Murray, et al. v. County of Santa Barbara, et al.;
Case No. 2:17-cv-08805
Remedial Plan Sixth Status Report
Terri McDonald Consulting LLC
Sacramento, CA
October 20, 2026

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Re: Sixth Expert Report on the Remedial Plan
Murray, et al. v. County of Santa Barbara, et al.;
Case No. 2:17-cv-08805

Dear Counsel,

Enclosed is the sixth expert report regarding compliance with the Remedial Plan (the "Plan") associated with the Stipulated Judgment in Murray, et al. v. County of Santa Barbara, et al. The report covers July 2025 through June 2026 and addresses custody operations, related clinical care, training, and oversight.

I appreciate the continued participation of the County, the Santa Barbara Sheriff's Office (SBSO), Wellpath, Counsel, and Class Members. Their input and the parties' thoughtful feedback have helped identify both meaningful progress and the work still needed.

This cycle shows important gains in reducing restricted housing and improving safety checks. It also shows how quickly progress can be lost when key staff leave or change assignments without adequate replacement coverage. Several practices supporting substantial compliance in the Fifth Report were not maintained.

Two provisions remained in substantial compliance, and the parties concur with discontinuing monitoring based on sustained performance:

- II.N.5 - Integration of Healthcare Grievances into Quality Management
- VII.C.2 - Restricting High-Risk Individuals from Cells with Suicide Hazards

Monitoring has been suspended for 13 provisions under the Court's May 4, 2026 order. The County remains responsible for maintaining compliance, and monitoring may be restored under Paragraph 53 of the Stipulated Judgment.

Four provisions advanced from partial compliance to substantial compliance:

- VII.A.1 - Housing Class Members in the Least Restrictive Setting
- VII.A.4 - Limiting the Duration of Restricted Housing
- VII.F.2 - Safety Checks
- VII.F.7 - Avoiding Release Directly from Restricted Housing

The reduction in restricted housing is a major achievement, supported by broader housing options and regular placement reviews. SBSO and Wellpath have made concerted efforts to find alternatives to restricted housing and are increasingly engaged in creative solutions for Class Members who would have been in restricted housing when monitoring began but are now residing in less restrictive and general population settings. Improved tracking and supervisory review also strengthened safety checks and the previous technical challenges associated with the safety check tracking systems have been resolved.

However, four provisions dropped from substantial compliance to partial compliance:

- III.F.11 - Supervisory Oversight and Tracking of the Disciplinary Process
- IV.G.3 - Staff Response to Suicide Attempts
- VII.G.1 - Grievance and Request Forms in Each Housing Unit
- VII.G.2 - Equal Access to Grievances and Requests in Restricted Housing

These declines involved lapses in disciplinary review, suicide-attempt tracking and review, documentation of emergency drills, and grievance access and oversight. These declines largely reflect staffing changes and the failure to sustain reforms through consistent oversight, policy, and auditing. The County has committed to return to substantial compliance in the next rating period by finalizing systems and training and improving oversight.

Use-of-force reporting and review remain a longstanding concern. Improved identification of incidents in 2025 was not sustained in 2026. The County reports renewed oversight after the review period; the next cycle will assess whether those changes produce reliable reporting, meaningful review, and corrective action. Updates to policy, training, tracking, and review remain long overdue.

While staffing review information has been shared over time, a custody staffing plan still has not been completed, and the County has not demonstrated that it has adequate custody staffing to comply with all applicable provisions of the Plan. Adequate staffing must extend beyond housing posts to support units, such as the compliance unit, access to care, use-of-force reporting and review, grievances, ADA coordination, classification, and other support functions. The County also has not demonstrated that daily supervisory and housing-officer coverage is sufficient.

Policies and training updates anticipated in the Fifth Report also remain unfinished while SBSO has committed to finalizing the policies and associated training. Other continuing concerns include access to healthcare, access to programming, out-of-cell time, program planning for SMIs in restricted housing, and access to tablets, along with planning for less restrictive housing and pre-release programming. Compliance requires evidence that these services and opportunities consistently reach individual class members.

The County deserves credit for moving forward with the Northern Branch Jail (NBJ) housing unit expansion project, which will allow portions of the Santa Barbara Main Jail (SBJ) to close. This is an important investment in improved housing and operations. Based on our recent meeting, we understand the County appears to support configuring four of the planned 64 bed units to separate into two small 32 bed units, with capacity to expand to 64. That approach offers greater flexibility to meet individual housing and treatment needs, and we look forward to seeing it reflected in the final design and staffing plan.

The planned IRC renovation also offers an opportunity to improve housing and safety. Before changes begin, the County should clearly articulate to the Experts the strategy to schedule renovations that ensure ongoing access to care, programming, out-of-cell time, tablets, visiting and other normal operational functions. The plan should explain how people currently housed in the IRC, including those with complex needs, will be safely relocated. Both temporary and renovated housing must address suicide hazards and allow appropriate staff observation. The renovations should address fixtures that pose suicide risks and the current lack of anti-jump barriers.

During the renovations, the appropriate Remedial Plan Experts and I are available to review plans with the County and monitor housing changes and any service interruptions. Subsequent reviews will assess whether required services were maintained and whether the completed changes improved conditions, including effects on other housing units and facilities.

The next period should focus on planning for a successful IRC renovation, finalizing and implementing the staffing plan, completing policies and training, increasing internal auditing and oversight, and ensuring consistent access to required services. Clear responsibilities, completion dates, and evidence of implementation remains essential.

The progress in restricted housing, safety checks, commitment to replace portions of SBJ and renovating the IRC is impressive and encouraging. Continued collaboration, adequate resources, and reliable supervision will be necessary to preserve those gains and address the remaining gaps. I appreciate the parties' continued work toward these goals.

Respectfully submitted,



Terri McDonald
Consultant/Monitor

Enclosure

Copy to:
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Homer Venters, M.D. – Medical Expert
Julian Martinez – ADA Expert
Daniel Godinez – Environmental Conditions Expert

Murray, et al. v. County of Santa Barbara, et al
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Terri McDonald Consulting LLC
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Santa Barbara County Jails
Remedial Plan Sixth Status Report
October 20, 2026

The following are excerpts from the Remedial Plan provisions (the "Plan") assigned to Terri McDonald for monitoring. The specific provision language is followed by the County's current response and the Expert's findings and recommendations. Unless otherwise noted in the body of the report, the reporting period is July 2025 through June 2026. For the restricted-housing population and placement analysis under VII.A.1, the K Unit refusal review under VII.D.6, and the safety-check sample under VII.F.2, January through June 2026 provided sufficient current information such that review of the prior six months (July-December 2025) was not necessary.

Provision	Requirement	Rating	Prior
II.F.9	Custody Escorts for Access to Care	PC	PC
II.N.5	Health Care Grievances Included in Quality Management Program	SC-DC	SC
III.A.7	Policies and Procedures on De-escalation and Role of Mental Health in Situations Involving SMI	PC	PC
III.D.6	SMI Exclusion from Restricted Housing	PC	PC
III.F.1	Qualified Mental Health Professional Role in Incarcerated Person Discipline	PC	PC
III.F.2	Develop Policies and Procedures for Mental Health Role in Discipline	PC	PC
III.F.4	Meaningful Consideration of Mental Health findings in Discipline	SC	SC
III.F.5	Meaningful Consideration to Minimize Deleterious Effects of Discipline	SC	SC
III.F.6	Documentation if Hearing Officer does not concur with clinical recommendations on discipline	PC	PC
III.F.7	Discipline Not to Prevent Delivery of Treatment or Adaptive Supports	DC	DC
III.F.8	No Discipline for Refusing Treatment or Medication	DC	DC
III.F.9	Effective Communication and Reasonable Accommodation in Disciplinary Process	PC	PC
III.F.10	Ensure the Provision of Effective Communication and Assistance in the Disciplinary Process	PC	PC
III.F.11	Supervisory Oversight and Tracking of Disciplinary Process	PC	SC
IV.D.3	Sanitation of Safety Cells	DC	SC-DC
IV.G.1	Availability of Safety Equipment; Staff Training/CPR	DC	SC-DC
IV.G.2	Monthly Inspection of Safety Equipment	DC	SC-DC
IV.G.3	Staff Response to Suicide Attempt	PC	SC
VII.A.1	Housing Incarcerated Persons in the Least Restrictive Environment	SC	PC
VII.A.2	Placement Based on Mental Health or Disability	PC	PC
VII.A.3	Placement Process for Restricted Housing	SC	SC
VII.A.4	Restricted Housing Reclassification Process	SC	PC

Provision	Requirement	Rating	Prior
VII.B.1	Classification Validation	SC	SC
VII.B.2	Clear Restricted Housing Classification and Documentation Guidelines	SC	SC
VII.B.3	Behavioral Health Participation in Placement Decisions for SMI	PC	PC
VII.B.4	Review and Documentation for Restricted Housing Placements	PC	PC
VII.B.5	PREA Screenings in a Private Location	DC	SC-DC
VII.C.1	Addressing Structural Suicide Hazards	SC	SC
VII.C.2	Restricting High-Risk Individuals from Cells with Suicide Hazards	SC-DC	SC
VII.C.3	Deactivation of Central 7 and Central 8	DC	DC
VII.C.4	Deactivation of South 1–16, West 18–29, and East 11–22	DC	DC
VII.D.1	Minimum Out-of-Cell Hours	PC	PC
VII.D.2	Northwest Out-of-Cell Hours	DC	SC-DC
VII.D.3	Normal Hours for Out-of-Cell Time	SC	SC
VII.D.4	Documenting Out-of-Cell Time	PC	PC
VII.D.5	Monthly Audits of Out-of-Cell Time	PC	PC
VII.D.6	Mental Health Referral for Repeated Refusal of Out-of-Cell Time	PC	PC
VII.E.1	Process for Disciplinary Restricted Housing Placement	DC	SC-DC
VII.E.2	Limitations on Disciplinary Restrictions of Out-of-Cell Time	SC	SC
VII.E.3	Thirty-Day Maximum for Disciplinary Restricted Housing	DC	SC-DC
VII.E.4	Prohibition on Safety Cells as Punishment	DC	DC
VII.E.5	Prohibition on Food Modification or Denial as Punishment	DC	DC
VII.F.1	Mental Health Review Before Restricted Housing Placement	SC	SC
VII.F.2	Safety Checks	SC	PC
VII.F.7	Avoid Release Directly from Restricted Housing	SC	PC
VII.F.8	Individualized Discharge Planning	PC	PC
VII.G.1	Grievance and Request Forms in Each Housing Unit	PC	SC
VII.G.2	Equal Access to Grievances and Requests in Restricted Housing	PC	SC
VII.G.3	Access to Phone Calls and In-Cell Activity Supplies	PC	PC
VII.H.1	Jail Capacity, Bed Assignment, and Sight-and-Sound Separation	PC	PC

NC — Non-Compliance; PC — Partial Compliance; SC — Substantial Compliance; SC-DC — Substantial Compliance, Recommend Discontinuation of Monitoring; DC — Monitoring Discontinued.

Commonly Used Acronyms

BHU	Behavioral Health Unit
CIT	Crisis Intervention Training
IDR	Inmate Disciplinary Report
IP	Incarcerated Person
MET	Medical Escort Team
MH	Mental Health
NBJ	Northern Branch Jail
RH	Restricted Housing
SBJ	Santa Barbar Jail
SBSO	Santa Barbara Sheriff's Office
STP	Sheriff's Treatment Program
SMI	Seriously Mentally Ill

PROVISIONS

II. F. Medical Care

9. The County shall designate and provide sufficient custody escorts to facilitate timely delivery of health care.

County Response – 2025 Status Report[1].

The County reports that it is continuing to implement this requirement. It states that NBJ generally meets the requirement because most visits occur in treatment rooms attached to housing units; that MET records are tracked and provided to the Experts; and that Wellpath was to begin tracking missed onsite and offsite appointments on November 1, 2025. The County and Wellpath report that they will address any appointments missed due to unavailable custody escorts and develop alternatives as necessary. The County anticipated substantial compliance within six months.

Expert Review

Compliance Rating: Partial Compliance
Prior Compliance Rating: Partial Compliance

Policy - Wellpath D-06 – Patient Escorts

Training - Disability Rights Remedial Plan Implementation

Metrics Medical Escort Team Tracking Reports
Grievances
Population Reports
Mental Health Expert Report

[1] Pursuant to the Joint Status Report of August 13, 2023, the County provides annual updates on or about November 1. Santa Barbara County 2025 Annual Status Report is the most recent County update for this report and will be referred to repeatedly as "County Response" in the header.

Observations

The Medical Escort Team (MET) operates at SBJ; NBJ does not have a MET. During this reporting period, SBJ listed an average of 3.7 deputy sheriff assignments to the MET each day reviewed, an increase from 2.6 in the Fifth Report. Coverage was not uniform: the recaps listed two or fewer MET assignments on 24 of the 120 sampled days and no assigned MET staff on one day.

It is positive to report, the additional resources corresponded with substantially more appointment activity and more completed appointments. Average scheduled appointments increased from 73 to 106 per day, while completed appointments increased from 52 to 61 per day. Table 1 provides the historical comparison beginning in July 2021, and Table 2 provides the month-by-month results for the current reporting period.

Table 1: Average Daily MET Escorts July 2021 through June 2026 – SBJ Only

Reporting Period	Appointments per day	Seen per day	Refused per day	Seen %	Refused %	ADP	Appointments per 100 Class Members
July 2021–June 2022*	105	86	16	82%	16%	697	15
July 2022–June 2023*	62	50	10	80%	18%	482	12.8
July 2023–May 2024*	63	55	14	78%	22%	413	15.3
July 2024–June 2025*	73	52	13	71%	18%	427	17
July 2025–June 2026	106	61	36	58%	34%	438	24.2

*Refer to prior monitoring reports for period details and sample periods. The current-period ADP is the average of the SBJ population reported on the 15th of each month from July 2025 through May 2026 (11 monthly counts).

Table 2: Average Daily MET Escorts – SBJ Only
July 2025 through June 2026*

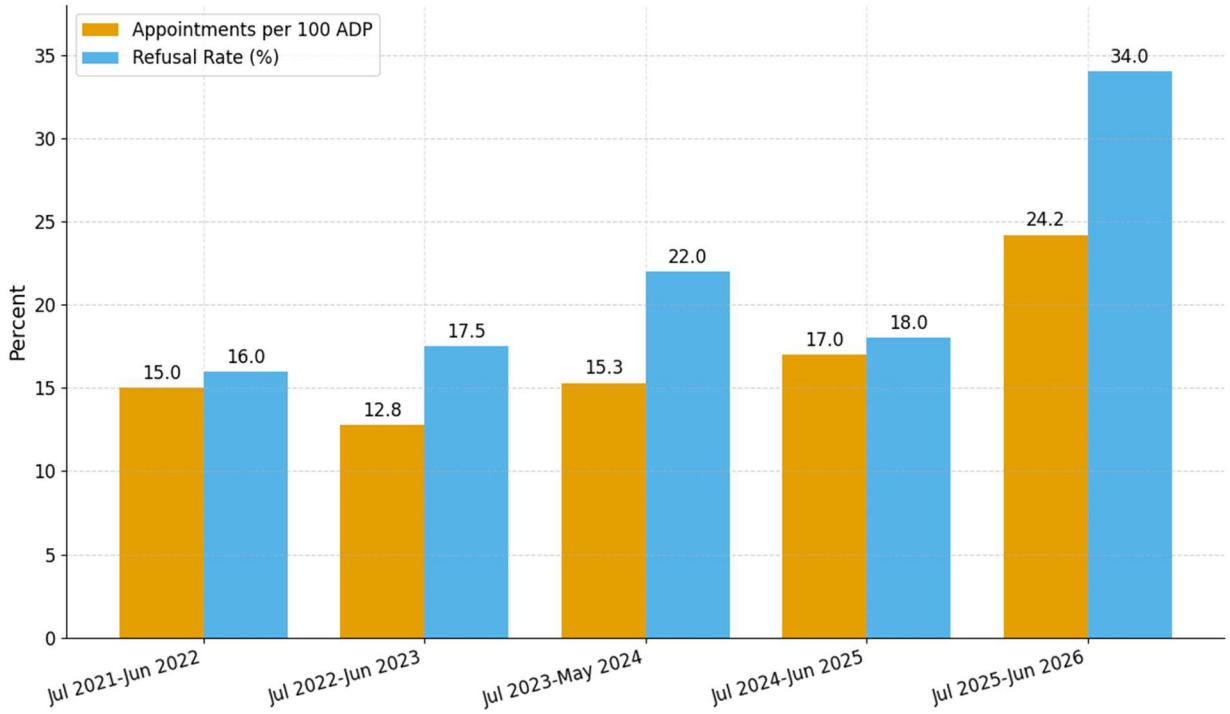
Month	Appointments/day	Seen/day	Refused/day	Seen %	Refused %
Jul-25	89	52	27	59%	31%
Aug-25	75	53	17	71%	22%
Sep-25	124	73	40	59%	32%
Oct-25	136	86	39	64%	28%
Nov-25	115	69	39	60%	34%
Dec-25	111	58	43	53%	39%
Jan-26	108	61	40	57%	37%
Feb-26	144	77	54	53%	37%
Mar-26	93	55	32	60%	35%
Apr-26	82	40	33	49%	41%
May-26	94	49	38	52%	41%
Jun-26	101	58	34	57%	34%
Average	**106**	**61**	**36**	**58%**	**34%**

*Based on the first ten daily MET recaps provided for each month.

The increase was not driven by population growth. The Fifth Report used an SBJ average daily population of 427. For this review, the SBJ population reported on the 15th of each month from July 2025 through May 2026 produced an 11-month ADP of 438. Using that current-period ADP, scheduled appointments

increased from 17.0 to 24.2 per 100 class members. Figure 1 displays this measure together with the refusal rate across the five monitoring periods.

Figure 1. Appointments per 100 class members and Refusal Rate by Monitoring Period



During this rating period, MET completed more appointments, but the proportion of scheduled appointments resulting in completed care declined. The completion rate fell from 71% to 58%, while refusals increased from 13 to 36 per day and the refusal rate increased from 18% to 34%. The pattern was not limited to the busiest months. February had the greatest appointment volume, but April and May had the highest refusal rates at 41%. The data therefore support both conclusions: MET escorted more people to completed appointments, but a much larger share of scheduled appointment capacity did not result in care. Without information about the reasons for refusals, repeated outreach, or whether declined slots could be reassigned, the records cannot establish the cause. They do identify a substantial opportunity to improve scheduling, engagement, and reuse of appointment capacity.

The MET records also have proof-of-practice limitations. The standardized form contains numerical fields for five assignments even when six staff members were listed, and some recaps recorded additional outcomes only in narrative notes. There were also isolated date and arithmetic inconsistencies, and the standard categories did not capture such issues as insufficient time or lack of an interpreter. The tables therefore use the standardized numerical fields from the first ten daily recaps provided for each month. They show documented activity consistently across the period but may not capture every escort-related encounter.

The 2025 and 2026 grievance trackers did not show a widespread pattern of grievances specifically alleging that custody failed to provide a medical escort. Three grievances directly raised escort or refusal-recording concerns: one alleged that transportation did not occur for an outside medical appointment, and two disputed that the individual had refused an appointment. The limited information in the trackers did not

permit independent validation or identification of the cause. The disputes nevertheless reinforce the need for reliable refusal documentation and appointment-level follow-up.

The County represented to Dr. Belavich that Wellpath would begin daily monitoring of missed and cancelled onsite and offsite appointments on November 1, 2025. His report does not provide results from that tracking, and no comparable missed-appointment report was included in the production reviewed for this provision.[2] The County also reported that Wellpath is currently evaluating a tracking mechanism for scheduled appointments and finalization of the effort is encouraged.

Dr. Belavich also reported that, based on the May 2026 tour and healthcare staff reports, unavailable escorts at times impeded confidential clinical encounters. He identified SBJ as the greater concern because treatment occurs off unit and escorts are more often required. During the May 2026 SBJ tour, clinical staff reported that custody staff were not always sufficient to support access to care.

The County has engaged in a staffing analysis. However, a formal completed staffing analysis has not been provided during this rating period for review.

Overall, performance improved in the number of MET resources, scheduled appointments, and completed appointments. Performance declined in the proportion of appointments completed and in the refusal rate. The increased MET resources are positive. The County reports the implementation of an interdisciplinary quality improvement process to evaluate escort needs, which resulted in increased MET staff. The County also reports that a tracking system is under development which should assist with adequately measuring appointment demand, missed and delayed care, the reasons for non-completion, and the custody resources required, which will assist in determining whether the current number of custody escorts is sufficient to facilitate timely delivery of healthcare. Partial Compliance remains appropriate.

Recommendations:

1. *[3]Wellpath to work with Santa Barbara Sheriff's Office (SBSO) and the Clinical Experts in creating a daily report of scheduled and missed clinical appointments. This should include both community and jail-based appointments and track the reason for the missed appointment.
2. *Continue to seek opportunities for additional offsite medical consultations contracts to provide services in the jails rather than in offsite facilities that require transport of the patients.
3. *Utilize an interdisciplinary team to address access to care barriers that have a nexus to custody resources. This should be included in the Quality Management review process.
4. *Finalize a comprehensive staffing analysis for clinical and custody to ensure adequate personnel to comply with this and other provisions. As appropriate, submit a staffing request via the budget process.
5. *In the interim, if insufficient custody resources are available to ensure access to care, continue to redirect resources in a manner that does not impact other provisions.
6. *Continue to ensure the newly established quality improvement plan regarding escorts also addresses needs at NBJ.
7. Work with the Medical and Mental Health Experts to engage in a meaningful Continuous Quality Improvement (CQI) project to address evaluating compliance with attendance at schedule appointments.

[2]Timothy Belavich, Ph.D., Remedial Plan Status Report (Aug. 2026), pp. 116–117.
[3] All recommendations that begin with an asterisk are carried over from previous report.

II.N. Quality Management

5. The County shall incorporate a systematic review of prisoner grievances related to health care into its Quality Management program.

County Response

The County reports that it has completed implementation of this provision and will maintain its current system while incorporating refinements based on the Expert's input.

Expert Review

Compliance Rating: Substantial Compliance - Recommend Discontinue Monitoring
Prior Compliance Rating: Substantial Compliance

Policies - Wellpath A-10 – Grievance Process for Health Care Complaints
Wellpath A-04 – Administrative Meetings and Reports

Training - Disability Rights Remedial Plan Implementation

Metrics Quality Management Reports

2025 and 2026 Grievance Trackers

Observations

The County continued the progress described in the Fifth Monitoring Report and maintained substantial compliance during this reporting period. Month after month, Wellpath reviewed healthcare grievances through the medical Quality Management process, separately for SBJ and NBJ, and used founded grievances to identify corrective action, responsibility, and closure. This sustained performance demonstrates that the process established during the last monitoring period is functioning in practice and is not simply a written policy or planned approach.

Specifically, Wellpath produced grievance-review materials covering each month from July 2025 through June 2026. The materials separately analyzed grievances at SBJ and NBJ, identified leading categories and founded grievances, and generally documented the corrective action, responsible staff, resolution date, and closure status for founded matters. This is the type of systematic, recurring review required by this provision.

The Medical Administrative Committee/Continuous Quality Improvement (MAC/CQI) minutes provide further proof that the grievance information was discussed as part of the management review process, rather than merely assembled in presentation materials. The minutes repeatedly summarize facility-level counts and trends, founded grievances, corrective actions, and results.[4]

The production has one proof-of-practice limitation. Response-time information was reported in some meeting minutes but was not presented consistently enough to calculate a full-period timeliness measure comparable to the Fifth Report's approximately 18 percent late-response finding. This limits the ability to compare response timeliness between monitoring periods, but it does not undermine the evidence that

[4]Wellpath, MAC Meeting Minutes July 2025 (meeting Aug. 26, 2025), Attendees and Grievance Review; MAC Meeting Minutes December 2025 & January 2026 (meeting Feb. 24, 2026), Attendees and Grievances & CQI Data; MAC Meeting Minutes February & March 2026 (meeting May 5, 2026), Attendees and Grievance Review.

grievances were reviewed monthly and that founded matters were assigned for corrective action and closure.[5]

The grievance trackers provide additional positive evidence. Across the 12-month review period, only two entries were clearly connected to an allegation about the response to, or implementation of, a healthcare grievance. One grievance alleged that an earlier healthcare grievance had not been answered. A second grievance alleged that an item promised in a prior response had not been received. Both were determined to be unfounded. Other entries alleging no grievance response were not healthcare grievances and are addressed under the custody grievance provisions.

The production did not include proof of the separate quarterly, custody-led grievance reviews described in the Fifth Report. That process is not required by this provision and will be addressed under Provisions VII.G.1 and VII.G.2. The recurring MAC/CQI minutes nevertheless confirm that custody participated in the medical Quality Management meetings: attendee lists included command and lieutenant-level custody representatives, and one meeting included the Chief, commanders, and lieutenants alongside Wellpath, County Health, and Behavioral Wellness representatives. This cross-disciplinary participation is positive, but the basis for compliance with this provision is the sustained, systematic medical review of healthcare grievances.

As a result, the Expert recommends that monitoring of this provision be discontinued, which has been agreed to by the parties and will be reflected in the next monitoring report.

III.A. Mental Health Policies and Procedures

7. The County shall develop policies and procedures on the use of de-escalation techniques and early involvement by Qualified Mental Health Professionals in situations involving an inmate with SMI.

County Response

The County reports that it is continuing to implement this provision. It states that Custody Operations Policy 241 has been updated; Policy 320 and Wellpath Policy F-03 are being updated; training, implementation tracking, and a process for post-incident review involving class members with SMI will follow approval; contracted mobile-crisis services are available from 11:00 p.m. to 7:00 a.m.; custody staff receive crisis-intervention training at the Core Academy; and the County is developing systems to track successful de-escalation and distinguish force involving people with SMI. The County also reports that it is exploring body-worn cameras for supervisors and other staff with frequent contact with people with SMI and anticipated completion within four to six months.

Expert Review

Compliance Rating:	Partial Compliance
Prior Compliance Rating:	Partial Compliance

Policies -	Custody Operations Policy G-07 – Use of Force – Draft
Training -	Disability Rights Remedial Plan Implementation Crisis Intervention Training (CIT) – No documentation provided for this reporting period

[5]Wellpath, MAC Meeting Minutes October and November 2025, Grievance Review; MAC Meeting Minutes May 2026, Grievance Review.

Metrics	Use of Force Logs Individual Use of Force Incident Packages Use of Force Reviews CIT Training Records Safety Cell and Related Incident Records Video Review Tours/Interviews

Observations

The County remains in Partial Compliance with this provision. The provision requires more than appropriate application of force once a physical confrontation occurs. It requires the County to develop and implement policies and procedures emphasizing de-escalation techniques and the early involvement of Qualified Mental Health Professionals when SBSO custody personnel interact with class members with serious mental illness. De-escalation requires that custody personnel are trained to recognize when time, communication, disengagement, supervisory consultation, mental-health intervention, or other alternatives may avoid or reduce the need for force. Five years into monitoring, SBSO has still not institutionalized the basic systems necessary to demonstrate that these requirements are being consistently implemented.

The Fifth Monitoring Report identified significant deficiencies in SBSO's ability to identify, document, track, and review use-of-force incidents involving class members with serious mental illness or exhibiting bizarre or unusual behavior, including whether de-escalation techniques and early mental-health involvement were used when circumstances permitted. During the latter portion of 2025, SBSO assigned a supervisor to specifically monitor incidents that might constitute reportable force. That intervention resulted in substantial improvement in the identification of incidents, collection of reports, and preservation of available video. The improvement demonstrated that the deficiencies were capable of being corrected when responsibility and accountability were clearly assigned.

However, the improvement was not sustained. The supervisor was subsequently redirected to other responsibilities, and SBSO did not establish a durable process to replace that function. The resulting regression was significant. For the January through June 2026 period, SBSO initially reported no use-of-force incidents for monitoring. Only after the Custody Expert questioned the absence of incidents did SBSO identify five. Because the current policy is not sufficiently clear regarding what constitutes a reportable use-of-force incident, additional force incidents identified during review of safety-cell placements, disciplinary records, and other custody documentation reflect that force is occurring far more prevalently than the County is identifying and reporting.

This is particularly troubling because it demonstrates that SBSO is not identifying the complete universe of force incidents involving the population protected by this provision. A system that identifies force only when an individual supervisor is specifically assigned to search for it—or when the external monitor discovers it through unrelated records—is not an adequate internal reporting and accountability system. Without reliable identification of incidents, SBSO cannot meaningfully track trends, evaluate de-escalation techniques, assess Wellpath involvement, identify avoidable force, provide corrective training, or determine whether it is complying with this provision. It is noted that the County reports the issue has been addressed since completion of the monitoring period and the Expert remains available to assist with implementation.

Policy and training remain similarly incomplete. Custody Operations Policy G-07 remains in draft form. No corresponding lesson plan was provided, and there was no documentation demonstrating crisis intervention training during this reporting period. The County therefore has not yet anchored the requirements of this provision in final policy, standardized training, and routine supervisory practice.

The individual incident review demonstrates both positive practice and significant areas of concern. Several incidents were emergent and the force appeared appropriate, including staff responses to fights or direct

assaults on custody personnel. In other incidents, SBSO custody personnel demonstrated patience and meaningful de-escalation before force was used. The strongest example involved a class member in crisis where Wellpath responded, staff repeatedly attempted to obtain voluntary compliance, offered food, changed personnel during the engagement, and conducted a videotaped emergency extraction only after the class member began banging his head against the wall. Another planned extraction was described in the reports as involving Wellpath before custody entered, although the available video did not clearly capture that engagement. These incidents are important because they demonstrate that the relationship between custody and Wellpath is established and that coordinated de-escalation can occur when the process is used.

Other incidents raised concerns directly related to the requirements of this provision. In one incident, custody personnel found a class member in significant distress and believed he was experiencing a panic attack. Custody appropriately contacted mental health, but the reports reflected that mental health directed the class member be moved to mental-health observation without first assessing him in person. The class member was not documented as having been assessed by mental health before removal from his cell or before placement in the mental-health observation cell. He resisted during the movement and force followed. The concern is not simply whether custody's response to the resistance was reasonable; it is whether an in-person clinical assessment and meaningful mental-health intervention before a nonemergent forced movement could have reduced or avoided the need for force.

