Consent Decree in Mays et al v. County of Sacramento

Fifth **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 2,380 incarcerated persons (IPs), and the RCCC is rated for 1,625 IPs. As of April 23, 2024, the Mail Jail population was approximately 1,800 IPs, whereas the RCCC held approximately 1,100 IPs. The jail system is operated by the Sacramento County Sheriff's Office (SSO), Medical services are provided to IPs through the County Department of Health Services' Adult Correctional Services (ACH), whereas mental health services are provided to patients by Adult Correctional Mental Health (ACMH), identified as "JPS" in *Mays* Remedial Plan, 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/Angela Goehring/Susi Vassallo, the joint medical experts), Mary Perrien (mental health expert), and Lindsay Hayes (suicide prevention expert) 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*.

To date, the Defendants have filed timely "status reports" every 180 days. The status reports are 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).

This current *Fifth Monitoring Report* covers the time period of July 2023 through July 2024. Therefore, Sacramento County's 7th Status Report, filed on July 5, 2023, Sacramento County's 8th Status Report, filed on January 8, 2024, and Sacramento County's 9th Status Report, filed on July 11, 2024, were all reviewed and utilized in this report.

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 "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.
>
> **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.

Fifth Monitoring Report

There are **62** suicide prevention provisions listed under Section VII (pages 41 through 50) of the Remedial Plan.[1]

Consistent with the four previous monitoring reports, this *Fifth Monitoring Report* is formatted to present each provision, followed by the provision's current status or rating (substantial, partial, or

[1]Previous monitoring reports incorrectly counted **Provision A) Substantive Provisions** as two sub-sections, resulting in 63 provisions. Although Provision A has two sub-sections, it remains only one provision, thus the correct number of provisions is 62.

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. In addition to the documents listed below, this report is based upon the expert's three-day on-site assessment conducted on April 23-25, 2024.

Documents Requested

In March 2024, this expert submitted a suicide prevention and quality assurance and continuous quality improvement document request to Sacramento County Defendant. The revised document request, reproduced below, was very focused and requested specific data (particularly in the area of training):

> 1) Any new or updated training curriculum regarding pre-service and in-service staff training, as well as curricula, handouts, etc., regarding suicide prevention and mental illness, **including SSO's 24-hour advanced CIT training**;
>
> 2) According to SSO 8th Status Update, "IOP and JBCT Deputies receive 24 hours of advanced CIT training." Provide verification of such training for deputies assigned to the IOP and SITHU as follows:
>
> - % (number of employees/employees trained) of **All Deputies assigned to the IOP and SITHU** as of March 31, 2024 that received the 24-hour advanced CIT training.
>
> 3) Documentation of overall staff completion rates for suicide prevention and first aid/CPR training presented as follows (using numerator/denominator):
>
> Pre-Service 4-Hour Suicide Prevention Training (**New Employees**)
> - % (number of employees/employees trained) of all NEW Deputies that received suicide prevention training as of December 31, 2023
> - % (number of employees/employees trained) of all NEW Medical Staff (including registry) that received suicide prevention training as of December 31, 2023
> - % (number of employees/employees trained) of all NEW Mental Health Staff that received suicide prevention training as of December 31, 2023
> - Annual 2-Hour Suicide Prevention Training (Non-New Employees)
> - % (number of employees/employees trained) of all Deputies that received suicide prevention training as of December 31, 2023
> - % (number of employees/employees trained) of all Medical Staff (including registry) that received suicide prevention training as of December 31, 2023
> - % (number of employees/employees trained) of all Mental Health Staff that received suicide prevention training as of December 31, 2023
>
> *For example, if there were 122 total Mental Health staff as of December 31, 2023, four (4) of whom were new employees, how many of the four received the 4-hour*

training, and how many of the remaining 118 non-new employees received the 2-hour training. Use same example for Deputies and Medical staff.

First Aid/CPR

- % (number of employees/employees trained) of All Deputies currently certified in First Aid/CPR as of March 31, 2024
- % (number of employees/employees trained) of All Medical Staff (including registry) currently certified in First Aid/CPR as of March 31, 2024

4) According to the SSO 8th Status Update, "Staff are prompted to review and acknowledge the (SSO suicide prevention) policy which is electronically recorded in Lexipol." Provide verification as to the percentage of custody deputies that have reviewed and acknowledged receipt of SSO Policy 721: Suicide Prevention and Intervention, presented as follows: "As of March 31, 2024, ___ % of SSO custody deputies have reviewed/acknowledged Policy/Procedure 722-Suicide Prevention and Intervention, effective September 12, 2023." *A statement that 100% of staff are required to review the policy is not sufficient. Proof of practice is required.*

5) Documentation of overall Health Care/Mental Health staff training for Suicide Risk Assessments presented as follows:

- % (number of employees/employees trained) of APU Nurses, Clinicians, and Psychiatrists who received Suicide Risk Assessment (one time) training as of March 31, 2024

6) According to the ACH 8th Status Update, "MH staff have received updated training on the new process of developing safety plans at the time of an SRA evaluation starting in January 2023 with a pilot study with ongoing training. Audits of compliance will happen after all MH staff have been trained on the new process." Provide the following:

- % (number of employees/employees trained) of Mental Health Staff who received updated safety plan training as of March 31, 2024

- Audits of compliance with safety planning

7) Listing of incarcerated persons with serious suicide attempts (incidents resulting in medical treatment and/or hospitalization) for the period of January 2023 to present;

8) Listing of incarcerated persons (with XREF numbers) on suicide precautions from October 1, 2023 thru March 31, 2024 (including those housed in safety, sobering, ad. seg. SITHU, other 3-West 200 pod, and APU cells);

9) Custody Logs and Suicide Precautions Observation Custody Instruction Sheets for all incarcerated persons on suicide precautions from January 1, 2024 thru March 31, 2024. If more convenient, originals or hard-copies can be provided onsite for review on April 23, 2024;

10) SSO Monthly Tracking History (in Excel format) of all incarcerated persons confined in safety, ad seg, and sobering cells *by month* from April 2023 through March 2024. *This report has not been sent to Lindsay Hayes on a monthly basis as required since March 2023*. See attached Excel format that includes incarcerated person's name, booking number, location (safety, sobering, ad seg) check-in, check-out, elapsed time, and reason for placement;

11) As recommended to SSO in 4th Monitoring Report on Suicide Prevention Practices (September 2023), provide any post order for Main Jail booking that addresses a requirement to sanitize the telephone in the ACMH Interview Room following each incarcerated persons use;

12) As recommended to SSO in 4th Monitoring Report on Suicide Prevention Practices (September 2023), provide a 2P-APU post order or protocol that requires any patient currently assessed as suicidal, but not in need of restraints, would not be housed in Cell P-1;

13) As recommended to SSO in 4th Monitoring Report on Suicide Prevention Practices (September 2023), provide revised Policy No. 4/05 - Use of Safety Cells/Segregation Cells/Multipurpose Rooms/North Holding No. 2. that should delete reference to multi-purpose rooms, including classrooms, as acceptable locations for the housing of suicidal incarcerated persons;

Quality Assurance and Continuous Quality Improvement

14) Any new policy, procedure, directive (including draft) related to quality assurance and continuous quality improvement for suicide prevention;

15) Provision VII.R)5. of the *Mays* Consent Decree requires:

> "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."

As such, provide all available documentation that addresses the above quality assurance requirements from January 2023 to present *that was not otherwise*

provided in attachments to monthly Suicide Prevention Quality Improvement Subcommittee meeting minutes; and

16) In addition to the *Mays* Consent Decree approved in January 2020, the parties entered into a Memorandum of Agreement (MOA) on May 27, 2022 (filed June 3, 2022, Docket 153-2) regarding the correction of several critical remedial provisions of Mental Health and Suicide Prevention. The MOA requires the County to develop a specific quality assurance process to address several provisions, including the "Use of Safety Smocks" and "Privileges" for incarcerated persons on suicide precautions. The requirements include:

> "9. Staff compliance with safety smock policies to prevent overuse and/or unnecessary use of safety smocks will be subject to a *documented quality assurance process for at least 12 months from the date of this Memorandum of Agreement*, with quality assurance review at the monthly Suicide Prevention Subcommittee meetings.
>
> a. *Health care and custody supervisors will conduct at least weekly reviews of safety smock use to ensure proper implementation*, with corrective action taken when warranted.
>
> 18. Staff compliance with the protocols set forth above (regarding privileges and property) will be subject to a *documented quality assurance process for at least 12 months from the date of this Memorandum of Agreement*, with quality assurance review at the monthly Suicide Prevention Subcommittee meeting (emphasis added).
>
> a. *Mental health, and custody supervisors will conduct at least weekly reviews to ensure proper implementation*, with corrective action taken when warranted."

As such, provide all available documentation that addresses the above quality assurance requirements from January 2023 to present *that was not otherwise provided in attachments to monthly Suicide Prevention Quality Improvement Subcommittee meeting minutes*.

<u>Documents Received and Reviewed</u>

- Sacramento County's 7th Status Report (July 5, 2023)
- Sacramento County's 8th Status Report (January 8, 2024)
- Sacramento County's 9th Status Report (July 11, 2024)

- First Floor Medical Intake New Construction Floor Plan, June 6, 2024; letter from Office of the County Counsel indicating *Resolution of Dispute* regarding failure to provide confidentiality during jail intake, August 23, 2024.

- Meeting minutes from the *Suicide Prevention Quality Improvement Subcommittee*, November 13, 2023, December 11, 2023, January 8, 2024, February 26, 2024, March 11, 2024, April 8, 2024, May 13, 2024, June 10, 2024, July 8, 2024, and August 12, 2024.

- Minutes from the *Suicide Precautions Multidisciplinary Meeting*, January 3, 2024, February 7, 2024, March 6, 2024, April 3, 2024, May 1, 2024, June 5, 2024, July 3, 2024, August 7, 2024, and September 4, 2024.

- SSO *Suicide Precautions Compliance Review – Monthly Report*, July 10, 2023, September 5, 2023, October 2, 2023, November 3, 2023, December 1, 2023, January 1, 2024, February 1, 2024, March 1, 2024, April 4, 2024, May 2, 2024, June 2, 2024, July 7, 2024, September 2, 2024.

- ACMH - *Suicide Precautions Weekly Review – Monthly Report or Quarterly Report*, October 23, 2023, November 13, 2023, December 11, 2023, January 8, 2024, February 12, 2024, May 13, 2024, June 1, 2024, August 12, 2024.

- ACMH – *Acute Psychiatric Unit Discharge Follow-ups – Timeline to Care*, November 14, 2023,

- ACMH *Completion of Suicide Risk Assessment and Safety Plan*, May 13, 2024.

- ACMH *Acute Psychiatric Unit: Clinical Restraints*, June 3, 2024.

- ACMH *Timelines to Care for Emergent, Urgent and Routine Referral/Appointments*, May 14, 2024.

- ACMH 26-slide PowerPoint presentation entitled *Assessing for Mental Health at Intake*, February 26, 2024.

- ACH *Nurse Intake Suicide Risk Inquiry Form (Chart) Audit*, January 22, 2024.

- ACH *Nurse Intake Suicide Risk Inquiry Form In-Person Audit*, February 27-28, 2024, and *Nurse Intake Suicide Risk Inquiry Form In-Person Audit*, undated.

- ACH-ACMH *Suicide Risk Inquiry Revised Questions*, Final Version, July 2024.

- Photographic evidence that ACMH interview room in booking loop of Main Jail now contains a speakerphone, April 2024.

- Sample medical chart review of 10 patients on suicide precautions in the SITHU and/or the Acute Psychiatric Unit during the review period, including the intake screening review of nine (9) patients determine status of mental health referral based upon prior placement on suicide precautions.

- Observed ACMH daily rounds of 17 patients on suicide precautions in booking and SITHU cells on April 23 – 25, 2024.

- Observed ACMH daily rounds of 12 patients in the Acute Psychiatric Unit on April 25, 2024.

- Observed the intake screening process and/or reviewed the intake screening forms in the medical charts of six (6) IPs on April 24 – 25, 2024.

- Observation records of six (6) patients on suicide precautions in the SITHU from the ATIMS jail management software.

- Out-of-cell records of five (5) patients on suicide precautions in the SITHU from the ATIMS jail management software.

- Out-of-cell records of five (5) patients on suicide precautions in the Acute Psychiatric Unit from the ATIMS jail management software.

- ATIMS Monthly Safety Cell (including ad. seg. and sobering cells) Tracking History, by month, from April 2024 thru August 2024.

- Various training data as of April 2024 and November 2024.

- Lessons plans on "Crisis Intervention Training," 24-hour Expanded Course; "Understanding Common Mental Health Disorders in the Correctional Setting," a 1.5-hour, 72-slide PowerPoint presentation; and "Effects of Brain Development in Forensic Settings," a 37-slide PowerPoint presentation.

- Suicide Prevention Quality Improvement Subcommittee's morbidity reviews from eight (8) serious suicide attempts between August 2023 and April 2024 (Case 17 through Case 24).

- The following policies:

- ACMH Policy 02-05: Suicide Prevention Program, revised January 30, 2024.
- ACMH *Critical Needs Assessment Program*, draft policy, July 2024.
- SSO Policy and Procedure 713: *Suicide Prevention and Intervention*, effective September 12, 2023.[2]
- SSO Policy and Procedure 519: *Safety, Separation and Sobering Cells*, May 21, 2024.
- SSO Post Order: *Acute Psychiatric Unit-Use of Cell P-1*, effective April 24, 2024.

Finally, the parties filed a joint Status Report RE: Monitoring of Consent Decree Implementation with the court on June 3, 2022 (Case 2:18-cv-02081-TLN-KJN. Document No. 153). The joint status report was developed following a Dispute Notice letter sent by plaintiffs' counsel on October 29, 2021 "demanding specific actions to implement critical remedial provisions regarding Mental Health and Suicide Prevention on which the County is not in compliance." The parties executed a Memorandum of Agreement regarding these issues on May 27, 2022 (filed June 3, 2022, Docket 153-2), and the Suicide Prevention provisions of the Agreement are presented as follows:

SUICIDE PREVENTION

Suicide Prevention Policies (Focus Area #1)

5. Adult Correctional Health, with input from the Subject Matter Experts and Class Counsel, completed revision of its Suicide Prevention policies (Policy No. 01-15 and 02-05) in September 2021.
a. Adult Correctional Health provided a two-hour suicide prevention training to health care staff on several dates between December 2021 and February 2022. Training of custody staff rolled out in March 2022.
b. In February 2022, the County finalized a 4-6 hour suicide prevention training that covers essential aspects of the Remedial Plan as to suicide prevention. The County will utilize a multidisciplinary team to deliver this training to all newly hired mental health, medical, and custody staff. Such training will begin in June 2022 and will be provided on an ongoing basis as staff members are onboarded.
c. The County will adapt the new-staff suicide prevention training referenced in Paragraph (b), above, to cover all essential suicide prevention aspects of the Remedial Plan, including requirements set forth in this Agreement, to be delivered to all current mental health, medical, and custody staff who have not received the

[2]The SSO Policy and Procedure 713: *Suicide Prevention and Intervention* has gone through numerous effective dates, as well as numerous policy numbers (721, 722, and 714). The correct effective date of September 12, 2023 reflects the final version that was approved by this court monitor. Policy No. 713 is reflected in the Sacramento County's 9th Status Report (July 11, 2024).

new-staff training. The training was reviewed and approved by the Subject Matter Experts. Training has begun and will continue until all staff members are trained.
6. The County will complete revision of the Sheriff's Office's Suicide Prevention policy, procedure, and training, including based on input from the Subject Matter Experts and Class Counsel, to ensure compliance with all relevant Remedial Plan provisions. The County's Suicide Prevention policies, procedures, and trainings will require the following, with appropriate documentation to show proof of practice:
a. Staff will offer patients on suicide precautions a shower at least daily, and upon reasonable request.
b. Staff will provide prompt assistance with hygiene and cleaning to patients on suicide precautions whenever circumstances warrant.
c. Staff will affirmatively offer patients on suicide precautions water at least every two hours, and upon request.
d. Staff will affirmatively offer patients on suicide precautions food at least consistent with normal daily meal provisions, and upon request (e.g., if they missed a meal due to their mental health or suicide observation status).
e. Staff will provide patients on suicide precautions and held in a cell that does not have a toilet access to a toilet promptly upon request.

Addressing Overuse and Unnecessary Use of Safety Smocks (Focus Area #2)

7. Adult Correctional Health shall, with input from the Subject Matter Experts and Class Counsel, has finalized revisions to its suicide prevention policies, including to clarify that (a) decisions about the removal of clothing and the issuance of a safety smock to class members on suicide precautions will be under mental health staff authority based on the clinical judgement of a licensed clinician, (b) class members will have clothing restored prior to discharge from suicide precautions and as soon as clinically appropriate while on suicide precautions, and (c) mental health staff will conduct at least daily assessments of a patient's readiness for restoration of clothing and shall document reasons for continued use when indicated.
8. The Sheriff's Department's Suicide Prevention policy and procedure will be revised to align with Adult Correctional Health policy regarding use of safety smocks.
9. Staff compliance with safety smock policies to prevent overuse and/or unnecessary use of safety smocks will be subject to a documented quality assurance process for at least 12 months from the date of this Memorandum of Agreement, with quality assurance review at the monthly Suicide Prevention Subcommittee meetings.
a. Health care and custody supervisors will conduct at least weekly reviews of safety smock use to ensure proper implementation, with corrective action taken when warranted.
b. The Mental Health and Suicide Prevention Subject Matter Experts will monitor safety smock policy implementation and the quality assurance process to ensure compliance with relevant Consent Decree requirements.

Patient Confidentiality for Suicide Risk Assessments, Mental Health Clinical Encounters (Focus Area #3)

10. The County has fixed the inoperable telephone inside the designated mental health Interview Room in the Main Jail's intake area, and will take additional steps to improve confidentiality in the Main Jail intake screening area to the greatest extent possible given the deficient physical plant. The Subject Matter Experts will review and assess these modifications on future monitoring visits.
11. As an interim measure to mitigate physical plant deficiencies impacting delivery of care, the County is utilizing two confidential attorney visit booths on the Main Jail's third floor, to improve confidentiality of mental health appointments. These interim measures, along with other measures to address deficiencies in the confidentiality of mental health contacts, will be reviewed by the Subject Matter Experts during on-site monitoring.
12. As an interim measure to mitigate physical plant deficiencies impacting delivery of care, the County will relocate (i) staff currently using Main Jail office space and (ii) storage space to a nearby off-site location, to free up rooms and the Main Jail 3-West classroom that has been used as office space. These spaces will be repurposed for confidential individual treatment and group therapy for people in the Intensive Outpatient Program or otherwise requiring mental health treatment. The Subject Matter Experts will assess the adequacy of these spaces during upcoming monitoring visits.
13. The County acknowledges that above-identified interim steps will not be sufficient to facilitate full remediation of the legal and constitutional deficiencies identified in the Mays case and addressed in the Consent Decree. Issues regarding provision of patient confidentiality for suicide risk assessments and mental health clinical contacts will be addressed through continued Dispute Resolution processes related to physical plant and staffing deficiencies, as set forth on Pages 10-13, below.

Direct Observation of Class Members on Suicide Precautions (Focus Area #4)

14. On November 15, 2021, ACH ordered an end to use of Closed-Circuit TV (CCTV) for purposes of observing class members on suicide precautions. The Mental Health Medical Director followed up with all psychiatry staff.
15. Adult Correctional Health, with input from the Subject Matter Experts and Class Counsel, finalized Policy No. 02-05 – Suicide Prevention Program on November 16, 2021, which removes CCTV observation and provides for direct observation consistent with Consent Decree requirements.
16. The Subject Matter Experts will evaluate implementation of suicide precaution observation practices during upcoming monitoring visits.

Appropriate Provision of Privileges and Property for Class Members on Suicide Precautions (Focus Area #5)

17. Adult Correctional Health shall, with input from the Subject Matter Experts and Class Counsel, finalized revisions to its suicide prevention policies to reflect Remedial Plan requirements regarding privileges and property for patients on suicide precautions. The Sheriff's Office's Suicide Prevention policy and procedure will be revised to align with Adult Correctional Health policy regarding privileges and property for patients on suicide precautions. These policies specifically shall provide:

a. Mental health staff shall have primary responsibility to determine, based on clinical judgment and on a case-by-case basis and in consultation with custody staff, the provision of: • Routine privileges (e.g., visits, telephone calls, recreation) that are otherwise permitted based on a person's classification security level • Clothing and possessions (e.g., books, slippers/sandals, eyeglasses) that are otherwise permitted based on a person's classification security level

b. Patients placed on suicide precautions shall be re-evaluated at least daily to assess clinical readiness for personal and jail-issued possessions, clothing, and privileges.

c. Placement on suicide precautions shall not preclude patients from receiving timely and regular access to (i) meals, (ii) liquids, (iii) prescribed medication, (iv) toilets, and (v) showers.

d. The County shall ensure full implementation of the requirements as set forth in Paragraph 6, above.

e. Class members on suicide precautions shall be allowed to attend scheduled court proceedings unless the clinician, based upon clinical judgment and in consultation with security staff, determines that transportation to court would adversely impact the individual's condition.

f. The removal of property and/or privileges shall be documented with clinical justification in the patient's medical/mental health record and reviewed on a regular basis. Cancellation of privileges should be avoided whenever possible and utilized only as a last resort.

g. Cell window coverings shall not be used on cells holding any class member 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, consistent with Remedial Plan Section VII.J. i. Placement of a patient in an opposite gender area (e.g., male placed in suicide precautions cell in female intake area) does not constitute a "security need" for purposes of this remedial provision.

h. The County will provide tear-resistant mattresses for all patients at the acute level of mental health care, in the SITHU, or on suicide precautions for more than four hours (and consistent with Remedial Plan Section VII.O.1).

18. Staff compliance with the protocols set forth above will be subject to a documented quality assurance process for at least 12 months from the date of this Memorandum of Agreement, with quality assurance review at the monthly Suicide Prevention Subcommittee meeting (emphasis added).

a. ACH, mental health, and custody supervisors will conduct at least weekly reviews to ensure proper implementation, with corrective action taken when warranted.

b. The Mental Health and Suicide Prevention Subject Matter experts will monitor policy implementation and the quality assurance process to ensure compliance with relevant Consent Decree requirements.

Given the enormity of responsibility to implement and sustain approximately 63 suicide prevention provisions of this Consent Decree's Remedial Plan, this expert had previously recommended that the Suicide Prevention Subcommittee meet on a monthly basis (not quarterly as previously practiced) and better focus on ensuring that all suicide prevention provisions of the Remedial Plan are implemented and sustained. The Defendants agreed, and began holding monthly Suicide Prevention Subcommittee meetings in November 2021. As noted in the above detailed Memorandum of Agreement, the Suicide Prevention Subcommittee now has the specific quality assurance responsibility to ensure "staff compliance" with the suicide prevention provisions of the Remedial Plan, "for at least 12 months from the date of this Memorandum of Agreement," including the five focus areas offered above.

Because the Memorandum of Agreement (MOA) was executed on May 27, 2022 (filed June 3, 2022, Docket 153-2) which followed this expert's on-site assessment of February 21-23, 2022, the "critical remedial provisions" contained in the above MOA began to be addressed within the *Fourth* Monitoring Report, with continued updates provided within this report.

