.

	2) Provide all draft policies to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). Medical chart review.

Provision R) 1. Quality Assurance and Quality Improvement	**The County shall establish regularly scheduled multidisciplinary meetings related to treatment, and plan of care issues, on a monthly basis, between medical, and mental health personnel.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by either the SCSO or ACH in the *First* Status Report (July 17, 2020), was omitted. This expert was provided various documents responsive to this provision, including meeting minutes from the ACH Safety Committee (September 29, 2020 and July 9, 2020), ACH Quality Improvement Committee (October 27, 2020), and Mental Health Quality Improvement (QIC) Subcommittee (September 26, 2020, June 12, 2020, January 24, 2020, and October 25, 2019). Review of all of these meeting minutes indicated that each was multidisciplinary, comprising medical, JPS and custody personnel (with the exception of the Mental Health QIC Subcommittee which for unknown reasons did not include SCSO representation). Most importantly, the general topic of suicide prevention did not appear to be discussed nor written in any of these committee meetings. Although this provision does not specifically mention the treatment or "plan of care" for suicidal inmates, a well-rounded multidisciplinary process should include a discussion about suicide prevention in general, as well as specific inmates on suicide precautions that pose unusual challenges to custody, medical, and/or JPS personnel. This provision is in Partial Compliance.
Recommendations	1) To the extent that the process does not already exist, SCSO and ACH/JPS should establish a multidisciplinary committee that meets on a regular basis to discuss the management of specific inmates on suicide precautions that pose unusual challenges to custody, medical, and/or JPS personnel. 2) Should the process already exist, documentation should be forwarded to the expert.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program.

	Various meeting minutes from the following: ACH Safety Committee (September 29, 2020 and July 9, 2020), ACH Quality Improvement Committee (October 27, 2020), and Mental Health Quality Improvement (QIC) Subcommittee (September 26, 2020, June 12, 2020, January 24, 2020, and October 25, 2019).

Provision R) 2. Quality Assurance and Quality Improvement	**The County shall, in consultation with Plaintiffs' counsel, revise its in-custody death review policy and procedures. Reviews shall be conducted with the active participation of custody, medical, and mental health staff. Reviews shall include analysis of policy or systemic issues and the development of corrective action plans when warranted.**	
Status	**Non-Compliance**	
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current practice." This provision is more or less duplicative with "Provision R) 3. Quality Assurance and Quality Improvement" below. Current SCSO and ACH/JPS suicide prevention policies do not provide an adequate description of the death review process for inmate suicide. Following multiple requests, this expert was eventually provided with documents pertinent to the inmate suicide in the Main Jail in August 2019 (Case No. 10). These documents included the SCSO Investigative Report, a two-page ACH Incident Report of the death, and a three-page Clinical Summary of the death by the former ACH medical director. In addition to these documents, the decedent's medical chart was reviewed and found the following. In Case No. 10, the inmate was booked into the Main Jail on June 7, 2019 for a parole violation. He had previously been confined in the facility, and the prior "problem list" within the medical record included bipolar and adjustment disorders, and FOSS Level III. During intake screening on June 7, the inmate denied any current suicidal ideation, but self-reported bipolar disorder and psychiatric hospitalization as a child. It appeared that only two mental health questions were asked by the intake nurse ("mental health hospitalization?" and "are you thinking about hurting/killing yourself now?"). The nurse also noted that the inmate had reported a history of panic attacks for which he previously took Xanax and, although he was not showing any signs of current distress, a mental health referral was initiated. Two days later on June 9, the inmate was referred to JPS by classification personnel due to a report of "excessive meth use." He was not seen until 10 days later when he received a mental health assessment from a JPS clinician. The inmate denied any suicidal ideation, but complained about being "angry, fast and quick, real depressed." The clinician noted the inmate's previous FOSS Level III, history of bipolar	