In another nonemergent incident involving a behavioral-health class member, a deputy initiated hands-on contact without waiting for backup even though the deputy had initially indicated the escort would occur when another deputy became available. The class member then resisted significantly, resulting in a takedown and additional staff response. The incident package contained no use-of-force review, and the absence of body-worn-camera audio prevented a reliable assessment of the communication and de-escalation that preceded the force. This is the type of event that should be identified internally as a potential de-escalation, supervision, and training issue.

One particularly troubling incident illustrates the consequences of the absence of an effective review process. A class member in restricted housing was living in conditions and exhibiting behavior indicative of significant decompensation. After he threw water at a deputy, staff entered the cell rather than closing the door, disengaging, contacting a supervisor, and developing a planned response. A force incident followed in an area not captured by the fixed camera. The class member later appeared restrained in a wheelchair and was ultimately placed in a safety cell wearing only underwear and without a suicide blanket. The available documentation did not demonstrate that Wellpath assessed him in connection with the force or safety-cell placement. The circumstances of the placement and the conditions in the safety cell appeared potentially punitive rather than clearly necessary for a clinical or immediate safety purpose. There was no use-of-force report, complete incident package, or use-of-force review provided, and the incident was discovered only through review of the safety-cell records.

Other reviewed incidents likewise demonstrate why a documented review process is essential. In one nonemergent encounter, a behavioral-health class member was seated on an examination bed when custody personnel entered and used physical force after he failed to comply with staff direction. There was time to seek supervisory consultation and consider alternative responses, but the available record does not demonstrate that this occurred. In a separate pre-planned cell extraction, Wellpath was contacted and attempted to engage the class member before entry, which was appropriate; however, staff ultimately fired 18 pepper-ball rounds into the cell, and no substantive use-of-force review was provided addressing whether that level of force was necessary and proportionate. The issue is not that meaningful review can be affirmatively shown not to occur in every case; rather, SBSO has provided insufficient proof of practice demonstrating that meaningful supervisory and management review is routinely occurring. Until the County can demonstrate a functioning internal review and monitoring process, substantial compliance cannot be achieved.

The County's practice of videotaping planned cell extractions is positive and should continue. Those recordings provide information about the time leading up to force, staff planning, efforts at de-escalation, Wellpath participation, and the interaction between custody personnel and the class member. They also illustrate why body-worn cameras remain important for force incidents occurring outside planned extractions. Fixed cameras frequently contain blind spots and generally do not provide usable audio of staff-class member communication. Without audio, SBSO cannot reliably evaluate what de-escalation techniques were attempted, how instructions were delivered, how the class member responded, or whether additional time or alternative approaches were reasonably available. Body-worn-camera footage would make the same type of information available for spontaneous and nonemergent force incidents that is currently available when planned cell extractions are specifically videotaped.

It is also important to recognize that custody personnel do contact Wellpath with some regularity and that the working relationship between custody and Wellpath is well established. The incident sample includes examples in which Wellpath responded and participated in efforts to avoid or manage force. The concern is therefore not an absence of collaboration. The concern is whether SBSO can consistently demonstrate when Wellpath was contacted, whether Wellpath responded in person when circumstances warranted, what clinical recommendations were made, and how those recommendations informed the custody response. That information must be reliably documented and incorporated into the use-of-force review process.

The most significant concern under this provision remains systemic. The evidence does not establish that SBSO custody personnel routinely engage in excessive or inappropriate force, and the sample contains several examples of controlled responses and meaningful de-escalation. But the County has still failed to build the institutional structure necessary to assure compliance: it cannot reliably identify all relevant force incidents; reporting remains incomplete; Wellpath involvement is not consistently documented or assured; meaningful supervisory and management review has not been demonstrated through proof of practice; video evidence is frequently inadequate; policy remains unfinished; and required training has not been demonstrated.

These are longstanding deficiencies, not newly identified implementation issues. The Fifth Monitoring Report identified the same fundamental problems and anticipated that the County would develop a formal use-of-force reporting and review process during this reporting period. That did not occur. The temporary improvement created by assigning a dedicated supervisor demonstrates that SBSO understands the nature of the problem and is capable of improving performance, but the deterioration after that supervisor was redirected demonstrates that the practice was never institutionalized.

For this reporting period, the provision will remain in Partial Compliance because there is evidence of appropriate staff practice in a significant number of incidents, examples of meaningful de-escalation and Wellpath involvement, and a prior period of improved incident identification when dedicated oversight was in place. However, Partial Compliance should not be viewed as an indefinite rating while the same systemic deficiencies continue. The County must use the next reporting period to finalize and implement the policy and associated training, establish a reliable system for identifying all relevant force incidents, require and document appropriate Wellpath involvement, implement substantive supervisory and management review, improve video evidence, and demonstrate sustained internal auditing.

Recommendations:

1. *Finalize the Use of Force Policy and Pre-planned Use of Force policy to incorporate the provision.
2. *Once the policies and procedures have been updated, the expert will collaborate with the parties on the appropriate processes for expert monitoring of and reporting on implementation.
    a. This must include the process for post incident analysis of use of force incidents involving SMI incarcerated persons.

3. *Continue training to support the policies and procedures designed to build upon developing and implementing de-escalation techniques for the staff and early involvement of mental health.
4. *Continue to ensure 24/7 mental health coverage to assist with de-escalation and crisis incidents, which can include Mobile Crisis after hours if they report to the jail(s) and support de-escalation practices prior to planned force.
5. *Ensure all custody staff receive appropriate crisis intervention training (CIT).
6. *Provide information on all use of force incidents involving behavioral health incarcerated persons involving cell extractions, placement in a safety cell/mental health observation, and involuntary medication.
7. *Track and report potential cell extractions that were resolved without force through de-escalation techniques.
8. *Explore a body worn camera program, focusing on high force locations, such as intake, restricted housing and BHUs to permit internal evaluation of deescalation techniques employed by staff during force incidents.
9. Establish a formal internal use-of-force reporting, supervisory review, management review, and auditing process that captures all reportable force; reconciles use-of-force records against safety-cell, disciplinary, mental-health observation, and other custody records; and verifies that incident packages contain sufficient reports, video, mental-health documentation, and analysis to evaluate de-escalation, necessity, proportionality, and corrective action. This should include a dedicated use of force supervisor to oversee the use of force policy, training and review processes.

II. D. Mental Health Services, Housing, and Access to Care

6. The County shall not house inmates with SMI meeting criteria for placement in specialized mental health units in a segregation or isolation unit, except as outlined below.
    a) In rare cases where such an inmate presents an immediate danger or serious danger for which there is no reasonable alternative, such an inmate may be housed separately for the briefest period of time necessary to address the issue, and only with written justification for the placement that is approved by a jail commander or designee.
    b) The County shall continue to provide supervision, treatment,and out-of-cell time consistent with the inmate's Modified Individualized Treatment Plan.

County Response

The County reports that it is continuing to implement this provision. It states that expanded BHU capacity and the IRC-100 BHU have significantly reduced use of restricted housing for people with SMI; that people with SMI are not placed there because of mental-health status, although some remain for documented safety and security reasons; and that weekly multidisciplinary restricted-housing meetings address current behavior, alternatives, and reintegration. The County reports that it tracks out-of-cell time, continues to offer treatment and services, and will work with the Mental Health and Custody Operations Experts to expand programming. It anticipated completion within six to eight months.

Expert Review

Compliance Rating: Partial Compliance
Prior Compliance Rating: Partial Compliance

Policies - Custody Operations Policy 301 – Inmate Classification
Custody Operations Policy 305 – Bed Assignment
Custody Objective Classification Plan
Custody Housing Plan
Wellpath F03 – Mental Health Services
Wellpath G02 – Segregated Inmates

Training - Disability Rights Remedial Plan Implementation

Metrics - Restricted Housing Tracker Rosters
Restricted Housing Placement/Retention Forms
HARP Records and Structured Activity/Out-of-Cell Records
Modified Individual Treatment Plans and Programming Records
Sixth Mental Health Expert Report
Tours/Interviews

Observations

The Fifth Report continued this provision at Partial Compliance. It credited the County's expansion of Behavioral Health Units and the substantial reduction in restricted housing, but found that people with serious mental illness remained disproportionately represented and that the promised secure, small-group treatment model for those retained in segregation had not been implemented. The absence of programming tied to a Modified Individualized Treatment Plan remained the central barrier to compliance.

The progress identified in the Fifth Report continued. The detailed restricted-housing population, placement, length-of-stay, and out-of-cell-time data are discussed in provisions VII.A.1 through VII.A.4 and VII.D.1 through VII.D.6. In summary, the County substantially reduced the restricted-housing population, new placements, and average length of stay during this reporting period. Although approximately 78 percent of the remaining population was designated for mental-health services, essentially unchanged from 77 percent in the prior period, the average number of people with that designation declined from 15 to 6.[6].. Review of the initial-placement notices and retention reviews also showed that initial decisions generally identified an individualized safety or security basis, included clinical and supervisory participation, and increasingly considered Behavioral Health Unit, compatible-pair, walk-a-pair, and other alternatives. The evidence therefore does not establish that people were routinely placed in restricted housing solely because of SMI.

The remaining deficiency, however, is materially the same as it was in the Fifth Report. Retention reviews too often omitted current clinical status, out-of-cell participation, treatment, programming, and a measurable path to less restrictive housing. Dr. Timothy Belavich similarly found that some class members in IRC 100, IRC 400, NERH, and NBJ K Unit required Behavioral Health Unit-level care, while clinical vacancies limited programming and consistent treatment-plan implementation. There was still no meaningful, consistently implemented Wellpath or Sheriff's Treatment Program model for SMI and other Behavioral Health Unit-level class members who remained in restricted housing. HARP assisted classification and clinical coordination, but did not substitute for treatment and programming under a Modified Individualized Treatment Plan. The County's reduced reliance on segregation and stronger initial-placement practices are significant, but the lack of meaningful programming requires that this provision remain in Partial Compliance.

[6] These figures represent average population counts, not unique individuals. See Provision VII.A.1 for the restricted-housing population analysis comparing January–June 2025 with January–June 2026

Recommendations

1. *Continue to refine the specialized mental health units and update associated policies, forms and training.
2. *Expand the programming provisions of specialized mental health units to all specialized mental health and restricted housing units.
3. *Refine process to track structured out-of-cell activities.
4. *Finalize the restricted housing program policy
5. *Finalize the updates to all associated classification policies to comply with provision.
6. *Finalize all associated Wellpath policies, in partnership with the Mental Health Expert, to comply with this provision.
7. *Continue to provide proof of practice through restricted-housing roster tracking, placement and retention documentation, structured-activity records, and Modified Individualized Treatment Plans for SMI incarcerated persons placed in restricted housing.

III.F. Mental Health and Disability Input in the Jail Disciplinary Process

1. The County shall adopt policies and procedures that require meaningful consideration of the relationship of an inmate's behavior to a mental health or intellectual disability, the appropriateness of disciplinary measures versus clinical or other interventions, and the impact of disciplinary measures on the health and well-being of incarcerated persons with Disability.

County Response

Completed. The County reports that the process requiring mental health input in the disciplinary process has been implemented at both NBJ and Main Jail. Custody personnel review mental health recommendations before disciplinary hearings and do not deviate absent safety or security concerns. Mental health reviews disciplinary reports involving incarcerated persons identified as having SMI, and effective communication is used for those with identified communication needs. The County reports that Policy 363 has been revised, related Wellpath policy revisions are underway, supervisory personnel have been trained, and Staff Assistant training is continuing. The County expects to reach substantial compliance within four months.

Expert Review

Compliance Rating: Partial Compliance
Prior Compliance Rating: Partial Compliance

Policies - Custody Operations Policy 363 – Inmate Discipline
Custody Operations Policy 241 – Health Care
Wellpath Health Services Policy F-03 – Mental Health Services
Wellpath Health Services Policy G-02 – Segregated Incarcerated Persons
Hearing Worksheet Forms

Training - Disability Rights Remedial Plan Implementation
Disciplinary-process training and operational coaching

Metrics Completed Policies and associated forms
Disciplinary Reports
Special Conditions List

Observations

Since the Fifth Report, SBSO and Wellpath have continued the disciplinary process at both facilities. Standardized forms for clinicians, Staff Assistants, and hearing officers are routinely used. The current evidence reflects substantial proof of practice and a high level of compliance with the operational process.

At SBJ, internal auditing began during this review period and included review of mental health assessments, hearing-officer concurrence, Staff Assistant use, and documentation of effective communication. The results are reflected in Attachment A. This is a positive development. NBJ, however, did not sustain its disciplinary auditing and quarterly reporting. The facility-wide supervisory and auditing gap is addressed under Provision III.F.11.[7]

The policy work, however, was not completed during this review period. The May 8, 2026 policy tracker shows that Policies 363 and 241 and the related Policy 363 forms had been revised and sent for final formatting but were not finalized or published. SBSO reports that the policies were being converted to Lexipol format and would be rolled out in the next review period. The evidence does not establish that these policies or forms were promulgated during July 2025 through June 2026.

Wellpath policy work also remains incomplete. Mental Health Expert Dr. Timothy Belavich reported that the County continued to provide completed mental health disciplinary evaluation forms each month; the forms reflected thoughtful clinical consideration and helpful information for custody personnel, and multiple clinical staff had been trained. He also found that Wellpath Policies F-03 and G-02 and Custody Policy 363 had not been finalized.[8]

The County finalized a disciplinary training package consisting of a lesson plan, facilitator guide, presentation, and knowledge test. The materials address Policy 363, mental health consultation, JMS flags, Staff Assistant duties, accommodations and effective communication, and the required forms. They direct staff to complete and submit the Mental Health Review Form and to wait for the completed review before proceeding with the disciplinary hearing. During the May 2026 tour, the Expert also met with personnel responsible for training. The volume and quality of compliant practice suggest that training occurred. However, the County did not provide attendance records or other documentation identifying who was trained, the dates of training, the number of staff trained, or coverage across roles, facilities, and shifts.[9]

The County has sustained and improved the operational practice required by this provision. The remaining work under this provision is to finalize and promulgate the applicable Custody and Wellpath policies and forms and continue to provide and document the associated training. The lack of sustained facility-wide supervisory auditing is addressed under Provision III.F.11. The provision remains in partial compliance.

Recommendations

1. *Finalize and promulgate the disciplinary policies and necessary forms for Custody and Wellpath. Ensure the Mental Health Expert is involved, giving the Remedial Plan Experts and class counsel the opportunity to review and provide input before finalizing.
2. *Improve early identification of SMI and intellectual or developmental disability (IDD) class members by flagging them for clinical review before adjudication of a disciplinary infraction.
3. *Continue to provide training to assigned clinicians and hearing officers and document staff completion.
4. *Complete the planned ATIMS upgrade so the jail management system incorporates the improved disciplinary process and provides the information needed to implement these and related provisions.

[7] SBSO, IDR Analysis 2026, SBJ worksheet (Attachment A). The NBJ worksheet contains no 2026 audit data.
[8] Timothy Belavich, Ph.D., Sixth Annual Mental Health Report, Murray v. County of Santa Barbara, Case No. 2:17-cv-08805, at 53.
[9] SBSO, IDR Process Training (rev. May 1, 2025); Disciplinary Policy Lesson Plan; Disciplinary Policy Facilitator Guide; and Disciplinary Policy Multiple Choice Test.

III.F. Mental Health and Disability Input in the Jail Disciplinary Process

2. The County shall develop policies and procedures on the consideration of mental health input in the disciplinary process.

County Response

Please see the County Response to Provision III.F.1.

Expert Review

Compliance Rating: Partial Compliance
Prior Compliance Rating: Partial Compliance

Policies - Custody Operations Policy 363 – Inmate Discipline
Custody Operations Policy 241 – Health Care
Wellpath Health Services Policy F-03 – Mental Health Services
Wellpath Health Services Policy G-02 – Segregated Incarcerated Persons
Hearing Worksheet Forms

Training - Disability Rights Remedial Plan Implementation
Disciplinary-process training and operational coaching

Metrics Completed Policies and associated forms
Disciplinary Reports
Special Conditions List

Observations

Provision III.F.2 requires completed policies and procedures governing the consideration of mental health input in the disciplinary process. As discussed in Provision III.F.1, the operational process is in use. The facility-wide auditing gap is addressed under Provision III.F.11. Associated training has occurred, although the County did not provide documentation establishing who was trained or the scope of completed training.[10]

Because this provision specifically requires the development of policies and procedures, proof of operational practice cannot substitute for finalized and promulgated policies. The County remains in partial compliance.

Recommendations

1. *Refer to recommendations in Provision III.F.1.

III.F. Mental Health and Disability Input in the Jail Disciplinary Process

4. Staff shall meaningfully consider the Qualified Mental Health Professional's findings and any other available disability information when deciding what, if any, disciplinary action should be imposed.

County Response

Please see III.F.1. The County reports that the Expert found the County in substantial compliance with this provision.

Expert Review

Compliance Rating: Substantial Compliance
Prior Compliance Rating: Substantial Compliance

[10] SBSO, IDR Process Training (rev. May 1, 2025); Disciplinary Policy Lesson Plan; Disciplinary Policy Facilitator Guide; and Disciplinary Policy Multiple Choice Test.

Policies - Custody Operations Policy 363 – Inmate Discipline
Custody Operations Policy 241 – Health Care
Wellpath Health Services Policy F-03 – Mental Health Services
Wellpath Health Services Policy G-02 – Segregated Incarcerated Persons
Hearing Worksheet Forms

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Observations

Custody personnel generally considered the Qualified Mental Health Professional's findings before determining whether to impose discipline.

An evaluation of 108 completed disciplinary proceedings in which a mental health evaluation was required found that completed mental health input was available and custody's consideration of that input was documented in 97 matters, or 90 percent. The results were nearly identical by facility. At SBJ, consideration was documented in 63 of 70 applicable proceedings, or 90 percent. At NBJ, it was documented in 34 of 38 proceedings, or 90 percent. Thus, the systemwide result does not conceal a facility-specific compliance problem.[11]

In the remaining 11 proceedings, or 10 percent, no completed mental health evaluation was located; seven occurred at SBJ and four at NBJ. Where completed clinical input was available, the evaluation did not identify a matter in which the hearing officer simply disregarded it. Custody's response to mitigation recommendations and its documentation of departures are addressed under Provisions III.F.5 and III.F.6. The evaluation also identified six completed proceedings involving a class member identified in custody records with intellectual or developmental disability. Completed mental health input was available and considered in four. In the other two, both at SBJ, no completed Mental Health Review Form was located before custody imposed discipline. These records show positive progress in identifying and providing information concerning some class members with intellectual or developmental disabilities. The evidence does not yet establish, however, that the entire covered class is consistently identified or that disability information is consistently provided to hearing officers in every applicable matter. Although the County has maintained Substantial Compliance, the Expert does not recommend discontinuation of monitoring until consistent identification of the intellectually disabled and SMI populations and appropriate information-sharing are established. Identification and assistance are also addressed under Provisions III.F.1 and III.F.9.

Recommendations

1. *Refer to recommendations in Provision III.F.1.

[11] SBSO, IDR Tracker 2025; SBSO, IDR Tracker 2026; individual disciplinary packets reviewed for July 2025 through June 2026.

III.F. Mental Health and Disability Input in the Jail Disciplinary Process

5. Staff shall meaningfully consider the Qualified Mental Health Professional's input on minimizing the deleterious effect of disciplinary measures on the prisoner in view of his or her mental health or adaptive support needs.

County Response

Please see III.F.1.

Expert Review

Compliance Rating: Substantial Compliance
Prior Compliance Rating: Substantial Compliance

Policies - Custody Operations Policy 363 – Inmate Discipline
Custody Operations Policy 241 – Health Care
Wellpath Health Services Policy F-03 – Mental Health Services
Wellpath Health Services Policy G-02 – Segregated Incarcerated Persons
Hearing Worksheet Forms

Training - Disability Rights Remedial Plan Implementation
Disciplinary-process training and operational coaching

Metrics Completed Policies and associated forms
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Observations

The County maintained Substantial Compliance. The evaluation identified 108 completed disciplinary proceedings involving a class member identified as SMI and/or as having an intellectual or developmental disability. Completed mental health input was available in 97 proceedings. The compliance analysis below combines all 97 proceedings, without separating matters involving SMI from those involving intellectual or developmental disability. Fourteen records reflected non-concurrence with a clinician's mitigation or no-discipline recommendation. Two did not result in an identifiable sanction and therefore did not constitute a substantive departure for purposes of this provision. Custody imposed sanctions contrary to the clinical recommendation in 12 proceedings (12 percent) and imposed no contrary sanction in 85 (88 percent). Results were nearly identical at the two facilities: 55 of 63 SBJ proceedings (87 percent) and 30 of 34 NBJ proceedings (88 percent) resulted in no sanction contrary to the clinical recommendation.[12]

Six of the 12 sanction overrides involved one class member; the remaining six involved six different class members. The concentration in one class member and the consistency between facilities weigh against treating the exceptions as systemwide noncompliance. The documentation nonetheless presents a material concern. Most written rationales addressed whether the class member understood the conduct or knew right from wrong, rather than why the sanctions would not worsen the class member's mental health or adaptive-support needs. The verified sanctions included loss of commissary and visitation privileges; four NBJ matters also included loss of tablet privileges.

The Fifth Report found nearly universal concurrence, identified one reasoned departure, and rated the provision in Substantial Compliance. The present results reflect some regression, but the strong majority and consistent facility results support maintaining that rating. The Fifth Report's recommendation

[12] SBSO, IDR Tracker 2025; SBSO, IDR Tracker 2026; completed disciplinary packets reviewed for July 2025 through June 2026.

concerning timeframes and review before adjudication was partially implemented: finalized training establishes the disciplinary timeline and directs hearing officers to await a completed Mental Health Review Form. Policies 363 and 241 and the associated forms were not promulgated, however, and training-completion records were not provided. Wellpath identified and provided disability information concerning some class members with intellectual or developmental disabilities during this reporting period, which represents positive progress. The record does not yet establish consistent identification of the entire covered class or consistent provision of disability information before sanctions are determined. Although the County has maintained Substantial Compliance, the Expert does not recommend discontinuation of monitoring until that consistency is established and confirmed by the Mental Health Expert. The remaining policy, form, and training obligations are addressed under III.F.1.

Recommendations

1. *Refer to recommendations in Provision III.F.1.

III.F. Mental Health and Disability Input in the Jail Disciplinary Process

6. If custody staff do not follow the mental health input regarding whether the behavior was related to symptoms of mental illness or intellectual disability, whether any mitigating factors should be considered, and whether certain sanctions should be avoided, staff shall explain in writing why it was not followed.

County Response

Please see III.F.1.

Expert Review

Compliance Rating: Partial Compliance
Prior Compliance Rating: Partial Compliance

Policies - Custody Operations Policy 363 – Inmate Discipline
Custody Operations Policy 241 – Health Care
Wellpath Health Services Policy F-03 – Mental Health Services
Wellpath Health Services Policy G-02 – Segregated Incarcerated Persons
Hearing Worksheet Forms

Training - Disability Rights Remedial Plan Implementation
Disciplinary-process training and operational coaching

Metrics Completed Policies and associated forms
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Observations

Of the 97 completed disciplinary proceedings with documented mental health input, custody imposed a sanction contrary to the clinical recommendation in 12. Hearing officers provided a written explanation in 10 of those 12 proceedings (83 percent). NBJ documented an explanation in all four sanction overrides; SBJ did so in six of eight (75 percent).[13]

The disciplinary form contains a designated field for explaining why a mental health recommendation was not followed, and hearing officers generally used it. The two SBJ exceptions involved guilty findings and loss of commissary and visitation privileges, but the override field was left blank. In several other matters,

[13] SBSO, IDR Tracker 2025; SBSO, IDR Tracker 2026; completed disciplinary packets reviewed for July 2025 through June 2026.

the written explanation was limited to the class member's awareness of the conduct or ability to distinguish right from wrong. Those explanations should be more directly tied to the clinical recommendation concerning discipline or sanctions, but they are materially different from the two matters in which custody provided no written explanation.

The Fifth Report rated this provision in Partial Compliance and referred the County to the recommendations under III.F.1 and III.F.5. Because the Fifth Report described nearly universal concurrence with clinical recommendations, it provided little opportunity to assess implementation of the written-explanation requirement. The greater number of sanction overrides during this reporting period permits a more meaningful evaluation. The prior recommendations were partially implemented. SBSO finalized training that requires a written explanation when a hearing officer overrides clinical input, but Policies 363 and 241 and the associated forms were not promulgated, and training-completion records were not provided. The central practice concern is the difference between the facilities. NBJ documented the required explanation in every applicable proceeding, while SBJ did so in only six of eight (75 percent). The two SBJ omissions demonstrate that the written-explanation requirement requires additional training at that facility. The provision therefore remains in Partial Compliance.[14]

It is anticipated that, if SBJ can address the lack of documentation, this provision can reach Substantial Compliance in the next reporting period.

Recommendations

1. Ensure that hearing officers clearly document the reason for deviation from the MH recommendations to articulate the reason the hearing officer(s) determined the behavior was not related to mental illness/developmental disability and/or the reason the sanction was imposed despite MH recommendation.

III.F. Mental Health and Disability Input in the Jail Disciplinary Process

7. Inmates shall not be subjected to discipline in any manner that prevents the delivery of mental health treatment or adaptive support needs.

Pursuant to the parties' stipulated joint request and the Murray court's May 4, 2026 order (Docket 106), monitoring for this provision has been suspended. The provision will therefore be subject to future monitoring only if it is determined that the County is no longer in substantial compliance, consistent with the procedure set forth in Paragraph 53.

III.F. Mental Health and Disability Input in the Jail Disciplinary Process

8. Inmates shall not be subject to discipline for refusing treatment or medications, or for engaging in self-injurious behavior or threats of self-injurious behavior.

Pursuant to the parties' stipulated joint request and the Murray court's May 4, 2026 order (Docket 106), monitoring for this provision has been suspended. The provision will therefore be subject to future monitoring only if it is determined that the County is no longer in substantial compliance, consistent with the procedure set forth in Paragraph 53.

III.F. Mental Health and Disability Input in the Jail Disciplinary Process

9. The County shall provide reasonable accommodations during the disciplinary process for inmates with mental health or intellectual disability.

County Response

Please see III.F.1.

[14] SBSO, IDR Process Training (rev. May 1, 2025); SBSO, Disciplinary Policy Lesson Plan; SBSO, Disciplinary Policy Facilitator Guide; SBSO, Disciplinary Policy Multiple Choice Test.

Expert Review

Compliance Rating: Partial Compliance
Prior Compliance Rating: Partial Compliance

Policies - Custody Operations Policy 363 – Inmate Discipline
Custody Operations Policy 241 – Health Care
Wellpath Health Services Policy F-03 – Mental Health Services
Wellpath Health Services Policy G-02 – Segregated Incarcerated Persons
Hearing Worksheet Forms

Training - Disability Rights Remedial Plan Implementation
Disciplinary-process training and operational coaching

Metrics Completed Policies and associated forms
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Observations

There was noticeable improvement during this monitoring period in the provision and documentation of accommodations during disciplinary proceedings. The Fifth Report found that, during Q2 2025, Staff Assistants were assigned in 48 percent of required proceedings and effective communication was documented in 38 percent. During this reporting period, an evaluation identified 108 completed disciplinary proceedings involving a class member identified as SMI and/or as having an intellectual or developmental disability. Sixty-seven resulted in a documented guilty finding and therefore required a Staff Assistant. A Staff Assistant worksheet was present in 59 of 67 (88 percent): 28 of 32 at SBJ (88 percent) and 31 of 35 at NBJ (89 percent).[15]

The Fifth Report's recommendations were implemented in part. SBSO developed and used the Staff Assistant worksheet, updated the disciplinary tracker, finalized disciplinary training addressing accommodations, and published ADA Policy 209 in May 2026. The County did not provide training-completion records, and the materials reviewed did not establish completion of translation-specific training. Policy 363 and Wellpath Policy F-03 also remained incomplete. Wellpath identified and provided disability information concerning some class members with intellectual or developmental disabilities during this reporting period. This is positive progress, but the record does not yet establish consistent identification of the entire covered class or consistent transmission of that information in every applicable disciplinary matter. The Staff Assistant exceptions, incomplete clinician effective-communication documentation, and unresolved identification process prevent a finding of Substantial Compliance. The provision remains in Partial Compliance. Given the substantial improvement demonstrated during this reporting period, the County is highly likely to achieve Substantial Compliance in the next reporting period if it resolves these remaining issues.

Recommendations

1. *See recommendations in Provision III.F.1.
2. *Continue to provide and document Staff Assistant and effective-communication training and continue use of the Staff Assistant worksheet.

[15] SBSO, IDR Tracker 2025; SBSO, IDR Tracker 2026; completed disciplinary packets reviewed for July 2025 through June 2026.

III.F. Mental Health and Disability Input in the Jail Disciplinary Process

10. The County shall take reasonable steps to ensure the provision of effective communication and necessary assistance to inmates with Disability at all stages of the disciplinary process.

County Response

Please see III.F.1.

Expert Review

Compliance Rating: Partial Compliance
Prior Compliance Rating: Partial Compliance

Policies - Custody Operations Policy 363 – Inmate Discipline
Custody Operations Policy 241 – Health Care
Wellpath Health Services Policy F-03 – Mental Health Services
Wellpath Health Services Policy G-02 – Segregated Incarcerated Persons
Hearing Worksheet Forms

Training - Disability Rights Remedial Plan Implementation
Disciplinary-process training and operational coaching

Metrics Completed Policies and associated forms
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Observations

This provision requires Custody to provide the assistance necessary for a class member with a disability to understand and participate in every stage of the disciplinary process, and to document effective communication. Depending on the class member's needs, that assistance may include a Staff Assistant who speaks the class member's primary language, an interpreter at the hearing, ASL or other assistance for a class member with a hearing disability, or assistance reviewing written materials for a class member with a visual disability. In prior reports, language assistance for non-English-speaking class members was discussed under Provision III.F.9. It is addressed here because effective communication and necessary assistance are the focus of Provision III.F.10. Other accommodations for class members with mental health or intellectual disabilities remain addressed under Provision III.F.9.