Executive Summary[3]

The *First Monitoring Report* found ***52*** of the 62 total suicide prevention provisions in Partial Compliance, with ***10*** suicide prevention provisions in Non-Compliance. ***No*** provisions were in Substantial Compliance. No progress was noted in the *Second Monitoring Report* whereby ***51*** of the 62 total suicide prevention provisions were in Partial Compliance, with ***11*** suicide prevention provisions in Non-Compliance. ***No*** provisions were in Substantial Compliance. The *Third Monitoring Report* found ***7*** of the 62 suicide prevention provisions in Substantial Compliance, ***47*** provisions in Partial Compliance, and ***8*** provisions in Non-Compliance. The *Fourth* Monitoring Report found ***9*** of the 62 suicide prevention provisions in Substantial Compliance, ***45*** provisions in Partial Compliance, and ***8*** provisions in Non-Compliance.

As shown in the table below, this *Fifth* Monitoring Report found ***24*** of the 62 suicide prevention provisions in Substantial Compliance, ***32*** provisions in Partial Compliance, and ***6*** provisions in Non-Compliance. Some of the improvement was attributable to implementation of the SSO suicide prevention policy (SSO Policy and Procedure 713: *Suicide Prevention and Intervention*), effective on September 12, 2023.

[3]Beginning in the Sacramento County's 6th Status Report, and continuing through Sacramento County's 9th Status Report filed on July 11, 2024, it was incorrectly stated on page 4 that the "Mental Health and Suicide Prevention Experts rate some indicators as a group and others individually." This statement is incorrect as it relates to suicide prevention. As indicated in all of this expert's monitoring reports, including this *Fifth* Monitoring Report, there are 63 suicide prevention provisions and *all* are rated individually. For example, Sacramento County incorrectly stated on page 7 of its 9th Status Report that the "Example: Nurse Intake Provision C. has five indicators but rated as one item" by the Suicide Prevention Expert, whereas a correct reading of this expert's monitoring reports indicates that Provision C – Nursing Intake Screening has always had six (6) individual requirements and each is rated separately.

Of note, Appendix A provides an overall summary of "Suicide Prevention Remedial Plan Compliance" from January 2021 to date.

Substantive Area for Suicide Prevention	Total Provisions	Substantial Compliance		Partial Compliance		Non-Compliance	
		#	%	#	%	#	%
1st Monitoring Report (1/19/2021)	62			52	84%	10	16%
2nd Monitoring Report (9/10/2021)	62			51	83%	11	17%
3rd Monitoring Report (8/19/2022)	62	7	11%	47	76%	8	13%
4th Monitoring Report (9/13/2023)	62	9	14%	45	73%	8	13%
5th Monitoring Report (11/11/2024)	62	24	39%	32	52%	6	9%

As detailed in this report, there were several areas of progress that deserve recognition, as well as key deficiencies requiring corrective action found during this monitoring period. For example:

AREAS OF PROGRESS

- Implementation of SSO Policy and Procedure 713: *Suicide Prevention and Intervention*, effective September 12, 2023.
- Revision to the Nursing Intake Encounter (intake screening) Form in July 2024 (Section C.3)
- Efforts to remediate lack of confidentiality in Main Jail booking area and housing units in August 2024 (Sections C, K)
- Employment of mental health workers to operationalize Constant Observation option (Section J)

KEY DEFICIENCIES REQUIRING CORRECTIVE ACTION

- Failure to consistently complete suicide risk questions on Nursing Intake Encounter Form (Section C.1).)
- Need for additional staffing to manage timelines for emergent mental health referrals and provision clinically indicated treatment (Sections E, F)
- Failure to place/treat people at risk of suicide in least restrictive setting (F)
- Failure to provide timely inpatient care (Section G)
- Inadequate supervision of patients on suicide precautions ((Section J), and limited out-of-cell time for suicidal patients (Section H)
- Inadequate Treatment/Safety Plans for patients discharged from suicide precautions (Section K.2)

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. The Sacramento County Sheriff's Office (SSO), Adult Correctional Health (ACH), and the University of California – Davis, Department of Psychiatry and Behavioral Sciences (referred here as "Adult Correctional Mental Health-ACMH") previously each had varying suicide prevention policies. Pursuant to the requirements of the Consent Decree, these policies were in need of varying degrees of revision. To date, and at the recommendation of this expert, ACH and ACMH have combined their respective suicide prevention policies into a joint policy entitled "ACH PP 02-05 Suicide Prevention Program" policy that was approved and became effective on November 16, 2021. In addition, several other suicide prevention-related policies were also developed during previous review periods, including the "ACH 01-15: Suicide Prevention Subcommittee" policy that was approved and effective on September 17, 2021; the "MH-04-09: Acute Psychiatric Unit - Admission, Program, and Discharge" policy that was approved and effective on May 6, 2022, last revised November 30, 2022; the "ACH 04-07: Acute Psychiatric Unit – Precautions and Observations" policy that was approved and effective on June 22, 2022; and "ACH 07-09: Constant Observation of Mental Health Patients" policy that was approved and effective on January 13, 2023. Most recently, the "ACH 02-05: Suicide Prevention Program" policy was revised on January 30, 2024. The SSO previously provided this expert with a draft "Suicide Prevention and Intervention" policy (No. 722) during the February 2022 on-site assessment. On March 4, 2022, this expert provided extensive edits to the draft policy based	

	upon the requirement to ensure the policy was consistent with the ACH PP 02-05 Suicide Prevention Program policy, as well as *Consent Decree* requirements. As noted above in the Introduction section of this report, the SSO Policy and Procedure 713: Suicide Prevention and Intervention has gone through numerous effective dates, as well as numerous policy numbers (721, 722, 713, and 714). The correct effective date of September 12, 2023 reflects the final version that was approved by this court expert. Policy No. 713 is reflected in the Sacramento County's 9th Status Report (July 11, 2024). In conclusion, although both the SSO and ACMH finally have approved suicide prevention policies, because all suicide prevention-related provisions are in varying degrees of compliance, and implementation has not been completed, this provision remains in Partial Compliance.
Recommendations	Fully implement all suicide prevention-related provisions of the ACMH and SSO suicide prevention policies.
Evidentiary Basis	Review of the following suicide prevention-related policies: ACH No. 02-05, Suicide Prevention Program policy, effective November 2021, revised January 30, 2024; MH-04-09: Acute Psychiatric Unit - Admission, Program, and Discharge policy, effective May 6, 2022; ACH 01-15: Suicide Prevention Subcommittee" policy, effective on September 17, 2021; ACH 04-07: Acute Psychiatric Unit – Precautions and Observations policy, effective June 22, 2022; and SSO "Suicide Prevention and Intervention" policy (No. 713), effective September 12, 2023.

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) jail 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 jail suicide; j) crisis intervention.**	
Status	**Partial Compliance**	
Discussion	Following several years of prolonged delay, the four-hour pre-service suicide prevention curriculum entitled "Suicide Prevention and Detection in Jail" was	

	finalized and approved on February 7, 2022. The curriculum, a 185-slide PowerPoint presentation, was developed by a 10-member training subcommittee of the Suicide Prevention Subcommittee utilizing this expert's *Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities* as a resource guide. Finally, there was acknowledgment that, consistent with Consent Decree requirements, both the pre-service and the annual suicide prevention training would always be conducted "live" in person in a classroom or virtual classroom setting. Pre-service training utilizing the new curriculum was initiated in June 2022. According to Sacramento County's 6th Status Report (January 9, 2023), "As part of pre-service training, the Adult Corrections Officer Supplemental Core Course has been revised where Module 19.0 addresses suicide prevention. This section has been approved by the Board of State & Community Corrections (BSCC) as well as the Standards and Training for Corrections (STC).....New employees have received the 4-hour suicide prevention training since May 22, 2022." The expert initially received the requested training data in April 2024, but found that data provided by ACH regarding its medical staff was unreliable. ACH provided updated data in September 2024. Based upon training data received by this expert in April 2024 and September 2024, the following rates of compliance for the four-hour pre-service suicide prevention training for new employees: Custody: 88% (37 of 42) Medical: 66% (31 of 47, includes registry staff) Mental Health: 100% (41 of 41) In conclusion, according to current training data, custody and medical personnel remain below 90 percent compliance. This provision remains in Partial Compliance and will be moved to Substantial Compliance when all three disciplines meet the 90 percent training compliance threshold.
Recommendations	Ensure that custody, medical, and mental health achieve and maintain the 90 percent training compliance threshold.
Evidentiary Basis	Sacramento County's 6th Status Report (January 9, 2023). "Suicide Prevention and Detection in Jail," four-hour, 185-slide PowerPoint presentation, effective February 7, 2022. Training data provided in April 2024 and September 2024.

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	See full discussion above in **Provision B) 1. Training**. The two-hour "Suicide Prevention: An Overview," 70-slide PowerPoint presentation, was finalized and approved on January 21, 2022. It was based upon this expert's *Training Curriculum and Program Guide on Suicide Detection and Prevention in Jail and Prison Facilities*. Due to continued confusion and provision of unreliable training data, this expert made the following request in the *Fourth* Monitoring Report: *Twice a year in January and June, provide updated data on the total number of current employees for each discipline (i.e., denominator), and the total of current employees (i.e., numerator) who received the two-hour suicide prevention training by discipline* (emphasize added). Unfortunately, only ACMH has consistently responded to this training request, and the expert initially received unreliable data from ACH in April 2024. Subsequent training data provided by ACH in September 2024 indicated the following rates of compliance for the two-hour annual suicide prevention training for current employees (<u>not</u> new staff who were required to receive the four-hour training): Custody: 90% (325 of 363) Medical: 80% (125 of 157, includes registry staff) Mental Health: 95% (76 of 80) In conclusion, because medical personnel remain below 90 percent compliance, this provision remains in Partial Compliance.
Recommendations	1) As previously requested in the *Fourth* Monitoring Report, *twice a year in January and June, provide updated data on the total number of current employees for each discipline (i.e., denominator), and the total of current employees (i.e., numerator) who received the two-hour suicide prevention training by discipline* (emphasis added). 2) Ensure that custody, medical, and mental health staff achieve and maintain the 90 percent training compliance threshold.

Evidentiary Basis	"Suicide Prevention: An Overview," two-hour, 70-slide PowerPoint presentation, effective January 21, 2022. Training data provided in April 2024 and September 2024.

Provision B) 3. Training	**Custody officers assigned to Designated Mental Health Units shall receive additional specialized training on suicide prevention and working with patients[4] with serious mental illness.**	
Status	**Partial Compliance**	
Discussion	Historically, this expert had interpreted "Designated Mental Health Units" (DMHUs) consistent with its definition as contained on page 2 of the Remedial Plan, i.e., "any specialized units specifically operated to house and serve prisoners requiring mental health treatment, including the inpatient unit (2P), the Intensive Outpatient Program (IOP), and the Outpatient Psychiatric Pods." With creation of the "Suicidal Inmate Temporary Housing Unit" (SITHU) in the Main Jail, that unit was also included in the DMHU definition. In a teleconference discussion with the parties on November 4, 2024 that included this expert and the mental health expert, there appeared to be agreement that the term "Outpatient Psychiatric Pods" was inaccurate and was better described as the "Outpatient Psychiatric Program" (OPP), but disagreement as to whether the OPP was an actual "program" or simply a classification designation utilized by SSO for patients in need of mental health treatment. These individuals were often "cohorted" in various housing units within the Main Jail, often within 3-East (100-Pod, 200-Pod, and 300-Pod) as they awaited placement in the IOP or Enhanced Outpatient Program (EOP). In an effort to resolve this disagreement, the parties agreed to hold further discussions in the future. For purposes of this provision, the agreed upon DMHUs in the Main Jail are currently located in 3-West (100-Pod, 200-Pod, and 300-Pod) and house the IOP, EOP, and SITHU, as well as the Acute Psychiatric Unit (APU) currently located on 2-P Pod. At the Rio Cosumnes Correctional Center (RCCC), the 400-Pod and 500-Pod at the Christopher Boone Facility (CBF) is utilized for IOP. Similar to previous reports, Sacramento County's initial response to this provision, as authored by the SSO in the 9th Status Report (July 11, 2024), was "IOP and JBCT Deputies receive 24 hours of advanced CIT training. Several IOP/JBCT Deputies also attended negotiation training specific to custody." In addition, according to SSO training data from April 2024, although various deputies received training in such topics as "brain development/mental health	

[4]Beginning with this *Fifth* Monitoring Report, the terms "prisoners" and "inmates" are replaced with the term "patients" in all *Consent Decree* provision headings and report narrative, with the exception of any term enclosed in quotation marks.

adaptive support" and "overview of mental health disorders," it was unclear how many of these deputies were assigned to Designated Mental Health Units. Training curricula for each of these workshops were not provided to this expert. In addition, although SSO provided data that indicated 30 deputies assigned to the IOP and SITHU had completed the 24-hour advanced crisis intervention training (CIT) program, data was not provided for deputies assigned to the other Designated Mental Health Units.

Following the November 4 teleconference with the parties, Sacramento County provided more definitive DMHU training data on November 8, 2024, as well as training curricula on three courses. According to the County, there are currently 20 deputies assigned to the IOP, SITHU (3-West), and APU (2-P) at the Main Jail, and 10 deputies assigned to the IOP at RCCC. In addition, the required "specialized training" required by these 30 deputies was identified as the following:

- "Crisis Intervention Training," 24-hour Expanded Course;
- "Understanding Common Mental Health Disorders in the Correctional Setting," a 1.5-hour, 72-slide PowerPoint presentation; and
- "Effects of Brain Development in Forensic Settings," a 37-slide PowerPoint presentation. (Both lesson plans were developed by the University of California – Davis, Adult Correctional Mental Health.)

Finally, the following training data was provided by Sacramento County:

Main Jail

Crisis Intervention Training	95% (19/20)
Understanding Common MH Disorders	5% (1/20)
Effects of Brain Development	90% (18/20)

RCCC

Crisis Intervention Training	90% (9/10)
Understanding Common MH Disorders	70% (7/10)
Effects of Brain Development	100% (10/10)

In conclusion, because the parties are not yet in agreement as to the total scope of the DMHUs in the Sacramento County jail system, agreement has not been reached regarding the totality of the "specialized training" required of DMHU deputies, and the recently provided training data indicated compliance levels below the 90 percent threshold for one course (Understanding Common Mental Health Disorders"), this provision remains in Partial Compliance.

Recommendations	1) The parties are encouraged resolve the disagreement regarding total scope of the DMHUs in the Sacramento County jail system, and the totality of the "specialized training" required of DMHU deputies. 2) Any training compliance data for custody personnel should always include: *a) the number of current custody personnel assigned to the Designated Mental Health Housing Units (the denominator), and b) the number of current custody personnel that received specialized suicide prevention and mental health training (the numerator) during the requested period.*
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). Training data provided in April 2024 and November. Lessons plans on "Crisis Intervention Training," 24-hour Expanded Course; "Understanding Common Mental Health Disorders in the Correctional Setting," a 1.5-hour, 72-slide PowerPoint presentation; and "Effects of Brain Development in Forensic Settings," a 37-slide PowerPoint presentation.

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	**Substantial Compliance**
Discussion	This expert previously reviewed the 103-slide PowerPoint presentation entitled "Suicide Assessment in Jail" that was developed for the ACMH. The curriculum was very comprehensive, and included instruction on safety planning. Sacramento County's response to this provision, as authored by ACH in the 9th Status Report (July 11, 2024), was: "All mental health staff, including clinicians, and psychiatrists, 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. The Suicide Risk Assessment Training was approved by SME. Staff complete the training within 3 months of hire and again every 2 years." According to training data from April 2024, all mental health clinicians and psychiatrists have received suicide risk assessment (SRA) training. Of note, nursing staff, including those assigned to the APU, are not required to receive SRA training because they are not authorized to complete suicide risk assessments. This provision remains in Substantial Compliance.
Recommendations	All future training data under this provision should be formatted as follows: *a) the number of current mental health clinicians and psychiatrists authorized to completed suicide risk assessments (the denominator), and b) the number of mental health clinicians and psychiatrists that are currently compliant with suicide risk assessment training (the numerator) during the requested period.*

Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024. 103-slide PowerPoint presentation entitled "Suicide Assessment in Jail." Training data as of April 2024.

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	**Substantial Compliance**	
Discussion	Sacramento County's response to this provision in the 9th Status Report (July 11, 2024) by both ACH and SSO states that "All mental health staff and custody officers are 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. This element has been incorporated into the Suicide Prevention Training. Safety Suits are used at the discretions of ACMH based on collaboration with custody staff and not as a behavior management tool. During the 4 hour and 2-hour Suicide Prevention Class there is training and discussion about proper safety suit use consistent with this remedial plan." As noted in previous monitoring reports, ACMH developed an 18-slide PowerPoint presentation entitled "Suicide Precautions: Observation, Housing, Clothing, Item Restriction, and/or Privilege Restrictions," with the presentation clearly stating on slide 13 that "*Safety suits are <u>not</u> to be used as/for…a default clothing for patients evaluated or pending evaluation for DTS, DTO, or GD*." This training presentation was subsequently folded in the 2-hour annual suicide prevention training, with ACMH informing the expert on August 7, 2023 that "Safety smock use, privilege and item restriction are covered in the Suicide Prevention Training (2 hr: slides 52-60 & 4 hr: slides 130-154). When we initially rolled out the Suicide Precautions form (2021) we provided training to the Sgts and some of the booking deputies. However, on an ongoing basis this has not been provided to SSO since *we cover these requirements in Suicide Prevention training.*" In conclusion, because training regarding the proper use of safety suits is now embedded in the two-hour annual suicide prevention training (see **Provision B) 2. Training** above), and both custody and mental health staff achieved over 90 percent compliance with two-hour annual suicide prevention training during the reporting period, this provision is raised to Substantial Compliance. It should be noted, however, that the expert found several examples of patients clothed in safety smocks and placed on 30-minute observation in the APU during this monitoring period, a violation of both ACMH policy and the	

	Consent Decree. This finding will be addressed in more detail in **Provision N) 6. Use of Safety Suits**.
Recommendations	None
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACMH's 18-slide PowerPoint presentation entitled "Suicide Precautions: Observation, Housing, Clothing, Item Restriction, and/or Privilege Restrictions," September 2021. "Suicide Prevention: An Overview," two-hour, 70-slide PowerPoint presentation, effective January 21, 2022. Training data as of April 2024.

Provision B) 6. Training	**The County shall ensure that all staff are trained in the new Suicide Prevention Policy.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SSO in the 9th Status Report (July 11, 2024), stated that "Suicide Prevention and Intervention Policy and Procedure 713 was updated on 09/12/2023. Staff are prompted to review and acknowledge the policy which is electronically recorded in Lexipol." According to SSO training data, approximately, 85 percent of SSO staff assigned to the Main Jail, and 88 percent of SSO staff assigned to the RCCC, read and electronically acknowledged the SSO Policy 713: Suicide Prevention as of March 31, 2024. During the previous monitoring period, this provision was in non-compliance because the SSO policy had not yet been finalized. Since then, the policy was finalized on September 12, 2023 and SSO staff began to receive training. In conclusion, because SSO personnel remain below 90 percent compliance, this provision is raised to Partial Compliance.
Recommendations	Ensure that all deputies have received training in SSO Policy 713: Suicide Prevention. Provide verification to the expert.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). SSO Policy and Procedure 713: Suicide Prevention and Intervention, effective September 12, 2023. Training data as of April 2024.

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 patient is placed in a housing assignment.**	
Status	**Non-Compliance**	
Discussion	Sacramento County's initial response to this provision, as authored by ACH in the 9th Status Report (July 11, 2024), was "Intake screening for suicide risk takes place at the booking Receiving Screening and prior to a housing assignment. If clinically indicated, a referral is made to ACH MH, who will then perform an additional clinical assessment after the patient is placed in a housing assignment." This response is non-responsive because it simply restates the provision requirements. In addition to the location of intake screening, this expert monitors the degree to which nursing staff asks all mental health/suicide risk questions and correctly completes the intake screening form. The "Nurse Intake: Intake Health" screening template, embedded in the "Athenahealth" electronic health record (EHR), contains the following Suicide Risk Inquiry: 1) Have you ever considered suicide? 2) Have you recently experienced a significant loss (relationship, death of family member/close friend, job etc.)? 3) Has a family member/close friend ever attempted or committed suicide? 4) Are you now or have you ever received either outpatient or inpatient mental health treatment? 5) Have you ever attempted suicide or engaged in self-harm behavior? 6) Do you feel there is nothing to look forward to in the immediate future (expressing helplessness and/or hopelessness)? 7) Do you have an upcoming court hearing that you are particularly concerned about? 8) *After reviewing the active and inactive problem list, was the inmate a suicide risk or receiving mental health services during any prior confinement within this facility (i.e., on suicide precautions, attempted suicide, 2P Pre-admit, FOSS level indicated, etc.)?* (Emphasis added) 9) Are you thinking about hurting and/or killing yourself?	

	With the exception of Question 8, all of the questions are required to be asked of the individual and their self-reported responses entered into the EHR. Question 8 requires the nurse to review the EHR to determine whether or not the incarcerated person (IP) had previously been confined in the Sacramento County jail system and was previously identified as either a suicide risk or receiving mental health services. As detailed in prior monitoring reports, this expert has consistently found that intake nurses were observed to be not asking all of the required questions in the Suicide Risk Inquiry section of the intake screening form, as well as falsely documenting in the EHR that they had asked those questions and reviewed the chart (pursuant to Question 8 on the form) regarding an IP's previous problem list. Due to this expert's prior findings, ACH quality improvement staff completed two "in-person audits" of the intake screening process in the booking area of the Main Jail. The first audit, date unknown and covering "Q4 FY 23/24," included observation of 18 intake screenings, and found that 46 percent of suicide risk questions either were only "partially asked" or "not asked" at all. The second ACH audit, conducted on February 27-28, 2024, included observation of 21 intake screenings, and found that 36 percent of suicide risk questions were only "partially asked" or "not asked" at all. Sacramento County acknowledged deficiencies in the intake screening process in a further response to this provision, as authored by ACH in the 9th Status Report (July 11, 2024), by stating on page 218 that: "Due to ongoing challenges with Intake nursing asking all suicide risk screening questions, QI Nursing began onsite monitoring of the nurse intake process, including suicide risk assessment questions to ensure compliance with screening requirements." This expert again observed the intake screening process on April 24-25, 2024. The screening of six (6) newly admitted individuals by four (4) different nurses was observed. Of the six cases, nursing staff were observed to be asking all of the suicide risk inquiry questions in only three cases (or 50 percent). For example, in one case (**Case No. 1**) observed on April 24, instead of asking the required question – "Are you now or have you ever received either outpatient or inpatient mental health treatment?" the nurse asked the individual – "Ever been to a mental hospital?" Instead of asking the required question – "Do you feel there is nothing to look forward to in the immediate future (expressing helplessness and/or hopelessness)?" the nurse simply asked – "Feeling okay?" Finally, a determination of the individual's prior placement on suicide precautions (Question 8 above) was not completed by the nurse. In a second case, a nurse attempting to create privacy and confidentiality during the process, rolled her chair close to the individual and asked questions with a

	soft voice. However, by rolling her chair away from the work station, the nurse was unable to reach her computer to record responses to the intake screening questions. Instead, the nurse used an "Intake Cheat Sheet," a long piece of paper containing various abbreviated questions. Although it was certainly commendable that the nurse was sensitive to the importance of privacy and confidentiality, the "Intake Cheat Sheet" did not contain the exact wording of the intake screening questions as they appeared in the embedded EHR. In addition, a separate review of medical charts by this expert during the current monitoring period found that mental health clinicians consistently completed timely suicide risk assessments (SRAs) for those individuals referred from intake nurses. In conclusion, based upon the continued finding that observed intake nurses were not asking all of the required questions in the Suicide Risk Inquiry section of the intake screening form, this provision remains in Non-Compliance.
Recommendations	1) Nursing staff should not utilize the "Intake Cheat Sheet" during intake screening. 2) Nursing staff should ask all of the required questions in the Suicide Risk Inquiry section of the intake screening form. 3) Given the long-standing non-compliance with this provision, ACH nursing supervisors should increase the audit frequency of the intake screening process to ensure that nursing personnel are accurately completing the suicide risk inquiry section of the Nurse Intake Encounter form. At a minimum, quarterly "in-person audits, not charts reviews, should be completed and forwarded to the expert.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). On-site observation at Main Jail on April 24-25, 2024. ACH PP 05-05 Nurse intake, revised December 1, 2022. ACH *Nurse Intake Suicide Risk Inquiry Form In-Person Audit*, February 27-28, 2024, and *Nurse Intake Suicide Risk Inquiry Form In-Person Audit*, undated.