	disorder, and current mood of being depressed and anxious. The clinician's "plan" was to "stabilize symptoms (anxiety and depression), kite JPS PRN, reviewed coping skills, clinic." It was unclear if the inmate was placed back on Foss Level III or if his symptoms were stabilized, but he was never seen again by a JPS clinician. The inmate submitted three sick call requests to restart his psychotropic medication (Trileptal) on June 20 ("I need to get back on meds," July 3, and July 28 ("I've been requesting getting back on my meds. My mood is unstable"). The inmate was finally seen by a psychiatrist on August 5 who noted his mood swings, racing thoughts, and increased irritability, with mood swings "all over the place." He denied any suicidal ideation, and his Trileptal medication was restarted. The inmate was scheduled to be seen again by a psychiatrist in four weeks. Three days later on August 8, 2019 at approximately 1:39pm, the inmate was found hanging from the fire sprinkler in his cell by a t-shirt by his cellmate who was returning from court. Other inmates yelled and got the attention of correctional officers who responded to the emergency and initiated cardiopulmonary resuscitation, assisted by arriving medical staff. The inmate was subsequently pronounced dead by paramedics. An investigation later determined that the inmate had made several telephone calls to his wife shortly before the suicide in which he allegedly threatened suicide. Other inmates in the housing unit later told investigators that the inmate had been crying and was visibly upset following these telephone calls. In sum, this expert's review of the medical record found several potentially problematic issues in need of further review, including 1) why the inmate, despite a history of mental illness and referrals by both intake nursing and classification personnel, was not seen by a JPS clinician for 12 days, 2) why the intake nurse only asked 2 of the approximate 11 mental health intake screening questions, and 3) why the inmate was not seen in a timely fashion by a provider and/or JPS clinician following three separately documented complaints of mood swings and wanting to restart his psychotropic medication. This expert reviewed a two-page ACH Incident Report summarizing the review of this case by JPS personnel. Dated October 18, 2019, the report noted that the case was "closed, incident resolved," a very problematic finding given the fact that none of the findings noted above were addressed in the report. Finally, as described in another provision below, there is a requirement to review: 1) the circumstances surrounding the incident; 2) the procedures relevant to the incident; 3) all relevant training received by involved staff;

	4) pertinent medical and mental health services/reports involving the victim; and 5) any possible precipitating factors that may have caused the victim to commit suicide or suffer a serious suicide attempt. Where applicable, the Review Team shall generate recommendations for changes in policy, training, physical plant, medical or mental health services, and operational procedures. Following review of all available documents in Case No. 10, as well as discussion with SCSO and ACH/JPS leadership, there was no indication that the above mortality review meeting and review process were conducted in this case. This provision is in Non-Compliance.
Recommendations	1) The previously established Suicide Prevention Task Force should be reinstated, or a similar multidisciplinary continuous quality assurance committee created, to become responsible for the comprehensive morbidity and mortality review of inmate serious suicide attempts and suicides. 2) All SCSO and ACH/JPS suicide prevention policies should be revised and include specific language for the multidisciplinary committee to review: 1) the circumstances surrounding the incident; 2) the procedures relevant to the incident; 3) all relevant training received by involved staff; 4) pertinent medical and mental health services/reports involving the victim; and 5) any possible precipitating factors that may have caused the victim to commit suicide or suffer a serious suicide attempt. Where applicable, the Review Team shall generate recommendations for changes in policy, training, physical plant, medical or mental health services, and operational procedures." 3) Provide all draft policies to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program. Review of SCSO Investigative Report, ACH Incident Report, and Clinical Summary of Case No. 10.

Provision R) 3. Quality Assurance and Quality Improvement	**For each suicide and serious suicide attempt (e.g., requiring hospitalization), the County's Suicide Prevention Task Force shall review: 1) the circumstances surrounding the incident; 2) the procedures relevant to the incident; 3) all relevant training received by involved staff; 4) pertinent medical and mental health services/reports involving the victim; and 5) any possible precipitating factors that may have caused the victim to commit suicide or suffer a serious suicide attempt. Where applicable, the Review Team shall generate recommendations for changes in policy, training, physical plant, medical or mental health services, and operational procedures.**
Status	**Non-Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was "Current practice." This provision is more or less duplicative with "Provision R) 2. Quality Assurance and Quality Improvement" above. Current SCSO and ACH/JPS suicide prevention policies do not provide an adequate description of the death review process for inmate suicide. In addition, this expert was informed that the Suicide Prevention Task Force, a monthly multidisciplinary committee previously coordinated by the SCSO, was disbanded sometime during 2019, with the last meeting minutes dated March 7, 2019. As detailed above, this expert reviewed the SCSO Investigative Report, ACH Incident Report, and Clinical Summary of Case No. 10 and, following discussion with both SCSO and ACH/JPS leadership, determined that there was no evidence to indicate a multidisciplinary mortality review meeting was conducted in this case. This provision is in Non-Compliance.
Recommendations	1) The previously established Suicide Prevention Task Force should be reinstated, or a similar multidisciplinary continuous quality assurance committee created, to become responsible for the comprehensive morbidity and mortality review of inmate serious suicide attempts and suicides. 2) All SCSO and ACH/JPS suicide prevention policies should be revised and include specific language for the multidisciplinary committee to review: 1) the circumstances surrounding the incident; 2) the procedures relevant to the incident; 3) all relevant training received by involved staff; 4) pertinent medical and mental health services/reports involving the victim; and 5) any possible precipitating factors that may have caused the victim to commit suicide or suffer a serious suicide attempt. Where applicable, the Review Team shall generate recommendations for changes in policy, training, physical plant, medical or mental health services, and operational procedures." 3) Provide all draft policies to expert for review.
Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020).

	SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program. Review of SCSO Investigative Report, ACH Incident Report, and Clinical Summary of Case No. 10. Suicide Prevention Task Force meeting minutes, March 7, 2019.

Provision R) 4. Quality Assurance and Quality Improvement	**The County will track all critical incidents which include prisoner suicides, attempted suicides, and incidents involving serious self-harm. The County shall review critical incidents and related data through its quality assurance and improvement processes.**	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was omitted. This expert determined that current practices are not yet compliant with the requirements of this provision. For example, ACH Incident Reports for 10 serious suicide attempts resulting in transport to a local hospital for treatment from July 19, 2019 thru June 12, 2020 were reviewed. Each two-page report was authored by the JPS director and provided a very brief description of the suicide attempt and the mental health services provided. A meeting was held to review each serious suicide attempt, but it appeared that only JPS personnel were participants at the meeting. Review of these 10 cases indicated that participants determined that appropriate care was provided in each case, and no corrective actions were necessary. In addition, this expert was informed by the ACH Quality Improvement (QI) Coordinator that "QI is tracking incident reports that have a breakdown of self-harm, suicides and suicide attempts. We have reviewed this data in the QIC. We have not yet begun periodic auditing of suicide prevention practices but intend to upon finalization of the policy. When that happens it will be reviewed in the MH Subcommittee who will then provide information, interventions and other data to the QIC." This provision is in Partial Compliance.	
Recommendations	1) All SCSO and ACH/JPS suicide prevention or other appropriate quality assurance and improvement policies should be revised to include the requirement to track and review track all suicide, suicide attempts, and incidence of serious self-harm. In addition, the language should state that while all incidents of self-harm should be tracked, only incidents of serious self-harm/attempts and suicides will be reviewed." 2) Provide all draft policies to expert for review.	

Evidentiary Basis	Sacramento County's *First* Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program. ACH Incident Reports for 10 serious suicide attempts from July 19, 2019 thru June 12, 2020.

Provision R) 5. Quality Assurance and Quality Improvement	**The County shall implement a continuous quality assurance/quality improvement plan to periodically audit suicide prevention procedures that include, but are not limited to: intake screening (to include audits to ensure that staff ask and record all suicide screening questions), mental health assessments, suicide risk assessments, crisis response, and treatment plans/behavior management plans for prisoners identified as being at risk of suicide or self-harm.**	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *First* Status Report (July 17, 2020), was omitted. This expert interprets this provision to indicate that the County must develop a continuous quality assurance/quality improvement plan to ensure that all of the suicide prevention provisions of this Consent Decree or implemented and sustained. Because all of the suicide prevention provisions are in various stages of compliance, and there is no indication that a continuous quality assurance plan has been implemented to date, this provision is in Partial Compliance.	
Recommendations	1) Given the enormity of responsibility to implement and sustain approximately 63 suicide prevention provisions of this Consent Decree, the previously established Suicide Prevention Task Force should be reinstated, or a similar multidisciplinary continuous quality assurance committee created, to exclusively focus on ensuring that all suicide prevention provisions of this Consent Decree are implemented and sustained. 2) All SCSO and ACH/JPS suicide prevention policies should be revised to include a description of this provision's requirements. 3) Provide all draft policies to expert for review.	
Evidentiary Basis	Sacramento County's First Status Report (July 17, 2020). SCSO Policy No. 10/05 - Suicide Prevention Program, CHS Policy No. 1412 - Suicide Prevention 2M-Joint Policy, and JPS Policy No. 1049 - Suicide Prevention Program.	