The documentation for non-English-speaking class members has improved since the Fifth Report. The most directly comparable historical finding was that language assistance had been documented in only 16 percent of applicable hearings in early 2023. The Fifth Report also reported that, during Q2 2025, the County documented a Staff Assistant in 48 percent of required hearings and effective communication in 38 percent; however, those two figures covered the broader population requiring assistance and were not limited to non-English-speaking class members. They therefore provide general context but are not directly comparable to the current language-assistance findings.[16]

Hearing officers checked or otherwise documented effective communication on the disciplinary forms in all 108 SMI/IDD proceedings. This form documentation does not establish that required language assistance was provided to non-English-speaking class members; that issue is evaluated under Provision III.F.10. Clinicians documented effective communication on the Mental Health Review Form in 80 of 108 (74 percent): 49 of 70 at SBJ (70 percent) and 31 of 38 at NBJ (82 percent). Thus, the principal documentation deficiency was at the clinical stage. SBJ's internal audit reported assistance in all 44 proceedings it identified as requiring a Staff Assistant or interpreter, but the packet review identified four guilty SMI proceedings at SBJ without a Staff Assistant worksheet. In one, the audit recorded that assistance

[16] Murray Fifth Custody Monitoring Report, Provision III.F.9.

was provided; in the other three, it did not identify a Staff Assistant as required. The internal audit therefore did not reliably capture the exceptions identified in the underlying records.

This represents improvement over prior reporting periods in the documentation of effective communication during disciplinary proceedings.

During this reporting period, 63 completed disciplinary proceedings involved a documented need for language assistance. Records stating that the class member was bilingual or did not require language assistance were excluded. For these proceedings, effective participation required two separate forms of assistance: a Staff Assistant who spoke the class member's primary language and met with the class member before the hearing, and assistance in the class member's primary language during the hearing. Both were documented in 43 of 63 proceedings, or 68 percent. Performance was substantially stronger at NBJ, where both were documented in 35 of 44 proceedings, or 80 percent, than at SBJ, where both were documented in eight of 19 proceedings, or 42 percent. Hearing-stage language assistance alone was documented in 53 of 63 proceedings, or 84 percent—42 of 44 at NBJ and 11 of 19 at SBJ. A checked box stating that the class member understood the proceeding was not treated as proof of effective communication when the record did not show communication in the class member's primary language or the use of an interpreter. Similarly, providing an interpreter at the hearing did not cure the absence of the required primary-language Staff Assistant before the hearing.[17]

The records provided little opportunity to evaluate how Custody assists class members with hearing or visual disabilities. Four disciplinary reports involved a class member flagged as hearing impaired, but none resulted in a completed hearing. No completed disciplinary proceeding involving a class member identified as visually impaired was located. This is not a compliance failure; it means there was no proof of practice during this reporting period concerning ASL, other hearing-related assistance, accessible written materials, or assistance for a class member with a visual disability. The County reported that the planned ATIMS upgrade will improve the ADA tracker and integrate information from the electronic health record into the jail management system. If implemented as described, the upgrade should help Custody identify class members who require language, hearing, visual, or other communication assistance, but it remained planned work during this reporting period.[18]

The County has made measurable progress, particularly at NBJ, but the inconsistent provision and documentation of both required forms of language assistance—most notably at SBJ—does not support a finding of Substantial Compliance. The provision remains in Partial Compliance. The County is well positioned to achieve Substantial Compliance if it consistently provides and documents necessary assistance and effective communication at every stage and demonstrates effective practices for class members with hearing and visual disabilities.

Recommendations

1. *Coordinate with the ADA Expert concerning effective communication and necessary assistance for class members with hearing and visual disabilities.
2. Complete the planned ATIMS ADA-tracking improvements so Custody personnel are notified when a class member who receives a disciplinary report requires communication assistance or other supports.

[17] SBSO, IDR Tracker 2025; SBSO, IDR Tracker 2026; completed disciplinary packets reviewed for July 2025 through June 2026.
[18] Santa Barbara County, November 2025 Status Report, Provisions V.E.1 and V.E.3, pp. 30–31.

III.F. Mental Health and Disability Input in the Jail Disciplinary Process

11. The County shall designate a supervisory-level custody staff member who shall be responsible for ensuring consistency in disciplinary practices and procedures. The County shall track and monitor this process, including the frequency that the recommendation of the Qualified Mental Health Professional was followed.

County Response

Completed. The County reports that the Expert found the County in substantial compliance with this provision.

Expert Review

Compliance Rating: Partial Compliance
Prior Compliance Rating: Substantial Compliance

Policies - Custody Operations Policy 363 – Inmate Discipline
Post Orders

Training - Disability Rights Remedial Plan Implementation
Disciplinary-process training and operational coaching

Metrics Staffing Reports
Interview with designated supervisors

Observations

The Fifth Report rated this provision in Substantial Compliance based on the work of a dedicated supervisor who audited disciplinary proceedings at both facilities and generated compliance information for management review. Because that supervisor was eligible for retirement, the Fifth Report emphasized the need for a trained backup.[19]

It is positive that SBJ assigned a supervisor who continued internal auditing during this reporting period. The audit reviews the disciplinary safeguards addressed in these provisions, including whether the hearing officer followed the mental health recommendation. Attachment A to the Report provides an example of the audit conducted by SBJ. SBSO should continue working with the Expert to refine the audit measures, but the establishment and continued use of the SBJ audit is meaningful progress.

NBJ did not identify a replacement supervisor after the prior supervisor retired. As a result, NBJ stopped conducting disciplinary audits and preparing quarterly reports. The County therefore did not maintain the facility-wide supervisory and monitoring system that supported the prior rating.

Although SBJ is producing an audit, the record does not show that SBSO management reviews the findings, identifies trends, directs corrective action, and verifies improvement. The audits appear to be reviewed primarily by the Monitor rather than used as an internal compliance-management tool. Changes to the Compliance Team affected continuity, but the broader concern is that system transformation remains person-dependent rather than institutionalized. Sustainable compliance requires management to review and act on its own compliance information. This provision is reduced from Substantial Compliance to Partial Compliance. SBSO has committed to reestablishing internal auditing at NBJ in the next reporting period.

Recommendations

1. *Conduct a thorough analysis of the needs to adequately resource a Compliance team to implement the Agreement.
2. *Ensure the person assigned to this provision has the training, time, support and authority to completely reform the disciplinary process, including associated policy, forms, training and tracking.

[19] Murray Fifth Custody Monitoring Report, Provision III.F.11.

3. *Create or update post orders for identified supervisor.
4. *Finalize the Discipline Policy which formalizes the supervisors' responsibilities in oversight of the disciplinary process.
5. Designate and maintain a trained supervisory-level custody staff member and backup at each facility to conduct disciplinary audits and prepare quarterly reports.
6. Conduct and document a quarterly management review of disciplinary audit findings at both facilities, including trends, corrective action, and follow-up to determine whether corrective action was effective.

IV. SUICIDE PREVENTION

IV.D. Treatment and Conditions for Individual Prisoners on Suicide Precautions

3. Safety cells shall be sanitized after every use and the sewer grate inspected to ensure cleanliness and appropriate conditions.

Pursuant to the parties' stipulated joint request and the Murray court's May 4, 2026 order (Docket 106), monitoring for this provision has been suspended. The provision will therefore be subject to future monitoring only if it is determined that the County is no longer in substantial compliance, consistent with the procedure set forth in Paragraph 53.

IV. G. Emergency Response

1. The County shall keep an emergency response bag that includes appropriate equipment, including a first aid kit, CPR mask or Ambubag, 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 bag and shall receive regular training on emergency response procedures, including how to use appropriate equipment.
2. The County shall ensure that all emergency response equipment at the jail is inspected monthly and after each use and is repaired and replaced as needed. The County shall ensure that the jail maintains a service log for all emergency response equipment.

Pursuant to the parties' stipulated joint request and the Murray court's May 4, 2026 order (Docket 106), monitoring for this provision has been suspended. The provision will therefore be subject to future monitoring only if it is determined that the County is no longer in substantial compliance, consistent with the procedure set forth in Paragraph 53.

IV. G. Emergency Response

3. It shall be the policy of the County that any staff who discovers a prisoner attempting suicide shall immediately respond and alert other staff to call for medical personnel. Trained staff shall immediately begin to administer standard first aid and/or CPR, as appropriate.

County Response

The County reports this provision is complete. It states that the County and Wellpath conduct monthly Suicide Prevention Committee meetings and that staff were trained and corrective action was initiated.

Expert Review

Compliance Rating: Partial Compliance
Prior Compliance Rating: Substantial Compliance

Policy -	Custody Operations 242 – Suicide Prevention
Training -	Disability Rights Remedial Plan Implementation
	CPR First Aid
Metrics	Lists of all Serious Suicide Attempts
	Suicide Prevention Committee Meeting Notes
	Review of Critical Incidents
	Tours/Interviews
	Training Rosters

Observations

This provision asks a straightforward question: when staff discover a suicide attempt, do they immediately intervene, summon medical personnel, and provide first aid or CPR when needed? The County returned to Substantial Compliance in the Fifth Report after correcting the hesitation and delayed cell entry identified in an October 2023 suicide. The current record does not support maintaining that rating. Some reviewed responses were prompt, but the County cannot identify all serious suicide attempts, and the process meant to review each response could not be validated. The County reports that they are focused on improving coordination between Wellpath and SBSO concerning the tracking and review of suicide attempts.

Custody produced two incidents for review under IV.G.3. Two more suicide-related emergencies surfaced in use-of-force records reviewed under another provision. Dr. Belavich reported six serious suicide attempts between April 2025 and March 2026, but questioned the accuracy of the data and reported that only one had been reviewed. It is not known whether those six overlap with the four incidents identified by the Custody Expert or concern different events. Without a common, accurate list, compliance cannot be evaluated in every serious suicide attempt.[20]

The only identified response of concern uncovered during this rating period occurred at NBJ on August 18, 2025. A deputy saw a class member actively pulling a shirt tied around the neck, called for other deputies, opened the food port, ordered the person to stop, and put on gloves. Waiting for backup may sometimes be reasonable, but according to the reports available, approximately three minutes passed before staff entered while the class member was actively asphyxiating themself. No video was provided. The report does not explain the delay or document an immediate summons for medical personnel. As written in the incident report, the class member was breathing and did not lose consciousness, so CPR was not indicated. The delay nevertheless was not an immediate response.

Other known responses were prompt. At SBJ on March 5, 2026, after a class member jumped from an upper tier, video shows custody and medical personnel arriving in approximately one minute. They responded together, obtained vital signs, summoned emergency medical services, and applied spinal precautions. The class member remained alert and stable, so CPR was not indicated. The multidisciplinary review found the response, equipment, communications, coordination, and lifesaving measures appropriate.

Two incidents found in the use-of-force records also show prompt intervention. In one, staff saw a ligature tightly wrapped around a class member's neck, immediately entered, controlled the person, and removed the ligature before medical and behavioral-health evaluation.

[20]Timothy Belavich, Ph.D., August 2026 Remedial Plan Status Report: Murray v. County of Santa Barbara, Case No. 2:17-cv-08805, pp. 111–12.

In the other, a tower officer saw a class member threatening to hang themself on the yard. Staff responded, used force, and took the person under control; there was no loss of consciousness or serious injury. Neither incident was included in the suicide-attempt production, and the records do not establish the timing of medical notification or whether first aid was provided when required.

This uneven record shows why collaborative review matters. After each serious attempt, the Suicide Prevention Committee should bring Custody, medical, Behavioral Health, and supervisors together to examine entry, medical notification, first aid or CPR, coordination, and corrective action. The Fifth Report already noted inconsistent committee documentation. During this period, only one multidisciplinary review was provided, and no consistent minutes showed that each applicable response was examined. Consistent with Dr. Belavich's findings concerning poor tracking and oversight, the collaborative review process could not be validated.

Quarterly drills are also missing. The Fifth Report called for documented emergency-response drills each quarter during this review period. None were documented at either facility. The latest documented drills—May 19, 2025, at NBJ and March 31, 2025, at SBJ—predated the rating period. The County therefore did not show that staff at both facilities continued to practice the response required by this provision.

Custody Operations Policy 242 remains pending publication. Training materials describe the required response, but current completion rosters and CPR/First Aid records were not provided. The evidence establishes expectations, but not consistent implementation.

The regression from Substantial to Partial Compliance is not based on a finding that every reviewed response failed. It is based on one unexplained delay during an active ligature attempt and the loss of the procedures and safeguards that supported the Fifth Report's rating: serious attempts are not being identified and reviewed consistently, the collaborative review process was not shown to be functioning, and quarterly drills were not documented. The County has not demonstrated that immediate response is institutionalized at both facilities. Partial Compliance is appropriate.

Recommendations

1. *The Suicide Prevention Committee should resume meeting at least quarterly and should include an assessment of the rendering of first aid and CPR in all incidents warranting intervention.
2. *Continue to train staff on expectation and ensure CPR/First Aid training is up to date.
3. *Provide Experts monthly lists of all serious suicide attempts and completed suicides.
4. Consistently conduct and document quarterly emergency- and suicide-response drills at both SBJ and NBJ, assessing immediate entry and medical notification, first aid or CPR, coordination, supervision, and corrective action.
5. Restore and document a multidisciplinary suicide-review process that evaluates each serious or apparent suicide attempt for immediate entry, immediate medical notification, first aid or CPR, custody-medical coordination, supervisory review, and needed corrective action.

VII. CUSTODY OPERATIONS/SEGREGATION

A. General Principles

1. Prisoners shall be housed in the least restrictive setting necessary to ensure their own safety, as well as the safety of staff and other prisoners.

County Response

The County reports that it is continuing to implement this provision. It contracted with the JFA Institute to validate the classification instrument and implemented several recommendations. One remaining change requires an ATIMS jail-management-system upgrade for which funding has been allocated. The County also opened a 32-bed transition unit for people leaving behavioral-health housing who would benefit from continued programming and conducts weekly multidisciplinary restricted-housing meetings to develop alternative placements. It anticipated full compliance within six months, when the jail-management-system upgrades were expected to be completed.

Expert Review

Compliance Rating: Substantial Compliance
Prior Compliance Rating: Partial Compliance

Policies - Custody Operations Policy 301 – Classification
Custody Objective Classification Plan
Custody Housing Plans

Training - Disability Rights Remedial Plan Implementation

Metrics Restricted Housing Trackers; Placement and Duration Analysis; Tours/Interviews

Observations

The fifth monitoring report documented a system moving in the right direction but not yet demonstrating that the change was sufficiently durable. The County had validated its classification scoring process with Dr. James Austin, maintained Behavioral Health Units at both facilities, and added a step-down option in IRC 200. During January through June 2025, the average daily population of all restricted-housing units declined to 19 Class Members with a high of 23 and low of 16 individuals per month on average. Those results were encouraging, but the gains were still recent, people with mental-health needs remained heavily represented, and proof that alternative placements and programming were consistently available was incomplete.

The Sixth Mental Health Expert Report provides current confirmation that the less-restrictive continuum has expanded. Dr. Timothy Belavich reports that the Behavioral Health Units now provide a functional capacity of 112 beds across the two facilities and that the County established a BHU in IRC 100 for people who cannot program in a Behavioral Health Unit but do not require restricted housing. The report also notes that suicide-resistant observation cells were retrofitted at SBJ and are intended to replace safety cells for some people on suicide precautions. These developments support the decline in restricted housing documented below. While beyond this reporting period, the County also reports the completion of the property and privilege form and implementation of the updated Suicide Prevention Policy, which will increase individualized assessments of privileges and property for Class Members on suicide observation.

The same report identifies important implementation work that remains. Policies and training governing the retrofitted observation cells were not yet complete, the property-and-privilege process had not been implemented, and clinical vacancies continued to limit consistent programming and individualized treatment in several complex housing units. The relevant mental health provisions therefore remained in partial compliance. Those findings qualify, but do not negate, the substantial custody-side progress reflected in the current restricted-housing data.

The use of restricted housing has substantially reduced during this review period. The following table presents the average daily population in the designated restricted-housing locations during this review period.

Table 3: Restricted Housing Average Daily Population

January through June 2026

Month	SBJ — ADP	SBJ — MH (avg)	SBJ — % MH	NBJ — ADP	NBJ — MH (avg)	NBJ — % MH	Combined — ADP	Combined — MH (avg)	Combined — % MH
Jan	9	8	88%	5	3	56%	13	10	77%
Feb	3	2	72%	4	4	96%	7	6	86%
Mar	0	0	100%	7	5	73%	8	6	74%
Apr	4	4	100%	5	4	79%	8	7	88%
May	3	3	97%	1	0	0%	5	3	72%
Jun	2	2	100%	1	0	0%	3	2	69%
Monthly Average	**4**	**3**	**93%**	**4**	**3**	**51%**	**7**	**6**	**78%**

(Sums may not add up due to rounding.)

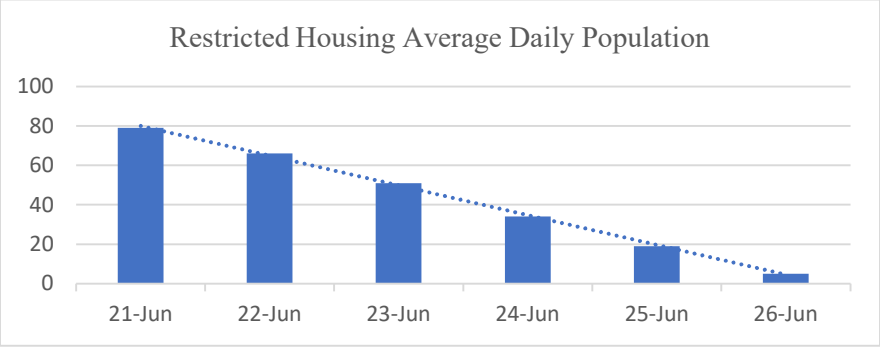
From January through June 2026, the combined restricted-housing ADP fell from approximately 13 to 3. The six-month combined average was 7, compared with 19 during the same period in 2025—an approximate 61 percent reduction. SBJ averaged 4 people in restricted housing, down from 13, while NBJ averaged 4, down from 6. The June comparison is even more pronounced: the combined ADP declined from 16 in June 2025 to 3 in June 2026, an approximately 81 percent decrease. Because the reduction persisted across the period and across facilities, it cannot reasonably be attributed to a single unusually low census day.

The following table and chart compare the June 2026 point-in-time population to the longer trend beginning in June 2021, which demonstrates the enormity of SBSO's commitment to reduce reliance on restricted housing.

Table 4: Restricted Housing ADP Point in Time[21]

Date	21-Jun	22-Jun	23-Jun	24-Jun	25-Jun	26-Jun
ADP	79	66	51	34	19	5

[21] Does not include IRC 100 and non-designated restricted housing class members in IRC 400, although these units function as quasi restricted housing units



The longitudinal measure reinforces the monthly findings. The June point-in-time restricted-housing population declined from 79 in 2021 to five (5) in 2026, a reduction of approximately 94 percent. It also fell to 19 in June 2025. Mental-health status, however, remains an important operational concern. Approximately 78 percent of the 2026 restricted-housing population was designated for mental-health services, essentially unchanged from 77 percent in 2025. The average number of mental-health patients in these units nevertheless fell from 15 to 6. The continuing high percentage should be understood in the context of a much smaller population, while still demanding sustained clinical engagement, structured activity, and timely step-down planning for those who must remain in a secure setting.

Monthly placements and observed time in restricted housing provide two additional measures of whether the County is relying on the least restrictive appropriate setting. Table 5 and the following charts compare those measures for January through June 2026.

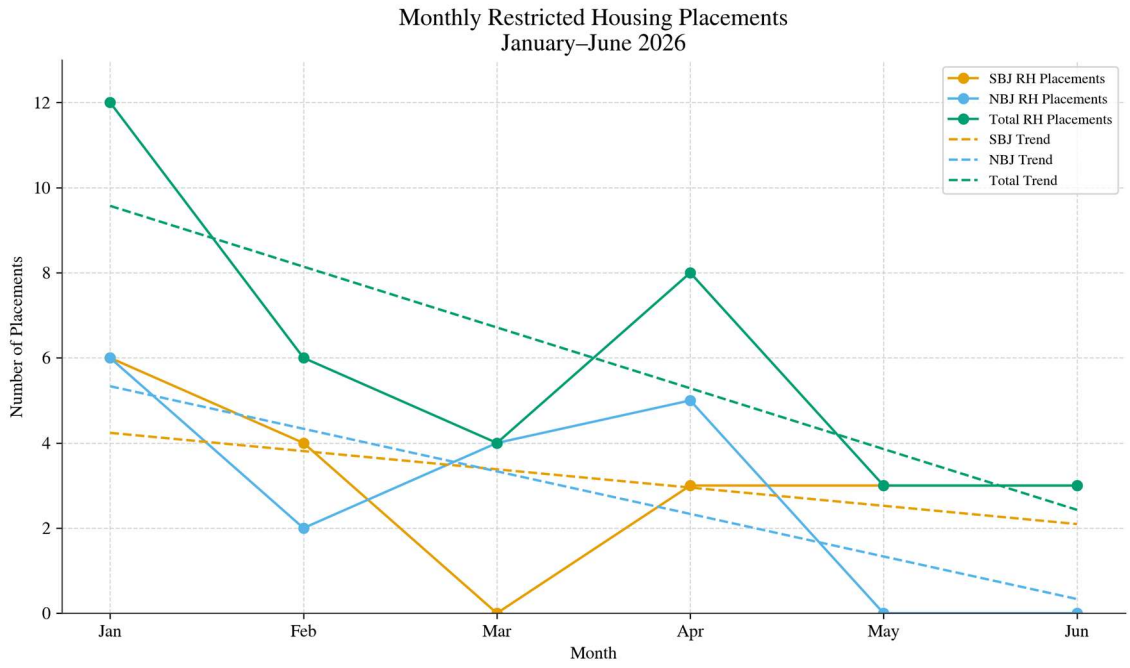
Table 5: SBJ & NBJ — Monthly Restricted Housing (RH) Placements and Average Days

January through June 2026

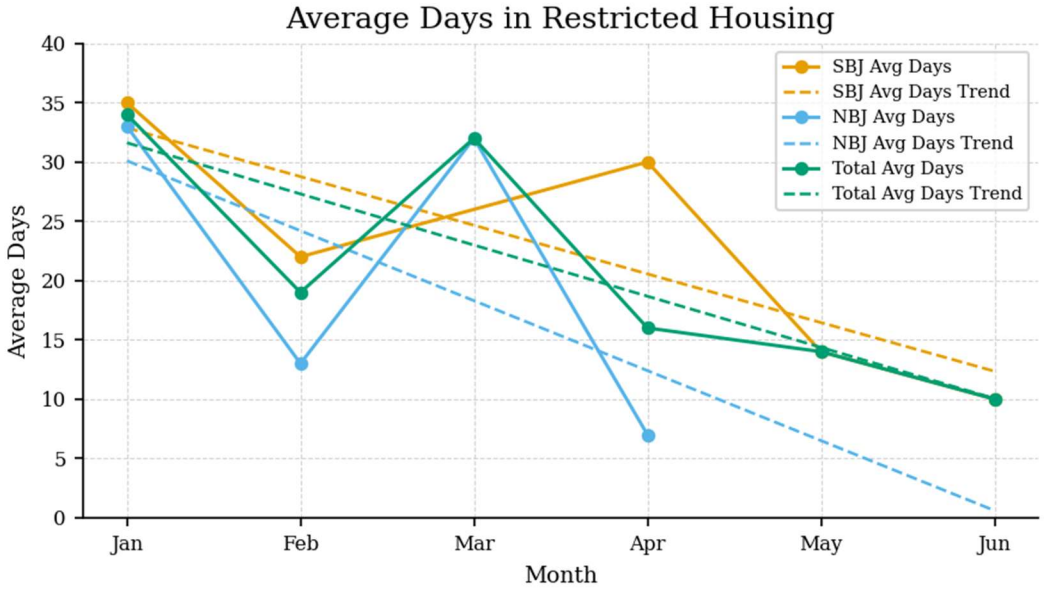
Month	SBJ RH Placement	SBJ Avg Days	NBJ RH Placement	NBJ Avg Days	Total RH Placement	Total Avg Days
Jan	6	35	6	33	12	34
Feb	4	22	2	13	6	19
Mar	0	N/A	4	32	4	32
Apr	3	30	5	7	8	16
May	3	14	0	N/A	3	14
Jun	3	10	0	N/A	3	10
Jan–Jun Average	3	22	3	21	6	21
Jan–Jun Total	19	N/A	17	N/A	36	N/A

Daily trackers used; May–June averages include open placements observed through June 30, 2026.

The placement data show a substantial change from the fifth report. Total placements fell from 118 during January through June 2025 to 36 during the same months of 2026, a reduction of approximately 69 percent. SBJ placements declined from 79 to 19, and NBJ placements declined from 39 to 17. Combined monthly placements were 12, 6, 4, 8, 3, and 3, respectively. The April increase was temporary and did not interrupt the broader decline; May and June each recorded only three placements systemwide.



Time in restricted housing also decreased. The overall average fell from 32 days in the first half of 2025 to approximately 21 observed days in 2026. SBJ decreased from 29 to 22 days, and NBJ decreased from 43 to 21 days. The combined monthly averages were 34 days in January, 19 in February, 32 in March, 16 in April, 14 in May, and 10 in June. The May and June results require appropriate caution because several placements remained open on June 30; those averages measure days observed through the close of the review period rather than completed lengths of stay. Even with that limitation, the completed earlier cohorts and the overall six-month average reflect meaningful progress from the prior period.



Taken together, the evidence tells a materially different story from the Fifth Report. At that time, the County had established a credible reduction in the use of restricted housing but had not yet demonstrated that the improvement would hold. The 2026 results show a sustained reduction in the number of people entering restricted housing, the number present on an average day, and the time they remain there.[22] The current Mental Health Expert's findings regarding expanded Behavioral Health Units, the IRC 100 BHU, and suicide-resistant observation cells provide additional evidence that a less-restrictive continuum is developing. The remaining implementation gaps are significant, but the combined evidence is sufficient to support substantial compliance with this custody provision.

This finding does not eliminate the caution identified in the fifth report concerning units that may function as restricted housing because of limited out-of-cell time. The table includes designated women housed in IRC 400 overflow but does not count other residents of IRC 100 or IRC 400 who are not formally designated for restricted housing. Continued substantial compliance depends on ensuring that those units provide sufficient out-of-cell opportunity and that any person held under restricted-housing conditions receives the applicable classification review, due process, health-care rounds and programming.

Safety cell use provides a second lens for evaluating whether class members are housed in the least restrictive setting consistent with safety. Table 6 compares quarterly utilization during the current and immediately preceding review periods. Addendum B provides the detailed monthly data by facility.

The following table, Quarterly Safety Cell Utilization, summarizes both the frequency of placement and the percentage of placements that exceeded 24 hours.

Table 6: Quarterly Safety Cell Utilization

July 2024 through June 2026

Quarter	Average Monthly Placements	Placements Exceeding 24 Hours
Q3 2024	36	5.5%
Q4 2024	30	8.9%
Q1 2025	39	4.3%
Q2 2025	37	6.3%
Q3 2025	38	0.0%
Q4 2025	24	2.8%
Q1 2026	39	0.0%
Q2 2026	35	1.0%

The current records show both a modest reduction in overall reliance on safety cells and a marked reduction in extended placements. From July 2025 through June 2026, SBSO documented 405 unique safety-cell placements, an average of 34 per month. The Fifth Report documented 427 placements during July 2024

[22] The "Average Days in Restricted Housing" placements are grouped by the month they began, and their observed duration may extend into subsequent months. Uninterrupted transfers between SBJ and NBJ are treated as one continuous placement; ongoing stays are measured through June 30, 2026. The January–June summary of 21 days is the equally weighted average of the six monthly combined averages, rather than an average calculated across all individual placements. It does not represent the completed length of stay for placements still ongoing at the reporting cutoff.

through June 2025, an average of 36 per month. NBJ continued to average approximately nine placements per month, while SBJ declined from 26 to 25.

Monthly utilization continued to fluctuate, ranging from 22 placements in October 2025 to 48 in September 2025. Quarterly averages fell to 24 placements per month in Q4 2025, rose to 39 in Q1 2026, and then declined to 35 in Q2 2026. Although the pattern is not a continuous month-to-month decline, the annual total is lower than in the prior review period.

The distribution of stays also improved. Placements lasting between 12 and 24 hours declined from 158, or 37 percent of all placements, in the prior period to 133, or approximately 33 percent, in the current period. Conversely, 269 placements, approximately 66 percent, ended in less than 12 hours, compared with 243, or approximately 57 percent, in the prior period.

The most substantial change involves extended placements. Review of the placement and removal timestamps identified three placements exceeding 24 hours, less than one percent of all safety-cell placements. The prior Addendum B documented 26 such placements, approximately six percent of the annual total. This represents an 88 percent reduction in the number of extended placements. The source folders initially identified six records as exceeding 24 hours, but form-level review established that three of those stays ended before the 24-hour threshold; Addendum B uses the verified durations.

Unlike the repeat extended stays discussed in the Fifth Report, the three current placements involved three different individuals. They occurred in October 2025 at SBJ, November 2025 at NBJ, and May 2026 at SBJ. No placement exceeded 24 hours in nine of the 12 months reviewed.

Safety cells remain an extreme placement and should continue to be used only for an acute and documented safety need. The Sixth Mental Health Expert Report reinforces both the progress and the need for continued caution. It found that safety cells were still used at times because less-restrictive suicide-resistant alternatives were not yet fully operational. It also reported that, among 267 placements from August 2025 through March 2026, 85 occurred between 11:00 p.m. and 7:00 a.m., and 25 of those overnight placements did not receive a Mobile Crisis response. Since the May 2026 tour, the County reports that people at intake awaiting a 5150 evaluation are maintained under constant supervision rather than placed in a safety cell solely while awaiting BWell Mobile Crisis. The combination of fewer placements, a larger proportion ending within 12 hours, and the near elimination of stays exceeding 24 hours is meaningful, but policy, training, clinical coverage, and less-restrictive placement options must continue to mature.

