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August 31, 2021

Wade Horton
County Administrative Officer
County of San Luis Obispo
1055 Monterey Street D430
San Luis Obispo, California 93408

Sheriff Ian Parkinson
San Luis Obispo County Sheriff's Office
1585 Kansas Avenue
San Luis Obispo, California 93405

Re: Investigation of the San Luis Obispo County Jail

Dear Officer Horton and Sheriff Parkinson:

The Civil Rights Division and the United States Attorney's Office for the Central District of California have completed the investigation into the conditions of confinement at the San Luis Obispo County Jail (the Jail), conducted under the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997, and Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. § 12132. We thank Jail leadership, administrators, and staff for accommodating our investigation and providing access to the Jail's facilities, staff, documents, data, and prisoners.

After carefully reviewing the evidence, we conclude that there is reasonable cause to believe that conditions at the San Luis Obispo County Jail violate the Eighth and Fourteenth Amendments to the United States Constitution and the Americans with Disabilities Act. Specifically, we have reasonable cause to believe that the Jail violates the constitutional and statutory rights of prisoners by its: (1) failure to provide constitutionally adequate medical care to prisoners; (2) failure to provide constitutionally adequate mental health care to prisoners; (3) use of prolonged restrictive housing under conditions that violate the constitutional rights of prisoners with serious mental illness; (4) failure to prevent, detect, or correct use of excessive force that violates the constitutional rights of prisoners; and (5) denial of equal access to prisoners with disabilities in violation of the ADA.

We are obligated to advise you that 49 days after issuance of this letter and the enclosed Report of Investigation, the Attorney General may initiate a lawsuit under CRIPA to correct the

alleged conditions we have identified if Jail officials have not satisfactorily addressed them. 42 U.S.C. § 1997b(a)(1). We hope, however, to resolve this matter through a more cooperative approach and look forward to working with the County to address the violations of law we have identified. The lawyers assigned to this investigation will therefore contact San Luis Obispo County Counsel to discuss options for resolving this matter amicably. Please also note that this letter and the Report of Investigation are public documents. They will be posted on the Civil Rights Division's website.

If you have any questions regarding this correspondence, please call Steven H. Rosenbaum, Chief of the Special Litigation Section, at (202) 616-3244 or Karen Ruckert, Chief, Civil Rights Section, Civil Division, at the U.S. Attorney's Office in the Central District of California, at (213) 894-2879.

Sincerely,

/s/ Kristen Clarke
Kristen Clarke
Assistant Attorney General
Civil Rights Division

/s/ Tracy L. Wilkison
Tracy L. Wilkison
Acting United States Attorney

cc: Rita L. Neal, Esq.
San Luis Obispo County Counsel

Encl: Report of Investigation of the San Luis Obispo County Jail

**INVESTIGATION OF THE
SAN LUIS OBISPO COUNTY JAIL
(SAN LUIS OBISPO, CALIFORNIA)**



United States Department of Justice
Civil Rights Division

United States Attorney's Office
Central District of California

August 31, 2021

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I. SUMMARY

After an extensive investigation, the United States Department of Justice provides notice, pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997b, and the Americans with Disabilities Act (ADA), 42 U.S.C. § 12132, that there is reasonable cause to believe, based on the totality of the conditions, practices, and incidents discovered at the San Luis Obispo County Jail (the Jail), that: (1) the conditions at the Jail violate the Eighth and Fourteenth Amendments of the Constitution; (2) these violations are pursuant to a pattern or practice of resistance to the full enjoyment of rights protected by the Eighth and Fourteenth Amendments; and (3) the conditions at the Jail violate the ADA.

Specifically, the United States provides notice of the following identified conditions:

The Jail fails to provide constitutionally adequate medical care to prisoners. The Jail fails to provide adequate medical assessments, does not timely evaluate or treat prisoners who request medical attention, and fails to provide adequate chronic and specialty care.

The Jail fails to provide constitutionally adequate mental health care to prisoners. The Jail fails to screen prisoners properly for mental illness; provide adequate treatment, treatment planning, and medication management; and treat and supervise suicidal prisoners appropriately.

The Jail's use of prolonged restrictive housing under current conditions violates the constitutional rights of prisoners with serious mental illness. The Jail subjects prisoners with serious mental illness to prolonged periods of restrictive housing under conditions that place them at a substantial risk of serious harm.

The Jail's failure to prevent, detect, or correct use of excessive force violates the constitutional rights of prisoners. The Jail's deputies use excessive force. The Jail does not provide adequate guidance or training to staff regarding the use of force, deputies do not fully report all uses of force, supervisors do not adequately review or investigate uses of force, and Jail leadership fails to take corrective action to address the use of excessive force.

The Jail denies equal access to prisoners with disabilities in violation of the ADA. The Jail does not provide individuals with mental health disabilities equal access to services, programs, or activities and places them in restrictive housing specifically because they have mental illness.

II. INVESTIGATION

In October 2018, the Department of Justice notified the County that it had opened a CRIPA investigation into conditions in the Jail. The investigation focused on whether the Jail: (1) violates prisoners' rights to adequate medical and mental health care; (2) violates the constitutional rights of prisoners who have mental illness by secluding them in restrictive housing for prolonged periods; or (3) violates the ADA rights of prisoners who have mental illness by denying them access to services, programs, and activities by reason of their disability.¹ The investigation has

¹ The investigation did not consider whether the Jail is physically accessible to individuals with disabilities.

been conducted jointly by the Department's Civil Rights Division and the United States Attorney's Office for the Central District of California.

In November 2018, representatives from the Department met with County officials and conducted a brief site visit of the Jail. In January 2019, representatives from the Department conducted another site visit of the Jail, this time accompanied by two consultants with expertise in correctional medical care and correctional mental health care. Both consultants have experience overseeing care in correctional settings and serving as court-appointed monitors in corrections cases. In February 2019, the Jail completed a transition from utilizing the County Health Agency to Wellpath LLC² (Wellpath), a private contract provider of medical and mental health care services.

In early August 2019, the Department expanded its CRIPA investigation to include staff use of force. We retained an additional consultant with expertise in Jail security and operations. This consultant is a former acting sheriff who managed a large jail system and has extensive experience serving as a corrections consultant and court-appointed monitor in other corrections cases. In August 2019, representatives from the Department and the medical, mental health, and security and operations consultants conducted a site visit of the Jail.

During our three site visits to the Jail, representatives from the Department and our consultants interviewed administrative staff, security staff, medical and mental health staff, and prisoners. We observed prisoners in various settings throughout the facility, including in general population and restrictive housing units. We conducted exit conferences with Jail officials upon the conclusion of our visits in order to provide technical assistance.

We commend the County for its cooperation and diligent efforts to respond to the Department's requests for information and documents. The County provided real-time access to the Jail's current and former electronic health records databases, and policies and procedures, incident reports, prisoner grievances, video recordings, training materials, and thousands of additional documents. Our consultants interviewed Jail staff and prisoners, reviewed documents, and provided their expert opinions and insight to help inform our investigation and its conclusions.

III. BACKGROUND

Our investigation examined medical and mental health care in the Jail, and whether the Jail's use of restrictive housing for prisoners with serious mental illness violated their constitutional rights. It further examined whether the Jail adequately protects prisoners from harm or risk of harm due to use of excessive force by staff. Finally, it examined whether the Jail violates the Americans with Disabilities Act (ADA) by denying prisoners with disabilities equal access to services, programs, and activities by reason of their disability.

A. Jail Overview

The Jail is located just outside the City of San Luis Obispo in San Luis Obispo County, California (the County). The San Luis Obispo County Sheriff's Office (the Sheriff's Office)

² Wellpath LLC is the name of the entity resulting from the merger of Correctional Medical Group Companies and Correct Care Solutions.

oversees the Jail. The Jail, which occupies a geographic area of seven acres, includes several facilities including the main jail; the West Housing facility; the Kansas jail; and the male honor farm. Its housing units include general population areas, protective custody areas, and administrative segregation cells. With approximately 540 prisoners at any given time³ and approximately 11,000 bookings a year, the Jail houses nearly everyone arrested in the County, including pretrial detainees and sentenced prisoners.

A significant proportion of the Jail's prisoners are individuals with mental illness. At any point in time, about 39% of the prisoner population is taking some form of psychotropic medication. The Jail has units where it typically houses prisoners with mental illness, many of which keep prisoners isolated in their cells nearly all hours of the day.⁴ Jail prisoners who decompensate and are found to be gravely disabled or else a danger to themselves or others are transferred to the County's Psychiatric Health Facility (PHF). Prisoners found to be incompetent to stand trial are sent to the PHF; a state psychiatric hospital, typically the Atascadero State Hospital (ASH); or (since July 2019) the Jail-Based Competency Treatment unit at the Jail.

Many of the Jail's prisoners also have substance use or co-occurring disorders. In January 2020 alone, the Jail identified at least 103 prisoners as actively withdrawing from the influence of drugs or alcohol. Additionally, the Jail estimated that over 90% of prisoners have substance abuse issues. The Jail's intake and release center (IRC) contains several cells with glass doors and walls known as "sobering cells" where prisoners known to be withdrawing from alcohol or other substances are frequently housed temporarily.

Before 2018, the Jail's medical clinic had a single examination room. In 2018, the Jail opened an expanded medical clinic with several exam rooms as well as a dental chair. The Jail does not have any specialized medical housing units.

B. Prisoner Deaths

Between January 2012 and June 2020, sixteen prisoners died while in Jail custody. On January 22, 2017, AA,⁵ a 36-year-old man with schizophrenia, died after spending 46 consecutive hours strapped to a restraint chair. Before his death, the Sheriff's Office had held AA in isolation for approximately 16 months. In January 2017, a court ordered that AA be involuntarily medicated and that he be sent to a psychiatric facility, yet AA remained in restrictive housing for the next ten days without receiving the involuntary medication. On January 20, 2017, after observing AA repeatedly strike himself in the face and head, Jail custody staff placed him in the restraint chair with his legs and arms shackled. He remained in the restraint chair until January 22, 2017, naked except for a blanket that sometimes slipped off his lap. Within 40 minutes after being released

³ In response to the COVID-19 crisis, the Jail's population temporarily decreased to a range of approximately 350 to 450 prisoners from late March through the end of September 2020.

⁴ Restrictive housing, elsewhere sometimes referred to as solitary confinement, segregation, or isolation, is any type of detention that involves three basic elements: removal from the general prisoner population, whether voluntary or involuntary; placement in a locked room or cell, whether alone or with another prisoner; and inability to leave the room or cell for the vast majority of the day, typically 22 hours or more. *Porter v. Clarke*, 290 F. Supp. 3d 518, 528 (E.D. Va. 2018) (citing U.S. Dep't of Justice, Report and Recommendations Concerning the Use of Restrictive Housing 3 (Jan. 2016)); see also *Disability Rights Mont., Inc. v. Batista*, 930 F.3d 1090, 1094 (9th Cir. 2019) (discussing allegations that prisoners were kept in solitary confinement for 22 to 24 hours a day with restricted privileges).

⁵ To protect the identity of prisoners, we use coded initials.

from the restraint chair, he died of a pulmonary embolism. Pulmonary emboli result from blood clots that form in the extremities, which can occur as a result of lack of mobility, particularly of large muscle activity. He spent his last minutes writhing on the floor of a cell while deputies watched him through the clear glass cell door.

In the months following AA's death, the County and Sheriff's Office made several public pronouncements about changes they planned to make "in an effort to prevent a tragedy like [AA's death] from reoccurring."⁶ These changes included discontinuing the use of the restraint chair; increasing the speed at which prisoners declared incompetent could be transferred to psychiatric facilities; changes in protocols relating to housing prisoners in safety cells; and training for deputies and medical and mental health staff.⁷ The Jail also hired a Chief Medical Officer to oversee all medical and mental health care provided in the Jail, and migrated to an electronic medical records system.

Still, additional untimely deaths occurred in 2017 and 2018, including after implementation of these reforms was scheduled to begin. On April 13, 2017, a 60-year-old prisoner named BB, who had hypertension, died of a heart attack in the Jail. The Jail did not give BB a comprehensive medical evaluation when he entered custody, performed no tests or laboratory examinations or otherwise monitored his condition, and prescribed him with high doses of Ibuprofen, a drug the FDA has warned can lead to heart attacks in people with high blood pressure.⁸ On the morning of his death, BB complained of left shoulder and arm pain, numbness and tingling, clamminess, and left sided chest pain, and yet Jail medical staff refused his requests to be sent to the hospital. After noticing that BB's breathing was abnormal, a deputy walked away and called medical staff, and did not return for five minutes, at which point BB stopped breathing and was unresponsive.

On November 27, 2017, CC, age 62, died following a pulmonary embolism. CC had Parkinson's disease and experienced auditory hallucinations and paranoia while in the Jail, and was observed eating his own feces, leading the Jail to send him to the PHF. On his return to the Jail, he was kept in isolation for over two weeks. The Jail disregarded his complaints about weight loss and weakness.

On September 1, 2018, DD, age 48, died by suicide in the Jail. On August 22, 2018, a court ordered that he undergo a mental health evaluation, but one never occurred. The day before DD killed himself, he was found to have tied his socks together and presented as extremely depressed and suicidal. Jail staff placed him in a suicide resistant cell, and medical staff gave him psychotropic medications by an intramuscular injection. Just five hours later, a licensed psychiatric technician discharged him from the suicide resistant cell. A psychiatrist was consulted by phone but did not evaluate DD in person. After his release from the suicide-resistant cell, DD was moved to an isolation cell with no suicide precautions such as property restrictions. Less than ten hours later, DD hanged himself in his cell.⁹

⁶ Press Release, County of San Luis Obispo, County Announces \$5 Million Settlement Over Jail Inmate Death (July 27, 2017), [https://www.slocounty.ca.gov/Departments/Administrative-Office/Featured-News/2017/County-Announces-\\$5-Million-Settlement-Over-Jail-I.aspx](https://www.slocounty.ca.gov/Departments/Administrative-Office/Featured-News/2017/County-Announces-$5-Million-Settlement-Over-Jail-I.aspx).

⁷ *Id.*

⁸ Safety Announcement, Federal Drug Administration, FDA Strengthens Warning That Non-Aspirin Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) Can Cause Heart Attacks or Strokes (July 9, 2015), <https://www.fda.gov/drugs/drug-safety-and-availability/fda-drug-safety-communication-fda-strengthens-warning-non-aspirin-nonsteroidal-anti-inflammatory> (listing ibuprofen as an example of NSAIDs that increase the likelihood of heart attack).

⁹ Three additional prisoners died during the course of our investigation.

C. Changes in the Jail During the Course of Our Investigation

Until February 1, 2019, the County Health Agency was responsible for providing medical and mental health services to prisoners through three different departments: Drug and Alcohol Services, Mental Health Services, and Public Health Services. That changed on February 1, 2019, when a company called Wellpath LLC took over medical and mental health services at the Jail under a contract with the County. Wellpath is the largest provider of correctional healthcare services in the country.

In May 2019, the County made large-scale changes to prisoner housing, resulting in the creation of several mental health housing units with specialized staff, programming, and services. Shortly afterward, the Jail opened an internal Jail-Based Competency Treatment (JBCT) unit with its own mental health staff for restoring to competency prisoners deemed to be incompetent to stand trial. The County also has taken steps to open a new Behavioral Health Unit to provide additional mental health services to prisoners.

IV. CONDITIONS IDENTIFIED

A. Medical Care at the Jail Is Inadequate in Violation of Prisoners' Constitutional Rights

The Department has reasonable cause to believe that the Jail has engaged in a pattern or practice of failing to provide prisoners with adequate medical care in violation of their constitutional rights. The Jail holds both sentenced prisoners and pretrial detainees, and fails to provide either group with constitutionally adequate medical care. The Eighth Amendment protects sentenced prisoners from cruel and unusual punishment. U.S. Const. amend. VIII. Correctional conditions violate the Eighth Amendment's prohibition against cruel and unusual punishment where they result from prison officials' deliberate indifference to serious harm, or the substantial risk of serious harm, to prisoners. *Farmer v. Brennan*, 511 U.S. 825, 828 (1994). The Eighth Amendment requires that the government provide adequate care to meet prisoners' serious medical needs. *Estelle v. Gamble*, 429 U.S. 97, 103–05 (1976); *see also Parsons v. Ryan*, 754 F.3d 657, 677–78 (9th Cir. 2014).

The rights of pretrial detainees are guaranteed by the Fourteenth Amendment, which, the Supreme Court has consistently held, provides protection at least equal to the Eighth Amendment. *Bell v. Wolfish*, 441 U.S. 520, 545 (1979) (“[P]retrial detainees, who have not been convicted of any crimes, retain at least those constitutional rights . . . enjoyed by convicted prisoners.”). In the Ninth Circuit, the applicable standard for violation of pretrial detainees' right to adequate medical care is whether the denial of care was objectively unreasonable. *Gordon v. County of Orange*, 888 F.3d 1118, 1124–25 (9th Cir. 2018); *see also Castro v. County of Los Angeles*, 833 F.3d 1060, 1068–69 (9th Cir. 2016) (en banc) (applying the objective standard for pretrial detainees' right to be free from excessive use of force as established by the Supreme Court in *Kingsley v. Hendrickson*, 576 U.S. 396–97 (2015)).

CRIPA authorizes the Attorney General to investigate and take appropriate action to enforce the constitutional rights of prisoners whose rights are violated subject to a pattern or practice of unconstitutional conduct or conditions. 42 U.S.C. § 1997. To prove a pattern or practice

of violations, the United States must “establish by a preponderance of the evidence that [] [violating federal law] was . . . the regular rather than the unusual practice.” *Int’l Bhd. of Teamsters v. United States*, 431 U.S. 324, 336 (1977); *see also Obrey v. Johnson*, 400 F.3d 691, 694–95 (9th Cir. 2005) (explaining a presumption of discrimination may be established by “demonstrating the existence of a discriminatory pattern or practice”) (quoting *Cooper v. Fed. Rsrv. Bank of Richmond*, 467 U.S. 867, 875 (1984)). In some sections below, we provide several examples to illustrate the variety of circumstances in which the violations occur, while in others we focus on just one or two examples that demonstrate the nature of the violations we found. The number of examples included in a particular section is not indicative of the number of violations we found. These examples constitute a small subset of the total number of incidents upon which we base our conclusions.