APPENDIX A

CHECKLIST FOR THE "SUICIDE-RESISTANT" DESIGN OF CORRECTIONAL FACILITIES

Lindsay M. Hayes

The safe housing of suicidal inmates and juveniles is an important component to a correctional facility's comprehensive suicide prevention policy. Although impossible to create a "suicide-proof" cell environment within any correctional facility, given the fact that almost all inmate and juvenile suicides occur by hanging, it is certainly reasonable to ensure that all cells utilized to house potentially suicidal inmates and juveniles are free of all obvious protrusions. And while it is more common for ligatures to be affixed to air vents and window bars (or grates), all cell fixtures should be scrutinized, since bed frames/holes, shelves with clothing hooks, sprinkler heads, door hinge/knobs, towel racks, water faucet lips, and light fixtures have been used as anchoring devices in hanging attempts. As such, to ensure that inmates and juveniles placed on suicide precautions are housed in "suicide-resistant" cells, facility officials are strongly encouraged to address the following architectural and environmental issues:

1) Cell doors should have large-vision panels of Lexan (or low-abrasion polycarbonate) to allow for unobstructed view of the entire cell interior at all times. These windows should never be covered (even for reasons of privacy, discipline, etc.) If door sliders are not used, door interiors should not have handles/knobs; rather they should have recessed door pulls. Any door containing a food pass should be closed and locked.

Interior door hinges should bevel down so as not to permit being used as an anchoring device. Door frames should be rounded and smooth on the top edges. The frame should be grouted into the wall with as little edge exposed as possible.

In older, antiquated facilities with cell fronts, walls and/or cell doors made of steel bars, Lexan paneling (or low-abrasion polycarbonate) should be installed from the interior of the cell.

Solid cell fronts must be modified to include large-vision Lexan panels or security screens with small mesh;

2) Vents, ducts, grilles, and light fixtures should be protrusion-free and covered with screening that has holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch;

3) If cells have floor drains, they should also have holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch (inmates have been known to weave one end of a ligature through the floor drain with the

other end tied around their neck, then lay on the floor and spin in a circular motion as the ligature tightens);

4) Wall-mounted corded telephones should not be placed inside cells. Telephone cords of varying length have been utilized in hanging attempts;

5) Cells should not contain any clothing hooks. The traditional, pull-down or collapsible hook can be easily jammed and/or its side supports utilized as an anchor;

6) A stainless steel combo toilet-sink (with concealed plumbing and outside control valve) should be used. The fixture should not contain an anti-squirt slit, toothbrush holder, toilet paper rod, and/or towel bar;

7) ADA-compliant grab bars that are located around the sink and/or toilet areas should be designed with a closed bottom (i.e., no open space) that prevents attachment of a ligature.

8) Beds should ideally be either heavy molded plastic or solid concrete slab with rounded edges, totally enclosed underneath.

If metal bunks are utilized, they should be bolted flush to the wall with the frame constructed to prevent its use as an anchoring device. Bunk holes should be covered; ladders should be removed. (Traditional metal beds with holes in the bottom, not built flush to the wall and open underneath, have often been used to attach suicide nooses. Lying flat on the floor, the individual attaches the noose from above, runs it under his neck, turns over on their stomach and asphyxiates themselves within minutes.);

9) Electricity should be turned off from wall outlets outside of the cell;

10) Light fixtures should be recessed into the ceiling and tamper-proof. Some fixtures can be securely anchored into ceiling or wall corners when remodeling prohibits recessed lighting. All fixtures should be caulked or grouted with tamper-resistant security grade caulking or grout.

Ample light for reading (at least 20 foot-candles at desk level) should be provided. Low-wattage night light bulbs should be used (except in special, high-risk housing units where sufficient lighting 24 hours per day should be provided to allow closed-circuit television (CCTV) cameras to identify movements and forms).