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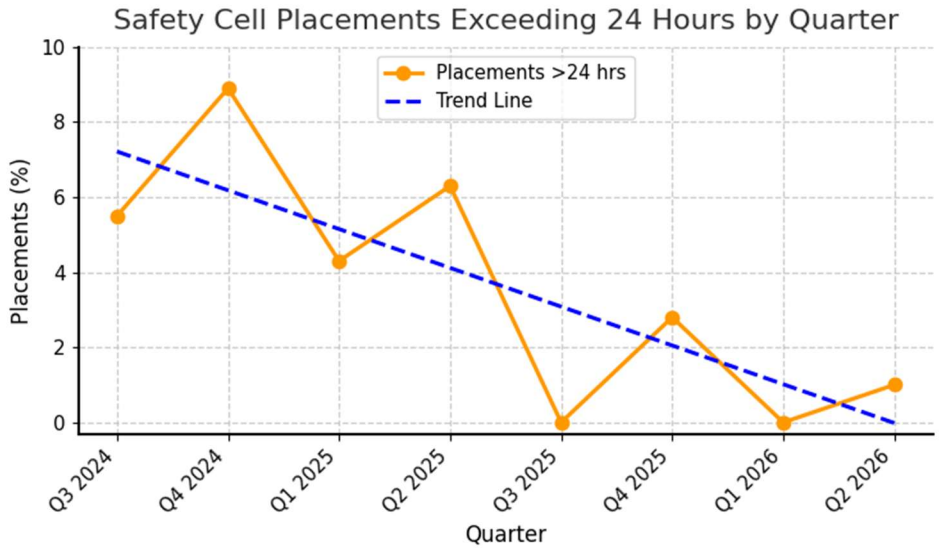
The following chart shows the quarterly percentage of safety-cell placements that exceeded 24 hours. The current period reflects a pronounced and sustained decline from the preceding four quarters.

Figure 2. Safety Cell Placements Exceeding 24 Hours by Quarter



The County should incorporate the Addendum B methodology into its internal monitoring so that duplicate scans, filing labels, and the underlying placement and removal timestamps are reconciled before trend reports are finalized. The safety-cell table in the Sixth Mental Health Expert Report covers April 2025 through March 2026 and relies on County summary data, while Addendum B covers July 2025 through June 2026 and uses a form-level review. The totals are therefore not directly comparable. A single reconciled method would improve both custody and clinical trend analysis.

The Fifth Report described the prior concern regarding safety-cell placement for combative behavior as largely resolved. The current records warrant a more qualified conclusion. A targeted review identified at least nine placements in which combative or assaultive behavior was documented as the primary basis for placement. Eight ended in less than 12 hours and one ended between 12 and 24 hours; none exceeded 24 hours. The records generally described immediate assaultive conduct, including kicking, spitting, attempted strikes or headbutts, and direct threats to staff. These circumstances differ from using a safety cell for punishment, but the recurrence requires continued review of whether de-escalation, clinical intervention, restraints, or another less restrictive alternative could safely have been used. By contrast, none of the three verified placements exceeding 24 hours was based solely on combative behavior.

The Sixth Mental Health Expert Report provides a more current account of IRC 100, IRC 400, New East Restricted Housing, and NBJ K Unit. It identifies the BHU in IRC 100 as a positive less-restrictive option for people who cannot program safely in a Behavioral Health Unit but do not require restricted housing. At the same time, the report found that clinical vacancies limited programming and the consistent implementation of individualized treatment plans, and it questioned whether current custody staffing can support the needed level of programming. The stated goal remains to provide services commensurate with a Behavioral Health Unit for people in these settings who require that level of care.

Those current findings sharpen, rather than reverse, the conclusion under VII.A.1. Formal restricted-housing use has fallen dramatically and the County has created additional step-down options, supporting Substantial Compliance. The completed placement, retention, and HARP review provides important context. Initial placement decisions generally identified an individualized safety or security basis, while recurring retention reviews were substantially less consistent in documenting current conduct, treatment,

programming, and a concrete path to a less restrictive setting. Missing dates, incomplete fields, and weak written explanations can be addressed through focused training, supervision, and quality assurance. More significant is the continuing reliance on restricted housing when an appropriate alternative is not available, particularly for transgender people whose safety cannot be maintained in available housing and people whose mental-health and behavioral needs are too complex for the existing Behavioral Health Units. The County developed or expanded alternatives late in the review period, including the BHU, compatible-pair options, and individualized access to the Sheriff's Treatment Program (STP). Those efforts should reduce pressure on restricted housing and permit more focused placement and retention decisions. Sustaining the rating will require the County to make those alternatives operational in practice and to ensure that Wellpath clinical staff and STP provide meaningful programming to people who remain in restricted housing, particularly during extended placements. HARP's biweekly classification committee review provides an important, broader layer of oversight beyond the formal placement and retention notices, but it does not substitute for multidisciplinary treatment planning or direct clinical and program services.

Recommendations

1. *Continue to operate meaningful specialized mental health treatment units for males and females at the necessary level of care and custody classifications.
2. *The County must address the program models in SBJ New East Restricted Housing unit, IRC 100 and IRC 400.
3. *Ensure that adequate clinical and programmatic support is available based on the clinical needs of the population.
4. *Finalize policies, procedures, post orders and training for the units. Work with the Mental Health Expert on the design of the unit, policies and training.
5. *In partnership with the Mental Health Expert, finalize the design the structured program model for behavioral health inmates who require retention in a restricted housing setting.
6. *Continue to utilize the restricted housing committee to monitor the program of those behavioral health incarcerated persons who require restricted housing. However, this committee is a classification process and does not substitute for the multi-disciplinary committee and individualized treatment plan requirements.
7. *The County should continue to expand alternative custody and specialized courts to address the needs of the low risk/high need arrestees in a community-based setting, rather than the jail.
    a. Proof of practices on these efforts should be refined.
8. *The County should ensure sufficient inpatient capacity in the community should that level of care be necessary for an incarcerated person.
9. *Finalize the policies and training to memorialize the practices implemented as a result of the Classification Validation project.
10. *Continue to refine internal auditing and trend analysis of restricted housing and safety cell utilization.

VII.A. Custody Operations/General Principles

2. The County shall not place prisoners in more restrictive settings, including Segregation, based on a mental illness or any other disability. Prisoners will be housed in the most integrated setting appropriate to their individual needs.

County Response

The County refers to its response under Provision VII.A.1.

Expert Review

Compliance Rating: Partial Compliance
Prior Compliance Rating: Partial Compliance

Policies - Custody Operations Policy 301 – Classification
Custody Objective Classification Plan
Custody Housing Plans
Wellpath Policy E-04 – Initial Health Assessment
Wellpath Policy E-05 – Mental Health Screening
Wellpath Policy F-03 – Mental Health Services

Training - Disability Rights Remedial Plan Implementation

Metrics Restricted Housing Trackers and Population Reports
Placement and Retention Notices
Mental Health and Programming Records
Tours/Interviews

Observations

The Fifth Report continued this provision at Partial Compliance. At that time, the County had made meaningful progress reducing the restricted-housing population and developing less restrictive housing options, but people with mental-health needs remained disproportionately represented and the available secure settings did not consistently provide the treatment, structured activity, or step-down planning necessary to function as integrated therapeutic environments.

The current data reflect additional progress, but the central concern remains. As discussed under VII.A.1 and reflected in Table 3, the combined restricted-housing average daily population declined substantially in this rating period. The average number of people designated for mental-health services fell from approximately 15 to 6. Even so, approximately 78 percent of the 2026 restricted-housing population was designated for mental-health services, essentially unchanged from 77 percent in the prior period. The high percentage does not, by itself, establish that people were placed in segregation because of a disability; the placement documentation reviewed under VII.A.3 generally identified an individualized security or safety basis. It does demonstrate that the small group who remain in restricted housing continue to have substantial clinical and programmatic needs.

The review was completed of the available initial-placement and continued-retention documentation through June 2026. Initial decisions generally articulated an individualized security or safety rationale; however, retention justifications were materially less consistent. They frequently failed to describe current behavior, out-of-cell participation, treatment or programming, compatible-pair or small-group opportunities, and the specific action necessary to move the person to a less restrictive setting. For example, concerns involved transgender class members who remained in restricted housing because no safe integrated placement was available and class members with significant mental-health needs who could not safely program in the existing BHUs. Even when an initial placement was warranted by assaultive, threatening, or otherwise unsafe conduct, continued retention too often lacked a documented clinical strategy or an active transition plan.

The restricted-housing placement and HARP committee records similarly did not establish a consistent restricted-housing program model delivered by Wellpath clinical staff or STP during most of the review period. The HARP records began to reflect limited individualized clinical worksheets and STP participation for some class members late in the period, including STP participation in June 2026. Those developments

are positive, but they do not demonstrate that meaningful clinical and rehabilitative programming was consistently available to the restricted-housing population throughout the period.

The same concerns extend to units that are not formally designated as restricted housing but operate in a similarly restrictive manner. As discussed under VII.A.1, limited structured activity, meaningful group programming, and socialization in portions of IRC 100 and IRC 400 can leave people living under conditions that are less integrated in practice than their non-restricted housing label suggests. Compliance with this provision requires more than avoiding placement based expressly on a diagnosis. It requires a setting that is appropriate to the person's custody and clinical needs and that provides a realistic opportunity for treatment, socialization, and progression.

The County has substantially reduced the number of people with mental-health needs in restricted housing and has developed credible less restrictive alternatives. Those achievements are significant and should reduce the operational pressure that previously contributed to both unnecessary retention and inadequate documentation. The remaining population, however, is still predominantly designated for mental-health services, and the County has not yet demonstrated that transgender people and people whose needs are too complex for the existing Behavioral Health Units are consistently housed in the most integrated appropriate setting. Nor has it demonstrated that people who must remain in a secure setting consistently receive commensurate treatment, meaningful Wellpath and STP programming, individualized multidisciplinary planning, and a workable step-down pathway. The County therefore remains in Partial Compliance with this provision.

Recommendations

1. *Refer to VII.A.1.

VII.A. Custody Operations/General Principles

3. The County shall not place a prisoner in Segregation units without first determining that such confinement is necessary for security reasons and/or the safety of the staff or other prisoners. The County shall maintain a system by which it documents in writing the specific reason(s) for a prisoner's placement and retention in Segregation housing. The reason(s) shall be supported by clear, objective evidence.

County Response

The County reports that it has completed implementation of this provision.

Expert Review

Compliance Rating: Substantial Compliance
Prior Compliance Rating: Substantial Compliance

Policies - Custody Operations Policy 301 – Classification
Custody Operations Policy 306 – Restricted Housing

Training - Disability Rights Remedial Plan Implementation

Metrics Restricted Housing Placement and Retention Notices
Restricted Housing Tracking Records
Classification Narratives and Case Reviews
Grievances
Tours/Interviews

Observations

The Fifth Report raised this provision from Partial Compliance to Substantial Compliance after the County substantially improved the quality and availability of its restricted-housing placement and retention documentation. The present review indicates that those improvements have generally been sustained. The County continues to use a written process for both initial placement and continued retention, and the available records generally permit the reviewer to understand why restricted housing was selected and whether continued placement remained necessary.

The review period for the Sixth Report is July 2025 through June 2026. The Custody Expert reviewed the available initial-placement and continued-retention notices from both SBJ and NBJ, together with corresponding restricted-housing tracking records, HARP records, and classification documentation. The 2026 notice production contained 88 PDF files. After obvious duplicate and misfiled copies were reconciled, the review identified approximately 82 distinct notice events: 26 initial-placement notices and 56 continued-retention reviews.

The initial-placement documentation was the strongest part of the County's current practice. The reviewed notices generally described specific conduct, threats, safety concerns, or other reliable information supporting the determination that placement in restricted housing was necessary. The records frequently reflected timely preliminary fact development, including contemporaneous interviews, camera review, examination of recent conduct, and consultation with medical or mental-health staff. This represents an important improvement from prior periods in which the investigation supporting placement was not always completed promptly. The records also generally reflected supervisory and clinical participation and consideration of the individual's circumstances. In contrast to earlier review periods, the justification was usually individualized and was not limited to a conclusory classification label or a restatement of the placement category.

Table 7 summarizes the completed placement, retention, and HARP review for the current reporting period. The quantitative figures describe the reconciled production and are not intended as formal pass-or-fail rates because individual notices frequently contained both positive practices and areas requiring improvement.

Table 7: Restricted Housing Placement and Retention Review

July 2025 through June 2026

Review Area	General Finding
Initial placement notices	Approximately 26 distinct notices were reviewed. The reviewed notices generally documented specific conduct or reliable information establishing a security or safety basis, and preliminary fact development was generally timely.
Continued-retention notices	Approximately 56 distinct reviews were evaluated. Periodic review was generally documented, but current behavior, programming, treatment, and closure of proposed alternatives were less consistent.

Table 7: Restricted Housing Placement and Retention Review	
July 2025 through June 2026	
Review Area	**General Finding**
HARP and quality assurance	The broader biweekly HARP process documented additional classification, clinical, discharge, and programming review beyond the formal notices and provided useful follow-up for most long-term placements. Proposed alternatives were not always closed out, and missing next-review dates, incomplete administrative fields, and inconsistent step-down documentation require focused training, supervision, and reconciliation.

The continued-retention process was generally functioning timely, but the quality of the written analysis was less consistent. The stronger notices identified information developed since the prior review, explained the current security or safety concern, considered less restrictive housing alternatives, and described what was required for transition. Other notices relied too heavily on the original placement rationale, described behavior without clearly connecting it to a present need for restricted housing, or failed to document current behavior, out-of-cell activity, treatment, programming, and the disposition of a previously proposed alternative. HARP's broader biweekly classification committee records often provided more current information than the served retention notice, including compatible-pair discussions, BHU or protective-custody options, armband changes, out-of-cell activity and refusals, mental-health and discharge-planning information, and facility transfers. The HARP records therefore demonstrate that additional review and coordination were occurring beyond the formal notices examined by the Custody Expert. However, HARP notes also sometimes repeated a proposed alternative without documenting whether it was attempted, rejected, completed, or replaced by another plan. Continued retention requires a current, individualized determination; neither the initial placement basis nor a recurring committee entry, standing alone, establishes that restricted housing remains necessary.

The recurring documentation concerns involved missing next-review dates, insufficiently specific or measurable step-down criteria, and occasional incomplete administrative fields in the Restricted Housing Placement and Retention Notices, as well as failure to document follow-through on prior recommendations in the HARP meeting records.These deficiencies are principally matters of training, supervision, and quality assurance and do not, standing alone, establish that the underlying placement decision was improper. The County should use the reduced restricted-housing population and the additional alternatives developed late in the period as an opportunity to improve the precision and completeness of every review. The more substantive concern—continued reliance on restricted housing because an appropriate clinical, protective, or integrated alternative does not exist—is addressed under VII.A.2 and VII.A.4 and cannot be resolved through better form completion alone.

The Mental Health Expert's Sixth Report provides relevant context for this provision. Dr. Timothy Belavich found that the Behavioral Health Units continue to provide a less restrictive and more appropriate setting for people who need increased mental-health treatment, and that the BHU provides an additional alternative for some people who cannot program in a Behavioral Health Unit but do not require restricted housing. He also identified continuing concerns about people housed in SBJ units 100, 400, and NERH and NBJ K Unit who require Behavioral Health Unit-level care, while staffing vacancies have limited programming and the consistent implementation of individualized treatment plans. These findings do not establish that a particular initial placement lacked objective evidence. They reinforce the need for retention decisions to incorporate current clinical input, services actually delivered by Wellpath and the Sheriff's Treatment Program, evaluation of available alternatives, and an individualized path to a less restrictive setting.

Taken together, the completed evidence supports continued Substantial Compliance. The County has sustained a written placement and retention process, initial decisions are generally supported by

individualized facts and timely preliminary review, periodic classification review is occurring, and HARP provides an additional forum for monitoring complex and long-term placements. The remaining documentation concerns are principally matters of consistency, training, and quality control rather than evidence of a systemic failure to make or document the required initial determination. Continued Substantial Compliance nevertheless requires the County to improve the quality of retention notices, document the result of alternatives considered by HARP, and ensure that the lack of a clinical or protective alternative does not become an indefinite justification for continued segregation.

Recommendations

1. *The SBSO should ensure adequate staffing as necessary to achieve compliance with the timeframes and procedures relevant to this provision.
2. *The Compliance Team should be augmented to begin internal auditing.
3. *The County should address critical vacancies in the Custody Division.
4. *Refer to other VII.A provisions for additional recommendations.

VII.A. Custody Operations/General Principles

4. Prisoners will remain in Segregation housing for no longer than necessary to address the reason(s) for such placement.

County Response

The County reports that it has completed implementation of this provision and continues to maintain and refine its restricted-housing practices. It states that weekly meetings address alternative housing, discharge planning, and step-down planning; that Thursday documentation includes meeting notes and corresponding treatment plans; and that staff have been trained to evaluate removal from restricted housing and improve meeting documentation.

Expert Review

Compliance Rating: Substantial Compliance
Prior Compliance Rating: Partial Compliance

Policies - Custody Operations Policy 301 – Classification
Custody Operations Policy 306 – Restricted Housing

Training - Disability Rights Remedial Plan Implementation

Metrics Restricted Housing Tracking Records
Restricted Housing Retention Documentation
HARP Logs
Grievances
Tours/Interviews

Observations

The Fifth Report found that the County had made significant progress reducing both reliance on restricted housing and the duration of placement, but continued this provision at Partial Compliance because the improvement was recent and the County had not yet demonstrated consistent compliance with more frequent reviews or durable strategies for people who were difficult to transition. The baseline average length of stay for January through June 2025 was 32 days.

The current data demonstrate that the improvement continued. As reflected in Table 5 under VII.A.1, the trackers identified 36 new restricted-housing placements during January through June 2026: 19 beginning at SBJ and 17 at NBJ. The combined average observed time in restricted housing was approximately 21 days, a reduction of roughly one-third from the 32-day baseline. SBJ decreased from 29 to 22 days, and NBJ decreased from 43 to 21 days. The combined monthly averages were 34 days in January, 19 in February, 32 in March, 16 in April, 14 in May, and 10 in June.

The May and June results require appropriate caution because several placements remained open on June 30. Those figures measure the time observed through the close of the review period rather than completed lengths of stay. The earlier completed cohorts nevertheless show the same overall direction, and the decline in average duration is consistent with the substantial reduction in the average daily population and new placements discussed under VII.A.1.

The documentation reviewed under VII.A.3 indicates that recurring classification review is generally functioning. HARP is a biweekly classification committee process with a broader scope than restricted housing. Its records address complex housing and classification matters, current conduct, out-of-cell activity and refusals, armband status, mental-health referrals and observations, discharge-planning information, programming, compatible-pair possibilities, BHU and protective-custody options, and movement between facilities. The 30 produced HARP workbooks—containing 340 person-meeting entries involving 64 individual Class Members—are generally consistent with the stated biweekly process and demonstrate that substantially more review and coordination occurred than is reflected in the formal placement and retention notices alone. Follow-up for active long-term placements was generally timely and sustained. Six of the seven tracker-identified placements exceeding 60 days appeared in HARP records; three appeared in every produced HARP meeting during their verified placement, and two others had only limited gaps. The apparent extended gap in the remaining reviewed case coincided with movement to a walk-a-pair arrangement and later return to restricted housing, exposing a tracker-continuity problem rather than establishing that the person remained in restricted housing without review throughout the full recorded span.

The averages do not eliminate concern about individual long-term placements. The trackers identified seven placements with documented spans exceeding 60 days during or extending into the current review period. The Custody Expert's July through December 2025 retention review also identified chronic or extended cases in which timely classification review did not produce a meaningful treatment, programming, or step-down strategy. Some of these placements involved continuing assaultive behavior, documented threats, refusal of available protective alternatives, or other circumstances supporting continued secure housing. In others, the written record did not consistently explain why improvement, willingness to program, or a change in circumstances had not resulted in an expedited reassessment or a trial of a less restrictive option.

A lengthy placement is not necessarily an improper placement. Some security risks cannot be resolved quickly, and some people decline available alternatives. The HARP records demonstrate repeated efforts in several difficult cases to use protective custody, the BHU, compatible-pair arrangements, armband reduction, facility transfer, and other step-down options. They also show a recurring weakness: an option could be discussed repeatedly without a clear entry documenting whether it was tried, why it failed, or what would occur next. As time in segregation increases, the County's obligation to demonstrate a current need and an active plan for transition becomes more—not less—important. Extended placements should receive enhanced supervisory and multidisciplinary review, including a documented assessment of current conduct, clinical needs, prior interventions, available housing or transfer alternatives, services actually provided by Wellpath and the Sheriff's Treatment Program, and concrete next steps. HARP is an important classification safeguard, but it cannot substitute for a clinical treatment plan or meaningful in-unit programming.

Taken together, the evidence supports advancing this provision to Substantial Compliance. The County has sustained a pronounced reduction in the restricted-housing census, reduced new placements, shortened the

average observed length of stay, and implemented a generally functioning recurring-review process through retention notices and the broader biweekly HARP process. The HARP production demonstrates additional classification, clinical, discharge, and programming review beyond the formal notices, as well as consistent engagement with most long-term placements. The remaining long-term cases, tracker entries that did not clearly distinguish continuous restricted-housing placement from movement to a walk-a-pair arrangement and later return to restricted housing, failure to close the loop on some proposed alternatives, and absence of a consistent Wellpath and Sheriff's Treatment Program model for extended placements require continued monitoring and focused corrective work. They do not, however, reflect the systemwide pattern of unnecessary prolonged segregation described in earlier reports.

Recommendations

1. *Continue to ensure the restricted housing tracking form is updated daily and accurately. Integrate this information in the planned update to the jail management system.
2. *Finalize the restricted housing tracking system and restricted housing committee policy.
3. *As behavioral health units are expanded, develop a program model to address higher security and higher need incarcerated persons to reduce reliance on restricted housing for this population.
4. *Finalize the policy to require more timely reviews of restricted housing retentions.
5. *Continue to increase offering programming and meaningful socialization opportunities in IRC 100.
6. *Remind classification staff of alternatives to restricted housing that may require collaboration with another county or CDCR.
7. *Develop documented stepdown strategies for class members who are choosing to remain in segregation when no risk to a less restrictive setting exists.

VII.B. Classification Procedures

1. The County shall implement a validated Classification System consistent with the provisions of this remedial plan.

County Response

The County reports that it has completed implementation of this provision.

Expert Review

Compliance Rating: Substantial Compliance
Prior Compliance Rating: Substantial Compliance

Policy - Custody Operations 301 – Classification

Training - Disability Rights Remedial Plan Implementation

Metrics
Classification Validation Report
Policy Tracking
Restricted Housing Placement and Retention Documentation
Tour and Meeting Materials

Observations

The County maintained substantial compliance with this provision during the current review period. The Fifth Report found that the County had achieved substantial compliance following Dr. James Austin's independent statistical validation of its intake and reclassification scoring systems, adoption of the

recommended scoring model, training of classification staff, and revalidation of staff proficiency. The current evidence does not indicate that the County abandoned or materially altered that validated classification system.

The Fifth Report did not, however, recommend discontinuation of monitoring. It provided the County with a clear and specific pathway to that result. The County was advised that a recommendation to discontinue monitoring would depend upon evidence of: (1) a finalized classification policy; (2) a finalized training module addressing intake and reclassification scoring; (3) routine internal monitoring and auditing of classification decisions; and (4) quarterly reports documenting classification activities and compliance with policy. The Fifth Report also emphasized the need to maintain sufficient classification staffing.

The County did not complete or document those sustainment requirements during this reporting period. The policy-tracking document dated May 8, 2026, identified Policy 301 as reviewed and ready for publication, but also reflected that it had not yet been finalized or published. Although publication and Classification Unit training were planned for June 2026, no finalized policy, completed training module, training records, internal classification audits, quarterly classification reports, or classification-specific staffing information was provided. The May 2026 tour materials similarly identified continuing difficulty anchoring improvements in policy, training, auditing, and adequate staffing.

The restricted-housing placement and retention records demonstrate that classification staff continued performing placement and review functions. As discussed under Provisions VII.B.2 and VII.B.4, however, those records do not establish whether intake and reclassification scores were applied accurately, consistently, and on time.

The previously validated system and the absence of evidence that it has been abandoned support continued substantial compliance. The County did not, however, complete the specific steps identified in the Fifth Report as necessary for discontinuation. Monitoring should therefore continue.

Recommendations

1. *Finalize and publish the classification policy and training module (intake and reclassification).
2. *Train existing and incoming classification staff on the policy and scoring systems.
3. *Implement monthly internal audits of a statistically valid sample assessing completeness, timeliness, and correct score application. Statistics should include:

    a) Documentation completeness of scoring packets (percent meeting all required elements).
    b) Timeliness of initial classification and scheduled reclassifications (percent on time).
    c) Accuracy and consistency: inter-rater reliability checks and variance analyses.
    d) Exception rate and closure time for corrective actions identified via audits.

4. *Produce quarterly classification reports summarizing volumes, timeliness, exception findings and corrective actions, and audit pass rates.
5. *Stabilize staffing: maintain designated classification FTEs; and track vacancy and reassignment impacts.

VII.B. Classification Procedures

2. The Classification System shall be based on clear criteria and procedures for placing prisoners in and removing prisoners from Segregation units. Placement in and removal from Segregation units shall be documented for all prisoners.

County Response

The County reports that it has completed implementation of this provision.

Expert Review

Compliance Rating: Substantial Compliance
Prior Compliance Rating: Substantial Compliance

Policy — Custody Operations 301 – Classification
Custody Operations 306 – Restrictive Housing

Training – Disability Rights Remedial Plan Implementation

Metrics — Restricted Housing Placement and Retention Notices
Restricted Housing Tracking Records
HARP Records
Classification Documentation
Policy Tracking and Tour Materials

Observations

The County maintained substantial compliance with this provision during the current review period. As discussed under Provisions VII.A.3 and VII.A.4, the County continued to use a written process for placement in and removal from restricted housing. Initial-placement notices generally documented individualized, objective facts, and recurring classification and HARP reviews generally documented continued retention, consideration of alternatives, and release or transition decisions.

The remaining concerns involved inconsistent continued-retention documentation, reliance on earlier conduct, insufficiently specific step-down criteria, and failure to document the outcome of some alternatives considered. Those issues are addressed under Provisions VII.A.3 and VII.A.4 and do not establish a systemic failure to document placement in or removal from restricted housing.

The governing policy and training framework has not been shown to be complete. As of May 8, 2026, Policy 301 was identified as ready for publication but not finalized or published. Policy 306 remained pending publication, was not finalized or published, and still required a lesson plan. Although publication and training were anticipated in June 2026, no final policies, completed lesson plans, training records, or other proof of implementation was provided. The documented practices support continued substantial compliance, but these deficiencies require continued monitoring and are addressed under Provisions VII.B.1 and VII.A.3.

Recommendations

1. *Refer to the recommendations under Provisions VII.A.3 and VII.A.4.

VII.B. Classification Procedures

3. The Classification System shall facilitate the following:
    a) Housing placements based on the behavior and clinical needs of prisoners who are identified as having Serious Mental Illness. Mental health staff shall provide input regarding the classification and placement of people with Serious Mental Illness.
    b) Screening to determine whether a prisoner should be separated from other prisoners for safety purposes. Where a prisoner is found to require separation from other prisoners for safety, placement will be in the least restrictive setting appropriate, and will allow for out-of-cell and recreation time consistent with the provisions herein.

County Response

The County reports that it has completed implementation of this provision.

Expert Review

Compliance Rating: Partial Compliance
Prior Compliance Rating: Partial Compliance

Policies - Custody Operations Policy 301 – Classification
Wellpath Policy F-03 – Mental Health Services
Wellpath Policy G-02 – Segregated Inmates

Training - Disability Rights Remedial Plan Implementation

Metrics Population Reports
Classification and Restricted-Housing Documentation
HARP and Clinical Review Records
Mental-Health and Programming Records
Tours/Interviews

Observations

The Fifth Report found meaningful improvement in collaboration between custody and mental health staff regarding housing decisions for class members with SMI, while identifying continued concerns regarding some mentally ill class members who remained in restricted housing because appropriate alternatives were not available.

During this review period, Wellpath and custody continued to collaborate on housing decisions for class members designated as SMI or requiring placement in a BHU. Mental health staff participate in decisions regarding BHU placement and discharge, and mental health review occurs before class members with SMI are placed in restricted housing. The record reviewed during this rating period did not identify instances in which custody overrode a clinical determination that a class member required BHU placement. Overall, this aspect of the provision is functioning well.

A remaining concern involves class members requiring protective custody who cannot safely be housed in available protective-custody settings or who refuse available protective-custody housing. During this review period, some class members remained in restricted housing for extended periods because an appropriate alternative had not been identified. In some cases, resolution can include co-locating with compatible cellmate in restricted housing but with greater out-of-cell activities, consideration for community based alternatives if safe to do so, or may require consideration of alternatives outside the

existing jail housing structure, including placement in another county or movement to the California Department of Corrections and Rehabilitation as a "safekeeper" The County has not yet established a consistent process for resolving these cases. Until this issue is resolved, Partial Compliance remains appropriate.

Recommendations

1. *Continue to establish specialized behavioral health units based on solid population projections and comprehensive mental health programs needs assessment, utilizing behavioral health and classification levels.
2. *Refer to recommendations from the Mental Health Expert's September 2026 Remedial Plan Status Report, Provisions III.D.2 through III.D.4.
3. *Improve programming and stepdown strategies for SMI class members housed in restricted housing and implement an alternate structured mental health program in a secure setting that incorporates case management and stepdown strategies for class members with SMI who require more structure than the current BHU programs can provide.