“[D]enial of medical care is cruel and unusual because, in the worst case, it can result in physical torture, and, even in less serious cases, it can result in pain without any penological purpose.” *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981) (citing *Estelle*, 429 U.S. at 103). “Prisoners are dependent on the State for food, clothing, and necessary medical care. . . . Just as a prisoner may starve if not fed, he or she may suffer or die if not provided adequate medical care. A prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society.” *Brown v. Plata*, 563 U.S. 493, 510–11 (2011). A government cannot evade its constitutional obligations to prisoners by contracting with a private party to provide medical care. *West v. Atkins*, 487 U.S. 42, 56 (1988).

1. Prisoners at the Jail have Serious Medical Needs Requiring Treatment

Many prisoners at the Jail have serious medical needs that require treatment and place them at substantial risk of serious harm if not adequately addressed. Indications of a serious medical need include “[t]he existence of an injury that a reasonable doctor or patient would find important and worthy of comment or treatment; the presence of a medical condition that significantly affects an individual’s daily activities; or the existence of chronic and substantial pain.” *Colwell v. Bannister*, 763 F.3d 1060, 1066 (9th Cir. 2014) (quoting *McGuckin*, 974 F.2d at 1059–60). Of the approximately 535 daily prisoners from June 2019 to January 2020, approximately 240 prisoners each day were on the chronic care list, a list on Wellpath’s electronic health system that identifies prisoners who have been assigned a “chronic care” alert for chronic medical needs, such as diabetes, HIV, Hepatitis C, and hypertension.¹⁰ The Jail does not have a medical housing unit; instead it either temporarily places prisoners with medical concerns in an intake cell for ease of observation or sends prisoners to a local hospital. In 2018, the Jail sent prisoners to the local hospital’s emergency department approximately 285 times; in 2019, the number decreased to approximately 216 times.

2. Prisoners Are Subjected to a Substantial Risk of Serious Harm as a Result of Inadequate Medical Care

The Jail has subjected prisoners to substantial risk of serious harm by failing to provide adequate medical care. Significant delays in care, as well as deficiencies in the care that was provided, have harmed prisoners and placed others at substantial risk of harm. *See Colwell*, 763

¹⁰ Before Wellpath took over care, there was no chronic care registry. In December 2017, the Jail had started maintaining a list of some prisoners with diabetes, hypertension, serious mental illness, and certain disabilities. However, the list did not include all prisoners in those categories, and the criteria for getting on the list were vague.

F.3d at 1066 (“Indifference ‘may appear when prison officials deny, delay or intentionally interfere with medical treatment, or it may be shown by the way in which prison physicians provide medical care.’” (quoting *Hutchinson v. United States*, 838 F.2d 390, 394 (9th Cir. 1988))). The Jail has failed to provide a medical screening system that ensures adequate diagnosis and treatment of serious medical conditions and continuity of care; has failed to ensure access to care for prisoners who report medical problems; and has failed to deliver an acceptable quality of care in several areas, including care for prisoners with serious medical conditions like HIV and hypertension, and care for pregnant women. These deficiencies have resulted in a system of inadequate medical care that violates prisoners’ constitutional rights.

a. *Deficient Medical Screening and Continuity of Care*

An essential part of a correctional healthcare system is a functioning medical screening system. The failure of a correctional institution to conduct adequate medical screenings may constitute deliberate indifference to medical needs in violation of the Constitution. *See Gibson v. County of Washoe*, 290 F.3d 1175, 1189 (9th Cir. 2002) (holding that policy that mandated delay in medical screening for certain combative or uncooperative prisoners posed a substantial risk of harm), *overruled on other grounds by Castro v. County of Los Angeles*, 833 F.3d 1060 (9th Cir. 2016) (en banc).

When nursing staff learn through initial screenings that prisoners have chronic diseases or are actively withdrawing from drugs, the Jail does not provide prompt evaluation and diagnosis by a medical provider.¹¹ The nursing staff who conduct the screenings sometimes fail to obtain prisoners’ medical histories or take appropriate follow-up action—such as making a referral for a medical provider to order laboratory tests or medications—for prisoners flagged as having significant medical conditions such as HIV or hypertension. These lapses and omissions for prisoners with serious medical conditions put prisoners at substantial risk of serious harm. *See Jett v. Penner*, 439 F.3d 1091, 1098 (9th Cir. 2006) (explaining delay in medical treatment can violate the Eighth Amendment if the “delay was harmful”); *see also M.H. v. County of Alameda*, 62 F. Supp. 3d 1049, 1077–78 (N.D. Cal. 2014) (holding that a jury could find deliberate indifference to the risk of severe alcohol withdrawal where a nurse conducting the initial medical intake failed to initiate the withdrawal protocol or otherwise ensure medical help, despite learning during the intake that the prisoner was at risk of alcohol withdrawal).

The Jail also fails to ensure adequate access to care through its post-admission medical assessments. Current Jail policy requires medical staff to conduct a comprehensive medical assessment on every prisoner within 14 days after admission.¹² But in practice, prisoners are routinely examined after the 14-day mark, or not at all. In addition, the Jail does not require that a medical provider conduct the assessment, but rather allows registered nurses (RNs) to perform them. Medical providers are supposed to review the assessments performed by RNs, but this review often occurs weeks or even months after assessment. This is a problem because Jail RNs do not receive adequate training to perform medical histories, physicals, and clinical evaluations without a medical provider’s supervision, and thus the Jail is likely failing to identify prisoners with significant medical problems. In addition, for prisoners with complex medical issues, the Jail

¹¹ The term “medical provider” as used in this document means a physician, physician’s assistant, or nurse practitioner.

¹² Before the transition to Wellpath, policy did not require the Jail to complete health assessments for prisoners: they were merely “recommended” when “appropriate based on an inmate’s health condition.” This was particularly dangerous because the initial intake screening did not routinely measure vital signs, meaning that medical staff could not determine which prisoners required medical evaluations more urgently than others.

has failed to obtain baseline laboratory or diagnostic tests, which should be obtained at the time of admission based on consultation with a provider or standardized protocols.

These deficiencies in the medical screening and assessment processes create a substantial risk of serious harm to prisoners in the Jail.

b. *Lack of Access to Care*

Prisoners at the Jail face numerous difficulties accessing medical care. Neither of the Jail's two channels for prisoners to notify staff about medical concerns—medical request forms and healthcare grievances—function properly. The primary means by which prisoners request medical care is through a medical request form called a “sick call slip” or “kite.” Medical staff gather sick call slips when they are on the housing units.¹³ In reviewing sick call slips, medical staff frequently overlook prisoners' concerns, fail to provide prompt care, or fail to provide care at all. In numerous instances, this failure to provide timely responses to prisoner sick call slips has led to harm or serious risk of harm to prisoners. Examples include the following:

- EE tested positive for HIV on April 30, 2019 while in the Jail. Labs and tests were ordered, but initially no appointment was ordered with an infectious disease specialist. EE submitted sick call slips on June 3, 2019, June 24, 2019, and July 2, 2019 requesting treatment for his HIV infection, including medication and an appointment with an infectious disease specialist. A specialist did not see him until July 8, 2019, and EE did not begin receiving medication until July 20, 2019—nearly three months after his diagnosis.
- FF submitted a sick call slip dated April 26, 2019 requesting to see a doctor because of severe pain in his left testicle. He submitted two additional requests before he was seen by a nurse practitioner 10 days after his initial request. The nurse practitioner ordered some tests on May 6, 2019, but did not seek a urology consultation or a radiology study to rule out testicular torsion (an extremely painful condition that can cause loss of blood supply to the testicle and is a surgical emergency). FF submitted another slip on May 13, 2019 complaining about ongoing pain in his left testicle, to which he never received a response before leaving the Jail on May 22, 2019.

The Jail's grievance system is the other mechanism for prisoners to report medical issues, yet the Jail routinely fails to give prisoners grievance forms, or provide them timely, even after repeated requests. Of the few grievances prisoners have completed, a significant proportion raise serious medical issues, including missed or unfilled medications, failure to provide follow-up care, and inability to access care through the sick call slip process. In the vast majority of cases, medical staff determine that prisoners' healthcare grievances are unfounded, and thus that no action is required. When prisoners appeal the dismissal of grievances, Wellpath staff frequently respond by instructing them to file a sick call slip, despite prisoners' frequent complaints that the sick call slip process does not work. Wellpath staff stated their practice was to require different staff to handle responses to initial grievances and subsequent grievance appeals, but frequently the same staff handle both responses, perhaps preordaining the dismissive response to appeals. Furthermore, in a monthly presentation for the County's Jail leadership about medical and mental health care,

¹³ Before Wellpath took over care, custody staff gathered the sick call slips and reviewed them to ensure they included a reason for seeking medical attention before forwarding to medical staff. This intruded on the confidentiality of prisoners with respect to their medical history and current medical issues, and may have created a chilling effect on prisoners who did not want custody staff to know about their medical problems.

Wellpath’s Health Services Administrator created a slide (see image to the right) with a popular meme, implying that healthcare grievances are a nuisance to staff. Wellpath and its staff appear not to take seriously prisoner grievances or the grievance process as a mechanism for prisoners to raise legitimate medical concerns. *See Watts v. Aly*, No. 218CV00693JVSMAA, 2020 WL 1224281, at *7 (C.D. Cal. Jan. 29, 2020).



Specific examples of grievances in which staff took no action or inadequate action on complaints of potentially serious medical concerns include:

- GG wrote a grievance on March 31, 2019 stating he had been in the Jail for 16 days with no medication for back pain, and that he had not seen a doctor despite having submitted multiple sick call slips. He received a response dated April 3, 2019 stating that he was scheduled for an evaluation. He responded on April 12, 2019 that he still had not seen a doctor, to which medical staff replied he was scheduled to see one. He wrote again on April 22, 2019 that he still had not seen a doctor. Medical staff responded on April 24, 2019 that they would schedule him for an appointment on April 25, 2019. He was finally seen by a nurse practitioner who prescribed him medication for spinal pain on April 30, 2019—a month after submitting his grievance, and more than six weeks without medication for what he described as significant back pain.
- HH submitted a grievance dated December 9, 2018 (before the Wellpath transition) complaining about a hernia. Medical staff responded that he was scheduled to meet with a general surgeon for a consult for surgery. On February 19, 2019 (after the transition), he wrote a new grievance complaining that the Jail’s previous medical provider had scheduled him for surgery, but that he still had not had it. On February 22, 2019, Wellpath medical staff responded by telling him to submit a kite. HH responded that he already had submitted multiple kites. Wellpath provided a reply on February 28, 2019, which is illegible. HH submitted a response, stating that he could not read Wellpath’s latest reply, and noting that Wellpath still had not scheduled his surgery. On March 5, 2019, medical staff replied that his hernia was not a medical emergency and that he would be released soon.
- II submitted a grievance dated February 18, 2019, shortly after the Wellpath transition, complaining that his inhaler, multi-vitamins, and a medication he had been taking for 20 years had all been discontinued. Custody staff denied the grievance because II was grieving multiple things at once.

The Jail also has blanket rules that exclude certain types of care for most prisoners, even those with chronic health conditions who might benefit from them. For example, the only prisoners eligible for double mattresses are pregnant prisoners in their third trimester.¹⁴ Thus, prisoners with conditions such as spinal fusions, scoliosis, or a fractured hip will not be prescribed a double mattress. Medical staff also appear to deny or take away accommodations from prisoners with chronic conditions that might ease their pain, such as chairs, wheelchairs, and special shoes, based

¹⁴ A single mattress is about two inches thick.

on factors that have no relationship with medical need, such as the housing area in which prisoners happen to live. Many accommodations of this type were revoked shortly after Wellpath took over medical care.¹⁵

In addition, the Jail fails to ensure adequate access to medical care by failing to provide effective communication to prisoners who are deaf or hard of hearing. Although video remote interpreting equipment may be available, the Jail does not routinely use it or provide in-person interpreters to communicate with these prisoners. Nursing staff told us that they rely on lip-reading to communicate with deaf prisoners, and the medical records we reviewed show they rely on lip-reading or written notes. Lip-reading does not ensure effective communication for many deaf or hard of hearing individuals, either because their English comprehension is limited¹⁶ or because they cannot catch many of the words being spoken. Courts have also held that note passing to communicate with deaf and hard-of-hearing prisoners may be insufficient to ensure access to medical or mental health care.¹⁷ The Jail's failure to ensure effective communication can significantly endanger prisoner health, particularly for prisoners with serious health conditions. For example, one deaf or hard-of-hearing prisoner who is HIV positive received substandard HIV care in the Jail and had to communicate with Jail staff through written notes, even though he had submitted an ADA request for video remote interpreting services. The medical record indicates that communication with the prisoner through notes was ineffective.¹⁸

c. *Inadequate Quality of Care*

The Jail does not provide adequate quality of care to many prisoners—especially those with serious chronic illnesses such as HIV or hypertension, and pregnant women—and therefore violates their constitutional rights.

For example, the Jail fails to provide adequate care for prisoners with HIV. Medications for prisoners with HIV are frequently delayed or not provided during the entirety of a prisoner's incarceration, which can cause treatment failure by creating drug resistance, or by failing to keep viral loads at an undetectable level. Other prisoners are given the wrong dosages for medications or receive ineffective combinations of medications. Prisoners with HIV endure very long waits to meet with medical providers concerning HIV treatment, and wait even longer to meet with specialty care providers, if they meet them at all. The Jail often fails to identify individuals who

¹⁵ The Jail used to lack an adequate system for *identifying or tracking* individuals with disabilities and accommodations that it did make, but appears to have improved in these areas.

¹⁶ American Sign Language and English are different languages. Therefore, individuals whose primary language is American Sign Language—even those born and raised in the United States—may have limited English comprehension.

¹⁷ See, e.g., *Armstrong v. Brown*, 857 F. Supp. 2d 919, 932 (N.D. Cal. 2012). In *Armstrong*, “[c]lass members with hearing impairments were not provided with sign language interpreters for important medical and mental health care appointments, which impeded or obstructed their access to those services.” *Id.* “One parolee with severe hearing loss was provided with a sign language interpreter only once in the seventy-five days he was at the . . . [j]ail, and went to medical appointments on three or four occasions without being provided access to a sign language interpreter.” *Id.*; see also *White v. City of Tacoma*, No. C12-5987 RBL, 2014 WL 172037, at *15 (W.D. Wash. Jan. 15, 2014) (explaining that whether passing notes is a sufficient accommodation in lieu of a sign language interpreter is a fact-specific inquiry that “‘will vary in accordance with the method of communication used by the individual; the nature, length, and complexity of the communication involved; and the context in which the communication is taking place’” (quoting 28 C.F.R. § 35.160(b)(2))).

¹⁸ For example, a nurse practitioner noted in June 2020 that, during a medical appointment, the prisoner “was only writing on paper to NP and at times only able to receive yes/no responses,” and that it was “difficult to obtain h[istory] from [the prisoner].”

are HIV positive, and often fails to determine who should be offered testing. These practices are extremely dangerous for prisoners with high-risk medical conditions. Specific instances in which the Jail placed prisoners at substantial risk of serious harm include the following:

- JJ, a prisoner with HIV and other serious medical conditions including severe cardiomyopathy and severe bradycardia (both diseases of the heart), received double the recommended dosage of his HIV medications for over two months in 2019, and was not provided appropriate HIV laboratory studies. In addition, the Jail did not schedule regular provider appointments for him as mandated by both Jail policy and professional standards for prisoners with chronic conditions.
- KK reported he was HIV positive to medical staff at intake in February 2019. Over the next sixteen months, the Jail provided HIV medications to KK, but discontinued one of his medications in June 2019, and replaced it for nine months with an ineffective drug that can cause drug resistant strains of the virus. Wellpath ordered laboratory studies to monitor the new medication's efficacy but never sent them to the lab. KK submitted a sick call slip asking to discuss his HIV status in July 2019, but a doctor did not see him until six weeks later. In addition, medical staff saw KK for just one chronic care appointment during his entire incarceration, and it occurred in March 2020, over a year after his admission.
- LL, who was admitted to the Jail in April 2019, received no HIV medications during her first week in custody. Then, the Jail began providing her only one of the three medications she had been taking to manage her HIV. This was the only drug she received for the next week before her release, and during that week she did not receive even that drug for three consecutive days. Receiving just one of three HIV medications creates a high likelihood of developing resistance to that medication, which is extremely dangerous.
- MM, admitted in July 2019, reported two weeks after admission that she had been HIV positive for 20 years and provided information about her medication and treatment in the community. The Jail did not begin providing medication until 11 days after she reported her HIV infection. She remained in the Jail for 10 months, during which time the Jail never ordered any tests to measure her viral load.

The Jail also fails to provide adequate medical care for women who are pregnant. Nursing and provider staff lack adequate training regarding management of obstetric emergencies, and the Jail fails to ensure timely access to obstetricians. Wellpath's pregnancy policy provides no specific guidance on how soon obstetric appointments should be scheduled after identifying pregnancy, and in fact obstetric consultations for pregnant women in the Jail are frequently delayed or do not occur at all. One woman was scheduled for an obstetrician consultation in January 2019, but it never occurred in the three months before she was released. Current policy requires that all women should be screened for pregnancy at intake, but this does not reliably happen. This can be very dangerous, particularly for pregnant women with alcohol or substance use disorders or other serious medical conditions. Two examples that illustrate many of these issues are:

- NN was placed on an opiate withdrawal protocol at intake in February 2019, but did not receive a pregnancy test as required by policy. Nine days later, she reported abdominal pain and said she had just learned her sexual partner had gonorrhea. She was tested for it, but there was a three-day delay in sending out the labs, and positive results did not come back for five days, when the Jail began treating her for gonorrhea. Two days later, the Jail conducted a pregnancy test, which came back positive, but she was not scheduled for an

obstetrician appointment. Five days later, she reported vaginal bleeding to medical staff, who ordered an obstetric referral two days after that. Her first examination by a medical provider—who was not an obstetrician—was almost a month after admission to the Jail (and ten days after her gonorrhea diagnosis and eight days after learning she was pregnant). The provider determined that NN was at high risk of miscarriage, and thus required weekly examinations, ultrasound monitoring, and management by an obstetrician. But the Jail did not refer her to an obstetrician. Instead, she continued to experience vaginal bleeding, for which she was seen periodically by medical staff until her release several weeks later. She returned to the Jail three days after her release, and tested negative for pregnancy at that time; an obstetrician diagnosed a miscarriage a month later.