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 patient but maintains sound privacy, unless there is a clearly identified security or safety risk.**	
Status	**Non-Compliance**	
Discussion	ACH 05-05: Nurse Intake policy, effective October 28, 2021 and revised on December 1, 2022, addresses confidentiality during the intake screening process as follows:	

	"a. Nurse Intake will be conducted in an area that ensures confidentiality of communications between the nurse and patient. Exception: If there is an individualized determination of safety risk, custody staff are positioned to allow visual observation but sound privacy is maintained. b. The nurse will document whether the encounter was confidential and, if not, the reason it was not and whether efforts were made to maintain privacy." During this expert's previous onsite assessment in December 2022, the nurses' station within the booking area of the Main Jail was being renovated, with construction subsequently completed in January 2023. As noted above, this expert observed several intake screenings in this newly renovated area on April 24-25, 2024. Although the area appeared clean, there continued to be three open nurses' stations remaining alongside each other, separated by partitions. There were no doors to each station, and this expert could easily hear each nurse ask questions while situated in various locations within the area. In addition, arresting officers continued to remain in the nurses' station. As such, due to the occurrence of multiple intake screenings at the same time, involving multiple nurses, incarcerated persons, and arresting officers, privacy and confidentially continued to be compromised. Sacramento County's response to this provision, as authored by ACH in the 9th Status Report (July 11, 2024), accurately conceded that "Nurse Intake stations were reconfigured in Booking to increase space and add soundboards to increase auditory privacy however it is still inadequate and out of compliance." In conclusion, despite the above described renovation efforts, the intake screening process in the booking area of the Main Jail remains dysfunctional and very problematic. As such, this provision remains in Non-Compliance. Of note, according to the Office of the County Counsel, four (4) medical intake rooms (with doors) were recently constructed in the booking loop and current medical screening area of the Main Jail. The project was completed in August 2024 and the Office of the County Counsel has informed this expert that arresting officers are now instructed to remain outside the medical intake rooms, with doors closed unless there is a security concern regarding a specific individual during the screening process. This expert will monitor this new process during the next scheduled onsite assessment.
Recommendations	None
Evidentiary Basis	ACH 05-05: Nurse Intake policy, revised December 1, 2022. On-site assessment of Main Jail on April 24-25, 2024.

	First Floor Medical Intake New Construction Floor Plan, June 6, 2024; letter from Office of the County Counsel indicating *Resolution of Dispute* regarding failure to provide confidentiality during jail intake, August 23, 2024.

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	**Substantial Compliance**	
Discussion	This expert had previously reviewed and made extensive comments to the "suicide risk inquiry" section of the "Nurse Intake Encounter" form (which is embedded within athenahealth EHR and utilized by nursing staff at booking. The comments included deleting options for "routine" mental health referrals and inserting options for "urgent" and "emergent" referrals to mental health clinicians based upon responses to questions, as well as restructuring certain suicide risk inquiry questions. As described earlier in this report, the revised form now includes the following suicide risk inquiry: 1) Have you ever considered suicide? 2) Have you recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)? 3) Has a family member/close friend ever attempted or committed suicide? 4) Are you now or have you ever received either outpatient or inpatient mental health treatment? 5) Have you ever attempted suicide or engaged in self-harm behavior? 6) Do you feel there is nothing to look forward to in the immediate future (expressing helplessness and/or hopelessness)?	

7) Do you have an upcoming court hearing that you are particularly concerned about?
8) After reviewing the active and inactive problem list, was the inmate a suicide risk or receiving mental health services during any prior confinement in this facility (i.e., on suicide precautions, attempted suicide, 2P Pre-Admit, FOSS level indicated, etc.)?
9) Are you thinking about hurting and/or killing yourself?

In July 2024, in order to reduce compound questions and give nursing staff better direction regarding referral type, ACH/ACMH again revised the suicide risk inquiry questions that now has been revised as follows:

1) *Have you thought about suicide in the past?* If yes, when? (Within the last 12 months: Urgent; Over 12 months ago: Routine)

2) *Have you ever attempted suicide?* If yes, when? (Within the last 30 days: Emergent; Over 30 days ago: Urgent)

3) *Are you currently having thoughts of suicide?* (Yes: Emergent); Do you have a plan? Yes/No If yes, describe)

4) *Are you currently thinking about hurting yourself?* (Yes: Emergent)

5) *Do you feel there is nothing to look forward to in the immediate future?* (Yes: Urgent)

6) *Have you recently experienced a significant loss?* What was the loss? If yes, when? (Within the last 30 days: Urgent; Over 30 days ago: Routine)

7) *Has anyone close to you ever attempted or died by suicide?* If yes, when? (Within the last 12 months: Urgent; Over 12 months ago: Routine)

8) *Are you now or have you ever received mental health treatment in the community?* (Yes: Routine)

9) *Have you ever been hospitalized for mental health treatment?* If yes, when? (Within the last 12 months: Urgent; Over 12 months ago: Routine)

10) *After reviewing active and inactive problem list, was the inmate a suicide risk or receiving mental health services during any prior confinement in this facility?*

	The above revised "suicide risk inquiry" section of the Nursing Intake Encounter form was reviewed by this expert prior to final revision and found to be consistent with the requirements of this provision. This provision remains in Substantial Compliance.
Recommendations	None
Evidentiary Basis	ACH-ACMH *Suicide Risk Inquiry Revised Questions*, Final Version, July 2024.
Provision C) 4. Nursing Intake Screening	**Regardless of the patient'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	**Non-Compliance**
Discussion	Sacramento County's response to this provision, as authored by ACH in the 9th Status Report (July 11, 2024), was "Regardless of a patient's behavior or answers given during intake screening, an automatic mental health referral is initiated if there is a documented history related to suicide or self-harm, including during a prior incarceration." Such a statement is contrary to this expert's previous and current findings. As previously noted in the *First Monitoring Report*, the Problem List embedded within athenahealth EHR allows for the storage of information regarding an individual's current and prior medical and mental health history. The Problem List had both an active (highlighted) and inactive view (shaded). Previous review of various multiple charts indicated that many patients 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 patient had been placed on suicide precautions and was awaiting placement in the 2P-Acute Psychiatric Unit. As noted in the provision above (C) 3., there is a requirement for nursing staff to complete "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." As indicated in the previous provision above, nurses who conduct intake screening are required to answer Question 8 (revised as Question 10 in July 2024) of the suicide risk inquiry section by reviewing the EHR of each newly admitted individual to determine if they had previously been confined in the Sacramento County jail system and, if they had, review the active and inactive Problem List, and determine if they were was "a suicide risk or receiving mental health services during any prior confinement in this facility (i.e., on

	suicide precautions, attempted suicide, 2P Pre-Admit, FOSS level indicated, etc.)? *The answer to this Question is obtained from the EHR, not the incarcerated person.* This expert's chart review of the intake screening process during the onsite assessment in April 2024 found continued examples of nurses not accessing the medical charts of newly admitted detainees to determine if they had previously been confined in the Sacramento County jail system and had histories of suicide risk and/or mental health services during prior confinement. Of nine (9) medical charts reviewed in which individuals appearing for intake screening had histories of placement on suicide precautions, only 56 percent (5 of 9) were appropriately referred to mental health. This provision remains in Non-Compliance because, based upon observation of the intake screening process and medical chart review, nursing staff continue to ignore the requirement of Question 8 (now revised as Question 10) in the suicide risk inquiry section of the Nurse Intake Encounter form to review the applicable medical chart of newly admitted incarcerated persons.
Recommendations	In order to better ensure that an individual's' prior placement on suicide precautions within the Sacramento County jail system is consistently captured in the Problems (both active/inactive) section of the EHR, ACH/ACMH should revise the suicide risk evaluation form to add a radio button that requires clinicians to document an individual's placement on suicide precautions. Such documentation will populate in the Problems section. To avoid duplication, programming should ensure that only the most recent suicide precautions placement appears in the Problems section.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). 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	**Substantial Compliance**
Discussion	Sacramento County's response to this provision, as authored by ACH in the 9th Status Report (July 11, 2024), was "County ACH updated and implemented the Nurse Intake policy and procedure that includes referrals to mental health by Intake staff. The policy corresponds with the triage system and timeframes set forth in the Mental Health Remedial Plan." Review of two ACH policies (ACH 05-05: Nurse Intake, October 28, 2021, revised December 1, 2022 and MH-01-10: Access to Mental Health Services,

	August 6, 2021) indicated that they were consistent with this provision. The MH-01-10: Access to Mental Health Services policy specifies that Emergent mental health referrals are required to be responded to "ASAP – within 6 hours," Urgent mental health referrals are required to be responded to "within 36 hours," and Routine mental health referrals are required to be responded to "within two weeks." The stated response times are consistent with Consent Decree requirements. In conclusion, because this provision requires creation of policies and procedures regarding timely mental health referrals from intake screening for individuals identified as possibly in need of mental health services (excluding suicide prevention), and this expert believes that ACH 05-05: Nurse Intake, October 28, 2021, revised December 1, 2022 and MH-01-10: Access to Mental Health Services adequately address this provision, August 6, 2021) are consistent with the requirements of this provision, this provision remains in Substantial Compliance. However, because this provision is specific to individuals in need of mental health services excluding suicide prevention, this expert would defer to the mental health expert in this Consent Decree for any contrary assessment regarding that aspect of the mental health referral process.
Recommendations	None
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 05-05: Nurse Intake, October 28, 2021, revised December 1, 2022. MH-01-10: Access to Mental Health Services, August 6, 2021.

Provision C) 6. Nursing Intake Screening	**Any patient 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	**Substantial Compliance**
Discussion	Sacramento County's response to this provision, as authored by ACH in the 9th Status Report (July 11, 2024), was "Any patient 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. See below for emergent referral data. Note the significant increase in emergent referrals since nurse intake questions and orders were changed due to this provision." The 9th Status Report included the following data indicating a significant increase in emergent mental health referrals from January 2021 through March 2024: 2021: 3,887 2022: 9,808 2023: 14,004

	2024: 3,279 (through March) It is extremely notable that the number of emergent mental health referrals have risen significantly since 2021, which roughly aligns with the start of *Mays* Consent Decree implementation efforts, including improved mental health and suicide risk screening. In 2023, there was an average of more than 38 emergent mental health referral *per day*. That rate roughly persisted in the first quarter of 2024, with more than 34 emergent mental health referral per day. It is critically important that ACMH maintain sufficient staffing resources to timely respond in these cases moving forward. Review of two ACH policies (ACH 05-05: Nurse Intake, October 28, 2021, revised December 1, 2022 and MH-01-10: Access to Mental Health Services, August 6, 2021) indicated that they were consistent with this provision. In fact, the MH-01-10: Access to Mental Health Services policy specifically placed this reviewer's previous recommended narrative into the policy as follows: "A patient identified at intake (or any time during confinement) as a possible current risk for suicide should be seen by a mental health clinician on an emergent basis, as well as under constant observation until assessment; whereas a patient identified at intake with a prior history of suicidal behavior will be seen by a MH clinician on an urgent basis." The ACH 05-05: Nurse Intake policy requires that: "Patients presenting with acute crises such as current suicidal and/or homicidal ideation, acute psychiatric symptoms, posing a danger to self or a danger to others or gravely disabled will prompt an emergent referral to MH and will be seen within 6 hours. Call the MH office at 916-***-**** and document the call. Notify custody and request appropriate housing and constant observation until assessed by a MH clinician." Review of various medical charts during the current monitoring period found that mental health clinicians continued to consistently respond to emergent mental health referrals from intake for incarcerated persons currently at risk for suicide on a timely basis. Of note, mental health staff are assigned to the Main Jail 24 hours a day in order to respond to emergent mental health referrals and triage referrals during the intake screening process. In conclusion, because this provision requires creation of policies and procedures regarding timely mental health referrals from intake screening for IPs identified as currently at risk for suicide, the MH-01-10: Access to Mental Health Services policy was revised consistent with this expert's previous recommendation, and medical chart review found that clinicians consistently responded to mental health referrals from intake for IPs currently at risk for suicide on a timely basis, this provision remains in Substantial Compliance.
Recommendations	None

Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 05-05: Nurse Intake, October 28, 2021, revised December 1, 2022. MH-01-10: Access to Mental Health Services, August 6, 2021. 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 patient but maintains sound privacy, unless there is a clearly identified security or safety risk.**	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by ACH in the 9th Status Report (July 11, 2024), was "MH clinicians document whether assessments are confidential or non-confidential including rationale. Structural/space issues continue to be a major barrier to achieving substantial compliance." Mental health clinicians assigned to the Main Jail continued to utilize various options for their interaction with patients on suicide precautions: 1) a converted attorney booth in booking referred to as the ACMH Interview Room, 2) classrooms on each housing floor (including 300-West Pod that houses the SITHU), 3) the outside control area of 300-West Pod in close proximity to the officer's desk and erroneously referred to as the "indoor recreation area," 4) the visiting booths in 300-West Pod, and 5) cell front of the booking cells (safety, ad, seg, or sobering) and 2P-APU. Cell front, as well as the outside control area/indoor recreation area of 300-West Pod are non-confidential because they are in close proximity to both officers and other patients. In October 2023, the County completed installation of a "confidential interview room" within the outside control area (indoor recreation area) of 300-West Pod. The room, comprised of plexiglass walls and a door, as well as table and several chairs, can accommodate one patient and one or more clinicians. During the April 2024 onsite assessment, this expert examined the interview room while a clinician was conducting a one-on-one assessment with a patient and found that there was adequate privacy and confidentiality with the door closed and deputies providing observation from their desk. This expert was informed that the County plans on installing 1 to 2 confidential interview rooms within the outside control area (indoor recreation areas) on each floor in the Main Jail by the end of 2024. In addition, the County subsequently reported that it plans to add a visual barrier between the housing units and the confidential interview rooms in the outside control area (which are otherwise separated only be transparent glass). This is an important measure that, if implemented appropriately, will reduce

	the ability of other incarcerated persons to visually observe a clinical encounter while allowing for appropriate visual observation by custody staff to ensure safety. This proposed enhancement will be monitored during the next monitoring site visit. During the on-site assessment from April 23-25, 2024, this expert shadowed several mental health clinicians as they were conducting daily assessments of the incarcerated persons identified as suicidal. During the three-day period, daily rounds of 17 patients on suicide precautions in booking and SITHU were observed, as well as rounds for 12 patients in the APU. Of those observed assessments, ACMH clinicians offered (and patients accepted) out-of-cell assessments to most patients in booking and the SITHU. These assessments were conducted in either the ACMH Interview Room in booking or in 300-West Pod classroom and confidential interview room. On April 25, 2024, this expert observed provider rounds in the APU for 12 patients. Rounds included a psychiatrist, and forensic psychiatric residents/medical students, nurse, mental health clinician, and deputy. Because the APU does not have any confidential out-of-cell space, all contacts for these 12 patients were provided cell front. On a case-by-case basis depending upon the perceived stability of the patient, the cell door was opened and the provider or psychiatric fellow interacted with the patient in the doorway alongside the deputy. Regardless of whether the cell doors were open or closed, all of these provider contacts were non-confidential. In addition, this expert reviewed the medical charts of 10 patients who were on suicide precautions for a multiple-day period before, during, and after the most recent on-site assessment. The review period spanned between approximately October 2023 through April 2024 with patients housed in the booking area (in safety, ad seg, or sobering cells), SITHU, and/or the 2P-Acute Psychiatric Unit (APU). Of note, four (4) patients of the 10 patients were subsequently placed in the APU. The medical chart review indicated that mental health clinicians consistently offered patients out-of-cell assessments in 90 percent (9 of 10) of the cases when housed in booking or the SITHU. However, when the four patients were housed in the APU, they never were offered out-of-cell assessments because of the aforementioned lack of confidential out-of-cell space. In conclusion, although there continued to be improvement observed during the expert's on-site assessment, the on-going lack of privacy and confidentiality during the daily assessment of suicide risk in the APU continues to be an impediment to full compliance with this provision. This provision remains in Partial Compliance.
Recommendations	Develop a corrective action plan to ensure that APU patients had offered the opportunity for private, out-of-cell assessments.

Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). On-site observation on April 23-25, 2024. 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 ACH in the 9th Status Report (July 11, 2024), was "Mental health staff are required to conduct assessments within the timeframes defined in the mental health referral triage system. Auditing of MH compliance meeting four (4) and six (6)-hour timelines to care is being completed and presented to MH QI Subcommittee and Suicide Prevention Subcommittee." The Status Report then displayed data on Emergent Referral response time for Safety Cell, Sobering Cell, and Segregation Cell placements. This provision, however, measures compliance with mental health assessments conducted within the timeframes defined in the mental health referral triage system, and is not limited to emergency responses for suicidal patients. The ACH response is better directed at **Provision E) 1. Responses to Identification of Suicide Risk or Need for Higher Level of Care**, see below. In addition, as this provision is similar to **Provision C) 5. Nursing Intake Screening** above and does not specifically or exclusively address suicidal patients, the expert would defer to the mental health expert in this *Consent Decree* as to whether the MH-01-10: Access to Mental Health Services, policy, effective August 6, 2021, satisfies compliance with this provision. At this time, the provision remains in Partial Compliance.	
Recommendations	None	
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). MH-01-10: Access to Mental Health Services, August 6, 2021.	

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 ACH in the 9th Status Report (July 11, 2024), was "MH has revised 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. Nursing Intake and SRA forms have been updated and approved by SME. MH is working with ACH to embed the Suicide Risk Assessment into the MH Clinical SOAP note. This will improve consistency of documentation, ease of locating SRA, and eliminate duplication/redundancy of documentation." As stated in previous monitoring reports, the ACMH Mental Health Assessment is embedded within athenahealth EHR 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 ACMH Initial Psychiatric Evaluation is also embedded within athenahealth EHR and contains the following domains: Current Psychotropic Medication, Mental Status Examination, DSM-V Diagnoses, and brief Suicide Ideation inquiry. The current ACMH Suicide Risk Assessment template embedded within athenahealth EHR contains adequate inquiry regarding prior and current suicide risk behavior. The expert would defer to the mental health expert in this Consent Decree as to whether the MH-04-04: Outpatient Mental Health Services and Levels of Care policy, effective October 13, 2021, satisfies compliance with this provision. At this time, the provision remains in Partial Compliance.	
Recommendations	None	
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACMH Suicide Risk Assessment form. MH-04-04: Outpatient Mental Health Services and Levels of Care, October 13, 2021.	

Provision E) 1. Responses to Identification of Suicide Risk or Need for Higher Level of Care	**When a patient 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	Consistent with findings from the previous monitoring reports, and following a recent medical chart review, this expert determined that this provision was again in various stages of compliance. Patients identified as suicidal are often placed on suicide precautions in a safety cell and almost always clothed in a safety smock by default by SSO staff. Mental health clinicians are immediately notified and required to respond in a timely manner to complete a suicide risk assessment (SRA). According to the ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, "If the patient was placed in a safety cell prior to the assessment, the SRA shall be started within 4 hours of the incident. Note: Only referrals of patients placed in safety cells require a 4-hour timeframe. While other emergent referrals shall be consistent with the 6-hour timeframe." As explained above, Sacramento County's response to this provision, as authored by ACH in the 9th Status Report (July 11, 2024), was incorrectly placed in **Provision D) 2. Post-Intake Mental Health Assessment Procedures**, and stated: "Mental health staff are required to conduct assessments within the timeframes defined in the mental health referral triage system. Auditing of MH compliance meeting four (4) and six (6)-hour timelines to care is being completed and presented to MH QI Subcommittee and Suicide Prevention Subcommittee. *Findings indicate that low staffing levels and high levels of emergent referrals are impacting compliance.*" **Summary** December 2023 – February 2024 Emergent Referral - Safety Cell Placements Total = 72 Seen w/in 4 hours = 28 (39%) Not seen within 4 hours = 44 (61%) Avg Response Time (hrs.) = 6.3 Emergent Referral - Sobering Cell or Seg. Cell Placements Total = 1,583	

	Seen w/in 6 hours = 938 (59%) Not seen within 6 hours = 645 (41%) Avg Response Time (hrs.) = 6.5 In sum, this data indicates that when placed in safety cells, incarcerated persons are not seen by mental health clinicians within the required 4-hour timeframe in 61 percent of cases, whereas IPs placed in sobering/segregation cells are not seen by mental health clinicians within the 6-hour timeframe in 41 percent of cases. As stated earlier in this report, although mental health clinicians consistently responded to emergent mental health referrals for IPs currently at risk for suicide, the response time was not always within the required timelines due to "low staffing levels." In conclusion, this provision remains in Partial Compliance.
Recommendations	The County has self-reported that "low staffing levels and high levels of emergent referrals" have resulted in the inability to consistently respond to emergent mental health referrals within the required 4-hour timeframe. A corrective action plan to restore previous levels, as well as a staffing analysis of current mental health staffing needs, are indicated.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACMH "Timelines to Care for Emergent. Urgent, and Routine Referral/Appointments," from December 2023 through February 2024, reported May 14, 2024. ACH 02-05: Suicide Prevention Program policy, November 16, 2021.

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 patient shall be transported to the Main Jail for emergency evaluation within two hours of the initial report.**	
Status	**Substantial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by ACH in the 9th Status Report (July 11, 2024), was "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. MH provides a tele-visit option for after-hours emergent referrals. If a Main Jail MH clinician is not available to complete the tele-visit assessment, SSO transports the patient to the Main Jail for an evaluation."	

	This response is consistent with the ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, which states that "If a patient at RCCC requires an emergent referral and an assessment from an MH clinician, and MH staff are not currently present at the RCCC facility: a. The patient will be seen within 6 hours through a video visit that is completed by MH staff at the MJ. b. If the video visit cannot be initiated, the patient will be transported to the MJ within 2 hours for the emergent referral to be completed." Prior medical chart review indicated that few incarcerated persons are identified as suicidal at RCCC and in need of transport to the Main Jail. However, when it does occur, an IP identified as suicidal at RCCC continues to be initially seen by a mental health clinician during regular business hours or tele-visit after-hours, and provided with an SRA. If the assessment indicates the need for further suicide precautions, the IP is transported to the Main Jail. If a clinician is not available on-site or through tele-visit, the IP is initially housed in the Safety Cell or North Holding No. 2 Cell and then transported to the Main Jail within two hours. In conclusion, because ACMH has implemented after-hours tele-visits at RCCC to ensure timely responses to emergent referrals, and the ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, adequately addresses this issue, this provision remains in Substantial Compliance.
Recommendations	None
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). Prior medical chart review. ACH 02-05: Suicide Prevention Program, November 16, 2021.