VII.B. Classification Procedures

4. The Classification System shall include a Classification Review Process.
   a) The Classification Review Process shall include clear, written criteria by which prisoners in a Segregation Unit can secure placement in a less restrictive setting as well as restoration of property or privileges. This review will include a private, out- of-cell interview (unless individual security issues prevent such an interview and are documented). The review shall occur at least every 30 days or sooner if circumstances warrant.
   b) If a prisoner is retained in a Segregation unit following the Classification Review, the reasons for retention and the specific steps to be taken to achieve restoration of property/privileges and transfer to a less restrictive setting will be documented.
   c) Prisoners in Segregation units will be provided an oral and written statement of the reasons for the outcome of each review, including what steps are necessary to gain restoration of property/privileges and to be moved to a less restrictive setting.

County Response

The County reports that it is continuing to implement this provision. It states that Guardian RFID will support restricted-housing practices; the revised Restricted Housing Notification Form documents placement reasons, restoration and step-down requirements, and service of the form; Policy 209 was updated to support communication during review; multidisciplinary meetings review all restricted-housing cases and include out-of-cell interviews; and formal housing reviews occur on the first and fifteenth of each month. The County reports that related policies and training have been completed and implementation is ongoing.

Expert Review

Compliance Rating: Partial Compliance
Prior Compliance Rating: Partial Compliance

Policies - Custody Operations Policy 301 – Classification
Objective Jail Classification Plan – Not provided for review

Training - Disability Rights Remedial Plan Implementation

Metrics Restricted Housing Tracking Log
Restricted Housing Placement/Retention Documentation
Grievances
Interview and Tours

Observations

This provision requires the County to maintain a Classification Review Process for class members in segregation. It must include clear, written criteria for restoration of property or privileges and transfer to a less restrictive setting. Reviews must occur at least every 30 days and include a private, out-of-cell interview unless individual security issues prevent the interview and are documented. When a class member is retained, the County must document the reasons and specific steps necessary for restoration or transfer and provide an oral and written statement of the outcome and those steps.

The Fifth Report continued this provision at Partial Compliance but recognized substantial improvement late in the monitoring period. It suggested that Substantial Compliance could be reached if those improvements were sustained and stated that the next review would focus on measurable performance and internal self-evaluation. During this monitoring period, the County generally conducted retention reviews every 15 days, and some follow-up reviews occurred within several days of placement. This frequency exceeded the provision's 30-day minimum and was a strong area of performance.

The requirement that each review include a private, out-of-cell interview unless individual security issues prevent the interview and are documented is not yet consistently demonstrated. The review form does not identify whether the interview occurred privately and out of cell or, if not, the specific security reason. Many narratives state only that staff spoke with the class member and do not identify the location. One review documented an interview through the cell food slot without documenting a security reason.

Documentation of the reasons for retention and the specific steps necessary for restoration or transfer remained mixed. Stronger reviews described recent behavior, direct engagement, and a targeted housing alternative. Others were sparse or repetitive or did not resolve a proposed compatible pairing or less restrictive placement. Directions to follow jail rules, avoid disciplinary violations, and avoid negative interactions were too generic without individualized expectations and a workable transition plan. Most forms recorded service of the written decision on the review date, but the records did not always establish that the class member received both the required oral and written statement of the outcome and next steps. Related clinical and programming concerns are addressed under Provisions VII.A.1 through VII.A.3, VII.B.3, and III.D.6.

To assist with implementation, the Expert routinely reviews placement and retention documentation and provides case-specific comments identifying areas for improvement. This process has resulted in notable improvement in the quality of the documentation, although the improvements have not yet been consistently applied across all placement and retention reviews.

The Fifth Report recommended that the County produce measurable outcomes for each requirement and conduct prompt internal audits and self-evaluations. No completed internal audit or requirement-by-requirement percentage analysis was provided during this monitoring period. The County deserves credit for timely reviews and routine written decisions, but it has not demonstrated sustained compliance with the requirements for private, out-of-cell interviews, oral and written notice, and individualized steps toward restoration or transfer. Partial Compliance remains appropriate.

Recommendations

1. *Refer to recommendations in other VII.B provisions.
2. Revise the restricted-housing review form to document whether each interview occurred privately and out of cell and, if not, the specific security reason.
3. Conduct and retain quarterly self-audits reporting compliance with review timing, private out-of-cell interviews, oral and written notice, and individualized step-down instructions.

VII.B. Classification Procedures

5. The County shall perform Prison Rape Elimination Act (PREA) screenings in a private location.

Pursuant to the parties' stipulated joint request and the Murray court's May 4, 2026 order (Docket 106), monitoring for this provision has been suspended. The provision will therefore be subject to future monitoring only if it is determined that the County is no longer in substantial compliance, consistent with the procedure set forth in Paragraph 53.

VII. C. Elimination of Dangerous or Improper Physical Plant Features

1. The County shall conduct an assessment of all Segregation cells and develop a plan to address structural suicide hazards, such as tie-off points within the cells, to the maximum extent feasible.

County Response

The County reports that it has completed implementation of this provision.

Expert Review

Compliance Rating: Substantial Compliance
Prior Compliance Rating: Substantial Compliance

Policies - Custody Operations 242 – Suicide Prevention
Custody Operations 305 – Bed Assignment

Training – Disability Rights Remedial Plan Implementation

Metrics Structural Hazard Review Corrective Action Plan
Restrictive Housing Placement Documentation
Site Visit Notes

Observations

The County has maintained substantial compliance with the cell-specific requirements of this provision. At the inception of monitoring, SBSO assessed cells and holding areas at both SBJ and NBJ and developed corrective-action plans to mitigate potential tie-off points and other structural suicide hazards. The most recent structural-hazard corrective-action plan provided for this review, dated July 18, 2025, documents completion of the remaining identified repairs in occupiable cells or the continued deactivation of cells that were not remediated. Nothing reviewed during the current reporting period indicates that previously remediated segregation cells have returned to use with known structural suicide hazards.

This finding, however, does not resolve the serious structural hazards outside the cells that were identified in the Fifth Monitoring Report. Current restricted housing documentation demonstrates that the absence of anti-jump barriers in multi-tier housing units is affecting housing decisions for class members with serious mental illness or other behavioral health needs. In one case, a class member with serious mental illness and a prior upper-tier suicide gesture was assigned a single-tier housing alert and ultimately placed in restricted housing because staff did not consider him safe in a tiered unit. In another, a behavioral health class member threatened to jump from the second tier of NBJ J-Unit, was placed in a safety cell, transferred to SBJ because NBJ had no housing option without an upper tier, and was ultimately placed in New East Restricted Housing because other safe housing options remained limited.

The risk is not theoretical. As discussed under Provision IV.G.3, a class member at SBJ jumped from an upper tier on March 5, 2026, in an apparent suicide attempt.

The May 2026 site visit similarly identify a "BHU beds lower-tier issue" involving a class member at risk of jumping and indicate that physical plant modifications is expected to include anti-jump netting. The record does not establish, however, that anti-jump fencing or netting has been installed in existing high-risk multi-tier units. Class counsel also continues to identify unresolved structural suicide hazards in dayroom and shower areas, particularly in the SBJ's Northwest BHU. No current-period documentation establishes that these hazards have been remediated or that an adequate interim corrective-action plan has been implemented.

The County's completed cell-remediation work continues to support Substantial Compliance with the specific language of this provision. That rating should not be interpreted as a finding that the broader structural suicide hazards in behavioral health and other multi-tier housing units have been adequately addressed. Given the continuing risk, its documented effect on housing decisions, and the lack of established remediation during this reporting period, the prior recommendation to consider discontinuing monitoring is not renewed. Monitoring should continue.

Recommendations

1. *Assess viability of installing anti-jump fencing in high-risk multi-tier housing units at both facilities.
2. *Discuss pertinent physical plant issues at Suicide Prevention Meetings.
3. *Parties and Experts should discuss non-cell attachment point and other structural suicide hazards that remain unresolved.
4. Develop and document an interim risk-mitigation plan for class members who cannot safely be housed in multi-tier units, including lower-tier or other safe placement options, and update the corrective-action plan to identify responsible parties and completion dates for anti-jump barriers and unresolved BHU dayroom and shower hazards. This should include all units that house intake, restricted housing, SMI and other high risk populations as well as the upcoming renovation to the IRC and planned new construction on the NBJ complex.

VII. C. Elimination of Dangerous or Improper Physical Plant Features

2. The County shall ensure that prisoners with serious mental illness or otherwise at elevated risk of suicide will not be housed in a cell that contains attachment points or other structural suicide hazards, as follows.
   a) The County shall maintain a list of Segregation cells containing structural suicide hazards.
   b) The County shall not place any person in a Segregation cell containing structural suicide hazards if the person has a diagnosed Serious Mental Illness.
   c) The County shall assess all cells used to hold prisoners awaiting intake screening or post-intake housing placement, including as intake "overflow," and shall ensure that they are suicide-resistant and do not contain structural blind spots, to the maximum extent feasible.

County Response

The County reports that it has completed implementation of this provision.

Expert Review

Compliance Rating: Substantial Compliance
Prior Compliance Rating: Substantial Compliance

Policies - Custody Operations 242 – Suicide Prevention
Custody Operations 305 – Bed Assignment

Training – Disability Rights Remedial Plan Implementation

Metrics Structural Hazard Review Corrective Action Plan
Site Visit Notes

Observations

The County has maintained Substantial Compliance with this provision. As discussed under Provision VII.C.1, the County completed remediation of occupiable segregation, intake, overflow, and holding cells, while cells with unresolved structural suicide hazards were deactivated. During the May 2026 site visit, the Expert confirmed that the unremediated cells remained locked and unused. The evidence reviewed for this reporting period did not identify any person with serious mental illness or an otherwise elevated risk of suicide who was placed in a cell known to contain an unresolved structural suicide hazard.

The serious structural concerns involving upper tiers and other areas of the mental health units are addressed under Provision VII.C.1. Those concerns do not establish regression under this provision, which is specifically directed to the identification and use of cells containing structural suicide hazards. The Expert recommends that monitoring of this provision be discontinued as has been approved by the Parties

VII. C. Elimination of Dangerous or Improper Physical Plant Features

3. No later than January 1, 2021, the County shall discontinue its use ofthe Main Jail's "double door" or other extreme isolation cells, including Central 7 and Central 8.

Pursuant to the parties' stipulated joint request and the Murray court's May 4, 2026 order (Docket 106), monitoring for this provision has been suspended. The provision will therefore be subject to future

monitoring only if it is determined that the County is no longer in substantial compliance, consistent with the procedure set forth in Paragraph 53.

VII. C. Elimination of Dangerous or Improper Physical Plant Features

4. No later than January 1, 2021, the County shall discontinue its use of Segregation housing units that lack access to a dayroom, including South 1-16, West 18-29, and East 11-22. The County may retrofit such units to ensure that they provide access to a dayroom and outdoor recreation areas and that they comply with contemporary correctional standards.

Pursuant to the parties' stipulated joint request and the Murray court's May 4, 2026 order (Docket 106), monitoring for this provision has been suspended. The provision will therefore be subject to future monitoring only if it is determined that the County is no longer in substantial compliance, consistent with the procedure set forth in Paragraph 53.

VII.D. Minimum Out-of-Cell Time

1. Absent exigent circumstances or exigent security concerns that aredocumented, the County shall offer each prisoner not subject to discipline (except in the Northwest unit), at a minimum, 18 hours out of their cell each week, and other structured programming, as follows:
   a) At least six (6) hours per week outdoors for exercise/recreation
   b) At least twelve (12) hours per week in a dayroom or other common area
   c) At least four (4) hours per day, on at least three (3) separate days per week, of in-cell structured programming – i.e., programming .

County Response

The County reports that it is continuing to implement this provision. It states that out-of-cell time has increased in restricted-housing and quarantine units; several class members were reclassified to permit larger recreational groups; tablets are provided daily; audits, exception documentation, and interim strategies are in place; the Main Jail yard remodel has been completed and the yard schedule revised; Guardian RFID will improve tracking; and the County continues to address refusals and strategies to increase out-of-cell time with the Expert. It anticipated meeting the requirements within three months.

Expert Review

Compliance Rating: Partial Compliance
Prior Compliance Rating: Partial Compliance

Policy – Custody Operations Policy 367 – Inmate Recreation

Training – Disability Rights Remedial Plan Implementation

Metrics
Out-of-cell Tracking Reports
Yard Schedules
Tablet Tracking Reports
Program Schedule
Grievances
Tours/Interviews

Observations

This provision addresses outdoor recreation, dayroom or common-area time, tablet access, and meaningful programming. These requirements are related, but they are not interchangeable. A housing unit may provide substantial time outside a cell and still fall short if class members do not receive outdoor recreation, if the available hours are offered at inappropriate times, or if there is little meaningful activity once class members leave their cells.

SBSO provided a substantial amount of out-of-cell data with a broad enough range to evaluate this provision. Taken together, the record reflects meaningful but uneven progress. IRC 400 improved substantially, IRC 100 continued to provide regular small-group out-of-cell time, the New East population declined while walk-a-pair opportunities continued, and the County created a dayroom in M Unit. At the same time, the SBJ main yard did not sustain the stronger hours reported at the end of the Fifth Monitoring Report; K Unit did not increase out-of-cell time as its population declined; M Unit utilization could not yet be measured; and the programming records did not demonstrate complete, equitable, and consistently delivered services across the housing units. These results support a continued finding of Partial Compliance.

SBJ Dorms

For class members housed in the SBJ dorms, this provision requires the County to offer at least six hours of outdoor exercise or recreation each week. For several reporting periods, the limiting factor was the SBJ main yard itself: one large space served the dorm population, and only one group could use it at a time. Before the Fifth Monitoring Report, the County divided the yard into three smaller sub-yards so that multiple dorms could recreate concurrently. The change was intended to remove a longstanding operational barrier and increase the amount of outdoor time available to each dorm.

The initial results were promising. In the Fifth Monitoring Report, the average weekly yard offering rose from approximately four hours per dorm from October 2024 through March 2025 to approximately eight hours from April through June 2025. The facility averaged 8.25 hours per dorm in May and 8.75 hours in June, well above the six-hour requirement. The central question for this review period is whether the County sustained that improvement. It did not.

Although the current logs show that the yard operated on a slightly larger share of days—77 percent compared with 73 percent in the prior reporting period—the average weekly offering per standard dorm fell from 5.5 hours to approximately 5.2 hours. More importantly, the spring 2025 gain disappeared. The facility averaged only 5.25 hours per dorm in May 2026 and 5.25 hours during the partial month of June. Because the three-sub-yard configuration previously supported more than eight hours per dorm, the current shortfall cannot be attributed to yard capacity. The facility has demonstrated the operational capacity to meet the requirement but is not consistently maximizing the available recreation hours.

Tables 8 through 10 compare documented daily yard operation, average weekly main-yard availability between reporting periods, and the current month-by-month results. Table 11 then examines the average weekly offering by dorm. The analysis also considers whether the time of day is contributing to refusals and separately assesses C-17, a four-bed isolated dorm that the Fifth Monitoring Report identified for additional review. The produced logs cover July 1, 2025 through June 2026; the unproduced days in June are not treated as days without recreation.

Table 8: SBJ Daily Main Yard Utilization

July 2024 through June 2026

Period	Days in Month	Yard Operated	Inclement Weather or Maintenance	No Staff*	No Notation	% Days Yard Operated	Self-Reported Compliance
July 2024–June 2025	30.5	22	2	0	2	73%	0%
July 2025–June 17, 2026*	29.3	22.5	0.5	0.1	6.3	77%	Not reported

Prior-period figures are reproduced from the Fifth Monitoring Report. A day is credited as operated when at least one dorm has a documented yard offering. Includes Sundays and holidays.

Table 9: SBJ Main Yard Average Weekly Availability Comparison

Fifth and Sixth Monitoring Report Periods

Reporting Period	Period Average Weekly Hours per Dorm	Months at or Above Six Hours	April	May	June	April–June Average
Fifth Report: Oct. 2024–Jun. 2025	5.5	3 of 9	7.25	8.25	8.75	8
Sixth Report: Jul. 2025–Jun. 17, 2026*	**5.25**	**1 of 12**	**5.75**	**5.25**	**5.25**	**5.5**

**June 2026 includes June 1–17 only. Period averages reflect different reporting-period lengths.*

Table 10: SBJ Main Yard Availability

July 2025 through June 2026

Month	Days Reviewed	Days Yard Operation Documented	Inclement Weather or Maintenance	No Staff	No Reason Given	% Days Yard Operated	Self-Reported Compliance
Jul-25	31	26	0	0	5	84%	Not reported
Aug-25	31	24	0	1	6	77%	Not reported
Sep-25	30	20	1	0	9	67%	Not reported
Oct-25	31	26	0	0	5	84%	Not reported
Nov-25	30	21	2	0	7	70%	Not reported
Dec-25	31	20	3	0	8	65%	Not reported
Jan-26	31	23	0	0	8	74%	Not reported
Feb-26	28	21	0	0	7	75%	Not reported

Month	Days Reviewed	Days Yard Operation Documented	Inclement Weather or Maintenance	No Staff	No Reason Given	% Days Yard Operated	Self-Reported Compliance
Mar-26	31	24	0	0	7	77%	Not reported
Apr-26	30	25	0	0	5	83%	Not reported
May-26	31	26	0	0	5	84%	Not reported
Jun-26*	17	14	0	0	3	82%	Not reported
Average	**29.3**	**22.5**	**0.5**	**0.1**	**6.3**	**77%**	**Not reported**

**June 2026 is a partial month. The production ends June 17; June 18–30 is not counted as days without yard.*

On one level, daily yard availability slightly improved. However, yard closures increased, diminishing the gains realized in the last reporting period and reflecting a minimal-standard approach to compliance. The three-sub-yard configuration created additional operational capacity, but SBSO did not fully capitalize on that capacity by consistently operating the yard.

The month-by-month trend confirms that the decline was not limited to a short winter interruption. The facility average was 5.75 hours in July 2025, reached six hours in October, fell to four hours in December, and recovered only to 5.75 hours in April 2026 before dropping to 5.25 hours in both May and the partial month of June. By comparison, the prior period averaged 7.25 hours in April 2025, 8.25 hours in May, and 8.75 hours in June. Thus, the April-through-June average fell from approximately 8.1 hours in 2025 to approximately 5.4 hours in 2026. Weather was identified as the reason for only six of the 82 days without documented operation and does not explain the sustained reduction. The two measures tell a consistent operational story: the yard opened on somewhat more days, but fewer hours were delivered to each dorm when it was open.

The following table represents, by dorm, the average weekly main-yard offering for the SBJ population from July 2025 through June 2026. S-Tank is included only for months with documented active offerings. C-17 and Northwest I/M Workers are excluded from the facility averages for consistency with the Fifth Monitoring Report:

Table 11: SBJ Main Yard Weekly Average Offering

July 2025 through June 2026

Unit	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Period Avg
B/C-1	6	5	4.75	6	4.75	4.5	5.25	5	5.5	5.5	5	6.25	**5.25**
B/C-4	5.5	5.5	4	5.75	5	4.5	5	4	5	5	4	5	**4.75**
East-1	5.25	4.75	4.75	4.75	4.5	3	5.25	5.25	5.25	6	7.5	6.75	**5.25**
East-23	5.75	4	3.75	6	3.5	3.75	5	5.5	5	6	5.75	5.75	**5**
East-24	5.75	6.25	4.75	5.5	5	4.25	5	5.25	5.5	5.5	6	6	**5.5**
East-4	6	5.5	4.25	6.25	5	3.75	5	4.75	5.75	6	6	5	**5.25**
East-6	5.5	4.25	4.25	8.75	4.75	4	5.25	5.75	4.75	5	5	5	**5.25**

Unit	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Period Avg
East-8	5	5.25	4.25	7	4.25	5	5.5	4.5	5.5	5.25	5.75	4	**5**
S-Dorm	6	5.75	4.75	5.75	4.75	4.5	4.5	5	5	6	6	4	**5.25**
S-Tank	—	—	—	—	—	—	5.5	5.5	5	6	1.75	1.75	**4.25**
West-1	5.75	4.25	4.5	5.75	4.75	4.75	5.25	4.75	5	6	5.25	5.5	**5.25**
West-10	5.5	4.25	5.25	6	4.25	4.75	5.25	5.5	5	6.25	4.25	7	**5.25**
West-13	6	4.25	4.75	6.5	4.25	4	6	5	5	8.25	4	6	**5.25**
West-16	6	5.5	4	6.75	4.25	4.5	6	5	5.25	6.5	5.5	6	**5.5**
West-4	5.75	6	4.75	5.25	5.5	4	7.25	5	5.5	5.5	6	4	**5.25**
West-6	5.75	6	4.75	5.5	5	3	7.25	5	5	4.5	6.25	4	**5.25**
West-8	6	4.75	4.5	5.25	4	3.5	5	5	5.5	6.5	5.75	7.75	**5.25**
Monthly Ave	**5.75**	**5**	**4.5**	**6**	**4.5**	**4**	**5.5**	**5**	**5.25**	**5.75**	**5.25**	**5.25**	**5.25**

The dorm-level results were also uneven. No dorm achieved a six-hour period average. B/C-4 had the lowest average among the continuously active dorms, at approximately 4.75 hours, and both B/C-4 and East-6 were below their month's facility average in nine of the twelve months reviewed. The logs also reflect that an offer is not the same as actual use. Across the standard dorms, average weekly yard use was approximately 3.4 hours, compared with approximately 5.2 hours offered.

Time of day appears to be an important part of the refusal pattern. Of the 1,946 offers with a usable start time, 452 began before 9:00 a.m. and 49 percent were refused. By comparison, 19 percent of the 1,494 timed offers beginning at or after 9:00 a.m. were refused. The difference was especially pronounced in several dorms: B/C-4 had a 44 percent refusal rate before 9:00 a.m. and 9 percent later in the day; East-1 was 70 percent compared with 7 percent; S-Dorm was 72 percent compared with 5 percent; and West-1 was 70 percent compared with 8 percent. These results are consistent with concerns raised during the prior reporting period that class members are less willing to recreate during cold, dark, or dreary early-morning hours. The data do not establish causation, and 349 refusal entries did not include a usable start time, but the relationship is too substantial to disregard.

The Fifth Monitoring Report recommended that the County publish an early-hour rotation, distribute 07:00 starts across all dorms, and cap any single dorm's monthly share. The current logs show some redistribution, but not an equitable rotation. In the prior period, West-10, East-1, and West-1 received approximately 42 percent of the 07:00 assignments. During the current period, the three dorms receiving the most 07:00–08:00 assignments—B/C-1, B/C-4, and West-16—received approximately 33 percent. The concentration therefore decreased and the most frequently assigned dorms changed, which suggests some effort to rotate the schedule. However, the recurring pattern remained pronounced. West-16 received 46 combined 07:00–09:00 assignments, B/C-1 received 43, East-8 received 40, and B/C-4 received 38. By contrast, East-23, East-4, and East-6 received only one early assignment each, all in June, and West-8 received only three during the entire period. Nearly half of the 08:00–09:00 assignments went to West-16, East-8, and S-Dorm. Thus, some redistribution occurred, but the early hours were not equitably distributed, and the production did not include a current published rotation or monthly cap demonstrating implementation of the prior recommendation.

The highest overall refusal rates were recorded in S-Tank (approximately 89 percent), West-8 (82 percent), West-6 (74 percent), West-4 (51 percent), East-6 (45 percent), and West-1 (43 percent). Early scheduling does not explain every refusal; for example, West-8's refusal rate remained high regardless of the start time. However, the results support testing later start times in the dorms where the difference is pronounced and

then measuring whether participation improves. Equitable rotation remains important, but rotating an undesirable time among dorms does not address the underlying barrier.

C-17

C-17 is a four-bed, isolated dorm that is intermittently used for a specialized population. C17 is a small, standalone four-bed dorm in a hallway away from the rest of the population and outside normal inmate observation areas. It has its own shower, toilet, table, television, and telephone, but no ambient light or opportunity to communicate with class members outside the dorm. Flaps routinely cover the hallway-facing door windows, limiting staff observation and occupants' ability to see staff passing. Occupants generally must bang or tap on the windows or door to attract staff attention, although they may not know when staff are nearby. The Fifth Monitoring Report appropriately excluded it from the standard dorm averages and stated that it would be assessed independently during this review period. The current out-of-cell trackers document 100 offers and show an average weekly offering of approximately 3.9 hours, average weekly use of approximately 0.6 hours, and an 83 percent refusal rate. Only two of the timed C-17 offers began before 9:00 a.m., and both were refused; however, refusals were also high later in the day. Therefore, unlike several of the larger dorms, C-17's refusal pattern cannot be attributed primarily to early-morning scheduling. The production does not establish C-17's daily occupancy or identify when the tank was empty, so the Monitor cannot determine how much of the measured shortfall reflects intermittent vacancy rather than missed opportunities while occupied.

Table 12: C-17 Separate Assessment

July 2025 through June 2026

Month	Weekly Hours Offered	Weekly Hours Used	Refusal Rate
Jul-25	5	2.75	42%
Aug-25	4.75	0.75	82%
Sep-25	5	1.75	64%
Oct-25	5.75	0	100%
Nov-25	4.75	0	100%
Dec-25	1.25	0	100%
Jan-26	5	1.25	73%
Feb-26	1	0	100%
Mar-26	2.75	0	100%
Apr-26	2.75	0.5	83%
May-26	4.5	0	100%
Jun-26*	4	0	100%
Period Avg	**4**	**0.5**	**83%**

**June 2026 includes June 1–17 only.*

Even with the occupancy limitation, the evidence does not demonstrate a consistent six-hour weekly outdoor-recreation offering for people housed in C-17. This is particularly concerning because people housed in an isolated setting may have fewer opportunities for movement, fresh air, natural light, and social interaction. A refusal should not end the inquiry. Staff should actively encourage participation, explain the benefits of leaving the cell and obtaining outdoor light, consider whether a different time of day would be

more successful, and make a renewed offer later when operationally feasible. Future production should pair the yard tracker with a daily occupancy record and separately identify offers, refusals, and actual use during occupied periods.

SBJ New East Restricted Housing

New East Restricted Housing continues to serve as SBJ's male restricted-housing unit. During this review period, however, the number of class members housed there declined substantially. By the latter part of the year, the unit frequently held only a few restricted-housing class members, was intermittently closed, or was used only for quarantine. This is important context for the data that follow. Fewer entries and fewer opportunities to use the walk-a-pair model late in the period may reflect the County's reduced use of restricted housing—a positive development—rather than a failure to provide out-of-cell time.

When New East housed eligible restricted-housing class members, some were permitted to exercise or program with another person under the practice generally referred to as "walk-a-pair." The practice reduces isolation and increases social contact without changing the unit's restricted-housing designation. This review examines the out-of-cell opportunities documented from July 1, 2025 through June 2026 and compares the results with both the 2024 review period and the Fifth Monitoring Report.

Review Method. The analysis applied the same counting adjustments used in the Fifth Monitoring Report. Class members on quarantine, medical isolation, or another documented restriction were excluded, as were persons released, transferred, or not present in the unit. Formula errors and overlapping yard and dayroom entries were corrected so that the same period was not counted twice. Days on which no eligible restricted-housing occupant was identified were not treated as days without recreation because the unit may have been closed or operating only for quarantine.

The following two tables provide complementary comparisons. Table 13 shows the change between the Fifth and Sixth Monitoring Report periods by measure. Table 14 then places the current results in the longer trend beginning with the 2024 review period.

Table 13: SBJ New East Restricted Housing Comparison

Fifth and Sixth Monitoring Report Periods

Measure	Fifth Report Jan.–Jun. 2025	Sixth Report Jul. 2025–Jun. 17, 2026	Direction
Average daily yard offered	1.75 hours	1.75 hours	No change
Average daily dayroom offered	1.25 hours	1.5 hours	Slightly better
Average daily combined offered	2.75 hours	3 hours	Slightly better
Average weekly combined offered	19.25 hours	20.5 hours	Better
Average weekly combined actualized	Less than 11 hours	11.5 hours	Modest improvement
Yard refusal rate	57%	64%	Worse
Dayroom refusal rate	39%	14%	Better

Fifth Report figures are reproduced as published. Current combined time removes overlapping yard and dayroom intervals. June 2026 includes June 1–17 only.

Table 14: SBJ New East Restricted Housing Trend Comparison

2024 Review, Fifth Monitoring Report, and Sixth Monitoring Report

Review Period	Yard Offered per Week	Dayroom Offered per Week	Combined Offered per Week	Combined Actualized per Week	Yard Refusal	Dayroom Refusal
2024 Review Jul. 2023–Jun. 2024	Approx. 13	Less than 9	Approx. 22	Approx. 12.5	Less than 50%	Less than 50%
Fifth Report Jan.–Jun. 2025	12.25	8.75	19.25	Less than 11	57%	39%
Sixth Report Jul. 2025–Jun. 17, 2026	**13**	**10.25**	**20.5**	**11.5**	**64%**	**14%**

The 2024 and Fifth Report figures are reproduced as published. Current combined time removes overlapping yard and dayroom intervals. June 2026 includes June 1–17 only.

Comparison to Prior Periods. The County's current results are somewhat better than those reported in the Fifth Monitoring Report, but they have not returned to the 2024 level. The combined weekly offer increased from 19.25 hours to approximately 20.5 hours, and actualized time increased from less than 11 hours to approximately 11.6 hours. In 2024, however, New East offered approximately 22 hours and class members actualized approximately 12.5 hours per week. Thus, current performance improved modestly from the Fifth Report but remains below both the 18-hour requirement and the actualized time reported in 2024.

The refusal pattern is also mixed. Yard refusals increased from 57 percent in the Fifth Report to 64 percent, while dayroom refusals fell from 39 percent to 14 percent. Improved dayroom participation accounts for much of the increase in actualized time. The higher hours documented later in the period should also be understood in light of the smaller population: with fewer class members housed in New East, staff had greater ability to offer longer and more flexible out-of-cell periods.

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Table 15 provides the month-by-month results for the current review period. It places the declining eligible restricted-housing population alongside the average hours offered and actualized, refusal rates, and days without yard.