- OO was admitted to the Jail three times in 2019, and was pregnant during all three admissions. She had a history of miscarriages, hypertension, and was in her late 30s. During her second incarceration, she did not receive a pregnancy test at intake, and her pregnancy was not identified until over two weeks later when she complained of nausea, a headache, and missed periods. The Jail sent her to the hospital, but when she returned to the Jail, no Jail provider examined her. A doctor reviewed her chart and recommended treatment for her hypertension, but the Jail did not begin monitoring her blood pressure until six days later. Because she had a complex pregnancy earlier that year and continued to have significant hypertension, her pregnancy required close monitoring. Instead, there were delays in treatment, including delays in ordering a pregnancy diet even though she had lost four pounds, and delays in visits for an ultrasound and obstetrician consultation. During the three-week obstetrician delay, OO had an elevated blood pressure reading, and the Jail ran out of the medication used to control her blood pressure for a two-day period. After her first obstetrician consultation, she did not have a follow-up obstetrician appointment until nearly a month later, a long period for the number of risks presented. During her third incarceration later in the year, she was identified as pregnant at intake, but not referred to an obstetrician. She complained of fluid leaking from her vagina and decreased fetal movement. But no ultrasound or obstetrician consultation occurred during this admission, which lasted more than three weeks, even though she complained of symptoms suggesting fetal distress and even though the Jail knew of her recent miscarriage.

The Jail also has systematic problems with medication management. This is extremely dangerous to prisoners whose health is threatened by serious medical conditions, and—as noted with respect to patients with HIV infection—increases the risk of developing medication resistance. Medications frequently expire while prisoners are in the Jail, often leading to missed medication administration for several days or longer until new medications can be ordered and delivered to the Jail. The delayed medications are often critical for the treatment of serious medical conditions, including HIV, hypertension, and hypothyroidism. If prisoners require medications that are not provided on the Jail formulary—a list of pre-approved medications compiled by Wellpath—they must submit a request for an exception, which Wellpath’s contract pharmacy can deny. Even if not outright denied, the exception process can delay a prisoner’s receiving the medication, compromising continuity of care and placing prisoners at serious risk of harm. In addition, the Jail does not allow prisoners to hold on to their own inhalers, which unnecessarily puts prisoners with asthma in serious danger, and fails to provide appropriate treatment or medications for many prisoners with asthma.

Treatment for substance use withdrawal in the Jail has significantly improved following the Wellpath transition and development of withdrawal management protocols. The Jail offers some forms of medication assisted therapy (MAT) for opiate use disorder. However, Wellpath providers are instructed to deny MAT to prisoners if they have a positive urine toxicology test for any opiates. This blanket rule serves no medical purpose and denies withdrawal treatment to prisoners who need it.

The Jail also fails to provide adequate specialty care to prisoners. Because specialty care appointments often concern very serious medical conditions, including cancer, heart disease, and complicated pregnancies, these delays create a serious risk of harm for patients. All specialty care appointments, other than with the onsite dentist and optometrist, must be scheduled with offsite providers. As discussed further *infra* Section IV.A.3, security staffing constraints make it difficult to transport prisoners to offsite appointments, meaning that many (if not the majority) of scheduled specialty care appointments must be cancelled or “rescheduled.” And even for the onsite dentist, staffing shortages limit the number of prisoners who can be brought to the clinic for appointments in a given day, leading to more delayed care. In addition, the Jail lacks an adequate system for prioritizing among specialties. All types of specialty consultations are assigned the same priority on the Jail’s electronic medical record. As discussed in more detail below, the Jail often cancels or reschedules prisoner medical appointments. Thus, the Jail’s inability to triage among them to ensure the most critical health needs are addressed first amplifies the dangerousness of the system.

There are also significant delays in ancillary services and other failures to provide follow-up treatment and care. Although laboratory services are readily available under contracts between the Jail and the nearby Sierra Vista Hospital and LabCorp, Wellpath does not have a practice of obtaining baseline laboratory studies for individuals with chronic diseases, such as HIV, Hepatitis C, hypertension, and heart disease. These serious conditions require routine labs to ensure adequate care. Similar to what we observed for specialty care appointments, laboratory draws and other tests are frequently “rescheduled” for no discernable or documented reason, resulting in very long delays or the failure to perform tests or deliver follow-up care entirely. When tests are ordered, often they are incomplete or inappropriate and important follow-up is absent, which is a particularly dangerous practice for HIV-positive prisoners.

Wellpath also refuses treatment for chronic conditions when prisoners are purportedly scheduled to be released soon, even though many of them have release dates weeks or months away or requested treatment months earlier. Specific examples of these deficiencies include the following:

- PP was admitted to the Jail in early 2018 and Jail staff became aware that he had Hepatitis C in January 2019. Nine months later, the Jail considered whether to provide him treatment, but opted against it because he would be released *the following July, nine months after that*, even though Hepatitis C treatment is completed in eight to 12 weeks. PP received no treatment for Hepatitis C before his release in June 2020.
- FF, a prisoner with severe heart disease and hypothyroidism, was in the Jail for a five-month period between 2019 and 2020. Despite being aware of his heart disease, medical staff did not obtain indicated tests, including an electrocardiogram to evaluate his arrhythmia (an irregular heartbeat) or a chest X-ray to evaluate the size of his heart, and cancelled an appropriately scheduled cardiology consultation. In addition, despite prescribing medication for his hypothyroidism, medical staff never ordered thyroid

laboratory tests, and failed to monitor his response to thyroid medication, which is very dangerous for someone with concurrent heart disease.

- QQ was incarcerated for a nine-month period between 2019 and 2020. He began requesting treatment for Hepatitis C in October 2019. Wellpath did not respond to this request for treatment until February 2020, when it refused treatment because QQ's release date was less than 12 weeks away. QQ was released as scheduled but returned to the Jail a week after his release. He still had not received treatment for Hepatitis C by June 2020, eight months after he initially requested it.
- RR entered custody in early 2017. On June 3, 2019, he complained of abdominal discomfort, nausea, dizziness, and dark stools for five days. A nurse evaluated his vital signs and found RR had an elevated pulse and blood pressure, but no further physical examination was conducted, no labs were ordered, and no treatment provided. On June 4, he complained of continued bleeding in his stool. Labs were ordered, which showed a decreased hemoglobin count (lost blood) and increased liver enzymes. However, a medical provider did not examine him, and the Jail did not send him to the emergency room. Five more days passed in which staff provided no additional laboratory studies, took no vital signs, and performed no examinations. On June 10, RR began vomiting blood. His pulse was twice the normal rate, and he complained of chest pain and shortness of breath. Instead of sending him to the emergency room, the nurse practitioner determined, without evaluating RR in person, to draw labs and monitor him. Sixteen hours later, medical staff consulted with a different nurse practitioner and sent him to the emergency room. The hospital determined that RR had lost almost half his blood volume, and had to intubate and sedate him to keep him alive. He remained in critical condition for five days.

3. Inadequate Staffing, Monitoring, and Oversight Contribute to Inadequate Medical Care

Wellpath fails to provide adequate staffing to prevent delays in medical care that place prisoners at substantial risk of serious harm. *See Brown*, 563 U.S. at 517–22 (examining staffing numbers and using expert testimony to conclude that insufficient numbers of clinical and correctional staff resulted in delays in medical and mental health treatment). Before the transition to Wellpath, the Jail had inadequate medical staffing, with one physician three hours per day, and between six and seven registered nurses and a similar number of licensed vocational nurses¹⁹ per weekday (and lower nurse staffing on weekends). Staffing levels provided under Wellpath's contract with the County are higher than before the transition.²⁰ However, there are unresolved inconsistencies in the work hours reported, and thus it is difficult to determine how many actual service hours have been provided.²¹ No matter the actual number of service hours, as illustrated

¹⁹ In California, a licensed vocational nurse is akin to a licensed practical nurse in other states.

²⁰ Wellpath's contract with the County requires a full-time health services administrator; 16 hours per week for a medical director (physician), which is a 0.4 full time equivalent (FTE) position; 56 hours per week for a non-psychiatric nurse practitioner or physician assistant (1.4 FTE); 336 hours for registered nurses (8.4 FTE); and 168 hours for licensed vocational nurses (4.2 FTE).

²¹ For instance, one specific nurse practitioner reported working 578.5 hours in July 2019 and 414.5 hours in August 2019, which is the equivalent of an average 18.7 and 13.4 hours per *calendar* day in July and August 2019, respectively. During an August 2019 interview, that nurse practitioner stated that she had been working about 50 hours

above and below, existing staffing appears inadequate to ensure timely access to various types of care.

The Jail is not performing timely medical assessments for all prisoners. For example, as discussed *supra* Section IV.A.2.a, some prisoners who are at the Jail for more than two weeks leave without ever undergoing the 14-day medical evaluation, and many are evaluated well after two weeks. There are also delays in access to provider sick call and nurse sick call.

Based on the volume of cancelled and rescheduled medical appointments, even after the Wellpath transition, the Jail is not providing adequate access to specialty care.²² For the 196 scheduled eye appointments from March to June 2019, only 27 occurred—38 were cancelled, 106 were rescheduled, and 24 were pending.²³ For dental care, the Jail’s dentist reported that, at the beginning of each day he worked at the Jail, he would select which patients to see from a list of prisoners needing a dental appointment and reschedule the rest.²⁴ Based on a review of approximately half of the patients seen by the dentist from August 2019 to December 2019, prisoners who requested dental care due to pain waited 27 days, on average, to be seen; the dentist reported to us that, but for custody staffing issues, he could see about twice as many patients a day. Delays also occurred for specialty consultations, including pregnant women’s access to obstetric consultations as discussed *supra* Section IV.A.2.c. Specialty care was often rescheduled repeatedly, and sometimes the prisoner was released from the Jail without receiving the consultation. Examples of these delays include:

- SS entered custody in May 2019 and within two days complained of an infection in her eye. She was given eye drops but not seen by a doctor. In early June, she submitted sick call slips stating her contact lens had “ripped” and was stuck in her eye, and that her vision was impaired. Medical staff gave her a saline fluid to wash out the lens. She asked to see the eye doctor again, reporting ongoing discomfort and that the lens remained stuck. Wellpath scheduled her for an optometrist appointment the next week, which was “rescheduled” to an unspecified date. Wellpath records show the appointment was rescheduled approximately 14 times over the course of two weeks.²⁵ When SS was seen, a nurse noted that SS’s right eye had swollen and was draining pus, and that her left eye was pink and in pain. A nurse practitioner ordered antibiotics. Over five weeks after her initial request, SS saw an optometrist, who diagnosed a central corneal ulcer and ordered hourly antibiotics as well as an emergency consultation with a corneal specialist. But instead of sending her to a specialist, Wellpath arranged an appointment with another optometrist four days later, who made a similar diagnosis and also requested an emergency referral to a corneal specialist, noting it should happen within two days. SS was released five days later without having seen a corneal specialist. About two weeks later, she returned to the

per week, which is substantially less. DOJ was unable, despite requests, to get a more accurate accounting from Wellpath.

²² Similar issues with cancelled and rescheduled medical appointments quite possibly existed pre-Wellpath as well. However, the sick call lists were shredded each day, and there was no way to reconstruct the data.

²³ Despite the low rate of successful appointments, access to optometry care under Wellpath is better than it was in the period before the transition for which we have data. During that period, between just one and four prisoners were seen a month, with no prisoners being seen from October 2017 until the end of February 2018.

²⁴ With Wellpath, there was a dentist on site twice a week as of August 2019. Before Wellpath, an offsite dentist provided dental care through a van that came to the Jail. In 2018, the dentist provided care for 10 full days and seven half days.

²⁵ Each time it was rescheduled to the following day.

Jail for a period of over two months. She asked to see the optometrist because of the ulcer in her eye. Wellpath made an appointment but then “rescheduled” it twice, and it never happened before her release.

- TT, who had anemia, complained of abdomen pain and black stools. Wellpath referred him to a gastroenterologist who recommended an urgent colonoscopy. Wellpath did not order the colonoscopy until 11 days later. The colonoscopy was scheduled for 16 days after the order was made, but TT was discharged before he obtained that urgent colonoscopy.
- UU, whose chronic conditions include hypertension and bilateral hip osteoarthritis, entered custody in December 2018. He was prescribed and received Naproxen for his hip pain. On January 30, 2019, shortly before the transition to Wellpath as the Jail health provider, X-rays of his pelvis and hips demonstrated severe degenerative changes in both hips. Wellpath cancelled his Naproxen prescription and gave him no pain medication for 16 days. He then received three doses over a two-day period in February before Wellpath stopped it again. He received no pain medications for another two weeks, when Wellpath began giving him a different pain medication. UU repeatedly complained that the new medication caused rashes, that he was in constant pain that was not responsive to his medication, and that he had a worsening gait. Nearly six months after UU entered custody, following months of requests and only after custody staff reported to medical staff that his gait had worsened, a nurse practitioner prescribed him a cane. During the eight months of UU’s incarceration, the Jail never referred him to a physical therapist, which was indicated for his condition.
- VV was booked at the Jail twice in 2019. VV suffers from ankylosing spondylitis—a painful, progressive type of arthritis that primarily affects the spine—in an advanced stage where there is a complete fusion of the bones and spine, turning the spinal column into one long bone. During both incarcerations, he did not receive any specialty consultation. The first incarceration began in March 2019 and lasted four months. At intake, VV informed medical staff of his condition and prescriptions, and signed an authorization for the Jail to obtain his outside medical records. However, Jail medical staff did not do so, did not perform an initial medical evaluation, and did not prescribe him medication. For nearly two months, VV was in lockdown, where he did not receive any specialty medical care or medication. After he was released from lockdown, he was prescribed ibuprofen, and 10 days later saw a nurse practitioner who did not prescribe any medication. He then informed custody staff that he intended to start a hunger strike because he did not receive pain medication, which led to a doctor prescribing a pain medication a day after reviewing his chart but no medication to slow disease progression. Nor did the doctor refer him to a specialist. The Jail did not evaluate him again before his release about one month later. During his second incarceration, which lasted approximately one month, he never received any pain medication or specialty care.

During interviews in August 2019, medical and dental staff stated that they could have been seeing many more patients during a given shift than they were, if not for delays in custody staff transporting prisoners to and from the medical clinic. Similarly, medical staff reported that they often needed to reschedule offsite medical appointments due to the unavailability of custody staff. Lack of staff to transport prisoners to the medical clinic and to outside medical appointments has resulted in prisoners missing their appointments or having their appointments delayed. Thus, both medical and custody staffing issues contribute to delayed medical care.

Both before and after the Wellpath transition in February 2019, the Jail has also had problems recruiting and retaining medical staff. From February 2019 through August 2019, three different individuals occupied the Medical Director position at the Jail. In addition to seeing patients, the Medical Director is responsible for the Jail’s medical program, including participating in quality oversight meetings and providing oversight and supervision regarding the performance of medical staff and the quality of medical records. The Jail went through one of these changes in its Medical Director shortly before our August 2019 Jail visit. However, medical staff did not know of the recent change, and some did not know or were apparently mistaken about who their supervisors were. The Health Services Administrator, a registered nurse with administrative oversight responsibilities including approving leave requests, was the only person identified by many healthcare providers—including a doctor, a nurse practitioner, and a dentist—as their direct supervisor. Indeed, the new Medical Director in August 2019—who had previously served as Medical Director for a number of months—reported to DOJ that he was not aware he had any supervisory responsibilities, instead believing his only duty was to provide patient care. Thus, he explained he did not conduct meetings, provide leadership to medical staff, or conduct chart reviews. In August 2019, the County’s Chief Medical Officer acknowledged the need for consistent, onsite medical leadership to provide necessary contemporaneous supervision. To that end, in February 2020, the County and Wellpath amended their contract to add a full-time Director of Nursing to provide additional supervision for nursing staff.

In addition, the Jail does not have monitoring systems in place to identify and address deficiencies in its medical care. Before Wellpath, the Jail did not conduct any analysis of the quality of care that it provides. Neither physicians nor the Director of Nursing did chart audits or chart reviews, which are necessary elements of an adequate quality assurance program that measures quality of care and identifies deficiencies to be addressed and improved. Before Wellpath, the Jail did not conduct critical incident reviews, and when prisoners died, death reviews failed to include a meaningful analysis into causal factors or systemic issues. The Jail provided no evidence that Wellpath has corrected these deficiencies. *See Madrid v. Gomez*, 889 F. Supp. 1146, 1258 (N.D. Cal. 1995) (“[A] primary component of a minimally acceptable correctional health care system is the implementation of procedures to review the quality of medical care being provided.” (quoting *Lightfoot v. Walker*, 486 F. Supp. 504, 517–18 (S.D. Ill. 1980))).

Wellpath does not routinely analyze the quality of care that it provides. Wellpath’s Health Services Administrator completes a series of audits every month, but none of them appears to involve a review of prisoner charts to evaluate medical care. Instead, the audits are generic and administrative in nature, and fail to aggregate or analyze available data—including through the sick call and grievance processes, as well as sentinel events such as health crises that require hospitalization—to identify potential deficiencies. One such audit of five out of nine prisoners with HIV in July 2019 determined care was 91% compliant based on five criteria. But three prisoners with HIV discussed *supra* Section IV.A.2.c, JJ, KK, and MM, were in custody during that month and received inadequate care at that time.