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	**Substantial Compliance**
Discussion	Sacramento County's response to this provision, as authored by ACH in the 9th Status Report (July 11, 2024) stated: "MH has revised its suicide risk assessment procedures and forms in consultation with Plaintiffs. The Suicide Risk Assessment captures the information listed in this provision. Suicide Risk Assessment and Suicide Prevention Program policy developed and revised in conjunction with SME and Class Counsel. MH staff complete a review of the patients EHR, including previous and current records pertaining to suicide attempts, self-harm and/or mental health needs. See Post-Intake Mental Health Assessment Procedures (Provision D.) for work accomplished in this area." This response is correct. In conclusion, this provision remains in Substantial Compliance because the suicide risk assessment form is very comprehensive and the ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, contains narrative consistent with the requirements of the provision.
Recommendations	None
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACMH Suicide Risk Assessment form. ACH 02-05: Suicide Prevention Program, November 16, 2021.

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 patients.**
Status	**Substantial Compliance**
Discussion	Sacramento County's response to this provision in the 9th Status Report (July 11, 2024), was omitted. The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, contains the following required language that is consistent with this provision: "Meal service or other custody related activity shall not cause a delay in conducting suicide risk assessments." SSO Policy and Procedure 713: Suicide Prevention and Intervention became effective on September 12, 2023.

	Review of various medical charts, as well as on-site observation, did not indicate any impediments to the timely suicide risk assessments (SRA) completion. In conclusion, because SSO Policy 713: Suicide Prevention and Intervention finally became effective on September 12, 2023 and this expert did not find any impediments to the timely SRA completion, this provision is raised to Substantial Compliance.
Recommendations	None
Evidentiary Basis	Medical chart review. ACH 02-05: Suicide Prevention Program, November 16, 2021, final. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023.
Provision F) **1. Housing of Patients on Suicide Precautions**	**The County's policy and procedures shall direct that patients, 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 ACH in the 9th Status Report (July 11, 2024), was "County's ACH MH Suicide Prevention Program policy and procedure directs that patients, including those identified as being at risk for suicide, be treated in the least restrictive setting appropriate to their individual clinical and safety needs. MH policies state all patients, including those identified as being at risk for suicide, are treated in the least restrictive setting appropriate to their clinical needs." The SSO response to this provision was simply "current policy." Despite both ACH and SSO suicide prevention policies stating that suicidal patients "are treated in the least restrictive setting appropriate to their clinical needs," current practices indicate the opposite. Review of various medical charts, as well as observation from the most recent April 23-25, 2024 on-site assessment, continued to indicate that most patients placed on suicide precautions were initially housed in safety cells, ad seg cells, and sobering cells located in the Main Jail's booking area and clothed in safety smocks by default. This expert observed multiple cases in which patients on suicide precautions were not placed in the least restrictive setting appropriate to their clinical needs. For example, there were at least three cases (**Case No. 2**, **Case No. 3**, and **Case No. 4**) on April 23, 2024 in which patients were housed in the safety cells in booking and required to be on constant observation status. At the time of the April 2024 assessment, SSO/ACH had a practice of only

	conducting constant observation in the booking area of the Main Jail (for the safety of mental health workers). Yet, because there were not enough ACMH workers to assign to each IP requiring constant observation on April 23, these three patients were instead being observed at 15-minute intervals. As a result, there was no reason to continue housing these patients in the most restrictive housing of safety cells, and they each should have been relocated to the SITHU. Of note, there were only three SITHU cells occupied on April 23, 2024. In a fourth case (**Case No. 5**), the patient was housed in the SITHU awaiting admittance to the APU list for grave disability. He also had a history of suicidal behavior and had been cleared from suicide precautions on April 22, 2024. According to mental health progress dated three days later on April 25, 2024, at 5:49pm, "Deputy ____ reported that patient endorsed SI with plan of hanging himself. Patient was taken to Seg. Cell in booking by custody *without clinical indication*. Night LCSW notified." Custody placed the patient in a safety smock. Approximately two hours later at 7:30pm, a mental health clinician went to booking and assessed the patient. The patient was subsequently cleared from suicide precautions and returned to the SITHU. He remained on the APU pre-admit list for grave disability. The entire episode of transporting the patient to the most restrictive setting and clothing him in a safety smock on April 25, 2024 could have been avoided if custody personnel had immediately contacted onsite mental health staff when the patient experienced suicidal ideation in the SITHU. **Case No. 5** is another example of the failure to house a suicidal patient in the least restrictive setting appropriate for their clinical and safety needs. In conclusion, despite ACH and SSO policies requiring that suicidal patients be housed under the least restrictive setting, current practices continued to find that the most restrictive setting of booking cells (safety, ad. seg, and sobering) in the Main Jail and issuance of safety smocks by default continued to be utilized on a regular basis. This provision remains in Non-Compliance.
Recommendations	1) With limited availability of mental health workers, ACMH supervisors should ensure that clinicians are being judicious in only ordering constant observation for those patients who are assessed as acutely suicidal and requiring such a high level of observation. 2) The County must ensure adequate staffing and processes so that clinicians are timely assessing and determining clinical placement needs and least restrictive setting appropriate for patients, with those findings implemented in coordination with custody staff. 3) SSO should eliminate the practice of utilizing safety, ad seg, and sobering cells as the initial default placement of patients on suicide precautions.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). Medical chart review. ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. Observation during on-site assessment of April 23-25, 2024.

Provision G) 1. Inpatient Placement	**The County shall ensure that patients 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 patient requiring inpatient level of care shall be initiated within 24 hours.**	
Status	**Non-Compliance**	
Discussion	Sacramento County's response to this provision, as authored by ACH in the 9th Status Report (July 11, 2024), was that: "MH staff ensures that patients are assessed for the APU and placed in the unit as soon as possible and within 24 hours when there is bed availability. Patients who are on the preadmission list beyond 24 hours are assessed daily for continuous need of placement or clearance. ACH has regular meetings with SSO Custody leadership to discuss space needs and options for increasing APU beds. See IOP, OPP, & Acute Bed Assessment & Planning (Section II. General Provision) for detail. MH meets daily to discuss patients pending APU admission and triage level of care. Facility deficiencies result in this area remaining non-compliant due to insufficient space for APU beds." The MH-04-09: Acute Psychiatric Unit - Admission, Program, and Discharge policy, effective May 6, 2022 and revised November 30, 2022, addresses the admission process, *excluding* the "24-hours of identification," as follows: "Referring Outpatient clinicians will contact the APU to coordinate the admission of a patient. a. If there is not a bed available on the unit, the patient will be placed on the Pre-Admit List for admission. b. Nursing staff will contact Outpatient staff when there is a bed available." The recent medical chart review of patients placed on suicide precautions continued to find that no patients are ever directly admitted into the APU. Rather, all cases resulted in automatic placement on the 2P Pre-Admit List. In practice, not all patients placed on suicide precautions were eventually placed in the 2P-APU. In fact, only a small percentage of suicidal patients were housed on the unit. Rather, most of these patients were initially housed in booking cells and then either cleared from suicide precautions or transferred to the SITHU where they remained for several days or longer while maintaining a pending 2P Pre-Admit order. Eventually, the suicidal ideation and/or behavior of most patients was resolved and the 2P Pre-Admit order was withdrawn. It is the expert's opinion that not all patients presenting with suicidal ideation and subsequently placed on suicide precautions met the criteria for a 5150 order and placement on the 2P-APU. Such clinical judgment is deferred to the mental health expert in the *Consent Decree*. However, this expert's observation is that, based upon limited bed availability within the 2P-APU, no patients identified as in need of inpatient psychiatric care are placed in the 2P-APU within 24	

	hours of identification unless, by coincidence, there happens to be immediate bed availability. Of note, ACMH developed a draft policy (ACMH Critical Needs Assessment Program) in July 2024 to address the issue of patients reporting suicidal ideation and/or engaging in chronic self-injurious behaviors but do not meeting criteria for inpatient treatment. In addition, SSO and ACMH are currently working on a proposal to expand the number of inpatient beds, thereby attempting to reduce the waitlist time for APU admission. The parties' 2022 Memorandum of Agreement (MOA) on Mental Health Care and Suicide Prevention affirms that the County must ensure adequate acute care capacity to meet the needs of the population, with the County developing and implementing a "plan to provide acute level of care to meet class member patient need, including with an adequate therapeutic milieu and appropriate treatment space, consistent with relevant Consent Decree requirements" (Paragraph 15, MOA p.13). This has not been achieved. Because data continues to indicate that patients in need of acute level of care are not placed in the APU within 24 hours of identification as required, this provision is lowered to Non-Compliance.
Recommendations	1) Provide adequate bed capacity for patients requiring APU level of care. 2) Implement the ACMH Critical Needs Assessment Program policy to better manage the waitlist for patients requiring acute level of care treatment. 3) Better ensure that patients in need of acute level of care are placed in the APU within 24 hours of identification.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). MH-04-09: Acute Psychiatric Unit - Admission, Program, and Discharge policy, May 6, 2022. Draft ACMH Critical Needs Assessment Program, July 2024 Medical chart review. Observation during on-site assessment of April 23-25, 2024.

Provision H) **1. Temporary Suicide Precautions**	**No patient 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 patient in the IOP unit if clinically indicated.**	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by the SSO in the 9th Status Report (July 11, 2024), was repeated from previous reports as the following: "The recently approved Jail Intake and Health Services Facility will bring the County in compliance. The County currently follow these timeframes as much as possible with the limited number of cells in the APU. The addition of 8 female IOP and 24 male IOP beds has brought us closer to compliance. Custody staff places the inmate/patient in the least restrictive setting as possible contingent on available space. Staff constantly attempts to move inmate/patients out of safety cells to segregation cells (toilet and sink) or a 3-West suicide resistant SITHU cell. The Main Jail has a total of 26 SITHU cells available." This response was only partially responsive because it did not include any data on compliance. The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, contains the following required language that is consistent with this provision: "Any holding cell, including safety or Ad Seg cells, should not be the default housing for patients with suicidal ideation and/or self-injurious behaviors. When utilized, patients shall not be placed in a holding safety or Ad Seg cell for more than 6 hours. If medical staff determine more time is needed due to detoxification, that patient may remain in the cell for a total of 8 hours. The reason for the extension must be clearly documented in the patient's chart." The SSO Policy 713: Suicide Prevention and Intervention, effective September 12, 2023, similarly states that: "No incarcerated person may be housed in a safety cell, separation holding cell, or other temporary suicide precautions housing unit for more than six hours. If Mental Health Services 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 hours. If exceptional circumstances prevent transfer within these timelines, those circumstances must be documented, and transfer will occur as soon as possible. This does not preclude the housing of an incarcerated person in a suicide-resistant cell in an Intensive Outpatient Program (IOP) unit if clinically indicated." As detailed in previous monitoring reports, 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-APU. In addition, there is 1 safety cell and 1 holding cell (North	

Holding No. 2) located at RCCC. There are 6 ad seg 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 patients, any of the remaining ad seg, and sobering cells are utilized as Temporary Suicide Precautions Housing.

It was previously determined that "Temporary Suicide Precautions Housing" excludes the Suicidal Temporary Housing Unit (SITHU) on 3-West Unit because suicidal patients may be clinically appropriate for placement in the SITHU while awaiting a determination for inpatient hospitalization. In addition, it was previously determined that "Temporary Suicide Precautions Housing" includes the Main Jail's ad seg cells and "sobering cell" (though the latter is not explicitly listed in the *Consent Decree* definition) because of the provision's allowance for utilizing such cells for "detoxification-related needs."

Beginning in March 2022, the SCSO began to routinely collect data on the average length of stay (ALOS) in Main Jail's booking cells (safety, ad seg, and sobering). Until March 2023, this data was not automated within the existing jail management system, and had to be manually calculated by SSO personnel counting individual Custody Logs. Upon receiving the data, this expert then calculated the ALOS and percentage of booking cell type.

On March 11, 2023, SSO's new jail management system, entitled ATIMS, was fully activated. Since then, this expert has received monthly "Safety Cell (including ad. seg. and sobering cells) Tracking History" reports (upon request) that provide the location (safety, ad. seg., or sobering cell) and length of stay for each incarcerated person. Unfortunately, the Excel formatted reports sent to this expert do not include a summary of the monthly ALOS or percentage of booking cell type. As a result, this expert manually calculated the average length of stay and presents two recent months of data as follows:

> In **April 2024**, 484 incarcerated persons were placed in booking cells for an average of 10.4 hours. Of note, 37 IPs were housed in these cells for over 24 hours.
>
> In **July 2024**, 464 incarcerated persons were placed in booking cells for an average of 10.9 hours. Of note, 44 IPs were housed in these cells for over 24 hours.

In sum, recent monthly reports indicate that the average length of stay in booking cells (including safety, ad. seg., and sobering) was over 10 hours, in violation of the *Consent Decree* timeline requirements. As noted earlier, current SSO/ACH practice is for suicidal patients requiring constant observation to be housed in the booking area of the Main Jail because it was said to better ensure the safety of mental health workers assigned to provide observation. As a result of this practice, there might very well be an increased

	ALOS in the booking cells. This expert was recently informed that there are plans to relocate this observation function to the 3-West Pod. This provision remains in Partial Compliance.
Recommendations	1) In order to better track compliance with provision, SSO should explore whether ATIMS data can be generated to provide monthly composite data on the average length of stay and percentage of cell location type. 2) The County must take proactive steps to ensure that no patient is housed in a safety cell, segregation holding cell, sobering cell, or any other holding cell beyond the timelines set forth in this provision, absent exceptional circumstances. The provision of sufficient treatment bed capacity to meet the population's treatment needs is of critical importance to achieving compliance.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. Monthly Safety Cell (including ad. seg. and sobering cells) Tracking History reports from April 2024 and July 2024.

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 patients in need of suicide precautions, as required under Operations Order 4/05 (i.e., within 12 hours of placement or the next daily sick call, whichever is earliest, and then every 24 hours thereafter).**
Status	**Substantial Compliance**
Discussion	Sacramento County's response to this provision, as authored by both the ACH and SSO in the 9th Status Report (July 11, 2024), was: "ACH revised the Mental Health policy 04-09 Acute Psychiatric Unit Admission, Program and Discharge (revision 11/30/22) including procedures to ensure the timely and adequate completion of medical assessments for patients in need of suicide precautions. Patients are receiving a medical assessment within 12 hours of placement and every 24 hours after and is documented in Nurse Sick Call encounters. If the patient is not transferred to the APU, the nurse continues to evaluate the patient. The APU Certified Nursing Assistant will monitor the patient once they move to the APU. ACH and SSO are in discussion to determine how to reinstate the open bed SITHU. Plans are in process. QI will develop an audit to monitor compliance." The SSO response to this provision was repeated from prior status reports as: "Current practice. Custody staff shall notify medical staff within fifteen (15) minutes that a prisoner is temporarily housed in a safety or segregation cell and medical staff shall complete an assessment within 12 hours of placement or the next sick call, whichever is earliest.

	The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, contains the following required language that is consistent with, and even exceeds, the requirements of this provision: "1. Patients may be temporarily placed in a safety and/or SITHU cell by custody or at the recommendation of MH staff. In these instances, nursing staff must: a. Conduct a medical assessment of the patient's physical condition within 1 hour of placement and every 4 hours thereafter. b. Notify the Nursing Supervisor and the Physician immediately if the nurse observes a significant change in the patient's physical health condition or if there is an adverse event. Staff will contact MH if there is a significant change in the patient's psychiatric condition. c. Document the time of visual observation and include their signature and title on the observation sheet located directly outside of the cell. d. Document their assessment using the Nurse Non-Face-to-Face encounter form within the EHR every 4 hours. 2. If a patient at RCCC requires an emergent MH referral and MH staff are not currently present at the RCCC facility, the RN shall consult with MH staff at MJ to determine an appropriate plan of care." This expert's medical chart review of patients on suicide precautions found that nursing staff almost always provided timely medical assessments (documented as SOAP notes in athenahealth EHR) within 12 hours of placement and then every 24 hours during the entirety of a patient's placement on suicide precautions. Patients in the 2P-APU were seen approximately three times per day by nursing staff. In conclusion, the ACH suicide prevention policy exceeds the requirements of this provision by stating that medical assessments are conducted "within 1 hour of placement and every 4 hours thereafter" and the SSO suicide prevention policy has been released. Although ACH self-reported that this provision remained in "partial compliance," this expert determined that the provision can be raised to Substantial Compliance.
Recommendations	None
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). Medical chart review. ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023.

Provision H) 3. Temporary Suicide Precautions	**The County shall ensure that any cell used for holding patients on suicide precautions is clean prior to the placement of a new patient, as well as cleaned on a normal cleaning schedule.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SSO in the 9th Status Report (July 11, 2024), was: "Current practice. Lexipol Policy on Safety, Separation, and Sobering Cells was published on 05/21/2024." However, review of this policy (Policy 519: Safety, Separation, and Sobering Cells) found it did not contain any narrative regarding cleaning cells housing suicidal patients. The SSO Policy 713: Suicide Prevention and Intervention, effective September 12, 2023, states that "Deputies will ensure that any suicide resistant cell used for holding incarcerated persons on suicide precautions is cleaned prior to the placement of a new incarcerated person, as well as cleaned on a normal cleaning schedule." In addition, SSO previously provided this expert with a copy of the "Housing Unit Cell Cleaning Process" Post Order, revised April 2021. In addition, only a handful SITHU cells were occupied during the three-day on-site assessment in April 2024, inspection of the empty cells found that they were only marginally clean. In the 2P-APU, two cells were redlined for maintenance repairs, and a third unoccupied cell (P-13) had a soiled mattress and safety smock on the floor on April 25, 2024. In conclusion, this provision will be monitored again during the next onsite audit and remains in Partial Compliance.
Recommendations	1) Verify that the SSO "Housing Unit Cell Cleaning Process" Post Order, revised April 2021, is still in effect; revise SSO Policy 519: Safety, Separation, and Sobering Cells, May 21, 2024, to include narrative on the cleaning schedule. 2) Ensure that the SSO's facility sanitation plan and quality assurance procedures specifically cover the adequate cleaning of all cells used to hold patients on suicide precautions, including prior to a new patient placement and based on the facility's normal cleaning schedule.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. SSO Policy 519: Safety, Separation, and Sobering Cells, May 21, 2024. SSO "Housing Unit Cell Cleaning Process" Post Order, revised April 2021. On-site inspection of SITHU, Main Jail booking cells, and 2P-APU cells.

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 patient is in cell used for holding patients on suicide precautions**.	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by the SSO in the 9th Status Report (July 11, 2024), was repeated from previous reports as: "Current practice. Will add language to the new suicide prevention policy. RCCC has no cells designated for long term housing of inmates on suicide precautions. RCCC does not have ACMH staff available 24 hours a day, but have tele-psychiatry available after-hours including weekend after-hours." This response is non-responsive to the provision requirements. The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, contains the following required language that is consistent with this provision: "Patients shall receive timely and regular access to meals, liquids, and prescribed medication while on suicide precautions, as necessary. Custody will provide access to a toilet upon request to patients placed in cells without a toilet, absent an immediate security or safety issue. Unless contraindicated by a licensed mental health clinician, all patients on suicide precautions shall be allowed access to showers consistent with schedules and other housing units." The SCSO Policy 713: Suicide Prevention and Intervention, September 12, 2023, states that: • Incarcerated persons on suicide precautions must be *offered showers on a daily basis*. Prompt assistance with hygiene and cleaning must be provided whenever circumstances warrant. • Incarcerated persons on suicide precautions, housed in a cell without access to water, must be affirmatively offered water at least every two hours, and upon request. • Incarcerated persons on suicide precautions must be affirmatively offered food at least consistent with normal daily meal provisions, and upon request (e.g., if they missed a meal due to their mental health or suicide observation status). • Incarcerated persons held in a cell that does not have a toilet must be provided access to a toilet promptly upon request. No one should ever be directed or forced to defecate on the floor or through a grate on the floor. • Deputies shall log when incarcerated persons on suicide precautions are offered hygiene items, food, water or provided access to a toilet.	

	Provision of hygiene items, food, water, and toilet access are also court-ordered requirements based on the parties' 2022 Memorandum of Agreement on Mental Health Care and Suicide Prevention (at pp. 5-6). The expert's observations during the April 2024 on-site assessment at the Main Jail, as well as review of various ATIMS Custody Logs for patients on suicide precautions in both the Main Jail booking cells and SITHU continued to find problematic practices. For example, patients housed in booking cells rarely, if ever, receive showers, whereas patients in the SITHU were more frequently offered the opportunity for showers, but not on a daily basis. The expert's current review of ATIMS Custody Logs for five (5) random suicidal patients housed in the Main Jail booking cells and SITHU during March and April 2024 found the following: **Case No. 4**: 11 days; 3 offered showers or 27% **Case No. 5**: 7 days; 5 offered showers or 71% **Case No. 6**: 42 days; 34 offered showers or 81% **Case No. 7**: 15 days; 8 offered showers or 53% **Case No. 8**: 9 days; 6 offered showers or 67% The SSO conducts monthly audits of out-of-cell activities for suicidal patients housed in the SITHU. A recent review of the *Suicide Precautions Compliance Review – Monthly Report* for June 2024, completed on July 2, 2024, found that 69 percent of 17 randomly selected SITHU patients were offered showers on a daily basis. This data does not include suicidal patients housed in the Main Jail booking cells. Based upon both SSO monthly data and this expert's review of ATIMS Custody Logs, this provision remains in Partial Compliance.
Recommendations	1) Pursuant to policy, SSO must begin allowing showers to patients on suicide precautions in the Main Jail booking cells, with priority to those patients housed over 24 hours. 2) The SSO *Suicide Precautions Compliance Review – Monthly Report* should be expanded to include auditing the provision of hygiene items, food, water, and toilet access to patients on suicide precautions in the Main Jail booking cells.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. Review of ATIMS Custody Logs for Five Patients in March and April 2024. SSO *Suicide Precautions Compliance Review – Monthly Report* (June 2024), July 2, 2024.

Provision H) 5. Temporary Suicide Precautions	**Patients 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	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SSO in the 9th Status Report (July 11, 2024), was non-responsive and simply stated "substantial compliance." The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, contains the following required language that is consistent with this provision: "Licensed clinicians have the primary responsibility to determine, based on clinical judgment and on a case-by-case basis in consultation with custody staff, the removal or return of routine privileges. This includes, but not limited to: a. Telephone calls; b. Visits (including social visits); c. Recreation/out-of-cell time; d. Court hearings; e. Other activities that are otherwise within the limitations of a patient's classification security level; f. Clothing and possessions….Custody shall ensure all patients on suicide precautions, regardless of length of stay, should receive showers on a schedule commensurate with schedules in other housing units….Patients shall be allowed dayroom or out-of-cell activities as determined by a licensed clinician in consultation with custody staff." The SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023, states that: • Incarcerated persons on suicide precautions will not automatically be placed on lockdown, and access to dayroom and other out-of-cell activities will be based upon security and clinical judgment. • Incarcerated persons on suicide precautions must be offered showers on a daily basis. Prompt assistance with hygiene and cleaning must be provided whenever circumstances warrant. Despite these policy requirements, this expert's observations during the April 2024 on-site assessment at the Main Jail, as well as review of various ATIMS Custody Logs for patients on suicide precautions in both the Main Jail booking cells and SITHU continued to find problematic practices. For example, pursuant to current practice, patients housed in booking cells are prohibited from any out-of-cell activities other than meeting with ACMH clinicians, whereas patients in the SITHU were more frequently offered the opportunity for out-cell-activities, but not on a daily basis and only for a short duration. Because current SITHU practice is to offer opportunities for showers and

	dayroom at the same time, the expert's current review of ATIMS Custody Logs for five (5) random suicidal patients housed in the Main Jail booking cells and SITHU during March and April 2024 is repeated from the provision above as follows: **Case No. 4**: 11 days; 3 offered dayroom or 27% **Case No. 5**: 7 days; 5 offered dayroom or 71% **Case No. 6**: 42 days; 34 offered dayroom or 81% **Case No. 7**: 15 days; 8 offered dayroom or 53% **Case No. 8**: 9 days; 6 offered dayroom or 67% The SSO conducts monthly audits of out-of-cell activities for suicidal patients housed in the SITHU. A recent review of the *Suicide Precautions Compliance Review – Monthly Report* for June 2024, completed on July 2, 2024, found that *69 percent of 17 randomly selected SITHU patients were offered dayroom on a daily basis*. *The average length of out-of-cell time for these patients was 26 minutes (for both shower and dayroom).* This data does not include suicidal patients housed in the Main Jail booking cells. The average duration of dayroom and shower time were documented in the monthly *Suicide Precautions Compliance Review* reports as follows: August 2024: 34 minutes June 2024: 26 minutes May 2024: 36 minutes April 2024: 19 minutes In addition, when touring the 3 West 300 Pod during the April 2024 assessment, a deputy informed this expert that patients on suicide precautions typically have access to the shower/dayroom from 6:00pm to 6:00am, one patient at a time, for approximately 15 minutes. This provision is similar to **Provision M) 1. Property and Privileges** and will be discussed further in that provision. In conclusion, because both the ACH and SSO suicide prevention policies now have been finalized, and SSO has demonstrated some improvement in the offering of out-of-cell activities to patients housed in the SITHU, this provision is raised to Partial Compliance.
Recommendations	SSO needs to develop a corrective action plan to increase the duration of out-of-cell activities for suicidal patients.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. Review of ATIMS Custody Logs for Five Patients in March and April 2024.