Table 15: SBJ New East Restricted Housing Monthly Analysis

July 2025 through June 17, 2026

Month	Avg. Eligible RH Occupants*	Avg. Yard Hours	Avg. Dayroom Hours	Avg. Total Hours	Avg. Actualized Hours	Yard Refusal Rate	Dayroom Refusal Rate	No-Yard Days
Jul-25	8	2	1	3	1.5	76%	16%	0
Aug-25	5	2	1.5	3.25	1.75	75%	9%	0
Sep-25	8	1.5	1.25	2.75	1.25	73%	22%	0
Oct-25	7	1.75	1.25	3.25	1.75	66%	18%	0
Nov-25	5	1.75	1.5	3.25	1.75	79%	7%	0
Dec-25	9	1.25	0.75	2.25	0.75	79%	20%	0
Jan-26	7	1.75	1.25	3	1.5	73%	10%	1
Feb-26	3	3.25	3.5	3.75	3.5	6%	4%	1
Mar-26	1	3	3	4	3	50%	0%	0
Apr-26	3	2	2	2.5	2	22%	7%	3
May-26	3	3	2.75	3	2.75	17%	11%	0
Jun-26*	1	4.5	4.75	5	5	0%	0%	1
Period	**6**	**1.75**	**1.5**	**3**	**1.75**	**64%**	**14%**	**6**

**Average eligible restricted-housing occupants is calculated only for days with an identified eligible population. The unit was intermittently closed or used only for quarantine. Blank days are not treated as recreation failures. June 2026 includes June 1–17 only.*

Population and Monthly Trend. The population declined markedly during the latter part of the review period. From February forward, the logs generally identified only one to three eligible restricted-housing class members on occupied days, including approximately one in March and partial June. The smaller population helps explain both the increase in average out-of-cell hours and the reduced number of documented walk-a-pair events. This is not a negative trend. It reflects that fewer class members were being held in the County's most restrictive male housing unit.

Days Without Recreation. The logs identified six occupied days without a yard offer. Four were attributed to rain or wet conditions. On April 1 and June 17, neither yard nor dayroom was documented and no reason was given.

Walk-a-Pair. The logs document shared out-of-cell intervals on 139 days, providing stronger proof that the walk-a-pair program was used than was available during the Fifth Monitoring Report. The May 2026 tour provided qualitative confirmation: the use of small groups and walk-a-pair in New East, including for transgender class members housed there, was noted positively. Most paired activity occurred while New East housed a larger restricted-housing population. The decline later in the year is consistent with fewer eligible class members being present and, at times, too few compatible class members to form a pair. The County should continue the practice whenever the population and safety considerations permit.

Documentation. The tracking records continue to require manual review because some entries were incorrect and some yard and dayroom entries overlapped. More importantly, the logs should identify whether New East was operating as restricted housing, closed, or used only for quarantine on each day. That simple distinction would prevent a reduction in the restricted-housing population from appearing to

be a documentation or recreation failure. Beginning in February 2026, the yard door was routinely open during portions of dayroom, allowing class members simultaneous access to both areas. As a result, yard and dayroom hours overlapped, and the average total out-of-cell hours beginning in February cannot be calculated by simply adding the separate yard and dayroom averages. The total-hours calculation reflects combined out-of-cell time without double-counting periods when both areas were available simultaneously.

Assessment. The current record reflects modest improvement in offered and actualized out-of-cell time, substantially better dayroom participation, continued use of walk-a-pair, and a meaningful reduction in the number of class members housed in New East. Those are positive developments. At the same time, the class members who remained in restricted housing actualized approximately 11.6 hours per week—better than the Fifth Report, but below the 18-hour requirement and below the 2024 result. Yard refusals also remained high. The County should continue reducing reliance on New East while ensuring that the smaller population still receives consistent and meaningful time out of cell.

SBJ IRC 100

It is clear that IRC 100 is not a restricted housing unit. It serves as a small-group setting that is used en lieu of restricted housing or as a stepdown option from restricted housing for male class members who can be out of their cells with others, generally in groups of approximately four. Staff open the dayroom and yard at the same time, allowing class members to choose where to spend the scheduled period. This operating model is less isolating than segregation and is intended to support gradual reintegration while maintaining a manageable group size.

The Fifth Monitoring Report found that IRC 100 was consistently providing combined dayroom and yard access. Table 12 of that report reflected an average of 3.5 hours per day, or 24.5 hours per week, and concluded that the central expectation for unstructured time out of cell was being met. The question for this review period is whether the County maintained or improved that level of access. Overall, it did, although the stronger performance documented in fall 2025 was not sustained through the end of the period. Structured programming is addressed separately in the programming analysis.

Review Method. The requested review period was July 2025 through June 2026, but no July 2025 IRC 100 tracker was produced. Complete activity entries were available from August 1, 2025 through June 16, 2026. Because staff frequently entered the same interval in both the yard and dayroom columns, overlapping time was counted once. A class member was counted as refusing out-of-cell time only when neither location was used; choosing dayroom instead of yard was not treated as a refusal of out-of-cell time.

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The following two tables place the current results in context. Table 16 compares the published Fifth Monitoring Report results with the current period and shows whether the improvement continued through the closing months. Table 17 then presents the current month-by-month results, including full refusals and confirmed days without recreation.

Table 16: SBJ IRC 100 Out-of-Cell Comparison

Fifth and Sixth Monitoring Report Periods

Measure	Fifth Report Jan.-Jun. 2025	Sixth Report Aug. 2025-Jun. 16, 2026	Direction
Average daily combined OOC	3.50 hours	3.75 hours	Slightly better
Average weekly combined OOC	24.50 hours	26.25 hours	Slightly better
Closing three-month daily average*	3.75 hours	3.25 hours	Lower
Closing three-month weekly average*	26.25 hours	23.5 hours	Lower

*The Fifth Monitoring Report narrative cited 3.39 daily hours and 23.8 weekly hours, while its Table 12 reported 3.50 and 24.50 hours. This comparison reproduces Table 12 as published. *Closing three months are April-June 2025 and April-June 16, 2026.*

Comparison to the Fifth Monitoring Report. IRC 100 averaged approximately 3.75 hours per day, or 26.24 hours per week, during the available current period. This is a modest improvement from the 3.5 daily hours and 24.5 weekly hours published in the Fifth Monitoring Report. The average eligible population remained relatively stable at approximately 14 to 15 class members, and class members used some out-of-cell time during approximately 97 percent of documented opportunities. Full refusals of both yard and dayroom were uncommon, averaging approximately 3 percent.

The overall average, however, obscures a notable change over time. From August through December 2025, class members averaged approximately 4.06 hours per day, or 28.42 hours per week. September and October were the strongest months, each exceeding 4.4 hours per day. From January through June 16, 2026, the average fell to approximately 3.46 hours per day, or 24.24 hours per week. During April through June 16, the average declined further to approximately 3.34 hours per day, or 23.40 hours per week. These later results remained above the combined 18-hour requirement, but they show that the County did not sustain the stronger fall 2025 performance and returned close to the level reported in the Fifth Monitoring Report.

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Table 17 shows the monthly progression. Because the dayroom and yard were opened simultaneously and the logs frequently duplicated the same time in both columns, the table reports combined out-of-cell time rather than adding the two entries together.

Table 17: SBJ IRC 100 Monthly Out-of-Cell Analysis

August 2025 through June 16, 2026

Month	Avg. Daily Combined OOC	Avg. Weekly Combined OOC	Full OOC Refusal Rate	Confirmed No-Recreation Days
Aug-25	3.75	26.25	0.2%	0
Sep-25	4.5	31.75	1.3%	0
Oct-25	4.5	31	5.2%	0
Nov-25	3.75	26.25	3.7%	0
Dec-25	3.75	26.75	1.8%	0
Jan-26	3.5	24.25	4.0%	0
Feb-26	3.5	24.5	5.8%	0
Mar-26	3.75	26.25	1.4%	0
Apr-26	3.25	23	4.8%	1
May-26	3.5	23.75	3.0%	0
Jun-26*	3.25	23.5	2.1%	0
Period	**3.75**	**26.25**	**3.0%**	**1**

**June includes June 1-16 only. July 2025 and June 18-30, 2026 were not produced. The unfinished June 17 tracker is excluded. Overlapping yard and dayroom entries are counted once, and a full refusal means that neither location was used.*

Tour Observations. During the May 2026 tour, IRC 100, IRC 400, and New East Restricted Housing were the cleanest and most orderly observed since monitoring began. These observations are consistent with the record showing regular small-group access and generally strong out-of-cell participation.

Days Without Recreation. There were only two days confirmed without recreation. It is positive that SBSO has demonstrated a commitment to daily out-of-cell time. The August 14, 2025 tracker is internally inconsistent: its general note states that neither yard nor dayroom was provided because the sliders were not operating, while every resident has recorded activity time. That date cannot reliably be characterized as a day with recreation and should have been reconciled by the County.

Operational Interruptions. A broken window affected the unit from late January through early February 2026. On several days, dayroom time was restricted or shortened while yard and showers were substituted. This disruption helps explain the lower January and February averages. Other interruptions were attributed to rain, maintenance, facility incidents, and staffing. Most were partial, and class members still received some out-of-cell time. The continued lower averages in April, May, and June, however, cannot be attributed solely to the temporary broken window.

Documentation. The IRC 100 trackers do not reliably distinguish whether a class member used the yard or dayroom because the yard door is routinely open during dayroom and staff frequently enter identical times in both columns. As a result, the records support the combined finding that class members were offered at least six hours of outdoor recreation and twelve hours of dayroom per week. However, the records included incorrect dates and other inconsistencies. In addition, marking yard as refused when a class member chose dayroom may overstate refusal behavior. When yard and dayroom are concurrently offered, a full refusal designation should be reserved for circumstances in which the class member declines both.

Assessment. IRC 100 continues to provide a less isolating, small-group setting for class members who can be out of their cells together. Combined out-of-cell time improved modestly from the Fifth Monitoring

Report, exceeded the 18-hour weekly minimum throughout the available monthly averages, and was generally used by the population. The isolated April 5 cancellation does not demonstrate a widespread failure to provide recreation. Nevertheless, the strong September and October performance was not sustained, the final months returned close to the prior-report level. The County should preserve the small-group model while restoring the stronger daily schedule and improving the reliability of its documentation.

SBJ IRC 400

IRC 400 is described as serving primarily the orientation unit for women. The population may include women classified for general population, protective custody, or other statuses that make some women incompatible with others. Staff therefore organize women into smaller groups based on classification and individual compatibility factors and operate multiple out-of-cell rotations. The unit should be evaluated as an orientation and non-segregated housing unit, not as restricted housing. This distinction is important because the Fifth Monitoring Report found that IRC 400 was offering and actualizing so little out-of-cell time that, despite its formal designation, it was functioning more like a restricted-housing unit.

Women on restricted-housing status may nevertheless be housed in IRC 400 on occasion. That occurred rarely during this review period. The records identify only one restricted-housing woman, accounting for 17 person-days near the end of the review period. Those entries were removed from the orientation calculations and evaluated separately. Medical-isolation days were excluded because those women were not eligible for routine out-of-cell activity. Separating the populations avoids allowing a rare restricted-housing placement to either depress the orientation results or disappear within the much larger IRC 400.

Review Method. The requested review period was July 2025 through June 2026. Completed activity records were available from July 1, 2025 through June 16, 2026. When yard and dayroom occurred at different times, both periods were counted. When staff entered the same interval in both columns, the overlapping period was counted once because the record reflects simultaneous access to the yard and dayroom rather than two separate out-of-cell periods. Medical isolation, hospitalization, transfer, release, and other documented absences were excluded.

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The following two tables present the orientation results without blending the two populations. Table 18 compares the current IRC 400 with the results published in the Fifth Monitoring Report. Table 19 then shows the month-by-month progression during the current period. Because the restricted-housing sample consists of only one woman over 17 days, those results are more clearly explained in the narrative that follows rather than presented as a broader unit trend.

Table 18: SBJ IRC 400 Out-of-Cell Comparison

Fifth Monitoring Report and Current Orientation Population

Measure	Fifth Report Jan.-Jun. 2025	Sixth Report Orientation Jul. 2025-Jun. 16, 2026	Direction
Yard available per week	6.75 hours	21 hours	Material improvement
Dayroom available per week	6.5 hours	21 hours	Material improvement
Combined OOC offered per week	Approx. 13 hours	25 hours	Material improvement
Combined OOC actualized per week	Approx. 7 hours	21.25 hours	Material improvement
Yard refusal rate	71%	25%	Substantially better
Dayroom refusal rate	20%	7%	Substantially better
Days with no recreation	Not reported	1	Isolated concern

Fifth Report figures are reproduced as published and included the unit's mixed population. Current figures exclude restricted housing and medical isolation. Beginning in late 2025, yard and dayroom were frequently available during the same period; the individual availability figures therefore overlap and are not added together to calculate combined out-of-cell time.

Comparison to the Fifth Monitoring Report. The Fifth Monitoring Report recommended that the County increase dayroom access, promote yard use and social interaction, and reduce the persistent yard refusals that had caused IRC 400 to operate more like restricted housing than an orientation unit. The County acted directly on those recommendations. During the current period, the IRC 400 was offered approximately 25 hours per week and actualized approximately 21.2 hours. Both measures substantially exceed the approximately 13 hours offered and seven hours actualized in the Fifth Monitoring Report. The current records also reflect sufficient average availability to meet the separate requirements for six hours of outdoor recreation and twelve hours of dayroom or common-area access. Although the comparison is not exact because the Fifth Report results included the unit's small restricted-housing population, the scale and consistency of the improvement are clear.

The improvement was not uniform across the full period. During July through October 2025, approximately 25 hours were offered each week, but women actualized only about 14.6 hours. Yard refusals remained approximately 68 percent, and full refusals of all out-of-cell time occurred during approximately 16 percent of documented opportunities. The problem during those months was therefore not simply the number of hours on the schedule; it was the unit's continuing difficulty converting scheduled opportunities into time actually used.

That pattern changed markedly beginning in November 2025. Staff expanded the number of classification-compatible groups that could be out and opened the yard at the same time as the dayroom, allowing women to choose between the two locations in the same manner as IRC 100. The response was both practical and effective. From November through June 16, women continued to be offered approximately 25 hours per week but actualized approximately 24.4 hours. Yard and dayroom refusals each fell to approximately 3 percent. From March through June 16, women actualized approximately 24.5 hours per week and full

refusals were below 1 percent. This represents one of the clearest operational improvements documented during the current review period and deserves recognition.

Table 19 shows this change over time. Because yard and dayroom were increasingly available during the same interval, the table reports combined out-of-cell time and full refusals rather than adding overlapping entries or treating a choice of one location as a refusal of all out-of-cell time.

Table 19: SBJ IRC 400 Orientation Population

July 2025 through June 16, 2026

Month	Avg. Daily Combined Offered	Avg. Weekly Combined Offered	Avg. Weekly Combined Actualized	Full OOC Refusal Rate	No-Recreation Days
Jul-25	3.5	23.75	10.75	22.7%	0
Aug-25	3.5	24.5	14.25	14.4%	0
Sep-25	3.75	26	16.5	11.2%	0
Oct-25	3.75	25.5	16.75	15.3%	0
Nov-25	4	28	26.75	3.7%	0
Dec-25	3.75	25.75	24.25	4.3%	0
Jan-26	3.25	23	21.25	7.6%	0
Feb-26	3.75	26	25.25	2.8%	0
Mar-26	3.5	25	24.75	0.2%	0
Apr-26	3.5	24.5	24.5	0.3%	1
May-26	3.5	25.25	25	0.4%	0
Jun-26*	3.25	23.25	23	0.4%	0
Period	**3.5**	**25**	**21.25**	**6.8%**	**1**

**June includes June 1-16 only. June 17-30 were not produced as completed activity days. Restricted-housing and medical-isolation person-days are excluded. A full refusal means that the woman used neither the yard nor the dayroom.*

Days Without Recreation. One orientation-population day with no documented recreation was identified. On April 5, 2026, the tracker lists approximately 20 orientation residents and documents that showers were provided, but it contains no yard or dayroom activity. This appears to be an isolated unit-wide occurrence rather than a recurring pattern. The records also contain occasional individual lock-downs for behavioral or operational reasons, but those events were limited and did not materially alter the overall orientation results.

Restricted Housing Women. The favorable orientation results do not describe the rare restricted-housing placements. Only one woman was identified on restricted-housing status, and only during the final 17 days of available records. The sample is too limited to establish a broader trend and should not be used to characterize the orientation unit as a whole. Her out-of-cell time was therefore calculated separately and is discussed here rather than presented in a table.

During those 17 days, the restricted-housing woman averaged approximately 1.32 hours per day, or 9.2 hours per week, well below the 18-hour benchmark. Three days contained no documented recreation. The May 31 entry includes no out-of-cell time and no explanation. On June 7, no dayroom was provided to the final programming group at the direction of the shift commander. On June 12, the group was locked down because of critical staffing. When out-of-cell time was offered, it was accepted; the deficiency therefore resulted from the amount and consistency of time provided, not refusal behavior. Restricted housing was rare in IRC 400, but the County must still ensure that any woman placed on that status receives the required out-of-cell opportunities.

Tour Observations. During the May 2026 tour, IRC 100, IRC 400, and New East Restricted Housing were the cleanest and most orderly observed since monitoring began. These observations are consistent with the record showing regular small-group access and generally strong out-of-cell participation.

Documentation. The trackers support the combined-hours analysis but do not always identify which location a woman selected because staff frequently entered identical times in both the yard and dayroom columns. Status designations were also embedded in the name field rather than recorded in a separate classification field. Future trackers should identify orientation, restricted-housing, and medical-isolation status in a dedicated field. This will permit supervisors to monitor each population separately and prevent a rare restricted-housing placement from being blended into the orientation results.

Assessment. IRC 400's out-of-cell time improved substantially from the Fifth Monitoring Report. The County addressed the prior recommendations by increasing the number of compatible groups that could be out, opening the yard and dayroom simultaneously, and giving women a meaningful choice about where to spend their time. The result was approximately 25 hours per week of out-of-cell access, more than 21 hours actualized across the full period, more than 24 hours actualized after November, and a sharp reduction in refusals. Except for the isolated April 5 cancellation, the records demonstrate regular access above the combined 18-hour requirement and sufficient average availability to meet the separate yard and dayroom requirements. This is a significant accomplishment. Based on SBSO's substantial efforts, IRC 400 should no longer be characterized as an unidentified or de facto restricted-housing unit.

The restricted-housing population presents a separate and much narrower concern. Restricted housing was rare, involving only one woman and 17 person-days, but the documented schedule averaged approximately 9.2 hours per week and included three days without recreation. The County should preserve the successful non-restricted population schedule while ensuring that any woman placed on restricted-housing status receives a separately documented schedule that meets the applicable out-of-cell requirements.

NBJ K Unit – Restricted Housing

K Unit is NBJ's male restricted housing unit. Class members are generally offered yard and dayroom separately, although compatible class members may be permitted to come out together through the walk-a-pair program. During the latter part of this review period, the population fell sharply. By May 2026, K Unit averaged approximately one class member, and in June a single protective-custody class member remained. Although that class member continued to be housed in administrative segregation because he could not program with the general population, the low census created a meaningful opportunity to reduce the effects of cell isolation through substantially more individual out-of-cell time.

Rather than producing individual tracking sheets for July through December 2025, the County produced daily activity logs. Those logs provide useful operational context but do not permit individual-level assessment. Individual K Unit out-of-cell tracking sheets were produced for January through May 2026.

Table 20 provides the apples-to-apples comparison between January through May 2025 and January through May 2026. It shows only a modest change in the scheduled offer.

Table 20: NBJ K Unit Out-of-Cell Comparison

January through May 2025 and January through May 2026

Measure	Fifth Report Jan.–May 2025	Sixth Report Jan.–May 2026	Change
Average daily yard offered	1.25 hours	1.25 hours	No change
Average daily dayroom offered	1.75 hours	2 hours	0.25-hour increase
Average daily combined offered	3 hours	3.25 hours	0.25-hour increase
Average weekly combined offered	21.25 hours	22.25 hours	1-hour increase

Hours are rounded to the nearest quarter hour. The January through May 2025 figures are calculated from the monthly results published in the Fifth Monitoring Report.

The current offer is essentially the same as the comparable period reviewed in the Fifth Monitoring Report. Combined yard and dayroom increased by only approximately one hour per week, from 21.25 hours to 22.25 hours. This is a small improvement on paper, but it does not demonstrate that the County used the declining K Unit census to provide substantially more time out of cell. This is particularly concerning for class members in protective custody status rather than persons engaged in substantial disruption.

Table 21 shows the monthly results for the five months supported by K Unit out-of-cell tracking sheets. It places the recorded offers alongside the changing population and demonstrates that the offer did not increase when the unit population declined.

Table 21: NBJ K Unit Population and Recorded Daily Offers

January through May 2026

Month	Average Daily Census	Yard Offered	Dayroom Offered	Combined Offered
Jan-26	5	1.25	1.75	3
Feb-26	4	1.25	1.75	3
Mar-26	8	1.5	2	3.5
Apr-26	5	1.25	2	3.25
May-26	1	1	1.75	2.75
Audited Period	**5**	**1.25**	**2**	**3.25**

Census is rounded to whole persons and hours to the nearest quarter hour. The May workbook records accepted-duration totals that exceed the corresponding offered totals. Because those fields are not directly comparable, they were not used to calculate a weekly actualized figure.

Population and Out-of-Cell Trend. During the five audited months, the population increased from approximately five class members in January to eight in March, then fell to approximately one in May. The out-of-cell offer did not increase as the population declined. To the contrary, the highest recorded offer was approximately 3.5 hours per day in March, when the unit averaged eight class members. In May, when the unit averaged only one class member, the recorded offer fell to approximately 2.75 hours per day.

The May and June census should have made it considerably easier to provide longer and more flexible out-of-cell periods. When only one protective-custody class member is housed in K Unit, that person should

ordinarily be permitted at least four hours out of cell each day, absent a documented behavioral or security reason. The person's administrative-segregation status does not prevent staff from providing extended individual dayroom and yard access. Even if the class member cannot program with another person, allowing substantially more time out of cell reduces the harmful effects of prolonged isolation.

Yard, Refusals, and Documentation. The Fifth Monitoring Report identified persistent yard refusals and recommended that the County determine why yard was not being used. The current records continue to show less use of yard than dayroom, but the weekly audit format does not identify the date of each offer or refusal. It therefore does not permit a reliable count of days without recreation or a definitive determination of whether the same class member refused all out-of-cell time for three consecutive days. Daily person-level documentation remains necessary.

Tour Observations. During the May 2026 tour, K Unit held two class members. Both reported that staff had discussed allowing them to program together, and the walk-a-pair program was viewed positively. The unit nevertheless had no structured programming beyond ordinary out-of-cell activity. The very small population provided staff with flexibility to reduce isolation, but that flexibility was not reflected in the recorded hours offered.

Assessment. K Unit did not materially improve its scheduled out-of-cell offering from the Fifth Monitoring Report. The modest increase in the five-month average is overshadowed by the May result: as the census fell to approximately one person, the offer decreased rather than increased. The County should provide the remaining protective-custody class member at least four hours out of cell each day absent documented behavioral or security concerns, including meaningful access to outdoor recreation. It should also maintain a daily record of each offer, the time actually used, any refusal or contraindication, and the reason for any day without recreation. The walk-a-pair program should continue when compatible class members are present, and structured programming should be added and tracked separately.

NBJ M Unit – Medical Housing

M Unit is a small medical-housing area for class members with complex and changing clinical needs. Its population may include class members on suicide precautions, quarantine, communicable-disease isolation, or another status that temporarily contraindicates routine yard or dayroom activity. The unit therefore cannot be evaluated by assuming that every occupied bed represents a person eligible for recreation. It must instead be evaluated by whether medically eligible class members are identified, offered appropriate out-of-cell time, and given a documented explanation when activity is restricted.

The most important development during this review period is that the County converted M-11, a multi-person dorm within M Unit, into a dayroom. This directly responds to the Fifth Monitoring Report's recommendation that the County create a small common area for M Unit rather than leave medically housed class members without any dayroom option. The physical change is significant and deserves recognition. The remaining question is whether the new space has been incorporated into a reliable daily schedule for eligible class members.

Follow-Up to the Fifth Monitoring Report. The County began preparing M-11 for use as a dayroom in April 2026, and the May tour confirmed that the room had been activated. Four medical class members were housed in M Unit at the time of the tour. Staff reported that access was being alternated between protective-custody and general-population groups and that class members were not receiving dayroom every day. The change therefore shows promise, but the County has not yet demonstrated consistent utilization of the new space.

The available records do not permit a reliable calculation of out-of-cell time in M Unit. The general unit logs contain occasional references to the new dayroom but do not identify each class member's clinical

eligibility, the time offered, the time actually used, a refusal, or the reason access was restricted. The monitor therefore cannot determine how often each eligible class member received dayroom, whether access was distributed equitably between classification groups, or how many days an eligible class member received no recreation.

Dayroom Utilization. The need to separate class members who are not compatible may require more than one dayroom rotation. It should not, however, result in a routine one-hour limit when the number of eligible class members and classification groups permits substantially more time. Adequate and equitable dayroom access for people housed in the M unit is required under this provision and is pertinent to ADA/program access requirements that are monitored by the ADA/disability expert. The M-11 dayroom should be used throughout the day, and each compatible group should receive the maximum reasonable access. When the unit holds only a few eligible class members, longer periods should be easier to provide.

Clinical Eligibility and Outdoor Recreation. M Unit does not have a documented mechanism for identifying who is clinically eligible for dayroom and yard on a given day. Some class members may appropriately be restricted because of suicide precautions, quarantine, infection-control requirements, or another individualized clinical condition. Placement in medical housing, standing alone, should not be treated as a contraindication. Class members who are clinically eligible should receive regular access to M-11 and should also be offered outdoor recreation. The production does not demonstrate that medically eligible M Unit class members were taken to yard during this review period.

Documentation. The clinical complexity of M Unit makes a daily eligibility record essential. The County should identify each class member; whether the person is eligible for dayroom and yard; any necessary compatibility group; the time offered and actually used; any refusal; and the specific clinical reason for a restriction. Without that information, an appropriate clinical limitation cannot be distinguished from an operational failure to provide out-of-cell time, and the County cannot demonstrate consistent proof of practice.

Assessment. The County should be credited for converting M-11 into a dayroom and beginning to use it. This was a meaningful and necessary improvement from the Fifth Monitoring Report. At the time of the May tour, however, access was not yet daily, the amount of time provided remained limited, and the County had not established the documentation needed to measure utilization or clinical eligibility. The County also had not demonstrated access to outdoor recreation for medically eligible class members.

Programming

Programming is an essential part of the out-of-cell requirements in VII.D. It is not enough for class members to leave their cells if there is little for them to do once they are out. The provision requires meaningful out-of-cell opportunities and also requires at least four hours per day, on at least three separate days each week, of structured programming . The Interim Measures further require complete and equitable programming across the facilities, including for class members with disabilities and those housed in South Dorm.

The Fifth Monitoring Report found a clear difference between the two jails. NBJ had a more developed program structure across its general-population units, while SBJ programming was concentrated in the behavioral-health units and a small number of modules. Restricted housing and the IRC units received little or no documented programming. The County was encouraged to expand structured and clinical programming, improve rotation schedules, increase custody and program-observation staffing, and provide reliable proof that scheduled programs actually occurred.

For this review, the County produced monthly program calendars for both jails from July 2025 through June 2026, college and cohort schedules, several vocational-program rosters, and two behavioral-health programming schedules. Programming is provided through two complementary systems. SBSO operates

STP and coordinates educational, religious, peer-support, volunteer, and vocational programs. Wellpath provides clinical and BHU-level treatment groups. The SBSO calendars and related records describe the first system, while Dr. Belavich's September 2026 Remedial Plan Status Report provides additional analysis of the Wellpath clinical program. Both sources are considered here to assess the overall programming opportunities available to class members.

The twelve-month production provides a better picture of the planned program structure than was available for the Fifth Monitoring Report. It still does not answer the most important question: whether every eligible class member received a reasonably equitable opportunity to participate in the combination of clinical, Sheriff-operated, and volunteer programming appropriate to the person's needs. Most of the records are calendars showing what was scheduled. With limited exceptions, the County did not provide attendance records, cancellation logs, or individual participation data showing that the sessions occurred and that class members were able to attend. Staff also reported an online behavioral-health programming tracker during the May tour, but that tracker was not included in the production.

Table 22 summarizes the change from the Fifth Monitoring Report. The comparison shows that the County maintained and expanded several important programs, particularly at NBJ, but it also identifies housing areas that did not receive a comparable documented program schedule. The remaining tables provide the unit-level detail and quantify what appeared on the monthly calendars.

Table 22: SBSO Programming Comparison

Fifth and Sixth Monitoring Reports

Area	Fifth Monitoring Report	Sixth Monitoring Report
NBJ	The broadest program structure, with STP, Allan Hancock College, AA/NA, yoga, Bible study, and chaplain services documented in several units. Restricted housing had no documented programming.	College, reentry, peer-support, and vocational options continued and expanded. Unit-specific programming remained concentrated in A, C, D, E, G., and H. BHU J had recurring STP and TMHA entries through February, but no SBSO calendar entries from March through June. Units B, K, and M did not have comparable documented SBSO schedules; tablets were available in the housing units.
SBJ	Programming was concentrated in BHU A, C, and D and a small number of modules. Most dorms did not have documented recurring access.	More modules appeared on the calendars, but the BHUs and a small recurring core continued to receive the most dependable access. Several East, West, and South areas appeared only briefly, and scheduled entries declined late in the period.
Restricted and IRC Units	IRC 100, IRC 400, New East Restricted Housing, and NBJ restricted housing had little or no documented programming.	A separate June Wellpath schedule identified clinical group blocks for IRC 100, IRC 400, New East Restricted Housing, and K Unit. Groups occurred in IRC 100 and IRC 400 during the May tour, but consistent proof of practice was not provided. No structured group was observed in New East Restricted Housing or K Unit during the May tour.
Tablets	Tablets were available individually at NBJ. SBJ was still implementing broader access and required reliable backfill and issuance practices.	Individual tablets continued at NBJ without a material access issue. SBJ continued shared-pool issuance, and class members again reported significant access problems during the May tour.