Although a County employee, the Jail’s Chief Medical Officer,²⁶ monitors the Jail’s contract with Wellpath to ensure that quality of care is adequate, there is no mechanism for the County to remedy deficiencies in Wellpath’s care; any limited oversight the County does have is

²⁶ This position is not to be confused with the Jail’s Medical Director, a Wellpath position. Because she is not a Wellpath employee, the Chief Medical Officer does not make and is not responsible for making decisions about care at the Jail. Instead, her role is limited to overseeing and evaluating Wellpath’s care on behalf of the County.

ad hoc and not systemic. The Chief Medical Officer admitted that she cannot tell Wellpath what to do and instead will bring issues, including acute patient issues that she learns about from third parties, to Wellpath's attention. When such situations arise, she will conduct a chart review and investigate the quality of care; if a problem becomes evident, she will bring it to Wellpath's attention. Although she appears to have done a good job problem-solving issues in individual cases, she does not have access to all Wellpath reports and data, so she has a limited ability to intervene on quality of care issues. Without more direct and systemic oversight, and also without the ability to obligate Wellpath to take specific actions, the County cannot adequately monitor or correct deficiencies in Wellpath's care.

4. Officials at the Jail Knew of the Risk to Prisoner Health and Safety Posed by Inadequate Medical Care and Disregarded It

Officials at the Jail have been aware of the deficiencies in medical care for years and have failed to address them adequately. By disregarding the obvious risks to prisoner health and safety, officials at the Jail evince a deliberate indifference to prisoners' constitutional rights to adequate medical care. *See Hope v. Pelzer*, 536 U.S. 730, 736–38 (2002) (disregarding obvious risk to prisoner health and safety constitutes deliberate indifference); *see also Toguchi v. Chung*, 391 F.3d 1051, 1057 (9th Cir. 2004) (“A prison official acts with ‘deliberate indifference . . . only if the [prison official] knows of and disregards an excessive risk to inmate health and safety.’” (alterations in original) (quoting *Gibson*, 290 F.3d at 1187)).

Jail officials have been aware of the harm caused to prisoners due to inadequate medical treatment and lack of access to care at least since the 2017 death of AA, which caused the County to evaluate the medical and mental health care at the Jail. For example, the Jail hired the chief medical officer for the San Diego County Sheriff's Department to conduct an audit of the Jail's medical and mental health services, which identified the need for centralized oversight of prisoner health care. Although the Jail added the Chief Medical Officer position (as discussed above) and switched medical providers two years after AA's death, medical care under Wellpath has not significantly improved for the reasons outlined *supra* Sections IV.A.2 and IV.A.3. Moreover, both pre- and post-Wellpath, the Jail has failed to conduct chart reviews, peer reviews, or critical incident reviews, or to implement other oversight mechanisms to ensure prisoners receive adequate medical care for the reasons outlined *supra* Section IV.A.3. Therefore, the Jail has disregarded obvious risks to health and safety in violation of prisoners' constitutional rights. *See Hope*, 536 U.S. at 736–38; *Toguchi*, 391 F.3d at 1057.

B. Mental Health Care at the Jail Is Inadequate in Violation of Prisoners' Constitutional Rights

The Department has reasonable cause to believe that the Jail has engaged in a pattern or practice of failing to provide prisoners with adequate mental health care in violation of their Eighth and Fourteenth Amendment rights. The Eighth Amendment's prohibition against cruel and unusual punishment requires jails to provide prisoners with adequate mental health care. *Gibson*, 290 F.3d at 1187 (holding that the “duty to provide medical care encompasses detainees' psychiatric needs”); *see also Bowring v. Godwin*, 551 F.2d 44, 47 (4th Cir. 1977) (noting “no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart”). As with medical care, deprivations of mental health care violate the Eighth Amendment if they are sufficiently serious and the prison official was deliberately indifferent to prisoner health or safety. *Wilson v. Seiter*, 501 U.S. 294, 298–99 (1991).

1. Prisoners at the Jail Have Serious Mental Health Needs Requiring Treatment

The Jail has large numbers of prisoners receiving some form of mental health treatment, including prisoners with serious mental illness.²⁷ In its monthly reports to California’s Board of State and Community Corrections, the Jail identified approximately 39% of its prisoners in 2018 as taking psychotropic medication for mental illness; from February to April 2019, after Wellpath had assumed care, the Jail identified approximately 27% of its population in those reports. Of the approximately 535 daily prisoners from June 2019 to January 2020, Wellpath identified approximately 81 prisoners, or 15% of the daily population, as having a serious mental illness.²⁸

2. Prisoners Are Subjected to Serious Harm and the Substantial Risk of Serious Harm as a Result of Inadequate Mental Health Care

The Jail’s inadequate mental health care causes serious harm to prisoners with mental illness or places them at substantial risk of serious harm.

a. *Inadequate Screening and Treatment Planning for Prisoners with Mental Illness*

The Jail does not adequately screen prisoners for mental illness at intake. *See Coleman v. Wilson*, 912 F. Supp. 1282, 1305 (E.D. Cal. 1995) (concluding that the Constitution requires a systematic screening program). Registered nurses should screen all prisoners who enter custody for mental illness, but the Jail fails to screen a significant proportion of them. In addition, the initial screenings are sometimes clinically inadequate, for instance failing to flag prisoners as requiring mental health treatment even if they had a history of suicide attempts or mental health treatment in the community or during a prior stay in the Jail.²⁹

Post-intake mental health assessments are also inadequate, and sometimes occur after significant delay. The quality of the mental health assessments is inconsistent, with some clinicians failing to capture information relevant to treatment planning and suicide risk assessment. The mental health assessments often fail to note diagnoses in the electronic health record or provide a rationale for creating certain mental health alerts, thus impeding other clinicians from providing informed, appropriate follow-up treatment. In addition, clinicians conducting the assessments often fail to make referrals for appropriate follow-up care, including for prisoners who require substance-use treatment or psychiatric evaluations.

²⁷ Neither the Jail nor Wellpath policies consistently define this term, although Wellpath provides a definition of prisoners with “**severe** mental illness” (emphasis added). They do not consistently apply any definition in identifying, assessing, or treating prisoners with serious mental illness. When we use the term “serious mental illness,” we are referring to a mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. Examples of serious mental illness include major depressive disorder, schizophrenia, and bipolar disorder.

²⁸ In October 2019, it appears that Wellpath changed its criteria for how it tabulated prisoners with serious mental illness. The number of prisoners with serious mental illness nearly doubled—from daily numbers of between 49 and 66, to between 103 and 128 (from October 2019 through January 2020)—but there does not appear to have been a significant change in the types or numbers of prisoners.

²⁹ In one example reviewed, a prisoner who returned to the Jail roughly one week after release was not flagged as requiring mental health treatment even though he had been receiving mental health treatment before his release.

The Jail also fails to provide adequate treatment plans for prisoners with mental health needs. Treatment plans should include prisoners' diagnoses, suicide risk and protective factors, treatment goals, treatment interventions including therapy or psychiatric care, and any other specialized needs that affect mental health. As the Jail's mental health program manager acknowledged, the Jail does not provide centralized treatment plans for most prisoners with mental illness, even those with serious mental illness. Psychiatrists will provide basic treatment plans limited to medication management, but they are often inadequate because they do not consistently contain clinically relevant laboratory assessments necessary to monitor side effects of medication. Psychiatric assessments do not consistently address areas of concern outside of medication such as safety risk, substance use disorders, or need for psychotherapy. Furthermore, psychiatrist notes frequently conflict with other mental health clinicians' notes, including with respect to diagnoses. The failure to provide adequate, centralized treatment plans that provide clarity with respect to basics such as diagnoses can lead to inappropriate treatment and place prisoners at risk of decompensation.

b. *Inadequate Follow-Up Treatment, Psychotherapy, and Medication Management*

The Jail fails to provide adequate follow-up mental health care and psychotherapy to prisoners when necessary. Wellpath in fact seems to discourage routine follow-up mental health care. Clinicians told us that they were discouraged from providing scheduled psychotherapy services to prisoners, and instead were encouraged to tell prisoners to submit sick call requests each time they wanted to be seen.³⁰ In addition, some psychotherapy services are primarily reserved for prisoners with long sentences, excluding most prisoners with mental illness at the Jail. For prisoners who return to the Jail from the psychiatric hospital, the Jail fails to integrate hospital records with Jail ones to ensure that treatment provided at hospitals is continued at the Jail. By failing to provide needed psychotherapy, counseling, and other follow-up mental health treatment, the Jail fails to provide adequate quality of care to prisoners with mental illness.

Psychiatric staff fail to manage prisoners' medications appropriately. Although it happens less frequently than it did before the transition to Wellpath, psychiatric providers still prescribe multiple antipsychotics for prisoners without appropriate clinical justification, which can be dangerous because of increased risk for medication side effects and medication interactions. Psychiatric providers fail to order a full set of timely laboratory studies to screen for underlying medical issues or for side effects. This is particularly dangerous because antipsychotic and mood stabilizing medications may increase risk for serious medical conditions including diabetes and heart disease, as well as death. The Jail also fails to provide a consent process for psychotropic medication, failing to apprise prisoners of health risks associated with such medication and thus preventing them from making informed decisions about their care.

In addition, there are often significant delays in providing psychotropic medications to prisoners with serious mental illness. A significant proportion of initial psychiatric evaluations occur more than 14 days after prisoners arrive at the Jail, and prisoners with serious mental illness are not appropriately expedited for urgent or emergent referrals. In addition, even where providers have deemed medications clinically appropriate or necessary, prisoners continue to have difficulty obtaining certain psychotropic medications that are not on the Jail's pre-approved medication list

³⁰ The mental health program manager, for example, informed us that when she started working at the Jail, she would try to see patients week after week, but then she "got corrected" and was told to focus on "here-and-now" help only, unless follow-up were clinically necessary.

or else experience significant delays in obtaining them. When supply of certain psychotropic medications runs out, there are also frequent delays in refilling the medications. Examples of significant psychotropic medication delays and irregularities include the following:

- WW, a prisoner with serious mental illness, entered custody in April 2019. Although his father informed mental health staff that WW had attempted suicide a month and a half before entering custody and had been taking psychotropic medications, and although custody staff asked mental health staff to evaluate him due to his bizarre behavior, Jail psychiatric staff did not assess him for medication until three months after he entered the Jail. During this three-month period, his mental health deteriorated to the point he was “floridly psychotic,” speaking in a “word salad” with “statements that did not make sense” and exhibiting signs of paranoia; as a result, he was placed in a safety cell.³¹ He began receiving psychotropic medications in July 2019. However, he stopped receiving one of those medications for a two-month period between August and October 2019, during which time he decompensated—experiencing auditory hallucinations, reporting suicidal thoughts, and exhibiting strange behaviors including rocking back and forth and talking to himself—and was again placed in a safety cell.
- XX, who has unspecified schizoaffective disorder, entered custody in April 2019. A few days later, he met with mental health staff, who noted that he had a wound on his forehead and that his behavior was bizarre. The next day, another mental health clinician made a note to “SEE TODAY no psych meds on board.” However, XX did not receive his initial psychiatric evaluation for another 10 days, over two weeks after entering custody. And he did not begin receiving psychotropic medication until three weeks after entering custody, during which time he decompensated, experiencing auditory and visual hallucinations.
- YY was in restrictive housing throughout February 2019, and Wellpath staff noted she was frequently unkempt, not eating, and that a strong odor was coming from her cell; mental health staff noted during one evaluation that she had stopped eating and drinking. In March 2019, she went to the County’s Psychiatric Health Facility (PHF), but when she returned to the Jail in early April, Jail mental health staff did not continue her on the medication she had been taking at the PHF. When mental health staff evaluated her weeks later, they noted signs of mental health deterioration, describing her as “hypervocal,” “grandiose about her competence,” and exhibiting “persecutory delusions” and “total lack of insight.”
- In March 2019, ZZ cut his own neck with a metal object in an intake cell and was sent to the PHF for being a danger to himself. Upon his return to the Jail, it took eight days for an offsite psychiatrist to complete an evaluation via tele-psychiatry. The psychiatrist ordered psychotropic medications, but ZZ did not receive them for five days. During that time, a clinician noted that ZZ “presented with anxious affect, tearful-mood-anxious and depressed,” exhibited “[p]ressed speech,” and articulated apparent delusions.
- In August 2019, AB entered the Jail, and custody staff alerted mental health staff that AB was acting bizarrely. Mental health staff noted that AB had previously been hospitalized at Atascadero State Hospital due to his mental illness and recommended that he be placed in a safety cell. The next day after consulting the primary care nurse practitioner, but not the psychiatric nurse practitioner or tele-psychiatrist, a “psych tech” administered a high one-time dosage of an anti-psychotic that could have caused an overdose. Symptoms of an

³¹ A safety cell is stripped of all furniture and any comforts in order to minimize any means for prisoners to harm themselves. For more discussion of these stark cells, see *infra* Section IV.B.2.c.

overdose from this antipsychotic include sedation and agitation. AB exhibited signs of sedation, including sleeping several hours in the middle of the day, refusing to wake up for mental health staff, and lethargy. Despite this, there was no indication that he was physically evaluated. A psychiatric nurse practitioner did not evaluate him until seven days later.

c. *Inadequate Treatment and Supervision of Suicidal Prisoners*

The Jail's suicide prevention procedures suffer from serious deficiencies, which cause harm and the substantial risk of serious harm. One of the most critical components of a minimally adequate mental health treatment program is the "identification, treatment and supervision of inmates with suicidal tendencies." *Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980), *aff'd in part and rev'd in part on other grounds*, 679 F.2d 1115 (5th Cir. 1982); *see also Coleman*, 912 F. Supp. at 1298 n.10. However, the Jail also does not appear systemically to track, aggregate, or analyze the number of suicide threats or self-inflicted injury incidents. The Jail also does not appear to comply with an internal policy requiring debriefings after suicide attempts.

Currently, prisoners who are acutely suicidal, or who have decompensated to the point of becoming a danger to themselves, are placed in a "safety cell" (see image to the right)—a cell that does not have a bed, toilet, sink, or water and which has a grate in the floor for prisoners to relieve themselves. They have a solid door with only a port for delivering meals. Prisoners are not allowed to bring any clothing or other items into the safety cells, nor are they permitted any blankets, sheets, bedding, or mattress. Instead, they are only issued a suicide-resistant smock.



Custody staff, typically in consultation with mental health staff, make the decision to place prisoners in safety cells. Mental health staff can also recommend placing prisoners in safety cells. Acutely suicidal prisoners and prisoners who are a danger to themselves can be housed in a safety cell for up to 48 hours.³²

Prisoners in safety cells are assessed by mental health staff speaking through the food port. Suicide evaluations are required by policy both before placing and before removing a prisoner from a safety cell. Although Wellpath has a form to measure suicide risk for prisoners in safety cells, the form is not always used, and the completeness and quality of the assessment varies across mental health staff. Before Wellpath, decisions to remove a prisoner from a safety cell typically involved a Licensed Marriage and Family Therapist (LMFT) or Licensed Psychiatric Technician (LPT) providing an onsite evaluation and discussing findings over the phone with an on-call psychiatrist; now an LPT or LMFT can approve removal without consultation with a psychiatrist. Because the quality of the assessments vary, prisoners may be released from a safety cell despite ongoing risk of suicide.

³² Before the Jail's reforms in the wake of AA's death, prisoners could be housed in a safety cell indefinitely. AA had been in a safety cell for 18 days straight in the weeks before his death.

The Jail schedules follow-up safety checks of prisoners recently released from safety cells that are supposed to occur within 24 hours, but those follow-ups frequently do not occur. In practice, about two-thirds of prisoners are seen within 24 hours after release from safety cells.³³ These follow-ups are typically conducted by LMFTs who do not conduct structured suicide risk assessments. Thus, although prisoners are seen by mental health staff following release from safety cells, the inconsistent quality of pre-release assessments and inconsistent follow-up places prisoners at risk of serious harm.

Wellpath's medical record system has the capability to create alerts for prisoners who have a risk of suicide, which assist staff in identifying and appropriately categorizing prisoners with needs related to heightened suicide risk in order to reduce the risk of future suicide attempts. Wellpath does not consistently create these medical alerts for prisoners placed in safety cells due to suicidal behavior. This creates a risk that staff who are not familiar with the prisoner may not be aware of that history.

Moreover, the Jail has a practice of transitioning prisoners from a safety cell directly to restrictive housing, where prisoners remain locked in their cells for the vast majority of the day and night, and have limited or no access to programming and activities or other long-term care. As discussed *infra* Section IV.C.1, the isolation and harsh conditions in restrictive housing are especially harmful to prisoners who have serious mental illness. On August 30, 2018, during a mental health sick call with an LPT, DD was observed curled in a fetal position on the floor, and during the interview, he was anxious, rocking, and made little eye contact. The psychiatrist, via phone, ordered a sedative for anxiety and an antidepressant. The next day, DD was placed in a safety cell for suicidal thoughts and agreed to take an antipsychotic medication. An LPT conducted an assessment, and a psychiatrist on call made the decision to release him from the safety cell because he denied suicidal thoughts and said he was feeling better. At 2:05 am on September 1, he was released from the safety cell and custody staff placed him alone in a cell without suicide precautions, such as property restrictions, where deputies could not observe him directly or by live video. The plan was to conduct a follow-up in 24 hours. However, at 11:45 a.m., he died after hanging himself in his cell using a piece of bed sheet that he tied to the top bunk.

An adequate suicide prevention program should regularly assess suicide risk and provide meaningful, ongoing therapeutic support. The described failures in suicide risk assessment, follow-up, monitoring, and treatment result in deficient medical care for prisoners.