	SSO Suicide Precautions Compliance Review – Monthly Reports (April thru August 2024. Observation during on-site assessment of April 23-25, 2024.

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, patient programs and treatment. Absent an emergency, the County shall not use the classrooms and multipurpose rooms to hold patients pending a mental health evaluation or on suicide precautions. Where such emergency occurs, the County shall document the reasons for retention and move the patient, within six (6) hours, to the inpatient unit or other appropriate housing location for continued observation, evaluation, and treatment.**	
Status	**Substantial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by both ACH and SSO in the 9th Status Report (July 11, 2024), with ASCH stating: "Classrooms are only being used for programs and treatment and no longer used to hold patients pending an evaluation or on suicide precautions," and SSO simply stating "substantial compliance." Both SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023, and SSO Policy 519: Safety, Separation and Sobering Cells, May 21, 2024, are consistent with this provision, with Policy 713 echoing the *Consent Decree* requirements by stating that "Absent an emergency, the classrooms and multipurpose rooms shall not be used to hold incarcerated persons pending a mental health evaluation or on suicide precautions. Where such emergency occurs, the reasons for retention shall be documented and the incarcerated person shall be moved, within six hours, to the inpatient unit or other appropriate housing location for continued observation, evaluation, and treatment." The expert reviewed ATIMS Monthly Safety Cell (including ad. seg. and sobering cells) Tracking History, by month, from April 2024 through August 2024 and did <u>not</u> find any incidents of classrooms and multi-purpose rooms being utilized to house suicidal patients. Based upon the above ATIMS Monthly Safety Cell Tracking History data, as well as SSO Policy 519 and Policy 713 being operationalized, this provision is raised to Substantial Compliance.	
Recommendations	None	

Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. SSO Policy 519: Safety, Separation and Sobering Cells, May 21, 2024. ATIMS Monthly Safety Cell (including ad. seg. and sobering cells) Tracking History, by month, from April 2024 thru July 2024.

Provision I) 1. Suicide Hazards in High-Risk Housing Locations	**The County shall not place patients identified as being at risk for suicide or self-harm, or for patients 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 SSO in the 9th Status Report (July 11, 2024) was repeated from previous reports as: "Current practice. Inmates at risk for suicide, self-harm, or IOP level of care are housed in suicide-resistant cells." The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, contains the following required language that is consistent with this provision: "Any cell designated to house a suicidal patient shall be suicide-resistant…. Cells with structural blind spots shall not be used for suicide precaution…" SSO Policy 713: Suicide Prevention and Intervention, effective September 23, 2023, states that "Any incarcerated person placed on suicide precautions shall be housed in a suicide-resistant cell. Cells with structural blind spots shall not be used for suicide precautions." In addition, the expert previously interpreted this provision to also include the requirement that suicidal patients housed in the 2P-APU be placed in suicide-resistant cells. During a prior on-site assessment (in February 2022), the expert inspected the 2P-APU cells and found that each contained suicide-restraint beds with hooks that were intended to be used in patient restraint. However, if a patient was placed in the cell without restraints, these hooks would be easily accessible and very conducive to a suicide attempt by hanging. In addition, there was a gap down between the bed and wall in some cells that could be utilized as an anchoring device in a suicide attempt by hanging. Following a discussion with both SSO and ACH leadership, the decision was made to remove the hooks from the restraint beds in all but one (P-1) of the 18 cells in the 2P-APU. The restraint bed in Cell P-1 would be replaced with a new restraint bed that was more suicide-resistant. In addition, any patient currently assessed as suicidal, but not in need of restraints, would not be permitted to be housed in Cell P-1. Of note, pursuant to the Memorandum of Agreement (MOA) on May 27, 2022 regarding the correction of several critical remedial provisions of Mental Health and Suicide Prevention:

	"16. The County will discontinue use of beds with attachment points of any kind (including the existing beds with 'handles' designed for restraint brackets) for Acute Psychiatric Unit (APU) patients. a. As soon as feasible, and in any case no later than September 30, 2022, the County will safely eliminate the 'handles' from at least 16 of the 17 existing Acute Psychiatric Unit patient rooms in the Main Jail 2P unit. If the County chooses to retain one Main Jail 2P APU room with restraint brackets, it will ensure that no patient who is 'danger-to-self' or at risk of suicide is held in that room (except in cases where clinical restraints are being applied). b. As part of the County's forthcoming plan to discontinue the Main Jail 2P unit as the APU, the County will ensure that all new APU beds are suicide-resistant and free of attachment points. The County may elect to install an anti-ligature restraint bed in the APU, after conferring with class counsel and the Subject Matter Experts to ensure appropriate measures against suicide." During the most recent April 2024 assessment, this expert toured the 2P-APU and observed that hooks had been removed from the beds in all cells except P-1. In Cell P-1, a new restraint bed was installed that is more suicide-resistant. In addition, as recommended in the *Fourth* Monitoring Report, a post order was generated during the April 2024 assessment that requires any patient currently assessed as suicidal, but not in need of restraints, would not be housed in Cell P-1. Further, during a previous assessment, this expert inspected most of the 10 SITHU cells (1 through 10) utilized to house suicidal patients and found that some cells had slight gaps between fixtures and walls/ceilings that could be utilized as an anchoring point in a suicide attempt by hanging (in which a patient wedges a ligature in the gap). As found in the morbidity reviews of two suicide attempts during 2023-2024, individuals utilized these gaps as anchoring points in their suicide attempts while housed in non-SITHU cells. As a result, the county Department of General Services initiated a project to repair the gaps with security caulking in all SITHU and 2P-APU cells. According to the SSO, all SITHU cells have been caulked, and the 18 2P-APU cells remain on the list to be completed. Of note, in addition to the original 10 SITHU cells in 3 West 300 Pod, 16 more cells were identified for housing of suicidal patients on the unit and retrofitted to be suicide-resistant. During the April 2024 assessment, this expert was

	informed that an additional 16 cells located in the adjacent 3West 200 Pod were also retrofitted to be suicide-resistant and available for housing suicidal patients. However, four of these cells (No. 6, No. 7, No. 13, and No. 14) are located in corners that have blind spots prohibiting deputies from having an unobstructed view of the entire cells. These four 3West 200 Pod cells should not be utilized for patients on suicide precautions. This provision remains in Partial Compliance and will be reassessed once the renovation has been completed.
Recommendations	The SSO should ensure, based upon a regular inspection schedule, that all cells designated to house suicidal patients, as well as those requiring IOP level of care, are suicide-resistant.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. SSO Post Order: Acute Psychiatric Unit – Use of Cell P-1, April 24, 2024. Observation during on-site assessment of April 23-25, 2024. Checklist for the 'Suicide-Resistant' Design of Correctional Facilities, Lindsay M. Hayes, December 2019. Memorandum of Agreement (MOA), May 27, 2022, regarding the correction of several critical remedial provisions of Mental Health and Suicide Prevention.

Provision I) 2. Suicide Hazards in High-Risk Housing Locations	**Cells with structural blind spots shall not be used for suicide precaution.**
Status	**Substantial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SSO in the 9th Status Report (July 11, 2024) was non-responsive and simply stated: "Current practice. Inmates at risk for suicide, self-harm, or IOP level of care are housed in suicide-resistant cells." Despite this non-response, both the ACH and SSO suicide prevention polices contain requirements that prohibit the housing of suicidal patients in cells with blind spots. Such cells are No. 7 and No. 8 in 3 West 300 Pod (SITHU) and as described above, cell No. 6, No. 7, No. 13, and No. 14) in 3 West 200 Pod cells. When touring 3 West 200 Pod during the April 2024 assessment, the accompanying deputy verified that these four cells were not utilized for housing suicidal patients. During the next monitoring site visit, this expert will review 3-West (200 Pod and 300 Pod) census data to ensure that patients on suicide precautions were not placed in cells with blind spots during the review period.

	This provision is raised from Non-Compliance to Substantial Compliance.
Recommendations	None
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. Observation during on-site assessment of April 23-25, 2024. Checklist for the 'Suicide-Resistant' Design of Correctional Facilities, Lindsay M. Hayes, December 2019.

Provision J) 1. Supervision/ Monitoring of Suicidal Patients	**The County shall ensure adequate visibility and supervision of patients on suicide precautions.**	
Status	**Non-Compliance**	
Discussion	Sacramento County's response to this provision, as authored by ACH in the 9th Status Report (July 11, 20243), was: "SSO expanded the number of suicide resistant observation cells in the Suicidal Temporary Housing Unit (SITHU) at the Main Jail." The SSO response was: "Substantial Compliance." Both responses were non-responsive because they did not address the degree to which suicidal patients are adequately observed. The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, contains the following required language that is consistent with this provision: "Each patient on suicide precautions shall have an observation sheet placed on the outside of their cell door. The observation sheet, or a separate form, should also document the patient's level of observation, as well as possessions and privileges allowed for the patient as determined by a licensed MH clinician. Observation Logs shall not be kept at the Deputy's station and/or desk." SSO Policy 713: Suicide Prevention and Intervention, effective September 23, 2023, states: "A Suicide Precautions and/or Grave Disability Observation Custody Instructions Form shall be initiated by a mental health clinician and provided to custody staff for each incarcerated person on suicide precautions. The form summarizes the observation level, clothing, possessions, and privileges authorized for each incarcerated person. The Suicide Precautions and/or Grave Disability Observation Instructions	

> Form shall be affixed near the cell door visible to staff.… Deputies shall document their observations of the incarcerated person, and any other staff interactions with the person, on a Custody Log form, or *electronic equivalent log*."

During the April 2024 assessment, this expert observed that the Suicide Precautions and/or Grave Disability Observation Instructions Form for each patient on suicide precautions is affixed to the outside of each cell door. In addition, with the SSO's recent transition to the ATIMS jail management software, observation was now logged on ATIMS which was embedded in desktop computers located at the deputy's desk. For patients housed in the SITHU, the desk was located outside the unit. Such a practice was not desirable, and continues to raise the possibility (although not observed by the expert) that observation sheets could be completed by a deputy without entering the SITHU and observing each patient.

During the April 2024 assessment, this expert examined the observation records of six (6) patients currently on suicide precautions in the SITHU, other 3 West 200 Pod cells, or Main Jail booking cells through the ATIMS jail management software. Each of these patients was on Close Observation status and required to be observed at staggered intervals not to exceed 15 minutes. The review focused on the 10-hour period of 12:00am thru 10:00am when patients were most likely to be housed in their cells (mostly on April 24). As shown below, the review found very problematic practices in the observation of patients on suicide precautions, with numerous violations of the required 15-minute observation checks for each of the six patients, with longest gap being 38 minutes:

Case No. 8: Cell 302, 24 violations, longest 37 minutes
Case No. 9: Cell 202, 14 violations, longest 24 minutes
Case No. 10: Cell 209, 22 violations, longest 38 minutes
Case No. 11: Cell 306, 20 violations, longest 35 minutes
Case No. 12: Cell 102, 23 violations, longest 38 minutes
Case No. 13: Seg. Cell, 21 violations, longest 30 minutes

These findings should be of great concern to the SSO. In addition, they are consistent with this expert's observation of deputies conducting rounds in the 3 West Pods during the April 2024 assessment in which they were frequently late.

When examining the observation logs in ATIMS, this expert was informed that although "notifications" are sent to SSO supervisors when both "institutional counts" and "60-minute housing unit checks" are late, there was no such notification currently programmed into ATIMs for 15-minute checks for patients on suicide precautions that are late.

	Further, during the April 2024 assessment, this expert observed three cases on April 23, 2024 (previously referenced earlier in this report as **Case No. 2**, **Case No. 3**, and **Case No. 4**) in which each patient was clinically order to be on constant observation status, but because there were not enough ACMH workers assigned during a shift, these three patients were instead being observed at 15-minute intervals. It should be of great concern to ACH and ACMH that patients who were clinically assessed at the highest risk for suicide were not be observed on constant observation as ordered. Due to the continued serious and extensive violations found in the documentation of observation of patients on suicide precautions, as well as the fact that ATIMS is only accessible from the deputies' desk *outside* of the SITHU, this provision remains in Non-Compliance.
Recommendations	1) The SSO should program ATIMS to allow for "notifications" to be sent to SSO supervisors when 15-minute checks for patients on suicide precautions are late. 2) The SSO should program ATIMS to allow for a retrospective review of patients placed on suicide precautions. Currently, ATIMS only allows for review of patients who are currently on suicide precaution. 3) SSO supervisors should conduct regular ATIMS audits of patients on suicide precautions. 4) To better ensure the integrity of observation of suicidal patients, the SSO should strongly consider purchasing an electronic surveillance system in which memory buttons are installed outside each cell housing a patient on suicide precautions and observation checks are verified by deputies touching a hand-held "pipe" against each memory button. Although such an electronic surveillance system does not guarantee that deputies will look into each cell, it does ensure that deputies are always physically at the cell front of patients on suicide precautions. 5) To better ensure the appropriate use of assigned mental health workers observing suicidal patients, the ACMH should audit the clinical justification for ordering constant observation of suicidal patients to verify that only those patients assessed as requiring the highest level of observation are placed on constant observation.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. Observation during on-site assessment of April 23-25, 2024. Examination of ATIMS observation records for six (6) patients currently on suicide precautions.

Provision J) 2. Supervision/ Monitoring of Suicidal Patients	**The County shall not cover cell windows with magnetic flaps or any other visual barrier preventing visibility into any cell that is housing a patient 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	**Substantial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by the SSO in the 9th Status Report (July 11, 2024), was repeated from previous reports as: "Current practice." The SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023, contains the following required language that is consistent with this provision: "Cell windows may never be covered with magnetic flaps or any other visual barrier preventing visibility into any cell that is housing an incarcerated person on suicide precautions, unless there is a specific security need and then for only a period of time necessary to address such security need." The ACH 02-05: Suicide Prevention Program, November 16, 2021, has a similar requirement, and it is further contained in the 2022 court-ordered Memorandum of Agreement on Mental Health Care and Suicide Prevention Remedial Plan Measures (at page 8). During the most recent inspection of the SITHU and Main Jail booking cells, this expert did not observe the covering of any cell windows by custody personnel. In conclusion, this provision is raised to Substantial Compliance.	
Recommendations	None	
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. Observation during on-site assessment of April 23-25, 2024.	

Provision J) 3. Supervision/ Monitoring of Suicidal Patients	**The County shall revise its policies regarding the monitoring of patients on suicide precautions to provide for at least the following two defined levels of observation:** **a) <u>Close observation</u> shall be used for patients 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 patients 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 patient shower.** **b) <u>Constant observation</u> shall be used for patients 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 patient on a continuous, uninterrupted basis. The observation should be documented at 15-minute intervals. Staff should be physically stationed outside of the patient's cell to permit continuous, uninterrupted observation.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by ACH in the 9th Status Report (July 11, 2024), in part, was: "Implemented Constant Observation Program and have filled all vacancies. Staff are available 24/7 to provide 1:1 constant observation. However, this area remains in PARTIAL COMPLIANCE due to limited number of MHWs to providing constant observation. Requested budget augmentation FY 24/25 for additional MHWs." The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, ACH 04-07: Acute Psychiatric Unit – Precautions and Observations, effective June 22, 2022, and SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023, each contain definitions and procedures for both Close Observation and Constant Observation that are consistent with this provision. In conclusion, as found during the April 2024 assessment, this provision remains in Partial Compliance because the option of placing a patient assessed as "actively suicidal, either threatening or engaging in self-injury, and considered a high risk for suicide" on Constant Observation is contingent on the number of available ACMH mental health workers, and there are sometimes not enough workers for the number of patients placed on constant observation.
Recommendations	As recommended in a previous provision above, to better ensure the appropriate use of assigned mental health workers observing suicidal patients, the ACMH should audit the clinical justification for ordering constant

	observation of suicidal patients to verify that only those patients assessed as requiring the highest level of observation are placed on constant observation.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. ACH 04-07: Acute Psychiatric Unit – Precautions and Observations, June 22, 2022. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2024.

Provision J) 4. Supervision/ Monitoring of Suicidal Patients	**For any patients requiring suicide precautions, a qualified mental health professional shall assess, determine, and document the clinically appropriate level of monitoring based on the patient's individual circumstances. Placement in a safety cell shall not serve as a substitute for the clinically determined level of monitoring.**
Status	**Substantial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the ACH in the 9th Status Report (July 11, 2024), in part, was: "Licensed MH clinicians make these determinations and document them in the SRA and on the Suicide Precaution form given to custody and entered into ATIMS. SSO expanded the number of suicide resistant observation cells in the Suicidal Temporary Housing Unit (SITHU) at the Main Jail. MH hired staff and implemented constant observation level of monitoring in March 2023. MH completes weekly audits on compliance determining and documenting housing, observation level, property, privileges, and clothing restrictions for patients placed on suicide precautions. Findings are reported to Suicide Prevention Subcommittee on quarterly basis." Both ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, and SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023, each contain the appropriate language that is consistent with the requirements of this provision: "For any patient requiring suicide precautions, the licensed clinician shall assess, determine, and document the clinically appropriate level of monitoring based on the patient's individual circumstances. Placement in a safety cell shall not serve as a substitute for the clinically determined level of monitoring." The expert again consistently found during the current medical chart review that when a patient is identified as suicidal and referred to a mental health clinician, the clinician assesses the patient, completes an SRA, required to assess the suicidal patient on a daily basis, and appropriately documents the management of the patient on suicide precautions to include level of observation, clothing, and out-of-cell activities.

	In addition, based upon the medical chart review, as well as observation of, and discussion with, multiple mental health clinicians, it appears that a patient's length of stay in Main Jail booking (safety, ad seg, and sobering cells) beyond the maximum allowable six (6) hours is a result of the inadequate number of beds available in both the SITHU and 2P-APU rather than a clinical determination. Further, although this expert's recent medical chart review found that patients on suicide precautions were not consistently seen on a daily basis as required by ACH policy, this deficiency will be addressed in **Provision N) 5. Use of Safety Suits** which requires daily assessment. In conclusion, although this provision addresses the use of safety cells, the expert has already addressed the inappropriate use of safety cells (and ad seg and sobering cells) for the default housing of suicidal patients in **Provision F) 1. Housing of Patients on Suicide Precautions** on pages 41-43 of this report. As such, based upon the ACH and SSO suicide prevention policies, current medical chart review and observations, this provision remains in Substantial Compliance.
Recommendations	None
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. Observation during on-site assessment of April 23-25, 2024. Medical chart review.

Provision J) 5. Supervision/ Monitoring of Suicidal Patients	**Video monitoring of patients on suicide precaution shall not serve as a substitute for Close or Constant observation.**	
Status	**Substantial Compliance**	
Discussion	In the joint Memorandum of Agreement regarding Mental Health and Suicide Prevention (May 27, 2022) stated that: 14. On November 15, 2021, ACH ordered an end to use of Closed Circuit TV (CCTV) for purposes of observing class members on suicide precautions. The Mental Health Medical Director followed up with all psychiatry staff. 15. Adult Correctional Health, with input from the Subject Matter Experts and Class Counsel, finalized Policy No. 02-05 – Suicide Prevention Program on November 16, 2021, which	

	removes CCTV observation and provides for direct observation consistent with Consent Decree requirements. 16. The Subject Matter Experts will evaluate implementation of suicide precaution observation practices during upcoming monitoring visits. Sacramento County's response to this provision, as authored by both SSO and ACH, was that this provision was in substantial compliance because CCTV is no longer utilized for observing suicidal patients. As reported in previous monitoring reports, CCTV monitoring was only available in the 2P-APU and occasionally cited in medical charts reviewed by this expert. According to ACMH leadership, CCTV monitoring was not approved to be an alternative to observation of suicidal patients at 15-minute intervals by nursing personnel, nor were nursing personnel assigned to exclusively monitor the CCTV. Therefore, according to ACMH leadership, providers assigned to the 2P-APU were instructed to no longer reference CCTV observation in their orders. This expert previously recommended that such a directive also be placed in ACH 04-07: Acute Psychiatric Unit – Precautions and Observations policy because the policy, effective June 22, 2022, did not contain any language regarding CCTV monitoring. To date, although the ACH 04-07: Acute Psychiatric Unit – Precautions and Observations policy was not revised to contain prohibition for the alternative use of CCTV to monitor suicidal patients, the expert did not observe (or find during the medical chart review) that any APU patients on constant observation during the April 2024 assessment. However, should problems be found in the future in which CCTV is utilized as an alternative to constant observation, ACH 04-07: Acute Psychiatric Unit – Precautions and Observations policy would need to be revised to include language that specifically prohibits provider orders and nurse practices for using CCTV monitoring in lieu of the physical observation of suicidal patients. In conclusion, this provision remains in Substantial Compliance.
Recommendations	Should problems be found during any future on-site assessments, the ACH 04-07: Acute Psychiatric Unit – Precautions and Observations policy would need to be revised to include language that specifically prohibits provider orders and nurse practices for using CCTV monitoring in lieu of the physical observation of suicidal patients.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 04-07: Acute Psychiatric Unit – Precautions and Observations, June 22, 2022. Observation during on-site assessment of April 23-25, 2024. Medical chart review.

Provision K) 1. Treatment of Patients Identified as at Risk of Suicide	**Qualified mental health professionals shall develop an individualized treatment plan and/or behavior management plan for every patient that mental health staff assesses as being a suicide risk.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by ACH in the 9th Status Report (July 11, 2024), was "MH staff have received updated training on the new process of developing safety plans at the time of an SRA evaluation starting in January 2023 with a pilot study with ongoing training. Audits of compliance will happen after all MH staff have been trained on the new process." This provision is duplicative with both **Provision K) 2. Treatment of Patients Identified at Risk of Suicide** and **Provision P) 2. Discharge from Suicide Precautions**. As such, these three provisions will be monitored as one provision. The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, contains requirements the following requirements that are consistent with this provision: "1. MH staff will develop and utilize a safety planning tool for patients on suicide precautions. The safety plan shall be completed with the patient and identify specific signs, symptoms, and circumstances in which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and specific actions (independent coping skills, personal and professional resources for support, etc.) the patient or staff can take if suicidal thoughts do occur. The plan should be updated as clinically indicated. 2.The treatment plan shall be updated to include goals and interventions specific to each patient's safety plan and discharge planning." As detailed in previous monitoring reports, ACMH introduced a new treatment planning program in January 2020 entitled "Safety Planning Intervention (SPI)" which was subsequently found to be problematic. In January 2023, ACMH introduced a new safety plan model with a pilot study. New safety plan training was also initiated. According to recent training data, 99 percent of mental health clinicians have been trained in the new safety plan model. Following review of several recent medical charts, the quality of safety planning will be discussed in more detail in **Provision K) 2. Treatment of Patients Identified at Risk of Suicide** below. In conclusion, this provision remains in Partial Compliance.