An alternative is to install an infrared filter over the ceiling light to produce total darkness, allowing inmates to sleep at night. Various cameras are then able to have total observation as if it were daylight. This filter should be used only at night because sensitivity can otherwise develop and produce aftereffects;

11) CCTV monitoring does not prevent a suicide, it only identifies a suicide attempt in progress. If utilized, CCTV monitoring should only supplement the physical observation by staff. The camera should obviously be enclosed in a box that is tamper-proof and does not contain anchoring points. It should be placed in a high corner location of the cell and all edges around the housing should be caulked or grouted.

Cells containing CCTV monitoring should be painted in pastel colors to allow for better visibility. To reduce camera glare and provide a contrast in monitoring, the headers above cell doors should be painted black or some other dark color.

CCTV cameras should provide a clear and unobstructed view of the entire cell interior, including all four corners of the room. Camera lens should have the capacity for both night or low light level vision;

12) Cells should have a smoke detector mounted flush in the ceiling, with an audible alarm at the control desk. Some cells have a security screening mesh to protect the smoke detector from vandalism. The protective coverings should be high enough to be outside the reach of an individual and far enough away from the toilet so that the fixture could not be used as a ladder to access the smoke detector and screen. Ceiling height for new construction should be 10 feet to make such a reasonable accommodation. Existing facilities with lower ceilings should carefully select the protective device to make sure it cannot be tampered with, or have mesh openings large enough to thread a noose through.

Water sprinkler heads should not be exposed. Some have protective cones; others are flush with the ceiling and drop down when set off; some are the breakaway type;

13) Cells should have an audio monitoring intercom for listening to calls of distress (only as a supplement to physical observation by staff). While the individual is on suicide precautions, intercoms should be turned up high (as hanging victims can often be heard to be gurgling, gasping for air, their body hitting the wall/floor, etc.);

14) Cells utilized for suicide precautions should be located as close as possible to a control desk to allow for additional audio and visual monitoring;

15) If modesty walls or shields are utilized, they should have triangular, rounded or sloping tops to prevent anchoring. The walls should allow visibility of both the head and feet;

16) Some individuals hang themselves under desks, benches, tables or stools/pull-out seats. Potential suicide-resistant remedies are: (a) Extending the bed slab for use as a seat; (b) Cylinder-shaped concrete seat anchored to floor, with rounded

edges; (c) Triangular corner desk top anchored to the two walls; and (d) Rectangular desk top, with triangular end plates, anchored to the wall. Towel racks should also be removed from any desk area;

17) All shelf tops and exposed hinges should have solid, triangular end-plates which preclude a ligature being applied;

18) Cells should have security windows with an outside view. The ability to identify time of day via sunlight helps re-establish perception and natural thinking, while minimizing disorientation.

If cell windows contain security bars that are not completely flush with window panel (thus allowing a gap between the glass and bar for use as an anchoring device), they should be covered with Lexan (or low-abrasion polycarbonate) paneling to prevent access to the bars, or the gap, should be closed with caulking, glazing tape, etc.

If window screening or grating is used, covering should have holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch;

19) A mattress should always be issued to an individual on suicide precautions unless the individual is observed to be utilizing it in ways in which it was not intended (i.e., attempting to tamper with/destroy, utilizes to obstruct visibility into the cell, etc.). The mattress should be fire retardant and not produce toxic smoke. The seam should be tear-resistant so that it cannot be used as a ligature;

20) Given the fact that the risk of self-harm utilizing a laundry bag string outweighs its usefulness for holding dirty clothes off the floor, laundry bag strings should be removed from the cell;

21) Mirrors should be of brushed, polished metal, attached with tamper-proof screws;

22) Padding of cell walls is prohibited in many states. Check with your fire marshal. If permitted, padded walls must be of fire-retardant materials that are not combustible and do not produce toxic gasses. Because padded cells do not contain a sink or toilet, they should not be primarily utilized for suicidal inmates, but, if utilized, the duration should be limited to a few hours; and

23) Ceiling and wall joints should be sealed with neoprene rubber gasket or sealed with tamper-resistant security grade caulking or grout for preventing the attachment of an anchoring device through the joints.

NOTE: A portion of this checklist was originally derived from R. Atlas (1989), "Reducing the Opportunity for Inmate Suicide: A Design Guide," *Psychiatric Quarterly*, 60 (2): 161-171. Additions and modifications were made by Lindsay M. Hayes, and updated by Randall Atlas, Ph.D., a registered architect. Last revised Lindsay M. Hayes in December 2019.