3. Inadequate Staffing and Oversight Contribute to Inadequate Mental Health Care

The Jail lacks adequate mental health staffing to treat prisoners with mental health needs. Courts have held that having enough mental health professionals is an essential part of any adequate mental health program. *Coleman*, 912 F. Supp. at 1306 (constitutionally adequate mental health care requires “mental health staff in ‘sufficient numbers to identify and treat in an individualized manner those treatable inmates suffering from serious mental disorders’” (quoting *Balla v. Idaho State Bd. of Corr.*, 595 F. Supp. 1558, 1577 (D. Idaho 1984))); *see also Brown*, 563 U.S. at 521 (noting that mental health treatment can be impeded by lack of adequate correctional staff, who are required to “escort prisoners to medical facilities or bring medical staff to the prisoners”).

³³ Before Wellpath, policy only required that the prisoner be seen at the next available psychiatric sick call. Only about one-third of prisoners were seen within 24 hours.

The Jail lacks adequate psychiatrist coverage. As of August 2019, Wellpath staffed the Jail with a psychiatrist for just 24 hours a week, the equivalent of 0.6 FTE, for an average of 100 or more prisoners with serious mental illness. In addition, eight hours of that psychiatrist's time were spent treating prisoners in the JBCT program. This left just 16 hours (0.4 FTE) for all other prisoners with mental health needs at the Jail. Wellpath appears to be aware that its psychiatric coverage is inadequate. The onsite Health Services Administrator told us that she assigned the psychiatrist 50% more patients per day than the psychiatrist felt comfortable seeing. Although there is a psychiatric nurse practitioner who, as of August 2019, worked at the Jail 16 hours a week (0.4 FTE), she acknowledged that her caseload mostly excluded prisoners with serious mental illness, and medical records reflect that her meetings with those prisoners were limited to emergencies or limited follow-up evaluations. The psychiatric nurse practitioner also told us her caseload had sometimes been difficult to manage—a challenge the psychiatrist also reported. The psychiatric nurse practitioner said that previously she sometimes had as many as 30 patients on her list per day even though she could only see between 10 and 12. She also reported that she did not review laboratory results that they ordered for patients on anti-psychotics to monitor potentially adverse side effects, placing prisoners at serious risk of harm. As discussed *supra* Section IV.B.2.b, many prisoners experience delays in receiving psychotropic medications due to these staffing deficiencies.

Staffing of other mental health positions is also too low to meet prisoners' mental health needs. As first observed in August 2019 and confirmed as recently as March 2021, the Jail had just three LMFTs on staff, which was not enough to meet the needs of the prisoner population; they had insufficient time to provide the contractually-required psychotherapy services at the Jail in addition to their other duties. The Jail also had a full-time psychologist and a social worker, but they were reserved for the Jail's JBCT program.

As discussed *infra* Section IV.C.1, the Jail houses many prisoners with mental illness in restrictive housing cells. Mental health evaluations and limited visits from mental health staff frequently occur cell-side, with the clinician speaking to the prisoner through the cell door while custody staff stand nearby, typically within view and sometimes within hearing distance of staff and other prisoners. This impairs the confidentiality of mental health communications, and has a chilling effect on prisoners that compromises care, placing prisoners at risk of harm. The reliance on cell-side evaluations appears to be related to staffing constraints that make escorting prisoners from their cells for healthcare evaluations a challenge.

The Jail lacks adequate supervision and oversight of mental health care. There is no individual onsite responsible for overseeing all aspects of mental health care. During our August 2019 site visit, the mental health program manager informed us that she supervised several categories of mental health staff, including LMFTs and LPTs. She told us that she did not clinically supervise the psychiatrist, the psychiatric nurse practitioner, or the psychologist in charge of the JBCT program, but emails we obtained between her and the psychiatrist suggest otherwise. The mental health program manager's supervision of the LPTs—and possibly the psychiatrist—is a problem because their responsibilities, including checking vitals and administering medication, were not within the scope of the mental health program manager's license. Mental health providers

and staff also expressed confusion about who supervised them.³⁴ In addition, the mental health program manager's own supervisor, the onsite Wellpath Health Services Administrator, was an RN who told us that she did not closely scrutinize mental health care at the Jail.³⁵ As a result, there were no qualified staff onsite responsible for supervising the activities of the psychiatrists, the psychiatric nurse practitioner, or the medical work of the LPTs.

The lack of clear supervisory structure and training results in some staff making treatment decisions or setting policies on matters that are plainly outside their licensure, putting prisoners at risk of significant harm. For instance, a nurse practitioner without specific training in psychotropic medications prescribed one prisoner a dangerously high dosage of a psychotropic medication he had not taken in months without any consultation with a psychiatrist.³⁶ This was never flagged by Wellpath staff.³⁷ Further, the onsite psychiatrist reported receiving pressure from other Wellpath staff to prescribe involuntary medications in circumstances she felt were inappropriate. A psychologist and an LCSW, both of whom lacked the ability to prescribe medications, acknowledged trying to make the psychiatrist change her medication practices because they disagreed with them. In addition, onsite Wellpath staff including the HSA and a psychologist drafted policies concerning the administration of involuntary psychotropic medication without consulting the onsite psychiatrist or psychiatrists from Wellpath's corporate offices.³⁸

The Jail also lacks adequate quality assurance and quality improvement systems for mental health care. In the event of a prisoner death or other critical incident such as a serious suicide attempt, there is no practice of holding morbidity and mortality reviews with mental health clinicians or administrators who work at the Jail. Although meetings occur at the Wellpath corporate level, they have minimal participation from onsite staff and no participation from the County. These corporate morbidity and mortality reviews may capture policy issues, but would miss nuanced risks or problems that are site specific.³⁹ The Jail also does not systematically track suicide attempts or other incidents involving self-directed violence,⁴⁰ and appears not to comply

³⁴ Based on her emails, the psychiatrist—who resigned the week before our August 2019 site visit—seemed to regard Wellpath's offsite corporate psychiatrists as her supervisors. The psychiatric nurse practitioner and the psychologist both told us their supervisor was the Wellpath Health Services Administrator (HSA), even though the HSA was an RN and neither psychotherapy nor psychotropic medications were within the scope of her licensure.

³⁵ The Health Services Administrator told us her supervision was limited to approving the mental health program manager's vacations, handling semi-annual personnel evaluations, and helping the mental health program manager gather data.

³⁶ An LPT consulted with the nurse practitioner and advised her to prescribe the medication because the prisoner was decompensating and she felt it was an emergency. The LPT told us she went to the nurse practitioner instead of contacting the on-call psychiatrist because she believed the former would be better at making judgment calls than the latter, who was offsite and unfamiliar with the patients.

³⁷ When DOJ brought this issue to the attention of Wellpath's regional medical director, his response was that the nurse practitioner should have contacted an on-call psychiatrist. However, he acknowledged that there were likely policy and training issues at play, and that additional instruction regarding the on-call psychiatrist might be needed.

³⁸ When the psychiatrist brought this to the attention of Wellpath's corporate psychiatrists, they informed her that the Jail did not have to get their approval on the policy.

³⁹ Before the transition to Wellpath, the County held morbidity and mortality reviews apart from the Jail for individuals on the County mental health caseload. The September 2018 suicide of DD was discussed during one of these reviews. Yet this review failed to include a summary of events, a root cause analysis of the suicide, or action steps to identify deficiencies or make improvements to care, hindering the Jail from averting similar suicides in the future.

⁴⁰ Although the Jail produced a list of suicide attempts and other critical incidents between February 2019 and October 2019, it was missing a self-harm incident and an apparent suicide attempt that we knew about from the same period

with an internal policy requiring debriefings after suicide attempts. The mental health program manager informed us that she did no systematic chart reviews, and she was aware of no quality assurance or minimal quality improvement meetings or processes. The Health Services Administrator sometimes conducts a “loose audit” of the notes of mental health staff, but since mental health treatment was not covered by her licensure, she said she examines only the completion and timeliness of patient evaluations. The Jail does not systematically track data that are essential to assess the quality of mental health treatment, including monitoring of laboratory testing of antipsychotic and mood-stabilizing medications, tracking and analysis of self-injurious behavior incidents, monitoring potentially harmful side effects of medication, or uses of force and restraints on prisoners with mental illness.

4. Officials at the Jail Knew of the Risk to Prisoner Health and Safety Posed by Inadequate Mental Health Care and Disregarded It

After the tragic death of AA in January 2017, the Jail made significant changes regarding some of the systemic inadequacies in its mental health system. These changes included improving Jail safety cell policies, improving protocols to admit decompensated prisoners at the PHF, and improving communication between mental health staff and custody. The County also reevaluated its mental health system, and ultimately contracted with Wellpath, which led to some improvements described *supra* Section III.C. These were important changes.

However, other systemic inadequacies, including inadequate psychotherapy and medication administration, subjecting prisoners with mental illness to isolation as described *infra* Section IV.C, and insufficient supervisory oversight of mental health staff resulting in inadequate care, have not been addressed systemically. The Jail’s failure to take adequate steps to eliminate these risks evinces deliberate indifference to prisoner health and safety. *See Farmer*, 511 U.S. at 837 (a prison official is liable under the Eighth Amendment if he “knows of and disregards an excessive risk to inmate health or safety”); *Hope*, 536 U.S. at 738–41; *Smith*, 589 F.3d at 738–39 (citing *Estelle*, 429 U.S. at 104–05). In response to concerns raised during our site visits, the Jail revamped its housing structure so that fewer prisoners with mental illness would be in restrictive housing and began using a standardized suicide risk assessment. However, as discussed *supra* Section IV.B.2.c, the standardized assessment is not always used, staff assessments still vary in quality and completeness, and the assessments are not tracked or analyzed. In addition to inadequate suicide risk assessments, inadequate treatment that allows prisoners to decompensate to the point that they are placed in restraints, housed in a safety cell, or sent to the PHF remains a significant concern to prisoner health and safety as further described *infra* Sections IV.C.3 and IV.D.1.

C. The Jail’s Use of Prolonged Restrictive Housing Under Current Conditions, Including the Failure to Provide Adequate Medical and Mental Health Care, Violates the Constitutional Rights of Prisoners with Serious Mental Illness

The Jail’s pattern or practice of using restrictive housing under current conditions—including the duration of restrictive housing and the failure to provide adequate medical and mental health care—subjects prisoners with serious mental illness to serious harm and places them at substantial risk of serious harm. Thus, there is reasonable cause to believe that the Jail’s use of

from other documents produced by the County, and otherwise contained far too few incidents for a jail of its size to be reliable. Furthermore, the Jail did not identify and produce information about two August 2018 suicide attempts until after we repeatedly pointed out that the Sheriff’s Office referred to them in a September 2018 press release.

restrictive housing for prisoners with serious mental illness under current conditions violates their rights under the Eighth and Fourteenth Amendments. *See Disability Rights Mont.*, 930 F.3d at 1098–99 (finding a complaint plausibly alleged an Eighth Amendment violation where it “described a distressing pattern of placing mentally ill prisoners in solitary confinement for ‘weeks and months at a time’ without significant mental health care” and alleged “frequent, improper use of this [solitary confinement] punishment for behavior arising from mental illness,” denial of “diagnosis and treatment” of mental illness, and failure to “respond appropriately to threats of suicide by mentally ill prisoners”); *Sweet*, 529 F.2d at 861 (noting that the “cumulative effect of several conditions will bring solitary confinement within the prohibition of the [E]ighth [A]mendment”).

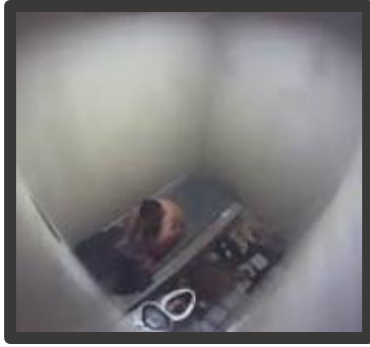
District courts in the Ninth Circuit have repeatedly held that isolating prisoners with serious mental illness can result in serious harm. *See, e.g., Coleman v. Brown*, 28 F. Supp. 3d 1068, 1105 (E.D. Cal. 2014) (explaining that placement of seriously mentally ill prisoners in California’s segregated housing units “can and does cause serious psychological harm, including decompensation, exacerbation of mental illness, inducement of psychosis, and increased risk of suicide”); *Graves v. Arpaio*, 48 F. Supp. 3d 1318, 1335 (D. Ariz. 2014) (“Holding inmates with serious mental illness in prolonged isolated confinement may cause serious illness and needless suffering in violation of the Eighth Amendment.”); *Madrid*, 889 F. Supp. at 1265 (“For these [mentally ill] inmates, placing them in the [isolation unit] is the mental equivalent of putting an asthmatic in a place with little air to breathe.”). According to the Ninth Circuit, “national prison health organizations” have found that “subjecting prisoners to extensive solitary confinement” is “unacceptab[le]” because it “can lead to or exacerbate mental illness and psychological deterioration, including increasing the risk of suicide.” *Disability Rights Mont.*, 930 F.3d at 1098.

1. Prisoners with Serious Mental Illness Are Subjected to a Substantial Risk of Serious Harm as a Result of the Jail’s Use of Prolonged Restrictive Housing

The Jail holds prisoners with serious mental illness in restrictive housing (see image of cell to the right), including administrative segregation, where they are offered out-of-cell time only once per day for up to one hour.⁴¹ Custody staff informed us that they put prisoners with serious mental illness in restrictive housing for their own safety and to “stabilize” them. Prisoners in restrictive housing receive virtually no structured programming. The reliance on administrative segregation to house such prisoners increases the likelihood that they will decompensate and suffer other harm secondary to decompensation.



⁴¹ As discussed more fully below, administrative segregation is distinct from the use of restrictive housing as a disciplinary sanction.



A special type of restrictive housing used by the Jail is the stepdown cell. The stepdown cell (see image to the left) is even smaller than a normal restrictive housing cell, with a bed that sits low to the floor, and little floor space apart from the bed, a sink, and toilet. Stepdown cells are monitored by video surveillance. The Jail uses the stepdown cells for multiple purposes, including for prisoners deemed to exhibit disruptive behavior. The Jail keeps some prisoners in stepdown cells for months at a time, including prisoners with known serious mental illness.

Because custody and mental health staff use different computer systems and because mental health staff do not inform custody staff which prisoners have serious mental illness, we could not determine precisely how many prisoners with serious mental illness were subjected to restrictive housing at a given time. However, Jail statistics produced in September 2019 show that 25.3% of Jail prisoners are held in protective custody and another 9.4% in administrative segregation, both of which are more restrictive than general population housing. These percentages are very high for a local jail,⁴² which by itself suggests the Jail inappropriately houses many prisoners in segregation for reasons other than safety, for example to manage behavioral issues associated with mental illness.⁴³ Our own observations from site visits corroborate this: the Jail houses many prisoners with mental illness in restrictive housing cells. Jail policy arguably sanctions this practice; a policy on managing prisoners with special needs inappropriately lists “mentally deficient” as a factor justifying placement of a prisoner in administrative segregation.

When prisoners are unable to function in general population because of their unmet mental health needs, the Jail sends them to restrictive housing on administrative segregation.⁴⁴ We saw many examples of prisoners being transferred from general population to restrictive housing on administrative segregation, sometimes with a status of “AS/MH,” which stands for “administrative segregation / mental health.” Similarly, a prisoner might serve a short stay in restrictive housing, possibly for disciplinary reasons,⁴⁵ but then be held in restrictive housing for longer periods of time on administrative segregation. Examples of prisoners with serious mental illness confined for long periods in restrictive housing include:

- WW, who has unspecified schizoaffective disorder, was in the Jail approximately six times from 2014 to 2018 before his April 2019 booking. Twelve days after his April booking, he was moved to a restrictive housing unit. Even though his father on at least two occasions informed mental health staff that WW had serious mental illness and had recently attempted suicide, and even though he had been in the Jail multiple times before, the first time he was seen by a psychiatric nurse practitioner or psychiatrist or received any

⁴² The unusually high use of protective custody and administrative segregation may arise from deficiencies in the Jail’s classification system. The Jail does not have a classification plan, policies, or directives explaining how to make classification decisions, scheduled periodic review of classification decisions, nor specialized structured training for the supervisor who oversees the classification unit. Because of these deficiencies, prisoners assigned a classification often appear to carry that status indefinitely, as well as misclassifications.

⁴³ Prisoners may seek segregation for their personal safety, for example if they believe staff are unable to keep them safe in other areas. Protective custody status should receive periodic review.

⁴⁴ Prisoners with serious mental illness, for the most part, do not appear to be spending long periods of time in restrictive housing due to disciplinary infractions.

⁴⁵ The Jail seems to discipline prisoners informally by placing them on lockdown, but that placement is not noted in official discipline documents. See *infra* Section IV.C.2.

medication during his 2019 stay was in July 2019. On July 2, 2019, he reportedly had “paranoid delusions,” temporarily was placed in a safety cell, and received emergency mental health medication. He returned to a standard restrictive housing cell until he entered the JBCT program on July 23, 2019. He stayed in the JBCT program until September 2019, and he was rehoused in the Kansas mental health unit. However, due to an apparent “staff error,” he was not given his psychotropic medication for two months, which resulted in him decompensating and being moved again to restrictive housing. He was placed in a safety cell five times from mid-October through the end of November. From approximately mid-September 2019 until his release in December 2019, he remained in some form of restrictive housing.