Recommendations	See recommendations included in Provision K.2, below.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. Medical chart review. Training data provided in April 2024.

Provision K) 2. Treatment of Patients 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 ACH in the 9th Status Report (July 11, 2024), was "Treatment plans are 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. MH staff have received training on this requirement in both SRA and Treatment Planning training." This provision is duplicative with both **Provision K) 1. Treatment of Patients Identified at Risk of Suicide** and **Provision P) 2. Discharge from Suicide Precautions**. As such, these three provisions will be monitored as one provision. The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, contains requirements the following requirements that are consistent with this provision: "1. MH staff will develop and utilize a safety planning tool for patients on suicide precautions. The safety plan shall be completed with the patient and identify specific signs, symptoms, and circumstances in which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and specific actions (independent coping skills, personal and professional resources for support, etc.) the patient or staff can take if suicidal thoughts do occur. The plan should be updated as clinically indicated. 2.The treatment plan shall be updated to include goals and interventions specific to each patient's safety plan and discharge planning." The expert reviewed the medical charts of 10 patients discharged from suicide precautions during the recent monitoring period and continued to find problematic practices. Of the 10 medical charts reviewed, only 5 of 10 (50 percent) had all required safety plans completed. In the other five cases, the patients were required to have multiple safety plans completed based on their	

multiple placements on suicide precautions. As such, only 22 of 29 required safety plans (76 percent) were completed on these 10 patients during the review period. Almost all of the safety plans were inadequate because they did not "contain individualized goals and interventions" as required by this provision. Most simply used boilerplate narrative such as "*ACMH, custody*" for response to "People I can ask for help," and "*Utilize emergency button*" for response to "Things I can do to keep myself safe."

The following three (3) case examples exemplify current struggles by mental health clinicians to develop adequate safety plans to reduce suicide risk:

Case No. 4:

Upon discharge from suicide precautions on April 24, 2024, the patient's safety plan was developed as follows:

> How do you feel before you feel suicidal or like harming yourself? "*Only because my girlfriend no longer wants to be with me*."
>
> One thing I can do on my own to take my mind off my problems. What has worked in the past? "*Read, watch TV, work-out*."
>
> People and/or social settings that provides distraction, so I can take a break from thinking about my problems: "*Watch TV*."
>
> People I can ask for help: "*Mental health workers, ACMH, custody, medical*."
>
> Things I can do to keep myself safe: "*Follow safety protocols.*"
>
> Things that make me feel hopeful: "*I've always wanted to live. I like living*."
>
> "If I feel I cannot keep myself safe, I will tell staff and push my emergency button." (boilerplate narrative contained in all safety plans)

Case No. 14:

Upon discharge from suicide precautions on June 13, 2024, the patient's safety plan was developed as follows:

> How do you feel before you feel suicidal or like harming yourself? "*Very depressed, anxious*."

One thing I can do on my own to take my mind off my problems. What has worked in the past? "*Reading magazines, looking out of the window*."

People and/or social settings that provides distraction, so I can take a break from thinking about my problems: "*Dayroom, watch TV*."

People I can ask for help: "*JPS, medical, custody*."

Things I can do to keep myself safe: "*Push emergency button*."

Things that make me feel hopeful: "*Maybe I'll get out of here and hit the lottery*."

"If I feel I cannot keep myself safe, I will tell staff and push my emergency button." (boilerplate narrative contained in all safety plans)

Case No. 7

Upon discharge from suicide precautions on October 10, 2023, the patient's safety plan was developed as follows:

How do you feel before you feel suicidal or like harming yourself? *No response*

One thing I can do on my own to take my mind off my problems. What has worked in the past? "*About music, grandkids*"

People and/or social settings that provides distraction, so I can take a break from thinking about my problems: *No response*

People I can ask for help: "*ACMH, custody*"

Things I can do to keep myself safe: "*Utilize emergency button*"

Things that make me feel hopeful: "*Getting out*"

"*If I feel I cannot keep myself safe, I will tell staff and push my emergency button.*" (boilerplate narrative contained in all safety plans)

The patient remained in custody and subsequently had four (4) APU admissions between October 2023 and February 2024. These placements included five (5)

incidents of suicide attempts and/or self-injurious behavior, and a total of seven (7) subsequent safety plans, the last of which was the following on May 28, 2024:

> How do you feel before you feel suicidal or like harming yourself? "*Having a bad day, having no hope, our thinking bad things, being in jail*."
>
> One thing I can do on my own to take my mind off my problems. What has worked in the past? "*Knowing each day is closer to getting out, sleeping, my grandkids;* 4/24/24: *read;* 4/30/24: *artwork*."
>
> People and/or social settings that provides distraction, so I can take a break from thinking about my problems: "*God, to my happy place, make things with toilet paper (artwork/crafts);* 4/27/24: *dayroom, watch TV;* 4/30/24: *talking to the treatment team, nurses and other staff*."
>
> People I can ask for help: "*officer, doctors and nurses, ACMH*."
>
> Things I can do to keep myself safe: "*follow the safety protocols, not think about things (distraction)*."
>
> Things that make me feel hopeful: "*knowing I'm going home and this will be over soon. My grandkids;* 4/27/24: *and for myself*."
>
> "*If I feel I cannot keep myself safe, I will tell staff and push my emergency button*." (boilerplate narrative contained in all safety plans)

In sum, the ACH suicide prevention policy requires that "The safety plan shall be completed with the patient and identify specific signs, symptoms, and circumstances in which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and specific actions (independent coping skills, personal and professional resources for support, etc.) the patient or staff can take if suicidal thoughts do occur." This provision requires the development of "individualized goals and interventions" to reduce suicide risk.

Citing "Watch TV" and "Looking out the window" as written in **Case No. 4** and **Case No. 14** above, are not effective goals and interventions to reduce suicide risk. In **Case No. 7**, despite the patient having four (4) APU admissions between October 2023 and February 2024 and five (5) incidents of suicide attempts and/or self-injurious behavior, the safety plan developed on May 28, 2024 was virtually the same as the plan developed on October 10, 2023.

	Part of the struggle for clinicians to develop adequate safety plans might be the formatting of questions that do not directly solicit specific identification of coping skills to reduce suicide risk. For example, the following inquiry might be helpful in the development of adequate safety planning: "What are some specific Internal Coping Strategies that we (clinician and patient) can identify that are accessible to you right now (in a carceral setting): e.g., listening to music, taking a shower, drawing, journaling, exercising, practicing relaxation (e.g., breathing) techniques, structured mindfulness exercises, etc." Finally, as stated in previous monitoring reports, mental health clinicians will continue to struggle with development of adequate safety plans unless the process is collaborative and instructional between the patient and the clinician, and patients are granted routine possessions (books, writing materials, etc.) and out-of-cell activities that can assist with coping skills in reducing suicidal ideation. In addition, if the patient does not have access to electronic appliances (such as a television, radio/earbuds, etc.) during incarceration, they should not be listed as possible coping strategies. If the patient has limited or no access to dayroom, it should not be listed as a possible coping strategy. However, there are items that a patient can reasonably be offered as a coping strategy. step to include not only "what helps" but also "what is provided/used" to that end. For example, an adequate safety plan may state: "Drawing is an activity that reduces this patient's anxiety/depression. Clinician provided color pencils and drawing paper to patient," or "Journaling has been a helpful activity to manage emotions. Clinician provided a journal to the patient. Patient may request another journal once this one is filled." This provision remains in Partial Compliance.
Recommendations	1) Through chart auditing, ACMH should develop a corrective action plan to address the deficiencies in this provision. 2) ACMH should revise the safety plan format to include the following inquiry: "*What are some specific Internal Coping Strategies that we (clinician and patient) can identify that are accessible to you right now (in a carceral setting): e.g., listening to music, taking a shower, drawing, journaling, exercising, practicing relaxation (e.g., breathing) techniques, structured mindfulness exercises, etc.*" 3) Clinicians should not include coping strategies to reduce suicide risk that are not immediately available to the patient. 4) On an individual basis, ACMH and SSO staff should collaborate to provide patients with approved items that will serve as coping strategies to decrease ongoing suicidal ideation.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. Medical chart review.

Provision K) 3. Treatment of Patients 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 patient but maintains sound privacy, unless there is a clearly identified security or safety risk.**	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by ACH in the 9th Status Report (July 11, 2024), was: "Staff utilize the confidential interview office in booking, classrooms, and attorney booths for confidential interviews when available. Facility deficiencies that result in a lack of confidential space keeps the status at Partial Compliance." This provision is duplicative of **Provision D) 1. Post-Intake Mental Health Assessment Procedures.** As previously stated in that section on pages 34-35 of this report, mental health clinicians assigned to the Main Jail continued to utilize various options for their interaction with patients on suicide precautions: 1) a converted attorney booth in booking referred to as the ACMH Interview Room, 2) classrooms on each housing floor (including 300-West Pod that houses the SITHU), 3) the outside control area of 300-West Pod in close proximity to the officer's desk and erroneously referred to as the "indoor recreation area," 4) the visiting booths in 300-West Pod, and 5) cell front of the booking cells (safety, ad, seg, or sobering) and 2P-APU. Cell front, as well as the outside control area/indoor recreation area of 300-West Pod are non-confidential because they are in close proximity to both officers and other patients. In October 2023, the County completed installation of a "confidential interview room" within the outside control area (indoor recreation area) of 300-West Pod. The room, comprised of plexiglass walls and a door, as well as table and several chairs, can accommodate one patient and one or more clinicians. During the April 2024 onsite assessment, this expert examined the interview room while a clinician was conducting a one-on-one assessment with a patient and found that there was adequate privacy and confidentiality with the door closed and deputies providing observation from their desk. This expert was informed that the County plans on installing 1 to 2 confidential interview rooms within the outside control area (indoor recreation areas) on each floor in the Main Jail by the end of 2024. In conclusion, and as previously detailed in **Provision D) 1. Post-Intake Mental Health Assessment Procedures**, although there continued to be improvement observed during the expert's on-site assessment, the on-going lack of privacy and confidentiality during the daily assessment of suicide risk (including when the expert is not onsite) continues to be an impediment to the	

	County's ability to provide a reasonable suicide prevention program. This provision remains in Partial Compliance.
Recommendations	Ensure that patients assessed for suicide risk are consistently offered privacy and confidentiality by continuing the County's project of installing an adequate number of confidential interview rooms throughout the Main Jail.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). On-site observation on April 23-25, 2024. Medical chart review.

Provision L) 1. Conditions for Individual Patients 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 patients 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	Sacramento County's response to this provision as authored by both SSO and ACH in the 9th Status Report (July 11, 2024) was that the provision was in substantial compliance because their respective suicide prevention policies and practices address the provision. 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. The relevant language from the ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, and SSO Policy 713: Suicide Prevention and Intervention, September 23, 2023, will be discussed in these subsequent provisions. This provision remains in Partial Compliance.
Recommendations	See recommendations set forth regarding Provisions M, N, and O, below.
Evidentiary Basis	Sacramento County's 6th Status Report (January 9, 2023). ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023.

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 patient's classification security level. Any removal of privileges shall be documented with clinical justification in the patient'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 both ACH and SSO in the 9th Status Report (July 11, 2024), was repeated from previous reports as: "Licensed MH clinicians make these determinations and document them in the SRA and on the Suicide Precaution form given to custody and entered into ATIMS" from ACH, and "Current practice. Prisoners placed in a safety cell shall be allowed to retain enough clothing or be provided with a suitably designed "safety garment" to provide for the prisoner's personal privacy unless specific identifiable risks to the prisoner's safety or to the security of the facility exist and are documented…. At the Main Jail the Intensive Outpatient Supervisor (IOP) conducts monthly audits for suicidal patients in the SITHU and in safety cells to evaluate compliance with mental health's recommendations. The results of these audits are shared with the SME" from SSO. The SSO response again incorrectly attributes this provision to "safety garments," whereas the provision is specific to clinical decisions regarding granting privileges such as visits, telephone calls, and recreation for patients on suicide precautions. The SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023, states that: • Incarcerated persons on suicide precautions will not automatically be placed on lockdown, and access to dayroom and other out-of-cell activities will be based upon security and clinical judgment. • Incarcerated persons on suicide precautions must be offered showers on a daily basis. Prompt assistance with hygiene and cleaning must be provided whenever circumstances warrant. As previously addressed in **Provision H) 5. Temporary Suicide Precautions**, despite these policy requirements, this expert's observations during the April 2024 on-site assessment at the Main Jail, as well as review of various ATIMS Custody Logs for patients on suicide precautions in both the Main Jail booking cells and SITHU continued to find problematic practices. For example,

	pursuant to current practice, patients housed in booking cells are prohibited from any out-of-cell activities other than meeting with ACMH clinicians, whereas patients in the SITHU were more frequently offered the opportunity for out-cell-activities, but not on a daily basis and only for a short duration. Because current SITHU practice is to offer opportunities for showers and dayroom at the same time, the expert's current review of ATIMS Custody Logs for five (5) random suicidal patients housed in the Main Jail booking cells and SITHU during March and April 2024 is repeated from the provision above as follows: **Case No. 4**: 11 days; 3 offered dayroom or 27% **Case No. 5**: 7 days; 5 offered dayroom or 71% **Case No. 6**: 42 days; 34 offered dayroom or 81% **Case No. 7**: 15 days; 8 offered dayroom or 53% **Case No. 8**: 9 days; 6 offered dayroom or 67% The SSO conducts monthly audits of out-of-cell activities for suicidal patients housed in the SITHU. A recent review of the Suicide Precautions Compliance Review – Monthly Report for June 2024, completed on July 2, 2024, found that 69 percent of 17 randomly selected SITHU patients were offered dayroom on a daily basis. The average length of out-of-cell time for these patients was 26 minutes (for both shower and dayroom). This data does not include suicidal patients housed in the Main Jail booking cells. The average duration of dayroom and shower time were documented in the monthly Suicide Precautions Compliance Review reports as follows: August 2024: 34 minutes June 2024: 26 minutes May 2024: 36 minutes April 2024: 19 minutes In addition, when touring the 3 West 300 Pod during the April 2024 assessment, a deputy informed this expert that patients on suicide precautions typically have access to the shower/dayroom from 6:00pm to 6:00am, one patient at a time, for approximately 15 minutes. This provision remains in Partial Compliance.
Recommendations	As previously offered in this report, SSO needs to develop a corrective action plan to increase the duration of out-of-cell activities for suicidal patients.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. Review of ATIMS Custody Logs for Five Patients in March and April 2024. SSO Suicide Precautions Compliance Review – Monthly Reports (April thru August 2024.

	Observation during on-site assessment of April 23-25, 2024.

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 patient's clothing and possessions (e.g., books, slippers/sandals, eyeglasses) that are otherwise within the limitations of a patient's classification security level. The removal of property shall be documented with clinical justification in the patient'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 both ACH and SSO in the 9th Status Report (July 11, 2024), was that through by policy and practice this provision was in substantial compliance. The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, contains requirements the following requirements that are consistent with this provision: "Any removal of clothing, property and/or privileges shall be documented with clinical justification in the patient's EMR and reviewed by a licensed clinician on at least a daily basis. For all patients on suicide precautions, the removal or limitation of clothing, property, and/or privileges shall be primarily determined by a licensed clinician. This determination shall be based on clinical judgement and on a case-by-case basis, depending on suicide risk, and in consultation with custody staff. This determination shall be documented in the patient's chart with clinical rationale. Collateral information regarding patient's current functioning obtained from custody and/or medical staff shall also be documented." In addition, ACH 04-07: Acute Psychiatric Unit – Precautions and Observations, effective June 22, 2022, requires that "Removal of any personal or jail-issued item from the patient must be documented in the EHR along with the clinical justification for removal and accompanied by a doctor's order and documented on the Denial of Rights form. Magnetic signage will be posted on the patient's cell door indicating that the patient has an item restriction order." This provision is monitored with specific attention to the removal and/or return of a patient's clothing and possessions (e.g., books, slippers/sandals, eyeglasses) *excluding* safety smocks which is addressed later in this report. In practice, patients placed on suicide precautions in booking safety, ad seg, and sobering cells never receive books, slippers/sandals, or eyeglasses. Rather, following a mental health assessment, they are simply provided either a safety smock or jail uniform. Other items (e.g., books, slippers/sandals, eyeglasses) are not provided until they are transferred to the SITHU. In contrast, for patients admitted into the 2P-APU on suicide precautions and initially clothed in a	

	safety smock, their uniform is generally returned to them within 24 hours, if not sooner. 2P-APU providers then follow a "Denial of Rights" (DOR) protocol that works as follows on a case-by-case basis: DOR1: Standard patient 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, an order for "DOR 1, 2, 5, 7" would translate to a denial of access to standard patient clothing, personal items, visits, and writing utensils." Of note, and as detailed in the preface of this report, the parties entered into a Memorandum of Agreement (MOA) on May 27, 2022 regarding the correction of several critical remedial provisions of Mental Health and Suicide Prevention. The MOA requires the County to develop a specific quality assurance process to address several provisions, including the "Property and Privileges" for patients on suicide precautions. The requirements include: *"18. Staff compliance with the protocols set forth above (regarding privileges and property) will be subject to a documented quality assurance process for at least 12 months from the date of this Memorandum of Agreement, with quality assurance review at the monthly Suicide Prevention Subcommittee meeting (emphasis added).* *a. Mental health, and custody supervisors will conduct at least weekly reviews to ensure proper implementation, with corrective action taken when warranted."* The MOA was developed based, in part, upon the expert's previous findings that **Provision M) 1. Property and Privileges** and **Provision M) 2. Property and Privileges.** Beginning in at least August 2022, ACMH had conducted monthly quality assurances audits entitled "ACMH Suicide Precautions Weekly Review-Monthly Report." Th audits were converted to quarterly reviews in early 2024 based upon improved compliance. These audits focus on the following regular clinical responsibilities: • Suicide Precautions form completed • MH assessments completed daily for restoration of privileges and property

	• Removal of property and privileges documented with clinical justification • Decisions about removal of clothing and use of safety smock recommended by MH staff • Daily assessments conducted to determine restoration of clothing or documentation of continued use As reported in the 9th Status Report (July 11, 2024), ACMH reported the following compliance on May 13, 2024 for the audit period of February 1, 2024 through April 31, 2024: • Suicide Precautions form completed (**100%**) • MH assessments completed daily for restoration of privileges and property (**95%**) • Removal of property and privileges documented with clinical justification (**99%**) • Decisions about removal of clothing and use of safety smock recommended by MH staff (**99%**) • Daily assessments conducted to determine restoration of clothing or documentation of continued use (**95%**) Although the above clinical audit found very high compliance rates, this audit is limited to clinical recommendations, and *not whether the patient actually received such property and privileges from custody personnel*. Such a determination could only occur following the required audit by custody supervisors. In July 2023, the SSO began to conduct comparable custody supervisory audits of approved property and privileges offered/received by patients on suicide precautions. The initial audit found that 82 percent (22 of 27) of patients received restoration of clothing within two (2) hours of the clinical assessments, with the remaining 8 percent receiving clothing with six (6) hours. SSO continues to conduct audits on a monthly basis. According SSO Suicide Precautions Compliance Review – Monthly Report, September 2, 2024, 87 percent (13 of 15) of patients received restoration of clothing within two (2) hours of the clinical assessments, with the remaining 13 percent receiving clothing with four (4) hours. In conclusion, this expert will audit this provision for one additional monitoring cycle before considering an increase to substantial compliance. It remains in Partial Compliance.
Recommendations	The SSO *Suicide Precautions Compliance Review – Monthly Report* should be expanded to include auditing the provision/return of clinically-approved possessions (e.g., books, slippers/sandals, eyeglasses) to patients on suicide precautions.

Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, effective November 16, 2021. ACH 04-07: Acute Psychiatric Unit – Precautions and Observations, effective June 22, 2022. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. Observation during on-site assessment of April 23-25, 2024. ACMH Suicide Precautions Weekly Review-Quarterly Reports, February 1, 2024 through April 31, 2024. SSO Suicide Precautions Compliance Review – Monthly Report, July 10, 2023 and September 2, 2024.

Provision M) 3. Property and Privileges	**Cancellation of privileges should be avoided whenever possible and utilized only as a last resort.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SSO in the 9th Status Report (July 11, 2024), was repeated from previous reports as: "Current practice. Cancellation of privileges would be done only as a last resort or if deemed necessary per ACMH." According to the Consent Decree, routine privileges include visits, telephone calls, and recreation opportunities. Although this provision is duplicative with **Provision M) 1. Property and Privileges**, the SCSO response continues to be contrary to this expert's observations and medical chart review. This expert's review of various SSO Suicide Precautions Compliance Review – Monthly Reports found that "there was a miscommunication regarding swing shifts and night shifts regarding who was getting showers and dayroom" (July 2, 2024), and discussed during the June 10, 2024 Suicide Prevention Quality Improvement Subcommittee, as well as observed during this expert's April 2024 assessment, there are some deputies assigned to the SITHU who wrongly assumed that patients clothed in safety smocks are automatically prohibited from attending any out-of-cell activity (despite a clinical assessment that authorizes such). In conclusion, this provision remains in Partial Compliance.
Recommendations	See recommendations noted above.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023.

	Observation during on-site assessment of April 23-25, 2024. SSO Suicide Precautions Compliance Review – Monthly Report, July 2, 2024. Suicide Prevention Quality Improvement Subcommittee, June 10, 2024.

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	**Substantial Compliance**
Discussion	Sacramento County's response to this provision, as authored by both ACH and SSO in the 9th Status Report (July 11, 2024), was that through by policy and practice this provision was in substantial compliance. Based upon this expert's narrow interpretation of this provision, the most recent medical chart review did not find any cases in which decisions regarding use of safety smocks was not based on individualized clinical judgment. Inappropriate use of safety smocks by non-mental health staff is covered in other provisions of this *Consent Decree*, see **Provision N) 2. Use of Safety Suits** below. This provision is raised to Substantial Compliance.
Recommendations	None
Evidentiary Basis	Sacramento County's 9th Status Report (January 9, 2023). ACH 02-05: Suicide Prevention Program, effective November 16, 2021. ACH 04-07: Acute Psychiatric Unit – Precautions and Observations, effective June 22, 2022. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. Medical chart review. Observation during on-site assessment of April 23-25, 2024.