NBJ. NBJ continued to offer the broadest mix of educational, reentry, treatment, peer-support, and vocational programs. Allan Hancock College, STP, Freedom to Choose, THRIVE, AA/NA, and GRID Solar were all represented during the year, and the GRID rosters provide more concrete evidence of participation than a calendar alone. The distribution was not uniform. A, C, D, E, G, and H Units had recurring unit-specific entries, while B Unit had no comparable unit-specific program listed. K and M Units

remained the most significant specialized-housing gaps. J Unit had no notable programming. Due to difficulty in providing services in Units J, K and M noted and discussed with the parties during the May 2026 on-site tour, the Custody Expert recommended the addition of a program officer Monday through Friday to support the provision of programming in those three units.

Table 23 identifies each NBJ housing area specifically reflected in the calendars, the number of months in which it appeared, and the remaining gaps. Facility-wide and cohort programs are listed separately because the calendars do not show which housing units or individual class members participated.

Table 23: SBSO Programming – Northern Branch Jail

July 2025 through June 2026

Housing Area	Documented or Scheduled Programs	Months Specifically Listed	Assessment
A Unit	Allan Hancock College; Freedom to Choose	12 of 12	Recurring educational and reentry programming.
B Unit	No unit-specific SBSO program identified	0 of 12	The calendars do not demonstrate comparable access.
BHU F	STP; TMHA; one Planned Parenthood workshop	9 of 12	Recurring entries through February 2026; only one additional SBSO entry in June. Wellpath clinical groups are a separate program stream.
BHU J	STP; TMHA	8 of 12	Recurring entries through February 2026; no SBSO calendar entry from March through June. Wellpath clinical groups are separate.
C Unit	Allan Hancock College; STP; Freedom to Choose	10 of 12	Substantial programming, but no unit-specific entry in August or September.
D Unit	Allan Hancock College; STP; Freedom to Choose; THRIVE	12 of 12	One of the strongest and most varied unit schedules.
E Unit	Allan Hancock College; Freedom to Choose; THRIVE	12 of 12	Recurring educational and reentry programming.
G Unit	Allan Hancock College; Freedom to Choose; THRIVE	12 of 12	One of the strongest and most varied unit schedules.
H Unit	Allan Hancock College; Freedom to Choose; STP	11 of 12	Recurring programming; no unit-specific entry in June.
K Unit	No recurring SBSO program; June Wellpath schedule listed daily clinical group time	0 of 12 SBSO calendars	No group was occurring during the May tour, and implementation of the June clinical schedule was not demonstrated.
M Unit	No structured group program documented	0 of 12	The new dayroom is positive but is not a structured-program model.
Facility-wide/cohort	AA/NA; GRID Solar; periodic TMHA and other presentations	12 of 12	The calendars and GRID rosters show activity, but generally do not identify participation by housing unit.
Tablets	Individual tablets	Daily model	No material facility-wide access concern identified during this review period.

The NBJ records support credit for maintaining college, reentry, and vocational opportunities, but they do not demonstrate equitable access across every housing area. A, D, E, and G Units appeared in all twelve monthly calendars; C and H appeared in most months. By contrast, no unit-specific SBSO programming was listed for B Unit. BHU F and BHU J had recurring STP entries earlier in the period, but BHU J had no SBSO calendar entry after February 2026. BHU F had only one entry (which was in June) after February 2026. Individual tablets were available in the NBJ housing units, and no material access problem was identified. On the available evidence, NBJ likely met the tablet-access-hour component. The production

did not, however, permit an analysis of whether the content or delivery of programming on the tablets satisfied the structured-programming requirement. Looking separately at Wellpath's clinical system, Dr. Belavich found that the female BHU met the structured requirement during the May tour, while the male BHU lacked enough clinical group slots. K Unit had a clinical group on the June schedule, but no group was occurring during the May tour. M Unit had no documented structured-program model. The County therefore cannot demonstrate equitable programming across all NBJ housing areas.

SBJ. SBJ's calendars reached more housing areas than those reviewed for the Fifth Monitoring Report, but access remained concentrated. BHU A, C, and D; Back Central 1/C-1; Back Central 4/C-4; East 1; East 23; and NWI/NWI Kitchen, which houses the Northwest workers, appeared throughout the year. Other housing areas received short rotations or a single type of activity, sometimes followed by many months without another unit-specific entry. The calendar volume also declined late in the period. This is broader reach, but it is not yet an equitable or dependable program structure across the jail.

Table 24 shows the distribution in greater detail and places the behavioral-health programming schedule produced in June 2026 alongside the SBSO calendars and what was reported or observed during the May tour. A schedule shows what the County planned to provide. It does not establish that a group occurred, that an eligible class member was offered the group, or that the class member attended.[23]

Table 24: SBSO Programming – Santa Barbara Jail

July 2025 through June 2026

Housing Area	Documented or Scheduled Programs	Months Specifically Listed	Assessment
BHU A	Recurring STP; periodic therapy-dog activity	12 of 12	Among the most consistently scheduled SBSO units. Wellpath clinical groups are separate.
BHU C	Recurring STP; periodic yoga	12 of 12	Among the most consistently scheduled SBSO units. Wellpath clinical groups are separate.
BHU D	Recurring STP; periodic yoga	12 of 12	Among the most consistently scheduled SBSO units. Wellpath clinical groups are separate.
Back Central 1/C-1	AA; book group; STP	12 of 12	One of the most dependable non-BHU schedules.
Back Central 4/C-4	AA; STP	12 of 12	Recurring access, although the menu was narrower than at NBJ.
East 1	AA; short STP rotations	12 of 12	Calendar presence was recurring, but much of it was a shared evening AA group.
East 4 and East 24	STP	1 of 12 each	A single short rotation does not establish dependable or equitable access.
East 6	STP	2 of 12	Listed only in July and August 2025.
East 8	Writing group	8 of 12	Recurring through March 2026, with no entry during the final three months.
East 23	Weekly book group; short STP rotation	12 of 12	A dependable activity, but the program menu remained limited.
NWI/NWI Kitchen	Recurring book group; one short STP rotation	12 of 12	The Northwest workers had a dependable activity, but the program menu remained limited.
South Dorm and South Tank	STP	3 of 12	Both appeared on December–February calendars. The calendars do not establish South Tank's opening date or prove that the listed sessions occurred.

[23] BHU Schedule (file created June 9, 2026). The schedule lists planned Wellpath clinical group blocks for IRC 100, IRC 400, New East Restricted Housing, and NBJ K Unit; it is not an attendance or completion record.

Table 24: SBSO Programming – Santa Barbara Jail

July 2025 through June 2026

Housing Area	Documented or Scheduled Programs	Months Specifically Listed	Assessment
West 1	STP; Planned Parenthood	5 of 12	Intermittent access with substantial gaps.
West 6	STP	2 of 12	Listed only in May and June 2026.
West 10	STP/journaling; Planned Parenthood	2 of 12	Listed only in February and June 2026.
West 13	AA; STP, including Spanish-language groups	11 of 12	More recurring access than most West housing areas, though much of it was a shared evening AA group.
West 16	STP	3 of 12	Listed in July and August 2025 and again in June 2026.
IRC 100	No recurring SBSO program; separate June Wellpath clinical schedule	0 of 12 SBSO calendars	Wellpath groups occurred during the May tour, but frequency, duration, and individual attendance were not consistently documented.
IRC 400	No recurring SBSO program; separate June Wellpath clinical schedule	0 of 12 SBSO calendars	Wellpath groups occurred during the May tour, but frequency, duration, and individual attendance were not consistently documented.
New East Restricted Housing	No recurring SBSO program; separate June Wellpath clinical schedule	0 of 12 SBSO calendars	No structured group was occurring during the May tour, and implementation of the June clinical schedule was not demonstrated.
Tablets	Shared-pool issuance	Not established	Recurring access complaints continued; issuance records did not demonstrate the required access.

IRC 100 and IRC 400 illustrate why STP and Wellpath programming must be evaluated together. SBSO provides STP and coordinates volunteer or community programming; Wellpath separately provides clinical treatment groups. Wellpath groups occurred in both units during the May tour, and the June clinical schedule identifies a more regular group structure. The County did not provide consistent proof showing how often those clinical groups occurred, how long they lasted, which eligible class members were offered a group, or who attended. Dr. Belavich found that vacancies limited Wellpath programming, that the clinical system was easily disrupted by vacancies or absences, and that the County tracked aggregate group hours rather than individual offers and participation. Custody staffing was also inhibiting the clinical groups. At the same time, the SBSO calendars did not identify recurring STP or volunteer programming in either unit. Unless custody coverage is augmented, staffing will likely remain a barrier to expanding and sustaining Wellpath programming, and the County must separately ensure that appropriate STP and volunteer opportunities reach these units.

New East Restricted Housing requires the same distinction between the two program streams. The SBSO calendars did not identify recurring STP or volunteer programming for the unit. A separate June Wellpath schedule included clinical group time, but no structured group was occurring during the May tour and proof of implementation was not provided. The use of walk-a-pair and the significant reduction in the New East population are positive developments, but neither replaces structured programming for the class members who remain there.

The unit-level distribution is also reflected in the number of discrete program entries on the monthly calendars. Table 25 provides the twelve-month totals by jail. These figures measure what was scheduled on paper, not completed sessions or individual participation.

Table 25: SBSO Scheduled Program Entries

July 2025 through June 2026

Month	Santa Barbara Jail	Northern Branch Jail
July 2025	92	99
August 2025	73	74
September 2025	83	97
October 2025	73	104
November 2025	55	85
December 2025	64	75
January 2026	61	86
February 2026	67	154
March 2026	76	122
April 2026	71	87
May 2026	50	144
June 2026	44	123
Twelve-month total	809	1,250
Monthly average	**67**	**104**

Note: A discrete calendar entry was counted once for each date shown. Holidays, staff-training notations, and administrative calendar notes were excluded. Combined activities serving more than one housing area were counted as one scheduled entry. These totals are not proof that the program occurred or that any particular class member attended.

The Fifth Monitoring Report compared the number of scheduled groups in March and April. That two-month snapshot does not provide an equitable basis for comparison with the full twelve-month review completed for this report. Accordingly, the prior two-month comparison is not repeated. Beginning with this report, future monitoring reports will measure and compare the total number of documented scheduled groups across the full twelve-month reporting period.

Tablet Programming. The two facilities continue to operate differently. At NBJ, class members are assigned individual tablets and no material facility-wide access problem was identified during this review period. At SBJ, tablets are issued from a shared pool. During the May tour, as during prior tours, class members raised significant complaints about access. The production did not include issuance records showing the dates or number of hours each class member had a tablet. The County therefore cannot demonstrate that SBJ class members received the required four hours per day on at least three separate days each week. Tablet access is discussed further in VII.G.3.

Equitable Access and Proof of Practice. The records reflect meaningful program activity, but not equitable access. NBJ maintained a substantially broader educational, vocational, and reentry menu than SBJ, yet its calendars still left several housing areas without comparable unit-specific programming. At SBJ, the BHUs and a small core of modules—including the Northwest workers identified as NWI/NWI Kitchen—appeared consistently, while many other housing areas received only brief rotations. IRC 100, IRC 400, and New East Restricted Housing did not appear on the SBSO calendars. The monthly calendar counts also moved downward at SBJ during the latter part of the year. None of these records establishes whether class members

with disabilities received appropriate accommodations or whether every eligible class member had a reasonable opportunity to participate.

Assessment. The County should receive credit for maintaining Allan Hancock College, adding THRIVE and Freedom to Choose, scheduling GRID Solar cohorts, and rotating STP into more SBJ housing areas. Those are meaningful program investments. The more detailed review nevertheless shows that the distribution remained uneven and that scheduled activity declined at SBJ late in the period. B Unit, K Unit, and M Unit did not receive a comparable documented SBSO program schedule at NBJ, although individual tablets were available throughout the NBJ housing units. At SBJ, numerous East, West, and South housing areas appeared only briefly, and the monthly SBSO calendars did not identify recurring programming for IRC 100, IRC 400, or New East Restricted Housing. Wellpath developed a separate clinical schedule for several specialized units, but health-care and custody staffing affected delivery and consistent proof of practice was not provided. A calendar is not proof that a program occurred, and an aggregate count is not proof that an individual class member was offered or attended. The next step is to staff both systems, deliver them consistently, distribute them equitably, and maintain records showing what each class member was offered and received.

Recommendations:

1. *Develop a viable strategy to increase out-of-cell time offerings in all restricted housing and the IRC units at SBJ. Recommend working with the Experts to develop a focused and tangible action plan, starting with IRC 400 and NERH.
2. *Improve out-of-cell documentation in all celled units and ensure daily trackers are available for internal and external monitoring.
3. *Prepare a consistent yard rotation schedule with daily documentation of any deviations from the schedule for the dorms at SBJ.
4. *Address critical staffing vacancies inhibiting compliance with this provision.
5. *Develop and implement a plan, with the input of the Experts, to take "all reasonable steps to provide out-of-cell time and programming as specified in the Remedial Plan to the maximum extent possible" at SBJ during the period of Main Jail remediation (Stipulated Judgment ¶ 11). This may include:
    a. Provide lighting in areas closed at dusk to increase evening recreation times.
    b. Re-evaluate yard and dayroom schedules to maximize all available programming hours.
    c. Identify potentially compatible populations to reduce recreate alone populations.
    d. For populations that are not able to program with others, identify potential treatment tables/chairs to provide groups safely and humanely.
    e. Increase escort and program observation staff, as necessary.
    f. Increase behavioral health and programming staff for structured out-of-cell time.
    g. Increase volunteers to provide structured programming.
6. *Implement the internal plan to conduct monthly auditing of out-of-cell activities for all units and create a corrective action plan for units not demonstrating compliance.
7. *Create tracking mechanism or standardized issuance of reading materials, writing supplies, etc.
8. *Ensure equitable and rotating access to the SBJ main yard.
9. *Explore mechanism for individual issuance of tablets at SBJ which will likely reduce the challenge of stolen, hidden and damaged tablets.
10. Maximize use of out-of-cell time in low population restricted housing to expand beyond 1 hour per day. Continue walk-a-pair when compatible class members are present, and add and separately track structured programming.
11. Use the M-11 dayroom according to the schedule developed in June 2026, avoid limiting access to one hour when longer periods are operationally possible, provide yard to every medically eligible M Unit class member, and maintain a daily record identifying clinical eligibility, compatibility restrictions, offers, actual use, refusals, and the reason for any restriction.

12. Work with the Experts to track length of stay based on classification status for SBJ IRC 400 with particular attention to females who require BHU level of care housing. Review reasons for retention in the unit beyond normal intake processing.

13. Assign at least additional deputy Monday-Friday to Units J, K, M to support the provision of programming in those units.

VII.D. Minimum Out-of-Cell Time

2. For those prisoners housed in the Northwest unit, absent exigent circumstances or exigent security concerns that are documented, the County shall offer each prisoner not subject to discipline at a minimum, 15 hours out of their cell each week, and other structured programming, as follows:
    a. At least six (6) hours per week outdoors for exercise/recreation
    b. At least nine (9) hours per week in a dayroom or othercommon area
    c. At least four (4) hours every other day (i.e., 3 or 4 times per week, on an alternating basis), of in-cell structured programming – i.e., programming .

Pursuant to the parties' stipulated joint request and the Murray court's May 4, 2026 order (Docket 106), monitoring for this provision has been suspended. The provision will therefore be subject to future monitoring only if it is determined that the County is no longer in substantial compliance, consistent with the procedure set forth in Paragraph 53.

VII.D. Minimum Out-of-Cell Time

3. The County shall provide prisoners out-of-cell time daily, at appropriate times of the day – *i.e.*, not during normal sleeping hours.

County Response

The County reports that it has completed implementation of this provision.

Expert Review

Compliance Rating: Substantial Compliance
Prior Compliance Rating: Substantial Compliance

Policy - Custody Operations Policy 367 – Inmate Recreation

Training - Not provided for review and not easily noted in Disability Rights Remedial Plan Implementation training

Metrics Out-of-cell Trackers
Grievances
Tours/Interviews

Observations

Daily out-of-cell time is distinct from the weekly recreation, dayroom, and programming requirements assessed under VII.D.1. As clarified in the parties' 2023 stipulation (Docket 103, p. 18), "each and every class member must be offered out-of-cell time every day, at appropriate times of the day." A unit may fall short of the required weekly hours while still meeting the daily-offer

requirement. The review therefore considers whether each class member received a daily offer during normal waking hours. .

As discussed in VII.D.1, the records reviewed across the SBJ dorms, New East Restricted Housing, IRC 100, IRC 400, and NBJ K Unit do not demonstrate a pattern in which class members were denied all out-of-cell time for an entire day. The records identified occasional days without outdoor recreation and isolated operational interruptions, but they did not establish a broader failure to offer daily out-of-cell opportunities. The available records also do not suggest that out-of-cell time was routinely provided during normal sleeping hours. Overall, these units appeared to provide daily out-of-cell opportunities.

M Unit remains the limited exception. The County should be credited for converting M-11 into a dayroom and beginning to use it. The available records, however, do not identify which class members were clinically eligible for dayroom or yard on a given day, whether each eligible class member received a daily offer, or the reason access was restricted. The evidence therefore does not yet demonstrate consistent daily out-of-cell opportunities for every clinically eligible M Unit class member.

Continued monitoring is necessary because the available M Unit records do not establish whether each class member received a daily out-of-cell offer or identify the individualized reason for any restriction.

Recommendations

1. Continue to provide out-of-cell time during non-sleeping hours. For M Unit, maintain a daily person-level record identifying clinical eligibility for dayroom and yard, the opportunity offered, the time used, and the specific reason when access is restricted.

VII.D. Minimum Out-of-Cell Time

4. The County shall implement a system of documenting the amount of out-of-cell time each prisoner is offered for each of the above categories.
5. The County shall conduct monthly audits to ensure that required out-of-cell time with respect to each of the above categories is made available to the jail population. Supervisory staff shall regularly review this data for quality assurance, and take steps to address any deficiencies.

County Response

The County reports that it is continuing to implement Provisions VII.D.4 and VII.D.5. It states that out-of-cell time is tracked through yard recaps and Excel workbooks; Guardian RFID/GPS has been installed at both facilities; another Sergeant was added to the Custody Quality Assurance Unit with responsibility for incarcerated-person tracking; and full implementation, staff training, and related policy updates were expected within six months. For VII.D.5, the County refers to this same response.

Expert Review

Compliance Rating: Partial Compliance
Prior Compliance Rating: Partial Compliance

Policy – Custody Operations Policy 367 – Inmate Recreation

Training – Disability Rights Remedial Plan Implementation

Metrics Monthly SBSO Monitoring Report – Not developed

Observations

These related provisions require the County to document the amount of out-of-cell time offered to each class member and to conduct monthly audits of that information. Supervisory staff must regularly review the data and address deficiencies. As discussed in VII.D.1 and VII.D.3, the County has improved both its documentation and the consistency of daily out-of-cell access during this reporting period.

The County continues to assign supervisory staff to oversee out-of-cell operations and has designated staff to monitor the tracking information. That focused attention has made a meaningful difference. The paper records are more consistent, and supervisors are better positioned to identify and address units that are not providing expected opportunities. The County should continue this practice while the permanent electronic system is operationalized.[24]

Paper logs remain useful, but they do not provide a sufficiently reliable system for measuring the amount of out-of-cell time offered to each class member. Manual entries are subject to omission and error. Although individual entries can be checked against video, that process is too time-intensive to serve as the County's routine method of validation. The Guardian RFID system is intended to provide the person-level data needed for accurate reporting and monthly auditing, but it has not yet been fully implemented in a manner that produces reports for regular supervisory review.

The County remains in Partial Compliance with VII.D.4 and VII.D.5. The continued use of paper logs and dedicated supervisory oversight reflects meaningful progress and has contributed to more consistent daily access. Substantial compliance, however, will require a reliable mechanism to document person-level out-of-cell time, monthly audits of that information, and proof that supervisors use the results to correct identified deficiencies.

Recommendations

1. *A sufficiently trained and resourced monitoring/QA unit should be established in Custody Operations to assist in monitoring all aspects of the Remedial Plan.
2. *A standardized internal monitoring tool should be developed and approved by the Expert.
3. *Recreation Policy 367 should be updated to reflect the requirements for each type of housing units and the internal supervisor monitoring requirements.
4. *Establish the tracking and reporting in formal policy, training and auditing.
5. *Create corrective actions plans for those units that are not able to meet the out-of-cell time pursuant to tracking audits.

VII.D. Minimum Out-of-Cell Time

6. In cases where a prisoner refuses out-of-cell time repeatedly and the reason for such refusals may be related to their mental health condition, Jail staff shall make a mental health referral for assessment and appropriate clinical follow-up.

County Response

The County reports that it is continuing to implement this provision. Policy 306 defines repeated refusal as two days and establishes documentation and mental-health-referral procedures; squad and unit supervisors briefed staff on the referral form; multidisciplinary meetings review activity logs and develop strategies; and the County is working with the Mental Health and Custody Operations Experts and Wellpath on

[24] The Guardian RFID system has been installed and is in the early stages of implementation.

auditable proof that referrals and clinical assessments occurred. Guardian RFID/GPS has been installed at both facilities. The County anticipated completion within six months.

Expert Review

Compliance Rating: Partial Compliance
Prior Compliance Rating: Partial Compliance

Policy - Custody Operations Policy 367 - Inmate Recreation
Wellpath Policy G-02 - Segregated Inmates - Requires Update

Training - Disability Rights Remedial Plan Implementation - Complete
Staff Briefing Beginning December 21, 2022 - Complete

Metrics Out-of-cell Tracking Logs
Referrals to Behavioral Health
Restricted Housing/HARP Committee Records
Shift Briefing Logs
Tours/Interviews

Observations

This provision requires custody staff to refer a class member to mental health when repeated refusals of out-of-cell time may be related to the person's mental health condition. Prior reviews did not identify reliable proof that staff were consistently making and tracking these referrals. This reporting period shows progress. The produced out-of-cell logs and HARP records demonstrate that referrals are occurring, but the practice is documented too inconsistently to support reliable internal monitoring.

The Expert reviewed the available person-level out-of-cell records for New East Restricted Housing, IRC 400, and K Unit. The New East and IRC 400 records covered July 2025 through June 2026. The K Unit trackers covered January through June 2026. That six-month period provided sufficient information for the person-level review; an additional six months was not necessary. M Unit was the only reviewed unit for which the produced records did not identify each class member's daily clinical eligibility, out-of-cell offer, participation, and refusal, and the Expert therefore could not conduct the same individual assessment there.

The review identified 43 periods of at least three consecutive days of documented out-of-cell refusal: 18 in New East Restricted Housing and 25 in IRC 400. No K Unit class member was identified as refusing all out-of-cell time for three consecutive days during the six months reviewed. Referral documentation could be readily connected to approximately seven of the 43 qualifying refusal periods, or 16%. Two periods contained a person-specific referral notation in the daily unit logs, and HARP provided reasonably contemporaneous referral documentation for five additional periods. This documentation rate is far too low to demonstrate a consistent practice or permit meaningful internal self-auditing. The absence of documentation does not establish that a referral did not occur; it establishes that the County cannot readily prove that it occurred.

The records include positive examples. In New East, staff documented a mental health referral during a six-day period involving repeated refusals of yard, dayroom, meals, and linen exchange. Staff also documented a referral during another eight-day refusal period. Other prolonged refusal periods did not contain a referral notation, including an eight-day period in New East and a seven-day period in IRC 400. These examples show both the improvement and the continuing documentation gap. Proof of referral for these cases was requested from Wellpath; none was provided for review.

HARP provides additional and more favorable evidence of multidisciplinary attention. Among 41 people with repeated-refusal or isolation indicators in the produced HARP records, 37, or approximately 90%, had a mental health referral marked yes at least once, and at least 12 had narrative documentation of clinical follow-up, which reflects lack of consistent clinical follow up from the referral. The narratives included a referral and treatment plan addressing low out-of-cell time and hygiene concerns, a referral and attempted psychiatric engagement related to persistent yard refusal, and a referral followed by mental health observation, treatment, and behavioral health housing consideration. HARP is meaningful evidence that referrals sometimes led to clinical attention. It is not, however, a substitute for the daily out-of-cell logs. The production did not include a HARP meeting for every week, and HARP did not use the same three-consecutive-day measure or document the referral date, assessment, and outcome consistently enough to reconcile each refusal period.

On balance, the County has improved from the prior reporting period and has demonstrated that staff sometimes make mental health referrals in response to repeated out-of-cell refusals. It has not demonstrated a consistent and auditable process that connects the daily refusal record to a timely referral, assessment, and appropriate clinical follow-up. The County should substantially improve the out-of-cell logs so they reflect when a referral was made and can be reconciled with the unit health record and HARP review. Without that documentation, supervisors cannot reliably identify missed referrals or conduct meaningful internal self-auditing. The County therefore remains in Partial Compliance with this provision.

Recommendations

1. *The policy should be clear in expectations, a form should be utilized and tracked for referrals, the out-of-cell tracking system should reflect the referral. Compliance should be monitored internally.
2. *The use of an integrated jail management system and radio frequency identification system (RFID) would help to quickly capture this information and assist with referral to mental health.
3. *Evaluate the ability to utilize the out-of-cell tracking system to document repeated refusals and referrals to mental health. Once refined and institutionalized in practice, ensure referrals are occurring in units where out-of-cell time is captured for the entire unit or entire tiers.
4. *A mechanism to demonstrate compliance with this provision through documented proof of practice, including on this provision's requirement for "appropriate clinical follow-up," must be established.

VII.E. Disciplinary Procedures

> 1. A prisoner may be housed in Segregation for disciplinary purposes only after the prisoner has received notice of the charges against him/her, a supervisor has conducted a disciplinary hearing at which the prisoner is given an opportunity to rebut the charges, and the prisoner is adjudicated guilty of the alleged violation(s). Where there is a serious and immediate safety risk and no other housing unit is sufficient to protect the inmate from harm, staff may place a prisoner in Segregation for the shortest period of time necessary. In such cases, supervisory custody staff will promptly review the case and must approve in writing continued retention in Segregation.

Pursuant to the parties' stipulated joint request and the Murray court's May 4, 2026 order (Docket 106), monitoring for this provision has been suspended. The provision will therefore be subject to future monitoring only if it is determined that the County is no longer in substantial compliance, consistent with the procedure set forth in Paragraph 53.

VII.E. Disciplinary Procedures

2. Prisoners serving a disciplinary term in Segregation may be subject to a reduction in out-of-cell time, including in-cell confinement not to exceed twenty-two (22) hours per day.

County Response

The County reports that it has completed implementation of this provision.

Expert Review

Compliance Rating: Substantial Compliance
Prior Compliance Rating: Substantial Compliance

Policy - Custody Operations Policy 363 – Inmate Discipline – Requires Update
Training - Disability Rights Remedial Plan Implementation
Metrics Disciplinary Logs
Restricted Housing Logs
Restricted Housing Placement Documentation
Out-of-Cell Tracking Logs
Grievances
Tours/Interviews

Observations

The County has maintained substantial compliance with this provision during the current reporting period. The Fifth Monitoring Report found that the County had returned to substantial compliance after an earlier review identified isolated instances in which out-of-cell time was reportedly cancelled for disciplinary reasons without due process. The current review found no evidence that SBSO returned to that practice. The disciplinary and restricted-housing records did not identify any instance in which a class member was placed in segregation as a disciplinary sanction or lost required out-of-cell time as part of a disciplinary disposition. The detailed review of out-of-cell practices under Provision VII.D.1 identified deficiencies involving the amount, consistency, and documentation of out-of-cell time in some units, but none was attributed to discipline. Where reasons were documented, missed or reduced opportunities generally involved operational lockdowns, critical staffing, maintenance, weather, refusals, or immediate behavioral and safety concerns.

The Expert reviewed grievance entries covering the July 2025 through June 2026 period. The May 5–8, 2026 site visit provided additional confirmation. Out-of-cell time had increased overall, people housed in restricted housing were observed outside their cells, and the use of small-group and walk-a-pair programs had expanded. Although the tour continued to identify concerns regarding programming and equitable out-of-cell schedules, neither interviews nor observations suggested that out-of-cell time was being denied for disciplinary reasons.

The County's practice remains substantially compliant, but the policy revision identified in the Fifth Monitoring Report remains incomplete. Policy 363 does not yet codify the immediate behavioral circumstances that permit restriction of out-of-cell time, the authorization and documentation required, or how required out-of-cell time must otherwise be facilitated. Accordingly, the County remains in substantial compliance, but monitoring should continue until the policy is revised and formally adopted.

Recommendations

1. *Continue to comply with the policy that disciplinary hearings cannot reduce out-of-cell time.

2. *Finalize Custody Operations Policy 363 – Inmate Discipline to put into policy the ability to restrict the location for out-of-cell time for legitimate and articulable reasons with the mandate that out-of-cell time be facilitated in an acceptable manner following the provision of due process.
3. *Update policy to codify the immediate behavioral circumstances that would warrant restriction of out-of-cell time and provide direction in how such denial must be authorized and documented in the OOC logs.

VII.E. Disciplinary Procedures

3. The County shall implement a 30-day maximum term in Segregation for any single or set of disciplinary violations stemming from the same incident.
4. The County shall not use safety cells for punishment.
5. The County shall not use the denial or modification of food as punishment. The County shall not use the "prison loaf" as a disciplinary diet.

Pursuant to the parties' stipulated joint request and the Murray court's May 4, 2026 order (Docket 106), monitoring for this provision has been suspended. The provision will therefore be subject to future monitoring only if it is determined that the County is no longer in substantial compliance, consistent with the procedure set forth in Paragraph 53.

VII.F. Safeguards for Prisoners Placed in Segregation

1. Prior to Segregation placement of any person with Serious Mental illness, with an intellectual disability, or who is exhibiting unusual or bizarre behavior, the County shall ensure completion of the mental health review process detailed in Section VII of the Mental Health Remedial Plan.

County Response

The County reports that it has completed implementation of this provision.