- AC, who has schizophrenia, was first booked at the Jail on May 23, 2019. He was in restrictive housing from May 23, 2019 until July 15, 2019 when he was moved to Kansas for approximately three days before transferring to the JBCT. He remained in that program until transferring to a state hospital.
- AD was first booked at the Jail on March 22, 2019 and designated “AS/MH,” though she was released that same day. On May 10, 2019, she returned to the Jail and was again classified “AS/MH.” Custody staff noted she was “still goofy and paranoid,” and sent a request to mental health for an evaluation. She was placed in restrictive housing for 20 days. On May 30, 2019, she was re-classified to “GP/MH,” meaning “general population/mental health,” yet she remained in the same restrictive housing unit. On July 10, 2019, she went to the PHF to regain competency to stand trial. When she returned, she was housed with a cellmate, but she remained in a restrictive housing unit.
- AE was first booked at the Jail in October 2016 and immediately designated “AS/MH” because he was “found mentally incompetent . . . in 2013,” “passive aggressive,” and “acting a fool.” He was placed in restrictive housing. He left custody a few days later, and returned in early November 2016, when he was again made “AS/MH.” He was placed in a safety cell for a day, and then in restrictive housing. He remained in restrictive housing until his release in early 2017. In 2018, he returned to the Jail and again was designated “AS/MH” and placed in restrictive housing. In February 2019, he was again booked at the Jail for probation violations and again classified as “AS/MH,” yet classification staff never interviewed him and there was no explanation for this determination. He was transferred to the PHF in May 2019, by which time he had decompensated, with mental health care staff observing he was “disorientated and floridly psychotic.” As a result, staff determined that transport to the PHF was necessary (and used pepper spray and restraints in making this move). For each of his four stays at the Jail—which totaled approximately 11 months from October 2016 through June 2019—he was in restrictive housing.
- In December 2017, AF entered custody and was assigned “AS/MH” and housed in restrictive housing, where he remained for nearly five months. In May 2018, the Jail sent him to a state psychiatric hospital for treatment, noting he had no discipline, safety concerns, or custody issues. The Jail placed him back in restrictive housing when he returned in November 2018. Nearly three months later, classification staff discussed moving him to a less restrictive unit with programming. He expressed concern about being housed with a cellmate, but otherwise was interested in the move. Classification staff indicated they would check with him again in a few days. There is no record that they did so. Instead, AF remained in restrictive housing for another two and a half months before his release.

In addition to being subjected to the physical conditions described above for prolonged periods of time, prisoners with serious mental illness in restrictive housing do not receive adequate mental health care. Documentation reflects that they do not receive meaningful out-of-cell activities such as individual and group therapy, health education groups, or unstructured activities that allow for social interaction. Prisoners there often do not receive out-of-cell or confidential treatment sessions. Instead, the only face-to-face contact mental health staff have with prisoners in restrictive housing often consists of staff walking to each cell and asking how the person is doing and whether they have any issues through a crack at the hinge of the solid metal door or through a food port opening. These conversations are often in the presence of custody staff, which makes it difficult to ensure confidentiality and hinders mental health staff's ability adequately to identify and monitor prisoners with acute symptoms in need of intervention.

The deficiencies in the Jail's provision of mental health services, discussed *supra* Section IV.B, contribute to the Jail's use of restrictive housing, including administrative segregation, because the Jail's inability to provide adequate mental health treatment, programming, and medication management exacerbates prisoners' mental health issues. In addition, as described in the previous paragraph, mental health staff are not given the support that they need to address effectively the mental health needs of prisoners in restrictive housing with serious mental illness.

The Jail does not aggregate or analyze data it keeps on the number of prisoners with serious mental illness held in restrictive housing, their length of stay there, or the number of repeated placements there. This absence of data analysis impedes the Jail's ability to correlate stays in restrictive housing to incidents of harm and mental health deterioration. The Jail also does not appear to aggregate or analyze the number of suicide threats or self-inflicted injury incidents to look for correlations between restrictive housing and these incidents or transfers.

In sum, the Jail's placement of prisoners with serious mental illness in prolonged restrictive housing under conditions including the denial of access to adequate medical and mental health care exposes them to a substantial risk of serious harm.

2. Jail Staff Inappropriately Use Isolation and Discipline Against Prisoners with Mental Illness Without Consulting Mental Health Staff

The Jail lacks an adequate system for managing and housing prisoners with mental illness. As a result, it appears that the Jail relies on inappropriate disciplinary sanctions, such as restrictive housing, to manage prisoners who manifest symptoms of serious mental illness or experience mental health crises.⁴⁶

The Jail's prisoner discipline process is deficient, particularly for prisoners with mental illness. When making the decision to house prisoners with known or apparent mental illness in "lockdown" for possible disciplinary reasons, Jail staff typically do not appear to give prisoners the procedural protections to which they are entitled.⁴⁷ *See Wolff v. McDonnell*, 418 U.S. 539, 563–67 (1974) (holding that procedural due process protections required in a disciplinary proceeding

⁴⁶ This may partially result from the absence of a housing plan at the Jail, without which the Jail cannot determine the number of beds needed for prisoners with special medical or mental health care needs, or for prisoners of different security levels.

⁴⁷ In nearly all files where classification make a notation of "LD" or lockdown for a possible disciplinary reason, there are no records of any disciplinary notice, hearing, or adjudication of that lockdown. Nonetheless, Jail staff frequently indicate that lockdown is eventually lifted with a notation, "times up," giving the appearance of discipline though there was no official discipline.

include written notice, time to prepare for the hearing, and a written statement of decision, among other things). Prisoners reported that staff do not inform them of their rights in the discipline process, including the right to call witnesses. Classification staff conduct discipline “hearings” in the housing units in sight of other prisoners. Prisoners we interviewed did not believe they had sufficient privacy during these encounters. Disciplinary actions also are not tracked in any systematic way, and the Jail appears not to maintain any aggregated data about disciplinary actions, appeals, types of charges, or outcomes (such as guilty, not guilty, or dismissed).

The sergeant who oversees the Jail’s classification unit and is in charge of discipline told us that he and his staff do not consult with mental health staff before imposing discipline against prisoners on the mental health caseload. He also told us that he was unsure about the intersection between discipline and mental health. This practice of failing to consult with the mental health staff before disciplining these prisoners has resulted in sanctions imposed by the Jail against prisoners with mental illness, effectively punishing behavior that may be a manifestation of mental illness without adequately considering mental illness as a mitigating factor or the potential deleterious effects of discipline on a prisoner’s mental health. Failure to consider the impact of mental health before imposing discipline is particularly concerning given the additional lapses in protection for prisoners with mental illness that we have identified, such as inconsistent use of mental health alerts in prisoner records, and failure to re-assess classification levels. Moreover, some of the routine discipline imposed, such as taking away visiting privileges, appears to have little impact on prisoner behavior, and could exacerbate mental illness.

Custody staff also subject prisoners with mental illness to informal “lockdown” discipline, confining prisoners to their cells with a very limited amount of out-of-cell time compared to what is allowed in their housing area, or temporarily placing them in a restrictive housing unit.

Staff’s use of lockdown as an informal disciplinary tool causes harm to some of the Jail’s most vulnerable prisoners, including those with mental illness.

3. Prisoners with Serious Mental Illness Have Suffered Serious Harm as a Result of the Jail’s Use of Restrictive Housing Under Current Conditions

The Jail’s overreliance on restrictive housing to manage prisoners with serious mental illness has subjected many prisoners to serious harm, including in some cases death. For example, DD, discussed *supra* Section IV.B.2.c, killed himself while housed in a restrictive housing cell with no suicide-preventative property restrictions. CC, discussed *supra* Section III.B, died of a pulmonary embolism after decompensating severely (including covering himself in and eating his own feces) over a period of weeks in restrictive housing, being transferred to the PHF, and then returning to restrictive housing where he again decompensated, exhibited signs of depression, and had virtually no physical activity.⁴⁸

The County also inappropriately uses restrictive housing to manage prisoners who have recently attempted suicide or engaged in acts of self-directed violence. Prisoners who have been housed in restrictive housing for prolonged periods frequently engage in acts of self-harm. The Jail sends these prisoners to a psychiatric facility, such as the PHF, or places them in a suicide-resistant safety cell. Afterward, they are frequently returned to restrictive housing environments—for many prisoners, the same environments in which they had just engaged in self-harm. Examples include the following:

⁴⁸ See also the case of AA, discussed *supra* Section III.B.

- A prisoner with unspecified psychosis, AG, was admitted to the Jail in early June 2019. He was placed in a restrictive housing cell, where he removed his clothes and remained naked for several days. Five days after admission to the Jail, he submerged his head in his toilet and began ingesting water. Staff removed him and placed him in a safety cell. Upon his release from the safety cell, he returned to restrictive housing, where he remained until he entered the JBCT in August 2019. In January 2020, he decompensated and was put back in restrictive housing where he stayed for the next five months.
- A prisoner with major depressive disorder admitted in July 2019, AH, cut her wrists with a spork and tied a towel around her neck in her cell. She was sent to the PHF, and returned to the Jail about a week later. Two days after her return, she tied another item around her neck, and Jail staff placed her in a safety cell. When she was released from the safety cell, she was kept in restrictive housing until her release about two weeks later.
- In May 2019, AI, a prisoner with bipolar disorder wrapped a torn towel around his neck and tied it to the bars of his cell, and then sat in a position to tighten the noose. A cellmate reported him to custody, and he was placed in a safety cell. Two days later, he was housed in a step-down cell where he remained for almost a month.
- In February 2019, AJ, a man with schizophrenia and bipolar disorder, entered custody and was immediately placed in a safety cell. When he left the safety cell, the Jail placed him in a lockdown cell, where he remained for nearly a month with the exception of four safety cell placements. In late March, he went to the PHF, and on his return custody staff put him back in restrictive housing, noting “Don’t think he’s cured, but I’m not a doctor.” He remained in restrictive housing for about three weeks, during which time he had an additional safety cell placement, and then was placed in a lockdown cell for nearly a month. Then, the Jail moved him to less restrictive housing in the Kansas Jail in May 2019. Based on his classification records, there were fewer incidents such as safety cell placements after the move to the Kansas Jail.

Mental health staff are responsible for monitoring prisoners in administrative segregation, but the process is not adequately supervised and mental health staff are not empowered to take action if prisoners appear to be decompensating. LPTs are supposed to do checks of administrative segregation cells. One clinician who did the administrative segregation checks said she would see 50–60 prisoners per shift in addition to handling various other duties, meaning her evaluations could not have been more than a few minutes per prisoner.⁴⁹ Prisoners who are asleep or unresponsive during the rounds typically receive no evaluation at all, impeding staff’s ability to evaluate whether they might be decompensating or at risk of self-harm. Indeed, the mental health program manager admitted that she did not review the checks to see if they were done consistently with policy, and that she was unsure what the policy was.

Prisoners with serious mental illness have suffered harm as a result of being kept in restrictive housing with inadequate monitoring by staff. In many cases, such as with AR described *infra* Section IV.D.1 and with AT described *infra* Section IV.D.2, prisoners in restrictive housing have decompensated, resulting in staff using force that could have been avoided had the prisoner not decompensated.

⁴⁹ The clinician reported that her assessments were about 10 minutes per patient. Mathematically this cannot be accurate, as it would mean she spent nine to 10 hours doing the administrative segregation rounds, in addition to her other responsibilities, including several hours of documentation and reviewing sick call slips submitted by prisoners.

4. Officials at the Jail Knew of the Substantial Risk of Serious Harm and Disregarded It

The death of AA in January 2017 put Jail officials on notice of potential risks that prolonged restrictive housing posed to prisoners with serious mental illness, such as further mental health deterioration, as described *supra* Section III.B. See *Hope*, 536 U.S. at 738–45 (disregarding an obvious risk to prisoner health and safety shows deliberate indifference); see also *Palakovic v. Wetzel*, 854 F.3d 209, 226 (3d Cir. 2017) (finding that it is an “obvious reality that extended stays in solitary confinement can cause serious damage to mental health”). Yet, the Jail has failed to take sufficient steps to eliminate systemic inadequacies in its treatment of prisoners with serious mental illness, evincing deliberate indifference to prisoner health and safety. The Jail continues to place prisoners with serious mental illness in restrictive housing for extended periods, where they are isolated in their cells for the majority of the day, not provided programming or adequate mental health treatment, and not monitored for signs of decompensation, which has resulted in serious consequences like those suffered by CC, DD, AG, and AH. See *supra* Sections III.B., IV.B.2.c, IV.C.3. That the Jail has not even analyzed the data it has on the length of time prisoners with serious mental illness spend in restrictive housing evidences a deliberate disregard of the risks presented by placing these prisoners in restricted housing under current conditions.

D. The Jail’s Failure to Prevent, Detect, or Correct Excessive and Inappropriate Uses of Force Violates the Constitutional Rights of Prisoners.

The Department has reasonable cause to believe that, in the totality of the circumstances described below, the Jail has engaged in a pattern or practice of failing to protect prisoners adequately from harm or the serious risk of harm due to the use of excessive force by staff.

As described *supra* Section IV.A, prison officials violate the Eighth Amendment’s prohibition against cruel and unusual punishment where prison officials are deliberately indifferent to a substantial risk of serious harm to prisoners. *Farmer*, 511 U.S. at 828; see also *Bell*, 441 U.S. at 545 (noting that pretrial detainees are entitled to at least equal protections under the Fourteenth Amendment). This includes punishments “which involve the unnecessary and wanton infliction of pain.” *Estelle*, 429 U.S. at 102–03 (internal quotations and citations omitted); *Rhodes*, 452 U.S. at 346. Prisons are required under the Eighth Amendment to protect prisoners from a range of types of harm and serious risk of harm and to take reasonable measures to provide for prisoners’ safety. *Farmer*, 511 U.S. at 832; *Helling v. McKinney*, 509 U.S. 25, 33–35 (1993). The Eighth Amendment prohibits infliction of pain that is “totally without penological justification.” *Rhodes*, 452 U.S. at 346; *Hoard v. Hartman*, 904 F.3d 780, 787–88 (9th Cir. 2018). Force may be necessary when a prisoner is noncompliant or if needed to gain control, but the use of force must stop when the need to maintain or restore control has expired. *Skrnich v. Thornton*, 280 F.3d 1295, 1304 (11th Cir. 2002); see also *LaLonde v. City of Riverside*, 204 F.3d 947, 961 (9th Cir. 2000) (applying Fourth Amendment excessive force standard); *Padilla v. Beard*, No. 2:14-cv-1118 KJM-CKD, 2017 WL 1253874, at *23 (E.D. Cal. Jan. 27, 2017) (collecting cases applying *LaLonde* to Eighth Amendment excessive force analysis). The use of excessive physical force against a prisoner may constitute cruel and unusual punishment even if the prisoner does not suffer serious injury. *Hudson v. McMillian*, 503 U.S. 1, 9 (1992); *Hoard*, 904 F.3d at 788; *Martinez v. Stanford*, 323 F.3d 1178, 1184 & n.2 (9th Cir. 2003).

1. Staff Use Force Regularly Where Unnecessary or to a Greater Degree than Necessary

Custody staff use force frequently against prisoners in circumstances where force is unnecessary, use a greater degree of force than necessary, and create circumstances necessitating the use of force against prisoners. In numerous instances, custody staff have deployed force on prisoners rather than first seeking their compliance by voluntary means. Prisoners who curse at deputies or disobey minor routine instructions—e.g., to stop yelling or kicking a cell—are often subjected to force even when the force is unnecessary to ensure safety. Below are several examples:

- In December 2018, AK yelled at deputies while secured in a caged area. Three deputies unlocked the door, and AK calmly exited. One deputy grabbed the unresisting AK from behind and pushed him headfirst into a wall, causing him to bleed. The deputy lied about the force in the incident report, stating that AK pulled away and “fell forward” toward the wall.
- In November 2018, a deputy reported “plac[ing]” AL against a wall to “gain better control of him” because he was complaining the handcuffs were too tight. AL filed an excessive force complaint that same day. When interviewed approximately two months later, the deputy stated for the first time he needed to “push” AL because AL “abruptly turned his head around, as if to face” the deputy.
- In May 2018, AM was allegedly kicking his cell door. Deputies opened his cell and lifted him by his elbows after cuffing his hands behind his back and dragged him at least 30 feet to a wheelchair. There was no documented reason for staff’s failure to bring him his wheelchair instead of dragging him to the chair.

Jail staff also have used a hair-pull takedown on a prisoner, AN, who posed no immediate threat. A senior deputy asked AN to exit her cell in the Jail’s intake area. She came out of her cell without wearing a top or bra, spoke with the senior deputy and another individual in plainclothes for several seconds, and then turned around and walked back into the cell she just left. As AN reentered the cell, the deputy followed her, and then—apparently unprovoked and without warning—snatched AN by her hair while she was facing away from him, and rapidly pulled her onto the ground. A sergeant and another deputy stood behind the senior deputy as he brought AN to the floor. This sequence occurred in less than a second. The senior deputy, with the other deputy’s assistance, then dragged AN by her hair into the adjacent cell. This action, also rapid, occurred within just a few seconds.

Custody staff also routinely use force on prisoners even when they are restrained or complying with instructions, such as with AK described above and AT described *infra* Section IV.D.2. In another example, AO allegedly cursed at two deputies from inside his cell. The senior deputy grabbed the prisoner by the neck and repeatedly shoved him against a wall and to the ground even though AO exited his cell with his hands behind his back. The senior deputy then pulled AO onto his feet and escorted him in the “chicken wing” hold⁵⁰ while handcuffed. The senior deputy then inserted his right thumb and applied pressure to the soft tissue under AO’s jaw

⁵⁰ The “chicken wing” hold is a control hold used to gain compliance with resistive prisoners. While a prisoner is handcuffed behind their back, a deputy places his arm underneath the prisoner’s armpit or elbow and lifts up the arm, forcing the prisoner on their toes.

while waiting for a gate to open even though AO was handcuffed and complying. After the gate opened, the senior deputy escorted AO while applying pressure against his neck and keeping him in the “chicken wing” hold for several hundred feet to another part of the Jail. At no point in time did AO appear to resist. Over a dozen custody staff observed and followed after the senior deputy as he escorted AO in this fashion—apparently abandoning their posts—but no one intervened.⁵¹ Then, after AO was seated by himself in a different cell, he twice banged the back of his head against the wall. Approximately one minute passed without further head banging, and then nine deputies, at a sergeant’s direction, entered the cell and placed him in the WRAP where he remained for one hour. The Jail found that the deputy who grabbed AO’s neck used excessive force, but the Jail did not examine other issues related to the force incident, including the bystander deputy’s failure to intervene despite being required to do so pursuant to policy, or the over a dozen custody staff who abandoned their posts yet failed to intervene. Critically, the Jail did not examine whether the sergeant’s direction to place AO in the WRAP was appropriate or retaliatory, even though video footage belied custody staff’s written statement that it was necessary to stop “self-destructive behavior.”