Provision N) **2. Use of Safety Suits**	**Custody staff may only temporarily place a patient 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 SSO in the 9th Status Report (July 11, 2024), was repeated from previous reports as: "Absent direction from ACMH deeming a "safety garment" necessary, a sworn

	supervisor must authorize custody staff to take the clothing and supply the prisoner with a 'safety garment.' Unless a "safety garment" is necessitated by the prisoner's behavior, prisoners shall be allowed to retain personal clothing except for shoelaces, shoes, belts, or any other clothing articles which could threaten his/her safety or damage property." Both SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023, and ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, mirror this provision's requirements by stating that "*Custody staff may only temporarily place a patient in a safety suit based on an identified risk of suicide by use of ligature*." until the licensed clinician's completion of the SRA." In addition, SSO's above declaration in the 9th Status Report that "*Unless a 'safety garment' is necessitated by the prisoner's behavior*, prisoners shall be allowed to retain personal clothing except for shoelaces, shoes, belts, or any other clothing articles which could threaten his/her safety or damage property," was not included SSO Policy 713: Suicide Prevention and Intervention. In practice, it continues to be this expert's finding that custody personnel issue safety smocks on <u>all</u> patients initially placed on suicide precautions by default prior to clinical assessment, not simply those identified at *risk of suicide by hanging* as required by this provision. This provision remains in Partial Compliance.
Recommendations	SSO personnel should abstain issuing safety smocks to all patients initially placed on suicide precautions by default prior to clinical assessment, and adhere to SSO Policy 713: Suicide Prevention and Intervention which requires the issuance of safety smocks *only* if "necessitated by the prisoner's behavior."
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. Observation during on-site assessment of April 23-25, 2024. Medical chart review.

Provision N) 3. Use of Safety Suits	**If a patient's clothing is removed, the patient shall be issued a safety suit and safety blanket.**	
Status	**Substantial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by SSO in the 9th Status Report (July 11, 2024), was repeated from previous reports as: "Current practice."	

	This expert's observations and the medical chart review during the most recent on-site assessment continued to find that there were no instances in which a patient on suicide precautions was not provided a safety smock and safety blanket. This provision is raised to Substantial Compliance because SSO Policy 713: Suicide Prevention and Intervention has been implemented.
Recommendations	None
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. Observation during on-site assessment of April 24-25, 2024. Medical chart review.

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 patient prior to discharge from suicide precautions.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SSO in the 9th Status Report (July 11, 2024), was "Current practice. Determination is made by ACMH. At the Main Jail, After Lindsay Hayes visit in November 2022, it was discovered SSO was not conducting QA reviews of safety smock use pursuant to the MOA filed June 3, 2022. Moving forward the IOP Sergeant conducts QA audits of safety smock use and timely return of clothing and property when notified by ACMH." This provision is similar to **Provision M) 2. Property and Privileges** and specifically focuses on restoring full clothing after patients were placed in safety smocks. Sacramento County's response to this provision, as authored by both ACH and SSO in the 9th Status Report (July 11, 2024), was that through by policy and practice this provision was in substantial compliance. Beginning in at least August 2022, ACMH had conducted monthly quality assurances audits entitled "ACMH Suicide Precautions Weekly Review-Monthly Report." Th audits were converted to quarterly reviews in early 2024 based upon improved compliance. These audits focus on the following regular clinical responsibilities:

	• Suicide Precautions form completed • MH assessments completed daily for restoration of privileges and property • Removal of property and privileges documented with clinical justification • Decisions about removal of clothing and use of safety smock recommended by MH staff • Daily assessments conducted to determine restoration of clothing or documentation of continued use As reported in the 9th Status Report (July 11, 2024), ACMH reported the following compliance on May 13, 2024 for the audit period of February 1, 2024 through April 31, 2024: • Suicide Precautions form completed (100%) • MH assessments completed daily for restoration of privileges and property (95%) • Removal of property and privileges documented with clinical justification (99%) • Decisions about removal of clothing and use of safety smock recommended by MH staff (99%) • Daily assessments conducted to determine restoration of clothing or documentation of continued use (95%) Although the above clinical audit found very high compliance rates, this audit is limited to clinical recommendations, and not whether the patient actually received clothing, property, and privileges from custody personnel. Such a determination could only occur following the required audit by custody supervisors. In July 2023, the SSO began to conduct comparable custody supervisory audits of approved property and privileges offered/received by patients on suicide precautions. The initial audit found that 82 percent (22 of 27) of patients received restoration of clothing within two (2) hours of the clinical assessments, with the remaining 8 percent receiving clothing with six (6) hours. SSO continues to conduct audits on a monthly basis. According SSO Suicide Precautions Compliance Review – Monthly Report, September 2, 2024, 87 percent (13 of 15) of patients received restoration of clothing within two (2) hours of the clinical assessments, with the remaining 13 percent receiving clothing with four (4) hours. In conclusion, this expert will audit this provision for one additional monitoring cycle before considering an increase to substantial compliance. It remains in Partial Compliance.

Recommendations	Continue progress to restore clinically-approved clothing within two hours with the goal of reaching and maintaining a 90 percent compliance threshold.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. Observation during on-site assessment of April 23-25, 2024. Medical chart review.

Provision N) 5. Use of Safety Suits	**A qualified mental health professional shall conduct <u>daily</u> assessments of any patient 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 9th Status Report (July 11, 2024), was: "All patients on the pre-admit list and in the APU are seen daily to assess continued use of safety suit, observation level and restriction of property and privileges. MH documents clinical justification for continued use of the safety suit and/or restriction of property and privileges." As noted in both **Provision M) 2. Property and Privileges** and **Provision N) 4. Use of Safety Suits**, ACMH has conducted monthly quality assurances audits entitled "ACMH Suicide Precautions Weekly Review-Monthly Report" since August 2022. The audits were converted to quarterly reviews in early 2024 based upon improved compliance. These audits focus on the following regular clinical responsibilities: • Suicide Precautions form completed • MH assessments completed daily for restoration of privileges and property • Removal of property and privileges documented with clinical justification • Decisions about removal of clothing and use of safety smock recommended by MH staff • Daily assessments conducted to determine restoration of clothing or documentation of continued use As reported in the 9th Status Report (July 11, 2024), ACMH reported the following compliance on May 13, 2024 for the audit period of February 1, 2024 through April 31, 2024: • Suicide Precautions form completed (100%)	

	• MH assessments completed daily for restoration of privileges and property (95%) • Removal of property and privileges documented with clinical justification (99%) • Decisions about removal of clothing and use of safety smock recommended by MH staff (99%) • Daily assessments conducted to determine restoration of clothing or documentation of continued use (95%) Despite findings from the above clinical audit of very high compliance rates, this expert found during the April 2024 assessment and medical chart review that patients on suicide precautions were not consistently being assessed by mental health clinicians on a daily basis as required by this provision. Of the 10 medical charts reviews for patients on suicide precautions, only one (1) patient (10 percent) was found to have been always seen by a mental health clinician on a daily basis. There were at least four (4) reviewed cases in which patients were not seen by clinicians for multiple days during their placement on suicide precautions (SP) with safety smocks. For example: **Case No. 14**: patient seen 37 of 55 days (67%) in April – July 2024 **Case No. 15**: patient seen 6 of 8 days (75%) in April 2024 **Case No. 16**: patient seen 17 of 20 days (85%) in April 2024 **Case No. 17**: patient seen 8 of 11 days (73%) in May – June 2024 In conclusion, this provision remains in Partial Compliance.
Recommendations	If patients on suicide precautions are not being consistency assessed on a daily basis because of low staffing levels, similar to **Provision E) 1. Responses to Identification of Suicide Risk or Need for Higher Level of Care**, a corrective action plan to restore previous levels, as well as a staffing analysis of current mental health staffing needs, are indicated.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. Observation during on-site assessment of April 23-25, 2024. Medical chart review.

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 patient, safety suits shall not be used on that prisoner.**	
Status	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by ACH in the 9th Status Report (July 11, 2024), was "When MH determines that 30-minute (or less frequent) observations are warranted for a patient, safety suits are not used for that patient." The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, adequately addresses this provision as follows: "Any patient placed on 30-minute observation shall never be placed in a safety suit. If a licensed clinician determines that a patient requires a safety suit, the patient shall be placed on suicide precautions." In addition, the ACH 04-07: Acute Psychiatric Unit – Precautions and Observations, effective June 22, 2022, states that "Patients not on suicide observation status (close observation/constant observation) will be observed at staggered intervals not to exceed 30-minute checks as ordered by the psychiatrist." The problem of patients on 30-minute observation being clothed in safety smocks was previously found in the medical chart review of patients in the 2P-APU. In the *Fourth Monitoring Report*, however, this expert did not find any patients in the 2P-APU (or elsewhere) clothed in safety smocks and ordered to be observed at 30-minute intervals. As such, this provision was then raised to substantial compliance. However, during the April 2024 assessment, this expert examined multiple charts in which patients on the 2P-APU were clothed in safety smocks and observed at 30-minute intervals. For example: **Case No. 5**: May 4, 2024 - Provider note: "Change Q15 min. to Q30 min. safety checks, renew DOR 1, 2, 5, 7." May 15, 2024 - Nurse's note: "Perform Q30 min. safety checks" May 15, 2024 - Provider note "Continue DOR 1, 2, 5, 7 SS and SB (safety suit and safety blanket) due to ongoing elevated risk of self-harming behaviors/impulsivity." **Case No. 7**: October 29, 2023 - Observed in safety smock, nursing note stated - "Perform Q-30 Minute safety checks."	

	Case No. 12: March 4, 2024 - Provider note: "Given her poor participation, we will continue DOR 1, 7 SS, SB, for previous impulsive behavior. May discontinue Q15 min. obs. as she has not been observed to have any SIB since the last ingestion." March 24, 2024 - Nurse's note: "Pt. placed on Q30 minute observation per MD's order. Pt. did not engage in self-injurious behavior throughout the night shift and as of this time. Pt. is in a safety suit and resting in bed quietly." **Case No. 16**: April 28, 2024 - Nurse's note at 1:00pm: "Patient endorsed suicidal thoughts with plan to hang self but denied intent and confirming he can be safe on the unit." April 28, 2024 - Provider note at 4:00pm: "Change Q15 min. to Q30 min. safety checks. No active SI, no self-injurious behavior… Renew DOR 1, 2, 5 ,7. Continue safety suit and safety blanket." Of note, as stated earlier in this report, 2P-APU providers follow a "Denial of Rights" (DOR) protocol for ordering clothing and possessions. An order for "DOR 1, 2, 5, 7" would translate to a denial of access to standard patient clothing, personal items, visits, and writing utensils." Based upon the recent finding of 2P-APU providers reverting to the practice of ordering 30-minute observation for patients placed in safety smocks, this provision is reduced to Partial Compliance.
Recommendations	Ensure that all staff abide by the ACH 02-05: Suicide Prevention Program policy requirement that "Any patient placed on 30-minute observation shall never be placed in a safety suit. If a licensed clinician determines that a patient requires a safety suit, the patient shall be placed on suicide precautions."
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. ACH 04-07: Acute Psychiatric Unit – Precautions and Observations, effective June 22, 2022. Medical chart review.

Provision N) 7. Use of Safety Suits	**Safety suits shall not be used as a tool for behavior management or punishment.**
Status	**Substantial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SSO in the 9th Status Report (July 11, 2024), was repeated from previous reports as: "Current practice. Safety suits are only used when necessary for the safety and security of the inmate." The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, adequately address this provision as follows: "Safety suits shall not be used as a default or as a tool for behavior management or punishment." SSO Policy 713: Suicide Prevention and Intervention was implemented on September 12, 2023 and contains a similar requirement. Although this expert did not find any evidence from the medical chart review during this monitoring period that safety smocks were being utilized as a tool for behavior management or punishment, the use of safety smocks as a default for all suicidal patients initially housed in the Main Jail booking cells could certainly be interpreted by a patient as a punitive management tool to deter perceived manipulative and/or attention-seeking behavior. In conclusion, this provision is raised to Substantial Compliance because SSO Policy 713: Suicide Prevention and Intervention has been implemented.
Recommendations	None
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. Observation during on-site assessment of April 23-25, 2024. Medical chart review.

Provision O) 1. Beds and Bedding	**All patients 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 patient 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	**Substantial Compliance**
Discussion	Sacramento County's response to this provision, as authored by the SSO in the 9th Status Report (July 11, 2024), was repeated from previous reports as follows: This is current practice. Those housed in safety cells in the booking area are moved to appropriate suicide resistant housing as soon as a bed/cell opens up." Such a response is non-responsive to the provision requirements of providing a mattress and bedding to those patients housed on suicide precautions for longer than four hours. The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, partly addresses this provision as follows: "If a patient utilizes a mattress to obstruct staff visibility or tampers with a mattress in a manner that poses danger to the patient, custody personnel may temporarily remove the mattress from the cell. The removal of a mattress and rationale shall be documented. Patients will be assessed regularly by a licensed clinician for the appropriate use of a mattress." SSO Policy 713: Suicide Prevention and Intervention, effective May 12, 2023, adequately addresses this provision by requiring: "All incarcerated persons housed for more than four hours on suicide precautions and/or in an inpatient placement shall be provided with an appropriate bed, suicide-resistant mattress, and bedding unless the incarcerated person uses these items in ways for which they were not intended (e.g., tampering or obstructing visibility into the cell). has not been finalized." A previous problem of individuals housed in Main Jail booking cells without adequate bedding for more than four hours has apparently been corrected. During the most recent April 2024 assessment, this expert found that all patients housed in both Main Jail booking cells and SITHU cells had mattresses and blankets. Based upon these findings, as well as issuance of SSO Policy 713: Suicide Prevention and Intervention, this provision is raised to Substantial Compliance.
Recommendations	None
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, effective May 12, 2023.

	Observation during on-site assessment of April 23-25, 2024.

Provision P) 1. Discharge from Suicide Precautions	**A qualified mental health professional shall complete and document a suicide risk assessment prior to discharging a patient 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 ACH in the 9th Status Report (July 11, 2024), was "A qualified mental health professional completes and documents a suicide risk assessment prior to discharging a patient from suicide precautions in order to ensure that the discharge is appropriate, and that appropriate treatment and safety planning is completed." The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, adequately addresses this provision as follows: "A licensed clinician shall complete an SRA for each patient discharged from suicide precautions. The SRA shall include recommendations for specific treatment goals based on the circumstances leading to placement on suicide precautions and/or acute psychiatric care including underlying diagnosis." This expert's medical chart review of 10 patients discharged from suicide precautions from March 2024 through July 2024 found that each had an SRA completed at discharge, including several patients that were also discharged from the 2P-APU. In addition, consistent with general rules of confidentiality between a patient and mental health clinician, information disclosed by the patient cannot be reported to others outside that session except for specific circumstances related to the self-reporting of danger to self, danger to others, and child abuse. Consistent with their California Board of Behavioral Sciences (BBS) licenses, it is a common practice for ACMH clinicians to notify patients of this disclosure at the beginning of each session. When observing the daily rounds of patients on suicide precautions by mental health clinicians during the April 2024 assessment, this expert noticed that, instead of informing the patient that their right to confidentiality excludes a self-report of danger to self, danger to others, and child abuse, a few clinicians began the session by stating that if "you report any danger to self, *we will have to take appropriate precautions*," with one clinician going even further by stating: "*If you report any suicidal ideation, you're remaining on suicide watch*." Such inappropriate statements could have the unintended consequence of deterring an otherwise suicidal patient from expressing suicidal ideation for fear they will be either placed on suicide precautions or continued on suicide precautions. Simply stating to the patient that their right to confidentiality is

	not covered by a self-report of danger to self, danger to others, and child abuse would suffice. Before considering raising this provision to substantial compliance, this expert will audit the practice of clinician disclosures to patients during the next onsite assessment.
Recommendations	ACMH supervisors should inform clinicians as the appropriate BBS disclosure that does not have the unintended consequence of deterring a patient from reporting suicidal ideation.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. Observation during on-site assessment of April 23-25, 2024.
Provision P) 2. Discharge from Suicide Precautions	**Treatment plans shall be written for all patients 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 ACH in the 9th Status Report (July 11, 2024), was "The treatment plan describes 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. MH staff have received training as part of the SRA and Treatment Planning trainings to ensure treatment goals are included to reduce suicide risk. Auditing of charts is needed to ensure substantial compliance." This provision is duplicative with both **Provision K) 1. Treatment of Patients Identified as at Risk of Suicide** and **Provision K) 2. Treatment of Patients Identified as at Risk of Suicide** that were addressed earlier in this report. As such, these three provisions will be monitored as one provision. The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, contains the following requirements that are consistent with this provision: "MH staff will develop and utilize a safety planning tool for patients on suicide precautions. The safety plan shall be completed with the patient and identify specific signs, symptoms, and circumstances in which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and specific actions (independent coping skills, personal and professional resources for support, etc.) the patient or staff can take if suicidal thoughts do

	occur. The plan should be updated as clinically indicated….The treatment plan shall be updated to include goals and interventions specific to each patient's safety plan and discharge planning." As noted above in **Provision K) 2. Treatment of Patients Identified as at Risk of Suicide**, safety plans reviewed during this assessment period did not contain specific interventions to reduce suicide risk. This provision remains in Partial Compliance.
Recommendations	See recommendations in **Provision K) 2. Treatment of Patients Identified as at Risk of Suicide**.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. Medical chart review.

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 patient) 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 patient shall be promptly transferred to appropriate housing.**	
Status	**Substantial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by ACH in the 9th Status Report (July 11, 2024), was "MH provides 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. Patients are transferred to the IOP (based upon bed availability) and/or assigned a clinically appropriate level MH care at time of discharge from the APU." The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, contains the following requirements that are consistent with this provision: "A licensed clinician shall also provide clinical input regarding clinically appropriate housing placement (e.g., whether isolation is contraindicated for the patient) upon discharge and document such input in the EHR. Custody and classification shall consider such clinical input in determining post-discharge placement and conditions of confinement. Once clinically discharged from suicide precautions, the patient shall be promptly transferred to appropriate housing." SSO Policy 713: Suicide Prevention and Intervention became effective on September 12, 2023.	

	Both SSO and ACMH leadership previously informed this expert that clinicians work collaboratively with custody personnel in the placement of patients following their discharge from suicide precautions. Recent medical chart review did not provide any evidence to the contrary. This provision is raised to Substantial Compliance because SSO suicide prevention policy has been implemented.
Recommendations	None
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, effective September 12, 2023. Medical chart review.

Provision P) 4. Discharge from Suicide Precautions	**Patients discharged from suicide precautions shall remain on the mental health caseload and receive regularly scheduled clinical assessments and contacts. Unless a patient'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 9th Status Report (July 11, 2024), was "Patients who are discharged from the APU after being treated for a suicide attempt or ideation receive follow up MH appointments (24 hours, 72 hours, and 5 days). Patients on the APU pre-admit list who have been discharged from suicide precautions receive follow-up MH appointments (24 hours, 72 hours again within one week of discharge). Partial compliance pending audit and confirmation that timelines to care are being met." The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, contains the following requirements that are consistent with this provision: "All patients discharged from suicide precautions shall remain on the mental health caseload and receive regularly scheduled clinical assessments and contacts. Unless a patient's individual circumstances direct otherwise, a clinician shall provide a follow-up assessment and clinical contact within 24 hours of discharge, again within 72 hours of discharge, and again within one week of discharge. a. Individual circumstances that might override the above requirement for follow-up assessments may include incidents in which a patient was placed on suicide precautions by either custody or medical personnel and subsequently discharged from suicide precautions by a licensed clinician within 24 hours and with finding that the placement was inadvertent (See G.3. above). b. However, if the licensed clinician's initial suicide risk assessment

	determined that continued suicide precautions beyond 24 hours was appropriate, then the scheduled follow-ups shall always occur." This expert's medical chart review of 10 patients discharged from suicide precautions from March 2024 through July 2024 found 8 (80 percent) patients received all of the required follow-up assessments (at 24 hours, 72 hours, and one week post discharge). Such findings are consistent with a recent ACH audit (cited in the 9th Status Report) that found 83 percent of patients received 24-hour follow-ups, 93 percent received 72-hour follow-ups, and 85 percent received 5-day follow-ups from January 2024 through March 2024. In conclusion, because scheduled follow-up assessments are not consistently occurring in all cases, this provision remains in Partial Compliance.
Recommendations	Similar to recommendations made in prior provisions, if patients discharged from suicide precautions are not consistency receiving all of the required follow-up assessments (at 24 hours, 72 hours, and one week post discharge) because of low staffing levels, a corrective action plan to restore previous levels, as well as a staffing analysis of current mental health staffing needs, are indicated.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. 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	**Substantial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by both ACMH and the SSO in the 9th Status Report (July 11, 2024), was that this provision was in substantial compliance. The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, contains the following requirements that are consistent with this provision: "Both the MJ and RCCC shall keep an emergency response cart or bag that includes a first aid kit, CPR mask or Ambu bag, and emergency rescue tool in close proximity to all housing units. All custody and medical staff shall be trained on the location of this emergency response cart and shall receive regular training on emergency response procedures, including how to use appropriate equipment." SSO Policy 713: Suicide Prevention and Intervention,	

	effective September 12, 2023, is also consistent with this provision's requirements. 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. Previous inspection of select Main Jail and RCCC housing units found that emergency rescue tools and pocket masks (not Ambu bags) were located in the deputies' "bubble" outside each housing unit. This provision is raised to Substantial Compliance because SSO Policy 713: Suicide Prevention and Intervention was implemented.
Recommendations	None
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023.

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 both ACH and SSO in the 9th Status Report (July 11, 2024), was that both custody and medical were in substantial compliance with this provision, with SSO stating "Current custody practice. Sworn staff receives CPR training every two years. It is part of our Advanced Officer Training (AOT) program." The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, contains the following requirements that are consistent with this provision: "All medical and custody staff are trained in first aid and CPR." SSO Policy 713: Suicide Prevention and Intervention, effective September 12, 2023, is also consistent with this provision's requirements. Recent training data indicated that 81 percent (293 of 363) of custody personnel were certified in CPR, and 98 percent (220 of 225) of medical personnel (nursing and providers, including registry) were currently certified in Basic Life Support (including CPR). This provision remains in Partial Compliance because there remains a percentage of custody personnel below the 90 percent threshold for substantial compliance.

Recommendations	1) The County should develop a corrective action plan to ensure that SSO deputies achieve and maintain a minimum 90 percent threshold for compliance with first aid and CPR certification. 2) As repeated from previous monitoring reports, training data should be forwarded to this expert according to the following schedule: *Twice a year in January and June, provide updated data on the total number of current employees for each discipline (i.e., denominator for both custody and medical personnel), and the total of current employees (i.e., numerator) who are currently first aid/CPR certified.*
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. Training data provided in March 2024 and September 2024.

Provision Q) 3. Emergency Response	**It shall be the policy of the County that any staff who discovers a patient 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	**Substantial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by SSO in the 9th Status Report (July 11, 2024), was simply that this provision was in substantial compliance. The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, contains the following requirements that are consistent with this provision: "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." SSO Policy 713: Suicide Prevention and Intervention, effective September 12, 2023, is also consistent with this provision's requirements. The Suicide Prevention Quality Improvement Subcommittee is responsible for completing mortality and morbidity review for incidents involving suicides and serious suicide attempts. The Subcommittee completed numerous morbidity reviews for serious suicide attempts during the assessment period, and this expert reviewed eight (8) of these completed cases. The review found that adequate emergency medical responses occurred in each case. As such, this provision is raised to Substantial Compliance.	
Recommendations	None	

Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. Meeting minutes from the Suicide Prevention Quality Improvement Subcommittee, November 13, 2023, December 11, 2023, January 8, 2024, February 26, 2024, March 11, 2024, April 8, 2024, May 13, 2024, June 10, 2024, July 8, 2024, and August 12, 2024. Suicide Prevention Quality Improvement Subcommittee's morbidity reviews from eight (8) serious suicide attempts between August 2023 and April 2024 (Case 17 through Case 24).