Expert Review

Compliance Rating: Substantial Compliance
Prior Compliance Rating: Substantial Compliance

Policies - Custody Operations Policy 241 - Mental Health Care
Custody Operations Policy 243 – Special Care Inmates
Custody Operations Policy 301 - Classification
Wellpath Policy G-02 - Segregated Incarcerated Persons
Wellpath Policy F-03 – Mental Health Services

Training - Disability Rights Remedial Plan Implementation; current provision-specific training records not provided for review

Metrics Restricted Housing Placement and Retention Notices
Restricted Housing Tracking Records
Mental Health Assessment Forms

Observations

The County maintained substantial compliance with this provision during the current reporting period. As established under Provision VII.B.3, pre-placement mental-health clearance occurred consistently from

July 2025 through June 2026. The Custody Expert did not identify a single instance in which the required mental-health review failed to occur before placement in restricted housing.

The practice is in place and consistent. The remaining issues are that the governing policies and procedures have not been finalized and routine internal auditing has not been implemented. As of May 2026, Custody Operations Policies 301 and 306 had not been finalized or published. The Mental Health Expert's Sixth Report similarly states that Custody Operations Policy 241 remained unfinished and Wellpath Policy G-02 remained under review. No finalized provision-specific lesson plan or current training records were provided. Substantial Compliance cannot be maintained indefinitely based on practice alone while the required policy, training, and auditing framework remains incomplete. If the County does not promulgate the governing policies and procedures, train staff, and engage in routine internal auditing during the next review period, the rating may be downgraded to Partial Compliance.

Recommendations

1. *Associated Custody and Wellpath policies and training require update.
2. *Ensure adequate mental health staffing, including on overnight shifts, to support implementation of this provision and the overall Remedial Plan.
3. Implement routine internal auditing by the Compliance Unit concerning review of the quality and timeliness of restricted housing placement and retention documentation.

VII.F. Safeguards for Prisoners Placed in Segregation

2. The County shall conduct visual cell checks (to ensure that prisoners are safe and breathing) for all prisoners in Segregation at least every 30 minutes, at staggered intervals. Completion of safety checks shall be timely documented and audited regularly by supervisory staff for quality assurance purposes.

County Response

The County reports that it has implemented a policy requiring visual checks of incarcerated persons in restricted housing at least every 30 minutes. The County added a Sergeant to the Custody Quality Assurance Unit to assist with auditing security checks and out-of-cell time. The County further reports that the NBJ WatchTour outage has been corrected and expects to return to substantial compliance within three months.

Expert Review

Compliance Rating: Substantial Compliance
Prior Compliance Rating: Partial Compliance

Policy - Custody Operation Policy 327 – Safety Checks

Training - Disability Rights Remedial Plan Implementation

Metrics Security Check Logs
Supervisor Discrepancy Reports
Video Observation of Security Checks

Observations

The County returned to Substantial Compliance with this provision during the current reporting period. The Custody Expert requested and received a random sample of supervisory reviews of safety-check deviation reports consisting of the first seven to ten days of each month from January through June 2026. The sample was sufficient to assess whether required security checks were occurring and whether supervisors were regularly reviewing and responding to apparent deviations.

The records demonstrate a functioning supervisory review process at both facilities. Supervisors reviewed apparent exceptions through video, housing-unit activity records, and daily operational recaps. Many apparent deviations were appropriately cleared when those sources established that a direct visual check occurred within the required interval. When a check was actually late or missed without a legitimate justification, the deviation reports identified the exception and documented that the responsible staff member was counseled. Some sampled reports reflected no deviations. Taken together, the records show that supervisors were not merely collecting electronic reports; they were evaluating the quality and timeliness of the underlying checks and documenting follow-up.

The WatchTour system remained operational throughout this reporting period. Late in the monitoring period, the County also reported that use of the RFID system to track security checks had produced a profound improvement, with compliance at approximately 90 percent. This development is promising and is likely to resolve many of the technology limitations experienced during the prior review period. Continued implementation should provide more reliable, timely, and readily auditable documentation of security checks.

The sample contained some late or missed checks and isolated equipment or recording issues. Those exceptions do not preclude Substantial Compliance where the required monitoring system is functioning, supervisors identify and investigate deviations, and corrective action is documented when warranted. The current evidence establishes those elements. The County should continue strengthening second-level review by the Compliance Unit so it can identify recurring reasons for deviations, determine whether individual staff demonstrate repeated performance concerns, and verify that appropriate corrective action occurs. Based on the sustained operation of the security-check process, the results of the random sample, documented supervisory follow-up, and the reported improvement associated with RFID implementation, the County is in Substantial Compliance with this provision. Once the Compliance Unit develops a method for internal monitoring of compliance, a recommendation to discontinue monitoring can be made.

Recommendations

1. *Continue to maintain a standardized process between SBJ and NBJ
2. *Ensure sufficient staff to comply with requirement.
3. *Continue to document when staff are counseled about missing a security check when no legitimate justification exists but determine how best to assess if this is a reoccurring issue for a particular staff member (*i.e.*, corrective action).
4. *Develop a mechanism for the Compliance Unit to audit quality of sergeant reviews and track reasons for deviation, with corrective action when warranted, to demonstrate internal systemic auditing.

VII.F. Safeguards for Prisoners Placed in Segregation

7. The County shall avoid the release of prisoners from custody directly from Segregation to the maximum extent possible.

County Response

The County reports that it has significantly reduced its use of restricted housing and developed specialized BHU and BHU housing with additional programming. The County improved its daily restricted-housing discharge tracker to identify upcoming release dates and designated a discharge planner to focus on the BHU population. The discharge planner participates in weekly BHU and Restricted Housing multidisciplinary meetings, where release dates are reviewed and efforts are initiated to move individuals to less restrictive housing before release. The County reports that it has revised the restricted-housing policy and is formalizing discharge-planning requirements, with anticipated substantial compliance within four to six months.

Expert Review

Compliance Rating: Substantial Compliance
Prior Compliance Rating: Partial Compliance

Policies - Custody Operations 301 – Classification
Custody Operations 341 – Release Criteria

Training – Disability Rights Remedial Plan Implementation

Metrics Restricted Housing Placement Log
Restricted Housing Committee Log
Population Reports

Observations

The County made substantial progress in meeting this provision by sharply reducing its use of restricted housing. As discussed under Provision VII.A.1, the combined restricted-housing average daily population was approximately seven from January through June 2026, declined to approximately three in June. New restricted-housing placements also declined substantially, including only three placements systemwide in May and three in June.

These results demonstrate that the County is managing nearly all incarcerated people outside restricted housing. Reducing the number of people placed and retained in segregation is the most effective means of minimizing the number who may ultimately be released directly from that setting. The County's development of alternative housing, including BHU housing, and its continuing review of people retained in restricted housing further support this finding.

The records did not consistently establish whether each person with a known release date was physically moved to another housing unit before release or transfer. That documentation issue is addressed under Provision VII.F.8, which specifically requires documented step-down efforts and individualized discharge planning for people approaching release. It does not outweigh the broader evidence under this provision that the County has substantially reduced its reliance on segregation and is managing almost all incarcerated people in less restrictive settings.

The County has not yet finalized and implemented the revised restricted-housing policy incorporating these practices. The County should complete the policy and continue monitoring releases from restricted housing to ensure that the current practice is sustained. Nevertheless, the operational evidence establishes Substantial Compliance with this provision. However, a recommendation to discontinue monitoring cannot occur until the policies and associated training are updated and promulgated.

Recommendations:

1. *Finalize the Restricted Housing Policy or Classification Policy to reflect the goal of stepping down restricted-housing populations before release to the community.
2. *Continue with implementation of mental health and behavioral health stepdown units.
3. *Continue to evaluate all incarcerated people in restricted housing for stepdown housing and for double cell and small group out-of-cell activity if they are required to remain in restricted housing.

VII.F. Safeguards for Prisoners Placed in Segregation

8. If a prisoner has an expected release date in less than 60 days, the County shall take and document steps to move the prisoner to a less restrictive setting, consistent with safety and security needs. Should Segregation become necessary during this time period, the County shall provide individualized discharge planning to prepare the prisoner for release to the community, including in light of the prisoner's Jail housing placement and status.

County Response

The County reports that it has significantly reduced its use of restricted housing and developed specialized BHU and BHU housing with additional programming. The County improved its daily restricted-housing discharge tracker to identify upcoming release dates and designated a discharge planner to focus on the BHU population. The discharge planner participates in weekly BHU and Restricted Housing multidisciplinary meetings, where release dates are reviewed and efforts are initiated to move individuals to less restrictive housing before release. The County reports that it revised the restricted-housing policy and is formalizing discharge-planning requirements, with anticipated substantial compliance within four to six months.

Expert Review

Compliance Rating: Partial Compliance
Prior Compliance Rating: Partial Compliance

Policies - Custody Operations 341 – Release Criteria
Wellpath Policy E-10 – Discharge Planning
Wellpath F-03 – Mental Health Services

Training – Disability Rights Remedial Plan Implementation

Metrics Restricted Housing Placement Log
Restricted Housing Committee Log
Population Reports

Observations

This provision imposes requirements beyond the general reduction of restricted housing addressed under Provision VII.F.7. When a person in restricted housing has an expected release date within 60 days, the County must document its efforts to move that person to a less restrictive setting. If continued segregation is necessary, the County must provide individualized discharge planning that accounts for the person's housing placement and status.

HARP records identified six people whose release dates became known within 60 days of release. The records demonstrate that multiple entities—including SBSO, Wellpath, parole, the Public Defender, and community providers—were engaged in release and placement efforts. Four of the six individuals had been reduced to green-armband status. The records or supplemental information also documented involvement by care managers, discharge planners, parole agents, the Public Defender's reentry team, or community programs. Individual outcomes included refusal of reentry services, transfer to DSH, parole involvement, medication planning, placement on a treatment-program waitlist, and refusal of alternative housing or programming.

The evidence nevertheless did not consistently establish compliance with both components of the provision. The records did not reliably distinguish between a reduction in restrictions, an attempted housing transition, and a completed move to a less restrictive setting. When individuals remained in restricted housing, HARP records did not consistently contain a completed individualized discharge plan. In some cases, parole, the Public Defender, or another partner reportedly developed or implemented a plan, but the plan was not shared with SBSO or included in the materials provided for review.

The principal concern is not that discharge-planning work was absent. Numerous people and agencies were participating. The remaining problem is the lack of a proof of practice regarding discharge planning to ensure clarity concerning the final re-entry plan and documentation of attempted or completed step-down before release.

During the May 2026 tour, SBSO also described its work regarding people subject to release-pending-bed-availability (RBA) orders. SBSO reported an interagency workgroup, shared tracking, additional treatment beds, and a reduction in the number of people awaiting placement. Some individuals nevertheless continued to await crisis residential treatment or other community placements.[25] Although the RBA population is not limited to people in restricted housing, these circumstances further demonstrate the need for continued coordination on the County's discharge-planning and placement processes.

The County remains in Partial Compliance. Its substantial reduction in restricted housing greatly limits the number of people affected by this provision and represents important progress. To achieve Substantial Compliance, the County must finalize its policies and demonstrate a coordinated process that consistently documents step-down efforts and individualized discharge planning for the remaining people who approach release while housed in segregation.

Recommendations:

1. *Continue to improve the documentation of the restricted housing committee actions when reviewing restricted housing incarcerated persons with 90 days or less time to serve when the release date is known and those likely to be released without a known release date.
2. *Update policies regarding individualized discharge planning for all restricted housing populations.

[25] RBA is tracked by the Public Defender and County BWell.

3. *Ensure Reentry staff continue to provide services to incarcerated persons in restricted housing and improve proof of practice documentation of collaboration efforts.
4. *Ensure sufficient discharge planning staff to meet the requirements of this provision.

VII.G. Grievances, Inmate Request Forms, Property/Privileges in Segregation

1. The County shall provide grievance forms and inmate request forms in each housing unit for prisoners to readily access and use.

County Response

The County reports that it has completed implementation of this provision.

Expert Review

Compliance Rating: Partial Compliance
Prior Compliance Rating: Substantial Compliance

Policies - Custody Operations Policy 361 – Grievances
Wellpath Policy A-10 – Grievance Process for Health Care Complaints
Inmate Orientation Handbook

Training - Disability Rights Remedial Plan Implementation

Metrics Grievance Logs
Individual Grievances
Tours/Interviews

Observations

The County did not maintain substantial compliance with this provision during the current review period. The Fifth Monitoring Report found that grievance forms were routinely available at NBJ, that class members at both facilities generally reported they could obtain forms, and that SBJ had begun using locked collection boxes. Quarterly grievance meetings also provided a measure of supervisory review. During the May 2026 tour, grievance forms were not available in the housing units toured, a secure grievance collection process was not in place, and class members reported that they did not trust the grievance system. Grievance tracking was inadequate, and the process lacked meaningful oversight.

A narrative review of the County's grievance trackers identified 31 grievances received between July 2025 and June 2026 that raised concerns about the grievance process itself, apart from ordinary appeals or disagreement with the resolution of an underlying complaint. Fifteen were recorded at NBJ and 16 at SBJ. Twenty-five alleged that a grievance or appeal was missing, delayed, or unanswered; six concerned obtaining, submitting, collecting, signing, or returning a grievance. The County coded 10 entries as "No Grievance Response," but two of those narratives did not describe a grievance-process problem, while 23 additional process complaints were coded under other subjects. These records are consistent with the concerns raised during the May tour and also demonstrate a material tracking and coding limitation.

There is no evidence that the quarterly grievance meetings designed to oversee access to the grievance system that were prevalent during the prior reporting period continued during this monitoring period. Those

improvements were largely dependent on one employee who oversaw the grievance process, and the system eroded after that employee retired. This reflects a recurring concern: improvements that depend on one person rather than being systemically operationalized through assigned responsibilities, supervisory oversight, and sustainable procedures. During the May 2026 tour, SBSO stated its intention to implement grievance submission through the tablets. Tablet-based submission would improve access to the grievance system and provide a more reliable means of tracking submissions and responses. It would not, however, eliminate the need for readily available paper grievance and inmate request forms and a secure paper collection process. SBSO has assigned staff to personally oversee the availability and collection of grievances daily. This occurred following feedback from the May 2026 tour and is a promising practice.

To return to Substantial Compliance, the County must demonstrate that grievance and inmate request forms are consistently available in every housing unit and that class members have a reliable and secure method for submitting them. The grievance process should be systemically operationalized by assigning supervisory responsibility with appropriate backup coverage, resuming quarterly grievance review meetings, and conducting routine audits at both facilities to verify form availability, secure collection, accurate tracking, timely responses, and corrective action when deficiencies are identified. If tablet-based grievance submission is implemented, the County should verify that access is equitable and maintain paper forms as an alternative. These practices must be documented and sustained over time rather than dependent on a particular employee. Until the County demonstrates that level of consistent implementation, Partial Compliance remains appropriate.

Recommendations:

1. *Conduct research into best practices in grievance systems in mid-sized jails and refine current policies, procedures, forms, training and tracking, including utilizing a supervisory-level custody position to lead efforts in this area.
2. *Make all reasonable efforts to place securable grievance form boxes in living units and in areas where easy access to the forms can be facilitated.
3. *Continue to evaluate ability to integrate a grievance system into the Tablets or other technology solutions to reduce allegations that grievances are not available or were not responded to.
4. *Continue the newly developed system of quarterly appeals meetings and ensure access to grievances and grievance forms is a component of the quarterly meetings at SBJ and NBJ.
5. *Refer to ADA Expert's recommendation and review regarding ADA grievances and effective communication for the grievance processes.
6. *Continue internal auditing to demonstrate sustained compliance.
7. *Update the grievance form to add a line to document "Copy given to incarcerated person" with a date, staff name printed and signature block.

VII.G. Grievances, Inmate Request Forms, Property/Privileges in Segregation

2. Prisoners housed in Segregation units shall have equal access to grievance and inmate request forms and procedures as compared to general population prisoners.

County Response

The County reports that it has completed implementation of this provision.

Expert Review

Compliance Rating: Partial Compliance
Prior Compliance Rating: Substantial Compliance

Policies - Custody Operations Policy 361 – Grievances
Wellpath Policy A-10 – Grievance Process for Health Care Complaints
Inmate Orientation Handbook

Training - Disability Rights Remedial Plan Implementation

Metrics Grievance Logs
Individual Grievances
Tours/Interviews

Observations

The County did not maintain Substantial Compliance with this provision during the current review period. The systemwide deterioration described in VII.G.1 affected both general population and restricted housing, but this provision requires an independent assessment of whether class members in segregation have equal access to grievance and inmate request forms and procedures. Because their movement is more restricted, the absence of forms that can be obtained and submitted without relying on housing-unit staff creates a heightened access concern.

At NBJ K Unit, grievance forms were not visibly available during the May 2026 tour. The housing officer reported providing forms upon request, and class members generally reported that they were able to obtain them. The grievance trackers contain 20 grievances filed from K Unit during the reporting period. Two concerned delayed or missing responses, but none alleged an inability to obtain or submit a grievance. The filing volume and class-member feedback demonstrate that the process was available to at least some class members. Nevertheless, access remained dependent on staff providing the forms, and there is no evidence that supervisors or the Compliance Unit routinely monitored form availability or confidential submission.

The evidence at SBJ was less consistent. Grievance forms were not visibly available in New East Restricted Housing during the May 2026 tour. In this indirect-supervision environment, staff were not readily available to provide forms, and class-member feedback about access was mixed. The grievance trackers do not identify New East Restricted Housing as a distinct location, so the number of grievances filed from that unit cannot be reliably determined. IRC 400, which houses some class members under restricted conditions but is not entirely restricted housing, generated 54 grievances during the reporting period. One alleged that deputies would not take grievances, and one alleged that a submitted grievance was not answered. The filing volume shows that some class members could use the process, but it does not establish that forms were readily available or that grievances could be submitted confidentially and without staff control.

To return to Substantial Compliance, the County must establish a reliable mechanism through which class members in NBJ K Unit and SBJ New East Restricted Housing can obtain grievance and inmate request

forms without depending on staff discretion. The County should provide a secure lockbox or another confidential method of submission and require supervisors and/or the Compliance Unit to monitor and document form availability, collection, and the ability to submit grievances. Monitoring should include a meaningful comparison with general population access and should separately identify New East Restricted Housing in the grievance tracking system. Any tablet-based process should improve access while preserving a readily available paper alternative. Until these practices are implemented and sustained, Partial Compliance remains appropriate.

Recommendations:
1. *Consider requiring daily rounds in restricted housing by a supervisor and certify in the logbooks the supervisor documenting any allegation of lack of grievance access.
2. *Refer to recommendations in VII.G.1.

VII.G. Grievances, Inmate Request Forms, Property/Privileges in Segregation

3. The County shall allow reasonable access to the following for all prisoners, including those in Segregation, absent a specific safety or security issue that is documented:
   a) Personal phone calls on a daily basis during normal business hours.
   b) Education, rehabilitation, and other materials (*e.g.*, books, magazines, radios, writing implements, art supplies, tablets) for in-cell activities.

County Response

The County is in the process of fully implementing this provision. The County reports that all housing areas provide telephone access during normal business hours and that incarcerated persons receive tablets and other in-cell materials, including books, newspapers, interactive journals, board games, writing materials, and art supplies. The County is developing unit-level tracking, transitioning to Guardian RFID, auditing and replacing missing tablets, and updating and training on Policies 383 and 209. The County anticipates completing this provision within six months.

Expert Review

Compliance Rating: Partial Compliance
Prior Compliance Rating: Partial Compliance

Policies - Custody Operations Policy 209 – Americans with Disabilities
Custody Operations Policy 383 – Phones

Training - Disability Rights Remedial Plan Implementation

Metrics Grievances
Interviews
Work Order Records

Observations[26]

During this monitoring period, the County continued positive work under this provision. Subsection (a) is satisfied. Class members, including those housed in segregation, were coming out of their cells daily and had routine access to telephones. The current record does not demonstrate a systemic problem involving nonoperational phones or a broader barrier to daily telephone access. The remaining compliance issue is limited to subsection (b): whether the County provides reasonable access to educational, rehabilitative, and other materials for in-cell activities and can demonstrate that access through reliable internal monitoring.

Tablet access at NBJ remained substantially more reliable than at SBJ, where the longstanding equitable-access problem persisted. The grievance trackers contain 64 tablet-related grievances during the reporting period—52 from SBJ and 12 from NBJ. Not all concerned access, but the SBJ narratives repeatedly alleged tablet shortages, inconsistent issuance, charging failures, delayed staff delivery, and inability to reach educational or legal materials. During the May 2026 tour, tablet access at SBJ was not equitable. Because tablets continued to be shared rather than individually assigned, the County lacked a reliable method to demonstrate that each class member received reasonable access. The County has identified infrastructure and bandwidth as potential barriers to individual issuance at SBJ, but those are solvable operational issues. The Expert continues to urge individual tablet issuance at SBJ.

The County also continued to provide some in-cell activities. During tours, class members intermittently reported receiving crossword puzzles, word games, and coloring activities, primarily from Wellpath. The monthly program calendars document recurring book and writing groups in some SBJ housing areas, and the February 2026 calendar also listed STP journal sessions. These activities deserve credit and support the conclusion that the County did not roll back its efforts during this period. However, group programming is not the same as providing materials for in-cell use, and the paper activities described by class members were intermittent and undocumented.

The central problem is proof of practice. Grievances reflected requests for books, puzzles, cards, and access to educational materials. Yet there is no consistent documentation identifying what in-cell materials were distributed, the housing units that received them, the frequency of distribution, or whether the materials were reasonably available to the full population. The same gap prevents the County from determining through its own internal compliance process whether access is consistent and where corrective action is needed. Although the evidence indicates that some in-cell activity materials are being provided, the lack of a monitoring mechanism has made this provision impossible to verify externally or internally.

To reach Substantial Compliance with subsection (b), the County must implement a unit-by-unit internal monitoring system that documents the regular distribution and availability of tablets, books, writing materials, paper activities, rehabilitative content, and other in-cell materials. The monitoring should identify the date, housing unit, type and quantity of materials, and the population served, with periodic supervisory or Compliance Unit audits to identify and correct gaps. At SBJ, tablet access must be equitable and supported by person-level or otherwise reliable tracking. If the shared-tablet model cannot demonstrate equitable access, the County should resolve the infrastructure limitations and implement individual issuance. Until the County establishes consistent practice and a reliable means of demonstrating it, Partial Compliance remains appropriate.

[26] This compliance finding does not cover the ADA/equal access to phones, as compliance with ADA remedial plan requirements will be addressed in the ADA monitor's report.

Recommendations

1. *Create a unit-by-unit strategy to comply with this provision, through regular and consistent provision of tablets, reading materials and other items for in-cell activities.
2. *Improve reporting mechanism to assist in demonstrating compliance for both routine material provision (i.e., writing materials, library services) and individualized materials (i.e., rehabilitative services, correspondence courses).
3. *Update the incarcerated person handbook to better describe how to access in-cell materials.
4. *Once the ADA policy concerning access to phones is complete, provide training to staff and an educational program the incarcerated population where appropriate.
5. *Monitor Grievances and ADA Grievances to identify any barriers or issues.
6. *Monitor work orders to evaluate any untimely delays in phone repairs.
7. *If the county cannot ensure equitable access in compliance with the provision, implement individual issuance of tablets at SBJ.

VII.H.1 Other Custody Operations

1. Capacity of Jail Facilities
   a. No later than January 1, 2021, the number of prisoners placed in a particular housing unit shall be limited to no more than the rated capacity.
   b. No later than January 1, 2021, the County shall assign a bed to all prisoners.
   c. The County shall establish procedures to ensure that no prisoner is placed in any cell or housing unit without a mattress and appropriate bedding unless there are individualized clinical or security concerns that are documented.
   d. Female prisoners shall be separated by sight and sound from male prisoners.

County Response

The County reports that it has completed implementation of this provision. The County was previously in compliance with subsections (a) through (c) and has completed policies addressing the sight-and-sound separation requirements of subsection (d).

Expert Review

Compliance Rating: Partial Compliance
Prior Compliance Rating: Partial Compliance

Policies - Custody Operations 242 – Suicide Prevention
Custody Operations 304 – Use of safety Cells
Wellpath B-05 – Suicide Prevention – Requires Update
Custody Operations Policy 305 – Bed Assignment
Custody Operations Policy 362 – Inmate Clothing/Personal Hygiene
Inmate Handbook Section 308/311

Training - Disability Rights Remedial Plan Implementation

Metrics Mental Health Expert's September 2026 Remedial Plan Status Report
Grievances
Tours/Interviews

Observations

Subsections (a) and (b) have remained in sustained compliance for several reporting periods and require no further substantive discussion absent evidence of regression. This review therefore addresses only subsections (c) and (d). In its November 2025 status report, the County reported that this provision was complete, noting prior compliance with subsections (a) through (c) and completion of policies addressing sight-and-sound separation under subsection (d). By the May 2026 tour, however, the core policy, form, training, and implementation work associated with subsection (c) remained in draft, and the current record did not establish completed implementation of the subsection (d) procedures. There is a gap between the County's reported completion and available proof of implementation. Partial Compliance remains appropriate.

c. Mattress and Bedding

Subsection (c) requires that no incarcerated person be deprived of a mattress or appropriate bedding unless an individualized clinical or security concern is documented. For people placed on suicide precautions, the County developed the Property and Privileges Form to operationalize that protection. This is not a general property form. It is intended to document a clinician's determination regarding what property and privileges may safely be retained, removed, or restored while a person is housed in a safety or observation cell, including access to clothing and reading materials, and to require reconsideration when the person is reevaluated. Together with the suicide-prevention policies, the form is the mechanism by which the County is expected to demonstrate that any restriction of a mattress, bedding, clothing, or other property is individualized, clinically supported when applicable, regularly reviewed, and ended as soon as circumstances permit.

During the May 2026 tour, SBSO stated that the Property and Privileges Form still required policy completion and custody training, including planned custody briefings. Dr. Belavich reached the same conclusion. Although the form had been developed and approved, he found that it had not been implemented by the May 2026 tour; Custody Operations Policy 242 had not been finalized; and Wellpath Policy B-05 remained under revision. The form had previously been expected to be implemented by fall 2025. The County then reported an anticipated September 2026 rollout and fall 2026 policy completion, both outside this monitoring period. The repeated postponement is significant. There is no current proof that clinicians consistently documented restrictions, reconsidered property and privileges at each evaluation, or that the practice was audited.

d. Sight and Sound Separation

Subsection (d) requires sight-and-sound separation between male and female incarcerated people and applies equally to men and women. The current grievance and tour record did not identify an instance in which men and women were housed within sight or sound of one another, and the available evidence does not indicate regression in ordinary housing separation. The County's November 2025 response stated that policies addressing sight-and-sound separation had been completed. The current record, however, does not establish that the County finalized and trained a procedure for circumstances in which men and women may be temporarily present in the same intake, medical, mental-health observation, or safety-cell area. Ordinary housing separation is not a substitute for a written operational procedure governing movement, observation, privacy, staff responsibilities, and temporary co-location in shared areas.

To reach Substantial Compliance, the County must finalize and implement the custody and Wellpath requirements governing written clinical input, authorization, and recurring review of mattress, bedding, clothing, and property restrictions; train custody and clinical staff; use the Property and Privileges Form consistently; and audit whether restrictions are documented and property is restored promptly. The County

must also finalize, train, and monitor a procedure that preserves sight-and-sound separation whenever male and female incarcerated persons are temporarily present in shared operational areas. The County must demonstrate completed implementation and sustained practice, not additional anticipated completion dates. Until both requirements are supported by proof of practice, Partial Compliance remains appropriate.

Recommendations

1. *Finalize the Suicide Prevention Policy 242.
2. *Working with the Mental Health Expert, update Wellpath policy to memorialize process for clinical staff to advise custody staff in writing any deviations of approved clothing/property issuance for incarcerated persons on suicide observation.
3. *Continue to house females at NBJ and the general population and Intake Areas of the SBJs in units not observable by male incarcerated persons. Ensure policy development to guide staff in the event co-location of genders is required in intake or the medical unit.

Inmate Disciplinary Report - SBJ

2026	Jan	Feb	Mar	Q1 Avg
Total IDRs	**74**	**54**	**61**	**63.00**
IDRs that are Late / Released /Medical Documentation - Dismissed	1	6	18	**8.33**
IDR involving SMI/DD/LD	24	8	17	**16.33**
IDR involving Non- English Speaking	0	3	4	**2.33**
IDR involving Hearing and Visually Disabled	0	0	0	**0.00**
IDR Involving unusual behavior	0	0	0	**0.00**
MH Review Form Required	24	4	13	**13.67**
MH MH Review Form Completed	24	4	3	**10.33**
% Mental Health Assessment Completed as Required	**100%**	**100%**	**23%**	**74%**
MH Recommended Discipline	0%	2	0	**0.67**
% Where MH recommended discipline	**0%**	**50%**	**0%**	**17%**
Hearing Officer Concurred with MH	15	2	2	**6.33**
% of IDRs where Hearing Officer Concurred with MH Recommendations	**100%**	**100%**	**67%**	**0.8888889**
IDR required Staff Assistant due to SMI/DD/LD	24	6	17	**15.67**
IDR Required Staff Asisstant/Interpreter (Non-English)	0	3	4	**2.33**
IDR Required Staff Asisstant due to Hearing/Visually Disabled	0	0	0	**0.00**
Total Staff Assistant Interpreters Required	**24**	**6**	**21**	**17.00**
Staff Assistant/Interpreter Provided as required	24	6	3	**11.00**
% of IDRs where a Staff Assistant /Interpreter was assigned as required	**100%**	**100%**	**14%**	**71%**
Effective Communication Required by Hearing Officer	24	6	3	**11.00**
Effective Communication Required Staff Assistant	24	6	3	**11.00**
Effective Communication Required by MH Clinician	24	4	0	**9.33**
EC Documented by Hearing Officer	24	6	3	**11.00**
EC Documented by Staff Assistant	24	6	3	**11.00**
EC Documented by MH Clinician	0	0	0	**0.00**
% of IDRs where Effective Communication was documented by Hearing Officer as required	**100%**	**100%**	**100%**	**100%**
% of IDRs where Effective Communication was documented by Staff Assistant as required	**100%**	**100%**	**100%**	**100%**
% of IDRs where Effective Communication was documented by MH Clinician as required.	**0%**	**0%**	**0%**	**0%**
% of IDRs that are late / Released / Medical Documentation / Deescalation	**1%**	**11%**	**30%**	**14%**