Custody staff often unnecessarily enter the cells of prisoners who are exhibiting bizarre behavior or who are known to be unpredictable even when there is no urgent need to do so, thus creating situations in which force becomes necessary. In each of the examples below, custody staff appeared to resort to force before exhausting alternatives such as de-escalation, yet in not a single instance did supervisors raise concerns or retrain staff:

- In January 2019, a deputy brought AP, who had been acting bizarrely, into a meeting room with plastic chairs and a table, and took off his handcuffs at the entrance of the room. AP wriggled free from the deputy’s grasp and walked toward the center of the room. The deputy—who was standing just outside the entrance, and could simply have sealed AP inside the room at this time—instead took out his OC, or pepper, spray, walked through the door toward the prisoner, and aimed the OC spray at him. AP then picked up a plastic chair inside the room, apparently in a defensive stance. The deputy then attempted to spray AP with the OC spray several times, but AP apparently deflected the spray with the chair. The deputy then took out his Taser and aimed it at AP for about a minute before finally exiting the room through the open doorway and sealing the door behind him. In their review, command staff did not criticize the deputy for failing to exit the cell earlier, which would have made the deployment of OC spray and brandishing of the Taser unnecessary.
- In October 2018, AQ was in a cell in the Jail’s strip-down area. He refused to take off his clothes as instructed by a deputy, and then allegedly raised his hands in a “fighting stance” while looking toward one of the deputies. The deputies—who were outside the cell—then entered the cell to secure AQ. They performed a takedown, and AQ alleged that a deputy punched him. AQ sustained injuries to his chin, upper cheek, and right ear. The use-of-force investigation did not examine why the deputies entered the cell rather than simply shutting the cell door with AQ inside and attempting to de-escalate.

⁵¹ A deputy who watched the senior deputy apply handcuffs and the pressure point technique stated that AO did not appear to be struggling during this incident. In addition, a sergeant filed a complaint against the senior deputy. The Jail investigated the incident, determined the senior deputy had used excessive force and falsified a report about the incident, and demoted him.

- In July 2018, a deputy instructed AR, a prisoner known by custody staff to have a mental illness, to remove disposable trays and empty milk cartons he had been hoarding in his cell. AR refused and cursed at the deputy. The deputy recognized that AR was not a threat but rather an “inmate with mental health issues having a crisis.” But rather than contact mental health staff, he radioed for backup and ordered AR to the ground. When AR did not comply, the deputy took out his OC spray and ordered AR again to the ground. According to the deputy, AR initially complied but then stood back up and took a threatening stance. The deputy was in the doorway and AR was in the back of his cell, so the deputy could have simply closed the cell door. Instead, he sprayed AR three times with OC spray for three seconds each. Staff then handcuffed AR, removed him, and placed him in the WRAP. The force was found to be within policy.

For many uses of OC spray documented by staff in jail incident reports or use-of-force reports, staff have failed to document whether they decontaminated affected prisoners. And in some of the documented instances, decontamination was delayed for at least one hour. In one jail incident report, staff appeared to justify not decontaminating prisoners in a housing area affected by OC spray, writing that a nurse had “advised that all other inmates housed in the 513 pod did not have a recorded history of respiratory issues should [OC] be utilized.” Failure to decontaminate prisoners after the use of OC spray can cause unnecessary pain, respiratory issues, and chemical burns, and thus can be extremely dangerous.⁵²

Jail staff appear to use Tasers in ways that create or increase risk of harm to prisoners.⁵³ For example, in November 2018, AS was injuring himself with a spork in his cell. Custody staff entered his cell after he refused to stop, grabbed his right arm, put it in a lock behind his back, and then laid him down on the ground. He refused to put his left hand behind his back. Although he was face down on the floor at this point, and a total of eight custody staff were in his cell, a sergeant and then a deputy repeatedly used Tasers on him. Reports stated that an emergency transport took him to the emergency room with no further explanation. The reports mentioned no efforts to de-escalate or secure compliance before staff deployed force, and gave no justification for using the Taser, much less multiple Tasers.⁵⁴

Custody staff also employ dangerous techniques when using force, which supervisors do not question even though they risk causing death or substantial injury to prisoners. For instance, in August 2018, a Custody Emergency Response Team (CERT)—which the Jail uses to perform cell extractions, handle major disturbances, and secure prisoners in restraints—used OC spray on, and then extracted, AT from his cell after he shoved urine and feces under his cell door. AT voluntarily placed his hands through the food port and allowed staff to handcuff him. The CERT team opened the door while AT’s hands were in the food port and pulled his legs straight out with

⁵² Relatedly, as discussed *infra* Section IV.D.2, staff almost always place prisoners in the WRAP without first consulting with medical staff.

⁵³ The County’s IAPro database reported just one use of the Taser in a use of force between March 15, 2016 and August 27, 2019. It is unclear whether this figure is intended to include instances in which the Taser is brandished but not discharged. The reports we reviewed included one instance in which a Taser was used on a prisoner, and another in which the Taser was brandished but apparently not used.

⁵⁴ The use-of-force investigation found that the force was within policy, though command staff recommended retraining because they concluded that staff should have used options less lethal than the Taser. No remedial actions were identified. The report does not address how the force could have been within policy if in fact less lethal force should have been used.

his body suspended. While AT's body was elevated, a deputy folded his legs, put them on the ground, and then placed his knee on AT's upper legs and applied his body weight as pressure. AT, whose torso was still suspended, cried out in pain, expressed concern about his back or bones breaking, and repeatedly asked to be restrained normally. But the deputy did not lift his knee. While AT remained partially elevated and cuffed in the door, custody staff stretched out his body and placed him in a WRAP.⁵⁵ The food port appears to have been used in a similar fashion in at least one other instance in August 2018.

In some instances, the sheer number of staff involved in uses of force against prisoners creates a substantial risk of harm to prisoners.

- In a December 2018 incident, a group of six deputies participated in a takedown, with at least three using their bodies to pin AU face down on the ground. Then, after the deputies appeared to have AU under control on the ground, one of the deputies slowly took out his OC spray and—about one foot from AU's face—sprayed it in his eyes.
- In one December 2016 incident, a total of 11 deputies and two sergeants were involved in a takedown of AV during which they struck him four times, including at least two strikes to the head, to “gain [his] compliance,” and then started to place him in a WRAP, possibly compromising his circulation. After partially restraining AV in the WRAP, the custody staff discovered that he was unconscious and not breathing, necessitating emergency hospitalization.⁵⁶

2. The WRAP Is Frequently Used Unnecessarily, and Staff Fail to Document It as a Use of Force

The Jail's “Use of Restraints” policy defines the WRAP as a restraint device consisting of “polyurethane soft restraints, waist restraints.”⁵⁷ Custody sergeants explained to us that prisoners typically resist WRAP placements. A use of force includes the application of control techniques against resistive prisoners. Staff explained that, to be placed in a WRAP, custody staff first lay a prisoner face down on the floor and cuff the hands behind the back. Usually at least two deputies use their body weight to keep the prisoner pressed against the ground, one securing the head and torso and another securing the legs to prevent kicking. Ankle straps are used to secure the feet, and then the bottom half of the WRAP is secured around the length of the legs as tightly as possible. Custody staff then apply the top half of the WRAP to the upper portion of the body, fitting it over the head and fastening it with a carabiner to handcuffs behind the back.



Custody then rolls the prisoner face-up, places the prisoner in a sitting position, and uses buckle

⁵⁵ At the time the use-of-force report was prepared, the sergeant (whose job was to determine whether the force was justified) noted he was unable to view video camera footage and only viewed surveillance video. However, the video camera footage in fact did depict the cell extraction, although much of it is hard to see because of the number of deputies standing around the prisoner. In addition, unlike the surveillance footage, it is the only footage that contains sound. Despite not reviewing the video camera footage, command staff determined the force to be within policy.

⁵⁶ Command staff recognized that there were training deficiencies with this force episode, noting that fewer staff should have entered AV's cell. But they nonetheless found the force to be within policy.

⁵⁷ The image is of a SLO Jail prisoner in the WRAP on January 17, 2018.

straps to fasten the top portion of the WRAP (around the torso) to the lower portion (around the legs) as tightly as possible. Custody may also apply a helmet to the head.

The Jail reports using the WRAP approximately 14 times each month. The WRAP presents an extreme risk of harm to prisoner health and safety. Placing a prisoner in a WRAP is dangerous because it restricts blood circulation and respiration, as well as causing pain and discomfort. Thus, certain prisoners, such as those who are geriatric or pregnant, generally should not be placed in a WRAP; if they are, policies and practices should account for their special needs. Nor should it be a way to manage prisoners who are experiencing psychosis or intoxicated. There should also be an evaluation as to whether prisoners with physical or mental disabilities can safely be placed in a WRAP. However, the Jail's Health Services Administrator and Wellpath's Regional Director of Mental Health informed us that they were not aware of any contraindications to WRAP placement. Indeed, they explained that medical staff are not consulted until *after* a prisoner is already in the WRAP.⁵⁸ Nationally accepted practices require that mental health be consulted before use of a four-point restraint like the WRAP when possible yet the Jail has no policy requiring their involvement pre-WRAP use.

Despite the risks posed by use of the WRAP, staff training is deficient and inconsistent with County policy. The policy and training-course outline contemplate that the WRAP can be used indefinitely, although the policy requires approval from the "Sheriff via chain of command" in conjunction with healthcare staff before extending beyond two hours, and the training-course outline states prisoners must receive medical checks "no later than four hours after placement" and "every six hours thereafter," and that a mental health consultation must occur "no longer than 8 hours from time of placement." The training materials do not refer to the policy requirement that prisoners be removed from the WRAP after two hours unless the Sheriff personally approves an extension.

Custody staff typically do not consult with medical or mental health staff prior to a WRAP placement to determine whether prisoners have a health contraindication that would make it dangerous. Custody staff also rarely call on medical staff to evaluate or assess prisoners before using the WRAP.⁵⁹ They also do not coordinate with mental health personnel to de-escalate prisoner behavior and thus avert the need for the WRAP. Indeed, many of custody staff's narrative descriptions supporting WRAP placement describe prisoner behaviors consistent with mental illness such as "erratic and unpredictable behavior" and "paranoia," yet there is no indication that mental health staff were consulted. This points to a potential failure to connect prisoners in crisis with critical mental health care, which is all the more troubling because WRAP placements themselves can cause adverse mental health effects.

The Jail frequently uses the WRAP on prisoners who are experiencing a mental health crisis, and after the WRAP has been applied, medical staff often administer emergency antipsychotic medications.⁶⁰ Sometimes, this appears to occur at the direction or request of custody

⁵⁸ We are aware of at least one instance in which a prisoner was placed into a WRAP despite complaining about chest pain. That prisoner went to medical staff because he had chest pain and, according to medical records, told the nurse that it "fe[lt] like my heart stopped," but was placed in a WRAP after making a passing comment to the nurse about wanting to bang his head.

⁵⁹ Only a single WRAP record we reviewed reflected that medical staff evaluated a prisoner before WRAP placement.

⁶⁰ Moreover, because the use-of-force policy permits staff to use force against prisoners to prevent destruction of property, staff routinely use WRAP placements against prisoners for potentially destructive behaviors including hitting cell doors that may implicate mental illness.

staff. Indeed, psychiatrists appeared to receive pressure from custody staff to authorize emergency medications for prisoners in the WRAP with mental illness to make them more manageable. Other times, a nurse administers emergency psychotropic medication without documented consultation with a psychiatrist.

In addition, contrary to policy, custody staff use the WRAP to restrain prisoners who are not exhibiting any self-injurious or destructive behavior. Frequently, custody staff justify the WRAP by referring vaguely to “uncooperative” or “resistive” conduct. Some examples include a prisoner being escorted to a cell who “stopped and began resisting . . . efforts to control him”; a prisoner “showing signs of paranoia and . . . actively resisting”; a prisoner who was screaming and “fail[ing] at following directions”; a prisoner “show[ing] no signs . . . of cooperation” and “continu[ing] to shout profanities”; and a prisoner arrested for public intoxication who refused instructions to enter the Jail and to kneel.

Furthermore, the majority of the WRAP placement records we reviewed did not reveal that a danger to prisoners or staff was present. In over a quarter of the cases we reviewed, the prisoner conduct concerned little more than potential (but unlikely) property damage, such as kicking cell doors or hitting cell windows with their hands. And in several other cases, custody staff used the WRAP after a prisoner’s unpredictable or uncooperative conduct had ceased and the prisoner was calm and cooperative. Examples include:

- A sergeant told AW who was yelling and punching his cell wall to stop, or else he would be OC sprayed. AW stopped, and then followed instructions to be handcuffed through the food port of his cell door. Staff then took him to IRC and placed him in the WRAP.
- A CERT team summoned to extract AT from a cell ordered AT to place his hands through the food port to be handcuffed. AT complied, and also complied with instructions to get down on his knees. Staff opened the cell door while he remained in the kneeling position with his hands through the food port, and then placed the lower half of his body in the WRAP.⁶¹
- AX shattered a glass window in his cell with a metal drawer from beneath his bottom bunk. The responding deputy noted that AX seemed angry at first, but by the time deputies entered his cell several minutes later, he had calmed down and was cooperative. Although he appeared to pose no further threat to himself or jail property, custody staff still placed him in a WRAP.

In addition, several records we reviewed reflected prisoners being sprayed with OC shortly before or while being placed in the WRAP. The combination of OC and the WRAP can have a grave effect on a prisoner’s medical condition and ability to breathe.

By accepting vague and uncertain grounds such as prisoner uncooperativeness or resistance to justify use of a WRAP, jail supervisors cannot assess whether WRAP applications are actually justified, especially given that use-of-force reports are rarely generated. This compromises accountability and enables staff to use the WRAP as a punitive device or for retaliation. The lack of medical and mental health assessments to determine whether the WRAP can be safely administered, lack of reporting and oversight, and apparent overutilization, makes the Jail’s use of the WRAP dangerous and likely to result in harm to prisoners.

⁶¹ See discussion *supra* Section IV.D.1.

3. The Jail's Policies, Training, Investigations, and Oversight Fail to Protect Prisoners from Harm

a. *The Jail's Policies and Training Provide Insufficient Guidance to Custody Staff*

Jail policies and training concerning jail operations, uses of force, and restraints are inadequate and fail to protect prisoners from the harm of excessive or unnecessary uses of force.

The use-of-force policy fails to give direction to staff or trainers. It provides no guidance about the types of situations that warrant a use of force, or the level of force allowed. Similarly, the policy permits carotid control holds⁶² to control a prisoner who is resisting or has the potential to harm others. The use-of-force policy also fails to list application of the WRAP as a use of force even though significant force is generally required to apply it. The lack of directives about force has given staff too little guidance about which circumstances warrant what level of force, which in turn poses a substantial risk of serious harm to prisoners.

Jail staff fail to comply with policies regarding use-of-force reporting. Although policy requires that every staff member who uses or observes force submits documentation (like an incident report), for almost every use of force we reviewed, there was just a single jail incident report prepared regardless of the number of deputies involved. Moreover, custody staff have differing understandings of what triggers the reporting requirement; many incorrectly state that jail incident reports are only required if a prisoner is injured, complains of injury, or threatens a lawsuit.⁶³

Beyond policy gaps and non-compliance, the Jail also fails to train its staff adequately regarding uses of force. There are significant inconsistencies between the Jail's policies and its training course outlines.⁶⁴ Staff are trained to use dangerous practices, such as a "hair pull takedown" that involves grabbing an individual's hair and pulling her off her feet.

b. *Staff Do Not Adequately Investigate Uses of Force*

Supervisory staff consistently fail to conduct adequate investigations when force is used. Investigations almost never include witness interviews, and reports do not even include a description of attempts to interview or record witnesses. Critical evidence including video footage is often ignored or omitted.

Other serious deficiencies were present in nearly half of the use-of-force files we reviewed. In many cases, such as with AK and AM described *supra* Section IV.D.1, clear inconsistencies between narrative accounts and video footage were unaddressed. In another example, video footage showed a 60-year old female prisoner, AY, who was 5'4" and 108 pounds, walking towards the cell door where a 6'3", 210-pound deputy stood. The deputy pushed her, causing her

⁶² With a carotid control hold, "an officer positioned behind a subject places one arm around the subject's neck and holds the wrist of that arm with his other hand. The officer, by using his lower forearm and bicep muscle, applies pressure concentrating on the carotid arteries located on the sides of the subject's neck." *City of Los Angeles v. Lyons*, 461 U.S. 95, 97 n.1 (1983). This hold can "render[] the subject unconscious by diminishing the flow of oxygenated blood to the brain." *Id.*

⁶³ Regarding complaints of injury, some staff said that jail incident reports are needed any time a prisoner complains of an injury, whereas others stated that reporting was required only if the prisoner's complaint of injury appeared reasonable based on the apparent level of force used.

⁶⁴ See *supra* Section IV.D.2.

to fall backward and hit the wall. The deputy reported that AY tried to rush past him and out of the cell.

In multiple reports, supervisory review failed to explore apparent policy violations, such as placing prisoners in WRAPs without any clear reason. Statements from staff involved in uses of force were omitted from multiple reports. Several reports showed investigators asking questions that seemed to assume—or were designed to establish—that the prisoners were at fault.⁶⁵ Additionally, reports lacked adequate follow-up investigation, including one that failed to resolve whether a deputy had used his Taser against a prisoner. Multiple reports failed to specify any remedial action despite acknowledging reasons for concern about officers' conduct.