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	**Substantial Compliance**
Discussion	Sacramento County's response to this provision, as authored by ACH in the 9th Status Report (July 11, 2024), was "MH implemented monthly Suicide Prevention Multidisciplinary meetings to discuss patients with complex mental health needs who engage in self-injurious behaviors (July 2022)." Both the ACH 02-05: Suicide Prevention Program policy and ACH 01-15: Suicide Prevention Subcommittee policy require that "The management of specific inmates on suicide precautions that pose challenges to custody, medical and/or MH personnel shall be discussed in a monthly multi-disciplinary Suicide Precautions Meeting….Meeting minutes shall be taken to record discussion, decisions and recommendations….Members of this multi-disciplinary meeting shall make recommendations, as appropriate, to the Suicide Prevention Subcommittee." The County established the "Suicide Precautions Multidisciplinary Committee" in July 2022 as a sub-committee of the larger Suicide Prevention Quality Improvement Subcommittee." According to meeting minutes, the purpose of the monthly Suicide Precautions Multidisciplinary Committee (comprised of mental health, medical, and custody personnel) is to discuss the "The management of specific inmates on suicide precautions that pose challenges to custody, medical and/or MH personnel." Patients to be discussed are based upon the following criteria: 1) three (3) or more referrals for suicidal ideation and/or self-injurious behavior (SIB) within last 30 days, 2) chronic SIB without suicidal intent, and 3) APU waitlist three (3) or more times within the last 30 days for danger to self (DTS).

	The expert reviewed the monthly meeting minutes from January 2024 through September 2024, including summaries of nine (9) case discussed. Each included a summary of the issue(s) and plan(s) of action. Based upon the above findings, this provision is raised to Substantial Compliance.
Recommendations	None
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. ACH 01-15: Suicide Prevention Subcommittee, September 17, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. Suicide Precautions Multidisciplinary Meeting Agenda and Minutes, January 3, 2024, February 7, 2024, March 6, 2024, April 3, 2024, May 1, 2024, June 5, 2024, July 3, 2024, August 7, 2024, and September 4, 2024.

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	**Substantial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by ACH in the 9th Status Report (July 11, 2024), was "ACH has, in consultation with Plaintiffs' counsel, revised its in-custody death review policy and procedures. Reviews are conducted with the active participation of custody, medical, and mental health staff. Reviews include analysis of policy or systemic issues and the development of corrective action plans when warranted." This provision is more or less duplicative with **Provision R) 3. Quality Assurance and Quality Improvement** below, and is monitored specific to the requirement for an adequate policy and procedure regarding the mortality and morbidity review process. **Provision R) 3** is monitored for the quality of the review process. ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, contains the following requirements of the Suicide Prevention Subcommittee that are consistent with this provision: "Provide a comprehensive morbidity review of serious suicide attempts (one involving medical intervention or hospitalization) and a mortality review of suicides. Reviews to include: 1. The circumstances surrounding the incident. 2. Possible precipitating factors that may have caused the patient to commit suicide or suffer a serious suicide	

	attempt. 3. Pertinent medical and mental health services, incidents and/or reports involving the patient. 4. The procedures relevant to the incident. 5. All relevant training received by involved staff. 6. Where applicable, the subcommittee shall make recommendations for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures." SSO Policy 713: Suicide Prevention and Intervention, effective September 12, 2023, is also consistent with this provision's requirements. Because this provision is monitored specific to the development of an adequate policy and procedure for mortality and morbidity reviews, and SSO Policy 713: Suicide Prevention and Intervention was finally implemented, this provision is raised to Substantial Compliance.
Recommendations	None
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. ACH 01-15: Suicide Prevention Subcommittee, September 17, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023.

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	**Partial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by the SCSO in the *Sixth* Status Report (January 9, 2023), was repeated from previous reports as: "Current practice. The Suicide Prevention Task Force has been reestablished and has already had its first meeting." The Suicide Prevention Task Force was subsequently renamed the Suicide Prevention Quality Improvement Subcommittee at the initiation of monitoring of this *Consent Decree*. This provision is more or less duplicative with **Provision R) 2. Quality Assurance and Quality Improvement** above, however, requires proof of practice that mortality and morbidity reviews are adequately completed. The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021,	

	contains the following requirements of the Suicide Prevention Subcommittee that are consistent with this provision: "Provide a comprehensive morbidity review of serious suicide attempts (one involving medical intervention or hospitalization) and a mortality review of suicides. Reviews to include: 1. The circumstances surrounding the incident. 2. Possible precipitating factors that may have caused the patient to commit suicide or suffer a serious suicide attempt. 3. Pertinent medical and mental health services, incidents and/or reports involving the patient. 4. The procedures relevant to the incident. 5. All relevant training received by involved staff. 6. Where applicable, the subcommittee shall make recommendations for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures." SSO Policy 713: Suicide Prevention and Intervention, effective September 12, 2023, is also consistent with this provision's requirements. The Subcommittee completed numerous morbidity reviews for serious suicide attempts during the assessment period, and this expert reviewed eight (8) of those cases. Each review, which included a brief clinical summary, was formatted with a Morbidity and Mortality Case Review template, based upon this expert's Mortality/Morbidity Review of Inmate Suicides Checklist." The template includes eight (8) areas of inquiry, including the final question of "What are specific corrective active plans (CAPs) for each recommendation, who is responsible party for each CAP, and what is expected timeframe to complete each CAP?" The expert's review of these eight (8) cases found this final follow-up section was inadequately completed in most reviews because: • Although most of the reviews contained recommendations, the final section regarding CAPs was marked "none" in 6 of the 8 cases. [One notable exception was Case 19 which generated five (5) formalized CAPs with timelines for completion]; • The expected timeframes to complete each recommendation was missing from most reviews; and • The status (open or closed) of recommendations was missing from all reviews. For purposes of continuous quality improvement, it is imperative to create a case review process that identifies and tracks the status of corrective actions and ensures durability of completed tasks. In one example that exemplifies the importance of tracking corrective actions, the following deficiency was listed in at least three (3) cases: "Recommendation to emphasize/educate that ACH should perform and document Neurological checks. No indication that checks occurred after this event." Despite this recommendation, this deficiency persisted arguably because a CAP was not formally created and tracked following the first case.

	In addition, several cases involved a finding that staff were non-complaint with required suicide prevention and/or CPR training, but CAPs were not formalized, with narration simply stating that "ACH to notify and follow-up" (Case 18), "ACH has ongoing messaging to ensure timely training" (Case 20), "Individual not up to date/lapsed on SP training (expired), subsequently renewed" (Case 21), and "One responder had completed initial SP training but had not yet received renewal class at the time of incident" (Case 22). Each of these findings should have resulted in corrective action plans. Further, the ACH response of "N/A" to the question "Had all correctional, medical, and mental health staff involved in the incident received both basic and annual training in the area of suicide prevention prior to the incident?" in Case 23 was incorrect because nursing staff had contact with the patient for several days leading up to the incident. This same case also contained a recommendation that "ACH nursing to better document level of review and clinical reason for no assessment performed," and a response that "ACH has followed up internally with above recommendation. No CAP." Such a response was improper. For reasons of durability and traceability, all recommendations should have CAPs. (With that said, it was questionable as to whether Case 23 should have even resulted in a morbidity review because available documentation suggested that the patient was not injured from the suicide attempt and was not sent out to the hospital for any medical treatment.) Finally, a critically important issue to any morbidity and mortality review is: "When was the patient last physically observed by staff?" In several reviewed cases, the responses were: "SSO: Hourly checks" (Case 20) or "SSO: Q15min checks" (Case 24). *Such documentation was non-responsive to the inquiry because it did not specify the time between the incident and last staff observation.* In Case 23, the review stated "Time of Incident: 19:20," with last check listed as "SSO: @1929 hours," a clearly incorrect time period and probably a typographical error. In another case (Case 21), the brief clinical summary stated that the patient attempted suicide by hanging and was sent out to the hospital on January 21, 2024. Upon return at 16:35, the patient was housed in the SITHU. At 19:04, the patient was again found attempting to hang himself and sent out to the hospital. *There was no indication what level of observation the patient was on in SITHU nor when he was last observed prior to 19:04.* When returned from the hospital a second time, the patient was rehoused in booking. On January 22, he attempted suicide a third time. In addition to omitting the time the patient was last observed prior to 19:04 on January 21, the response by SSO of "hourly" checks in this case was obviously incorrect because patients are required to be suicide precautions in the SITHU, with observed required at staggered intervals that do not exceed 15 minutes.

	The review of Case 21 also found that the patient was *last* observed by a mental health clinician on "1/19/2024 1015 hours, assessed for 72 hours post-clearance for DTS on 1/16/2024. At that time he reported no suicidal ideation or intent." This response appeared incomplete because it was the only notation for mental health and suggested the patient was not seen by a clinician on either January 21 or January 22 when he was on suicide precautions. At a minimum, this issue needed to be clarified during the morbidity review and a CAP generated, if applicable. In conclusion, it is recommended that, consistent with the intent of the Morbidity and Mortality Case Review template, when recommendations are generated based upon deficiencies found in a specific case, corrective action plans should be created that identifies each recommendation, followed by identified stakeholder(s), status (open/closed), and deadline for implementation. The progress, if any, of all open CAPs should be tracked on a scheduled basis in separate documentation. This provision remains in Partial Compliance.
Recommendations	1) Address all of the deficiencies listed above, including, but not limited to, the following: Ensure that each recommendation generated based upon deficiencies result in a corrective action plan (CAP) that identifies each recommendation, followed by identified stakeholder(s), status (open/closed), and deadline for implementation. The progress, if any, of all open CAPs should be tracked on a scheduled basis in separate documentation. 2) The Subcommittee should strive to shorten the period between the incident and the morbidity review. Most of the cases took between 6 to 8 months to review from the time of the incidents. A timeframe of 30-60 days would be reasonable.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. ACH 01-15: Suicide Prevention Subcommittee, September 17, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. Meeting minutes from the Suicide Prevention Quality Improvement Subcommittee, November 13, 2023, December 11, 2023, January 8, 2024, February 26, 2024, March 11, 2024, April 8, 2024, May 13, 2024, June 10, 2024, July 8, 2024, and August 12, 2024. Suicide Prevention Quality Improvement Subcommittee's morbidity reviews from eight (8) serious suicide attempts between August 2023 and April 2024 (Case 17 through Case 24).

Provision R) 4. Quality Assurance and Quality Improvement	**The County will track all critical incidents which include patient 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	**Substantial Compliance**	
Discussion	Sacramento County's response to this provision, as authored by ACH in the 9th Status Report (July 11, 2024), was "MH tracks incidents of suicide, attempted suicide and serious self-harm. MH completes incident reports and reviews on deaths by suicide, attempted suicide and serious self-harm and submits incident reports to ACH QI for review and tracking." This provision is more or less duplicative with **Provision R) 3. Quality Assurance and Quality Improvement** above because it involves review of both suicides and serious suicide attempts, but also includes tracking of attempted suicides (that are not necessarily determined to be serious). The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, contains the following requirements of the Suicide Prevention Subcommittee that are consistent with this provision: "Tracking of all suicides, suicide attempts, and incidents of serious self-harm by the QI Coordinator, with incidents of serious self-harm/attempts and suicides reviewed by the subcommittee." SSO Policy 713: Suicide Prevention and Intervention, effective September 12, 2023, is also consistent with this provision's requirements. Because ACH previously demonstrated the ability to track suicides and suicide attempts, and SSO Policy 713: Suicide Prevention and Intervention was finally implemented, this provision is raised to Substantial Compliance.	
Recommendations	None	
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. ACH 01-15: Suicide Prevention Subcommittee, September 17, 2021. SSO Policy 7132: Suicide Prevention and Intervention, September 12, 2023.	

Provision R) 5. Quality Assurance and Quality Improvement	**The County shall implement a <u>continuous quality assurance</u>/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 patients identified as being at risk of suicide or self-harm.**
Status	**Partial Compliance**
Discussion	Sacramento County's response to this provision, as authored by ACH in the 9th Status Report (July 11, 2024), was that the County was in substantial compliance. ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, contains the following requirements that are consistent with this provision: "The Suicide Prevention Subcommittee is a designated subcommittee of the Quality Improvement Committee. The composition of the subcommittee includes representation from all disciplines and both facilities. The subcommittee meets monthly and is facilitated by the Mental Health Medical Director." In addition, the ACH 01-15: Suicide Prevention Subcommittee policy, effective September 17, 2021, provides a full description of the Subcommittee's areas of responsibility, that include, but are not limited to, "Ensuring that all required suicide prevention policies are implemented and sustained." SSO Policy 713: Suicide Prevention and Intervention, effective September 12, 2023, is also consistent with this provision's requirements. Based upon this expert's previous finding that continuous quality improvement was not being practiced, the Suicide Prevention Subcommittee converted to monthly meetings in November 2021. Review of meeting minutes found that the Subcommittee consistently maintained monthly meetings during the review period. This multidisciplinary subcommittee, comprised of mental health, medical, and custody personnel, is facilitated by the ACMH on-site medical director. This expert is also a periodic participant at the Subcommittee meetings. To date, as reflected in the minutes and observation of several meetings attended by this expert, most of the time spent during monthly Subcommittee meetings continues to focus primarily on the morbidity review of various serious suicide attempts occurring in the Main Jail. With the exception of ACMH providing helpful monthly audit data on clinical recommendations for clothing and privileges, timely responses to emergent referrals, suicide risk assessment completion, and follow-up assessments, as well as SSO beginning to provide audit data on out-of-cell activities offered to patients on suicide precautions, *the meetings have not consistently addressed one of the Subcommittee's main areas of responsibility, i.e., "ensuring that all required suicide prevention policies are implemented and sustained."* For example, as

	discussed earlier in this report, there has been limited auditing of nursing intake screening. In addition, instead of reporting how many staff received suicide prevention training during the month, it would be more helpful to report the current level of compliance for custody, medical, and mental health personnel. The ACH 02-05: Suicide Prevention Program policy, effective November 16, 2021, contains the following requirements of the Suicide Prevention Subcommittee that are consistent with this provision: "Periodic auditing of intake screening (to include audits to ensure that nursing staff ask and record all suicide risk and mental health screening questions), mental health assessments, suicide risk assessments, crisis response, and treatment plans/safety plans/behavior management plans for patients identified as being at risk of suicide or self-harm." As detailed in the Introduction section of this report, a Memorandum of Agreement executed by the parties (on May 27, 2022) in the joint *Status Report RE: Monitoring of Consent Decree Implementation*, filed with the court on June 3, 2022 (Case 2:18-cv-02081-TLN-KJN. Document No. 153), contained very specific requirements regarding quality assurance and continuous quality improvement for the suicide prevention provisions of this *Consent Decree*. In fact, Section 18 (page 9) of the Agreement specifies that: "*Staff compliance with the protocols set forth above will be subject to a documented quality assurance process for at least 12 months from the date of this Memorandum of Agreement, with quality assurance review at the monthly Suicide Prevention Subcommittee meeting (emphasis added).* *a. ACH, mental health, and custody supervisors will conduct at least weekly reviews to ensure proper implementation, with corrective action taken when warranted.* *b. The Mental Health and Suicide Prevention Subject Matter experts will monitor policy implementation and the quality assurance process to ensure compliance with relevant Consent Decree requirements."* This expert previously interpreted this provision to indicate that the County must develop a continuous quality improvement/quality assurance plan to ensure that all suicide prevention provisions of this *Consent Decree* or implemented and sustained. This Memorandum of Agreement now more specifically describes those responsibilities. This expert had previously recommended that the *Consent Decree* and MOA requirement to "*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" be inserted as a "standing item" in the monthly Suicide Prevention Quality Improvement Subcommittee meeting agenda as a reminder to committee members of these quality assurance responsibilities. Although this narrative was subsequently inserted into the template for the monthly meeting agenda, as described above, review of the monthly Suicide Prevention Quality Improvement Subcommittee meeting minutes during the review period found that suicide prevention requirements such as intake screening and safety plans are rarely discussed. Because all of the suicide prevention provisions in the *Consent Decree* are in various stages of compliance, and the Memorandum of Agreement lays out specific continuous quality improvement/quality assurance requirements, this provision remains in Partial Compliance.
Recommendations	1) Consistent with the requirements of the Memorandum of Agreement in the joint *Status Report RE: Monitoring of Consent Decree Implementation*, filed June 3, 2022 (Case 2:18-cv-02081-TLN-KJN. Document No. 153), future Suicide Prevention Quality Improvement Subcommittee meetings should include discussion of continuous quality assurance measures taken to ensure all required suicide prevention policies are implemented and sustained. 2) In order to accomplish Recommendation No. 1 above, the Subcommittee should begin tracking the progress of implementing each of the recommendations contained within this *Fifth* Monitoring Report of Suicide Prevention Practices.
Evidentiary Basis	Sacramento County's 9th Status Report (July 11, 2024). ACH 02-05: Suicide Prevention Program, November 16, 2021. ACH 01-15: Suicide Prevention Subcommittee, September 17, 2021. SSO Policy 713: Suicide Prevention and Intervention, September 12, 2023. Memorandum of Agreement, May 27, 2022. Suicide Prevention Quality Improvement Subcommittee Meeting Agenda and Minutes, monthly from January 2024 through September 2024.

APPENDIX A
Suicide Prevention Remedial Plan Compliance Summary

Provision	Requirement	Substantial Compliance	Partial Compliance	Non-Compliance
A) 1-2	All suicide prevention provisions		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	
B) 1	Training (pre-service)		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	
B) 2	Training (annual)		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	
B) 3	Training (DMHU)		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	
B) 4	Training (SRA)	8/19/2022 9/13/2023 11/11/2024	1/19/2021 9/10/2021	
B) 5	Training (smocks)	11/11/2024	1/19/2021 9/10/2021 8/19/2022 9/13/2023	
B) 6	Training (policy)		11/11/2024	1/19/2021 9/10/2021 8/19/2022 9/13/2023
C) 1	Intake Screening (completeness)		1/19/2021 9/10/2021	8/19/2022 9/13/2023 11/11/2024
C) 2	Intake Screening (privacy)			1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024
C) 3	Intake Screening (form)	8/19/2022 9/13/2023 11/11/2024	1/19/2021 9/10/2021	
C) 4	Intake Screening (referral)		1/19/2021 9/10/2021	8/19/2022 9/13/2023 11/11/2024
C) 5	Intake Screening (triage)	8/19/2022 9/13/2023 11/11/2024	1/19/2021 9/10/2021	

C) 6	Intake Screening (policy)	8/19/2022 9/13/2023 11/11/2024	1/19/2021 9/10/2021	
D) 1	Post-Intake Assessment (privacy)		8/19/2022 9/13/2023 11/11/2024	1/19/2021 9/10/2021
D) 2	Post-Intake Assessment (timeframe)		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	
D) 3	Post-Intake Assessment (policy/forms)		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	
E) 1	Responses to Identification of Suicidal Patient (timeframe)		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	
E) 2	Responses to Identification of Suicidal Patient (RCCC)	8/19/2022 9/13/2023 11/11/2024	1/19/2021 9/10/2021	
E) 3	Responses to Identification of Suicidal Patient (policy/forms)	8/19/2022 9/13/2023 11/11/2024	1/19/2021 9/10/2021	
E) 4	Responses to Identification of Suicidal Patient (meal service does not delay SRA)	11/11/2024	1/19/2021 9/10/2021 8/19/2022 9/13/2023	
F) 1	Housing of Suicidal Patients (policy on least restrictive setting)			1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024
G) 1	Inpatient Placement (timeframe)		1/19/2021 9/10/2021 8/19/2022 9/13/2023	11/11/2024
H) 1	Temporary Suicide Precautions (placement timeframe)		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	
H) 2	Temporary Suicide Precautions (medical assessment timeframe)	11/11/2024	1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	

H) 3	Temporary Suicide Precautions (cell cleanliness)		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	
H) 4	Temporary Suicide Precautions (meals, fluids, hygiene, showers)		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	
H) 5	Temporary Suicide Precautions (out-of-cell access)		11/11/2024	1/19/2021 9/10/2021 8/19/2022 9/13/2023
H) 6	Temporary Suicide Precautions (non-use of classrooms)	11/11/2024	1/19/2021 9/10/2021 8/19/2022 9/13/2023	
I) 1	Suicide hazards (suicide-resistant)		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	
I) 2	Suicide Hazards (blind spots)	11/11/2024	1/19/2021	9/10/2021 8/19/2022 9/13/2023
J) 1	Supervision (documentation)		1/19/2021 9/10/2021	8/19/2022 9/13/2023 11/11/2024
J) 2	Supervision (no window coverings)	11/11/2024	1/19/2021 9/10/2021 8/19/2022 9/13/2023	
J) 3	Supervision (two levels)		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	
J) 4	Supervision (limited safety cell use)	8/19/2022 9/13/2023 11/11/2024	1/19/2021 9/10/2021	
J) 5	Supervision (no CCTV use)	9/13/2023 11/11/2024	1/19/2021 9/10/2021 8/19/2022	
K) 1	Treatment (policy)		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	
K) 2	Treatment (individualized plan)		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	

K) 3	Treatment (privacy)		8/19/2022 9/13/2023 11/11/2024	1/19/2021 9/10/2021
L) 1	Conditions of Precautions		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	
M) 1	Property/Privileges (privileges)		8/19/2022 9/13/2023 11/11/2024	1/19/2021 9/10/2021
M) 2	Property/Privileges (clothing/possessions)		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	
M) 3	Property/Privileges (cancellation)		8/19/2022 9/13/2023 11/11/2024	1/19/2021 9/10/2021
N) 1	Safety Smocks (individualized use)	11/11/2024	1/19/2021 9/10/2021 8/19/2022 9/13/2023	
N) 2	Safety Smocks (emergent assessment)		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	
N) 3	Safety Smocks (issued if clothing removed)	11/11/2024	1/19/2021 9/10/2021 8/19/2022 9/13/2023	
N) 4	Safety Smocks (timely restoration of clothing)		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	
N) 5	Safety Smocks (daily assessment)		1/19/2021 8/19/2022 9/13/2023 11/11/2024	9/10/2021
N) 6	Safety Smocks (cannot be used with 30-minute observation)	9/13/2023	9/10/2021 8/19/2022 11/11/2024	1/19/2021
N) 7	Safety Smocks (cannot be used as punishment)	11/11/2024	1/19/2021 9/10/2021 8/19/2022 9/13/2023	
O) 1	Beds/Bedding	11/11/2024	1/19/2021 9/10/2021 8/19/2022 9/13/2023	
P) 1	Discharge from Precautions (SRA)		1/19/2021 9/10/2021	

			8/19/2022 9/13/2023 11/11/2024	
P) 2	Discharge from Precautions (treatment plan)		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	
P) 3	Discharge from Precautions (housing recommendation)	11/11/2024	1/19/2021 9/10/2021 8/19/2022 9/13/2023	
P) 4	Discharge from Precautions (follow-up schedule)		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	
Q) 1	Emergency Response (equipment in close proximity to housing unit)	11/11/2024	1/19/2021 9/10/2021 8/19/2022 9/13/2023	
Q) 2	Emergency Response (first aid/CPR training)		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	
Q) 3	Emergency Response (immediate response)	11/11/2024	1/19/2021 9/10/2021 8/19/2022 9/13/2023	
R) 1	CQI (multidisciplinary committee for complex cases)	11/11/2024	1/19/2021 9/10/2021 8/19/2022 9/13/2023	
R) 2	CQI (policy)	11/11/2024	8/19/2022 9/13/2023	1/19/2021 9/10/2021
R) 3	CQI (morbidity/ mortality review)		9/10/2021 8/19/2022 9/13/2023 11/11/2024	1/19/2021
R) 4	CQI (track incidents)	11/11/2024	1/19/2021 9/10/2021 8/19/2022 9/13/2023	
R) 5	CQI (periodic audit of suicide prevention program)		1/19/2021 9/10/2021 8/19/2022 9/13/2023 11/11/2024	