The Sheriff's Office's handling of a complaint against a senior deputy who grabbed a female prisoner off her feet and dragged her along the floor by her hair is emblematic of many of these deficiencies. Although the senior deputy completed a jail incident report, a sergeant who witnessed the incident neither documented it in the sergeants' log nor prepared a use-of-force package, despite being required by policy to do both. Custody staff also did not summon medical staff to evaluate the prisoner even though policy required them to do so. The incident came to the Sheriff's attention, and the deputy who performed the hair-pull was ultimately fired. But before that happened, he was allowed to continue working with prisoners for several weeks, during which time he was involved in another use of force in which a prisoner was injured. No other individuals—such as the sergeant who failed to report the incident—received discipline. High-ranking members of the Sheriff's Office told us the reason no other staff were investigated was that the hair-pull incident was “optically bad,” but not in violation of Jail policy.

The Jail's failure to conduct adequate, objective investigations into uses of force or violations of the use-of-force policy places prisoners at significant risk. The failure to detect violations of policy and take appropriate remedial action fosters a culture that allows this behavior to continue.

c. *The Jail Lacks Adequate Accountability, Data Collection, Analysis, and Corrective Action to Protect Prisoners from Harm*

The Sheriff's Office does not adequately supervise or oversee investigations into uses of force to identify potential problem areas or trends, thus increasing the risk of harm to prisoners. Jail officials do not gather and analyze data about known uses of force and WRAP placements in a way that permits them to track patterns of staff misconduct, identify problem employees and supervisory issues, and identify corrective actions. The use-of-force database the Sheriff's Office maintains does not include many use-of-force reports and complaint investigations, and it contains inadequate or inaccurate information about the uses of force that are in the system. Because the Jail does not accurately capture use-of-force information in its database, there is no assurance that uses of force will be adequately reviewed or that appropriate corrective action will be taken.

Finally, even when the chain of command identifies policy violations or a need for training, there often is no documentation whether any remedial action was taken. This further impedes tracking of incidents and identification of systemic needs. The Jail fails to collect and analyze data

⁶⁵ For example, one investigator asked a prisoner at the beginning of the interview, “did you follow directions like a good inmate?” In another, the investigating sergeant asked why the staff had to put the prisoner on the floor. The same sergeant questioned another prisoner in English after the prisoner repeatedly attempted to speak Spanish. And another investigator pressed forward with an interview after the prisoner said he was not fit to proceed.

on critical issues, which is necessary for the development of corrective actions, employee intervention, and training improvements. Without this oversight, prisoners cannot be safe.

E. The Jail Denies Equal Access to Individuals with Disabilities

Title II of the ADA prohibits jails from excluding prisoners with disabilities from, or denying them the benefits of, the services, programs, or activities they offer other prisoners. 42 U.S.C. § 12132. This includes the obligation to “make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability. . . .” *Pierce v. County of Orange*, 526 F.3d 1190, 1215 (9th Cir. 2008) (internal quotations and citations omitted). Public entities on notice about an accommodation need are “required to undertake a fact-specific investigation to determine what constitutes a reasonable accommodation.” *A.G. v. Paradise Valley Unified Sch. Dist. No. 69*, 815 F.3d 1195, 1207 (9th Cir. 2016) (internal quotations and citations omitted). Failing to provide accommodations to individuals with disabilities, including mental health disabilities, may violate the ADA. *See, e.g., Merino v. County of Santa Clara*, No. 18-CV-02899-VKD, 2019 WL 2437176, at *11 (N.D. Cal. June 11, 2019) (holding that a jail could be liable for failing to provide accommodations under the ADA); *Leonard v. Denny*, No. 2:12-cv-0915TLN-AC-P, 2016 WL 43550 at *3, 7–8 (E.D. Cal. Jan. 5, 2016) (same).

Prisoners with mental health disabilities are excluded from many of the programs and services the Jail offers. Information provided to us about eligibility for various programs and services, ranging from mental health groups to education and work programs, showed that individuals with disabilities were excluded entirely from many—including construction maintenance, bicycle repair and maintenance training, culinary, and graphics arts—for no reason except disability. The sergeant and a civilian staff person who oversee Jail programs and services confirmed that individuals with disabilities were often excluded from programs and services, and offered explanations based on stereotypes or generalizations, for example stating that a culinary program was open only to prisoners who could work, and thus prisoners with disabilities were ineligible. They also told us that many programs and services were unavailable to prisoners with disabilities because only prisoners living in particular housing areas could participate, thus excluding, for example, prisoners with mental illness living in the Jail’s restrictive housing areas. Categorically excluding prisoners with disabilities from programs or activities such as work opportunities or outdoor recreation—including by housing them in areas that do not offer such programs, services, or activities—violates the ADA. *Pierce*, 526 F.3d at 1221 (stating “an inmate cannot be categorically excluded from a beneficial prison program based on his or her disability alone,” and that a jail “may not shunt the disabled into facilities where there is no possibility of access to [such] programs” (citing *Penn. Dep’t of Corr. v. Yeskey*, 524 U.S. 206, 210 (1998))).

In addition, the Men’s Honor Farm—a coveted housing area among prisoners with a work program and outdoor recreation space, to which prisoners must apply to participate—is unavailable to many prisoners who take any psychotropic medications or other medications that prisoners by policy are not allowed to self-administer, with only a single exception that we could identify. This practice inappropriately excludes many prisoners with mental health disabilities, including those who would have no difficulty performing work tasks at the Honor Farm and whose disabilities can be effectively managed with medication.

Prisoners with mental health disabilities are routinely placed in restrictive housing because of their disabilities. As discussed *supra* Section IV.C.1, custody staff routinely designate prisoners

as “AS/MH,” meaning administrative segregation/mental health. These prisoners are placed in restrictive housing by reason of their disability in violation of the ADA, because the prisoner’s mental health status is the Jail’s sole justification for placing the prisoner in restrictive housing. This is different from placing a prisoner in restrictive housing for a permissible disciplinary reason.

The Jail also appears to place prisoners in restrictive housing based on behaviors that are likely symptoms of their disabilities, in violation of the ADA. *See Latson v. Clarke*, 249 F. Supp. 3d 838, 856–57 (W.D. Va. 2017) (denying a motion to dismiss a prisoner’s ADA claim that prison officials discriminated against him on the basis of his mental health disabilities by placing him in restrictive housing for symptoms of his disabilities without a reasonable modification, and by denying him access to benefits while in restrictive housing). For example, the Jail kept an 84-year-old man with serious mental illness, in restrictive housing without privileges for over a year-and-a-half for rude conduct. In addition, staff have placed prisoners with known mental illness in restrictive housing for days and weeks as a “time out,” without offering them protections associated with the formal discipline process. As the examples *supra* Sections IV.C.1 and IV.C.2 show, Jail staff do not typically review whether prisoners with mental health disabilities should remain in restrictive housing, and thus prisoners with mental health disabilities can be and are housed in restrictive housing without temporal limit. *See Hewitt v. Helms*, 459 U.S. 460, 477 n.9 (1983) (explaining prisoners in isolation for extended periods must receive “some sort of periodic review” to verify that they “remain[] a security risk”).

The Jail does not place every prisoner with mental illness in restrictive housing. Indeed, after we expressed our concerns regarding the use of isolation against prisoners with mental illness in January 2019, the Jail made significant changes to its housing configuration so as to allow more male prisoners with mental illness to be housed in a less restrictive environment. *See* Section III.C. Moreover, the Jail places some prisoners with mental illness in restrictive housing for reasons other than their disability, which by itself does not violate the ADA. However, it remains that custody staff with minimal mental health training—and no mental health training specific to correctional facilities or training about correct classification assessments—make determinations about eligibility for mental health housing units and restrictive housing units. These determinations are not guided by written protocols or consultation with the Jail’s mental health staff.

Prisoners with mental illness who are placed in restrictive housing on the basis of their disability are—like all other prisoners in restricted housing—excluded from structured and unstructured programs and benefits offered to prisoners not in restrictive housing. This includes confidential mental health treatment (as opposed to cell-side clinician visits conducted within the hearing range of other prisoners and staff, which are available for prisoners in restrictive housing), group mental health treatment, substance use treatment programs, work and education programs, and opportunities to interact with other prisoners in a common space during meals or dayroom time.

To prevent discrimination on the basis of disability, jail officials must “make reasonable modifications in policies, practices, or procedures.”⁶⁶ For example, the Jail could make individual

⁶⁶ The ADA’s obligation to make “reasonable modifications in policies, practices, or procedures” is not limitless. A modification is not required if it would “fundamentally alter the nature of the service, program, or activity.” 28 C.F.R. § 35.130(b)(7)(i). The modifications described here would not “fundamentally alter” the Jail’s programs. The Jail already offers some services tailored toward prisoners with mental illness, including some mental health training for custody staff and some mental health treatment to prisoners. It even has some designated mental health units. In

exceptions to the policy that excludes prisoners taking psychotropic medication from participating in the Honor Farm, either by assigning a nurse to distribute those medications, or by allowing self-administration. It could provide more comprehensive mental health training for custody staff, more mental health treatment housing alternatives, or better mental health treatment and strategies for the prisoners that staff label as “mentally deficient,” rather than place them in restrictive housing because of behaviors related to their untreated disabilities. *See Brown v. Wash. Dep’t of Corr.*, No. C13-5367, 2015 WL 4039322, at *11 (W.D. Wash. May 13, 2015) (finding that placing a prisoner in a restraint chair for behavior that is related to his mental illness rather than “accommodating [his] mental illness with appropriate treatment” may indicate a “discriminatory response”), *report and recommendation adopted*, 2015 WL 4039270 (W.D. Wash. July 2, 2015).

V. MINIMUM REMEDIAL MEASURES

To remedy the constitutional and statutory violations identified in this Report, the County of San Luis Obispo should implement, at minimum, the remedial measures listed below. In listing these remedies, we note that over the course of our investigation the Jail has made changes to its personnel, policies, and procedures. We have taken those changes into account, but find they are inadequate to protect prisoners from the harms identified.

A. Medical Care

1. Revise Jail policies, procedures, and practices relating to intake, chronic care, continuity of care, sick call, access to medical care by those in restrictive housing, medical grievances, medication administration, and quality assurance, to ensure that prisoners receive adequate medical care.
2. Conduct a staffing study and increase medical staffing by hiring sufficient additional staff with appropriate credentials (e.g., MDs, RNs, and LVNs) and increasing the hours that current staff with higher credentials are onsite on evenings and weekends to ensure that prisoners receive adequate medical care.
3. Conduct a staffing study and increase staffing to ensure that there are sufficient staff to escort prisoners to the medical clinic for their appointments, and transport prisoners to outside medical appointments.
4. Ensure that adequate health assessments are provided.
5. Ensure that trained medical care providers conduct or review the complete health assessments performed on prisoners within their first 14 days in custody (or sooner if clinically indicated) in order to provide prisoners timely access to medical providers as clinically appropriate.
6. Ensure that prisoners’ acute and chronic health needs are identified in order to provide adequate medical care.
7. Ensure that prisoners with chronic conditions are routinely seen by a medical provider or specialist as clinically appropriate, and that needed laboratory studies are completed

addition, the Jail may “impose legitimate safety requirements necessary for the safe operation of its services, programs, or activities.” 28 C.F.R. § 35.130(h). However, those requirements must be “based on actual risks, not on mere speculation, stereotypes, or generalizations about individuals with disabilities.” *Id.* Thus, the reason for holding a prisoner with mental illness in restrictive housing cannot be based on speculation, stereotypes, or generalizations about individuals with disabilities. In addition, mental health staff should be consulted before placing a prisoner in restrictive housing to minimize the risk they will decompensate as a result.

- and evaluated to assess the prisoners' health status and the effectiveness of the medication and treatment.
8. Ensure that the Jail provides appropriate treatment to individuals who are HIV positive.
 9. Ensure that all women are screened for pregnancy at intake and that pregnant women receive adequate treatment while in custody.
 10. Ensure that prisoners have adequate access to appropriate medications without gaps in medication administration.
 11. Ensure that the medical request process for prisoners provides them with adequate access to medical care. This process should include logging, tracking, and timely responses by medical staff as clinically appropriate, and should include regular audits by Jail staff to ensure compliance with this process.
 12. Ensure that medical and sick call requests are appropriately triaged based upon the seriousness of the medical issue. Ensure that medical requests submitted in the form of a grievance or through another mechanism are appropriately triaged, even if submitted through improper channels.
 13. Provide for physician oversight, including periodic review of sick call, and adoption of nursing protocols and clinical assessment forms that guide the nurses performing sick call.
 14. Ensure that prisoners are provided with diagnoses for identified medical problems and that appropriate treatment plans are developed.
 15. Provide timely medical appointments, including appointments for specialty care outside of the facility.
 16. Ensure that prisoners receive appropriate testing and treatment that adequately addresses their serious medical needs in a timely and appropriate manner.
 17. Ensure that the Jail provides effective communication to prisoners who are deaf or hard of hearing, in particular with respect to addressing their health care needs.
 18. Ensure that all custody, medical, and mental health staff receive adequate preservice and annual in-service training on first-responder medical care, mental health care, and suicide prevention.
 19. Conduct timely and adequate multidisciplinary morbidity-mortality reviews for all prisoner deaths, including suicides and serious suicide attempts (i.e., suicide attempts requiring hospitalization). Ensure the senior Jail staff have access to all such reviews conducted by the Jail's medical or mental health provider.
 20. Ensure that the Jail's quality assurance program identifies and corrects deficiencies with the medical care system.

B. Mental Health Care

1. Ensure that all initial screenings are performed by staff who are trained to identify mental health issues and that appropriate care is taken to record accurately a prisoner's current medications.
2. Ensure that comprehensive health assessments of all prisoners are conducted within 14 days after their arrival (or sooner if clinically indicated), with a psychiatrist conducting the screening or overseeing RNs who conduct the screening.
3. Provide immediate treatment to prisoners who are suicidal or psychotic, as soon as those conditions are known to the Jail. Ensure timely access to mental health professionals when the prisoner is presenting symptoms requiring mental health care.

4. Ensure that all reasonable efforts are made to obtain a prisoner's prior mental health records from prior jail admissions and from community services boards or other community providers. Ensure that this information is incorporated into prisoners' medical charts.
5. Develop and implement policies and procedures to ensure prisoners with serious mental health needs receive timely treatment as clinically appropriate, in a clinically appropriate setting.
6. Ensure that appropriate, detailed treatment plans are developed for prisoners with mental health needs and implement procedures whereby treatment plans are regularly reviewed to ensure they are being followed.
7. Ensure that all prisoners with serious mental health needs have access to clinically necessary therapy and counseling.
8. Ensure access to inpatient-level care or other appropriate levels of care, as clinically necessary.
9. Ensure that conversations between mental health professionals and prisoners can be conducted in a confidential setting to allow for effective information sharing and treatment.
10. Provide adequate psychiatry coverage and psychiatry support staff in order to address prisoners' serious mental health needs timely.
11. Ensure that the psychiatrist conducts follow-up assessments, as clinically appropriate, with prisoners on any new psychotropic medications or change in medication dosage.
12. Ensure that psychotropic medications are ordered in a timely manner, are accurately delivered to prisoners on lockdown status, and are administered to prisoners in the correct dosages.
13. Ensure that medication administration records are regularly audited by Jail staff for completeness and accuracy.
14. Ensure that suicidal prisoners receive the level of care and housing classification appropriate to their acuity, as determined by a qualified mental health professional.
15. Ensure that suicidal prisoners receive adequate mental health treatment and follow-up care, including out-of-cell counseling as determined by a qualified mental health professional.
16. Provide quality, private suicide risk assessments of suicidal prisoners on a daily basis.
17. Ensure that the Jail's quality assurance program is adequately maintained and able to identify and correct deficiencies with the mental health care system.
18. Reduce the unnecessarily harsh nature of mental health watch. Removal of a prisoner's clothing (excluding belts and shoelaces), as well as use of physical restraints and shackles, and cancellation of routine privileges (e.g., showers, visits, telephone calls, recreation), should be avoided whenever possible, and only utilized as a last resort for periods in which the prisoner is physically engaging in self-destructive or assaultive behavior.

C. Restrictive Housing

1. Ensure that Jail policies, procedures, and practices regarding the use of restrictive housing for prisoners with serious mental illness comport with the Constitution.
2. Ensure that if a prisoner shows credible signs of decompensation in restrictive housing, the prisoner's mental health needs are assessed by a qualified mental health professional and promptly addressed.

3. Ensure that prisoners expressing suicidality or self-harming behavior are not placed, by reason of their suicidal ideation or self-harming behavior, in restrictive housing and instead are provided clinically appropriate mental health care except as provided by remedial measure C.4.
4. Ensure that custody staff consult with mental health staff before placing a prisoner in restrictive housing or discipline, to determine whether it is appropriate in light of the prisoner's mental health. If it is impracticable to consult with mental health staff before the placement, then mental health staff should evaluate the prisoner as soon as possible after placement to determine the appropriateness of the placement.
5. Conduct periodic review of all prisoners in restrictive housing to determine whether their housing is appropriate.
6. Report and review data regarding lengths of stay in restrictive housing, particularly with respect to prisoners with serious mental illness, and take appropriate corrective action.

D. Use of Force

1. Ensure Jail policies provide sufficient guidance on the use of force and what constitutes excessive force.
2. Modify use of force policies to:
 - a. Emphasize de-escalation as a first resort and clarify that force is to be used only after all other reasonable efforts to resolve a situation have failed.
 - b. Require that, where practical, physical force shall not be used until the following conditions have been met: (i) a warning or command has been given, and, if practical, repeated; (ii) the prisoner has had time to comply with the warning or command; and (iii) it appears that the prisoner is going to continue to resist the order or the staff's effort to control the situation.
 - c. Incorporate additional non-force alternatives, including crisis intervention methods and specific defusing techniques.
 - d. Contain explicit prohibitions on the following: (i) the use of force to retaliate against a prisoner; (ii) the use of force in response to a prisoner's verbal insults, taunts, or swearing; (iii) the use of force on a prisoner who is under control; and (iv) the use of unjustifiably painful escort or restraint techniques.
 - e. Contain an explicit requirement stating that "all force shall cease when control of the prisoner has been established."
3. Ensure that all staff are properly trained on policies and procedures surrounding use of force, including chemical agents, electronic control devices, and the WRAP, with particular emphasis on permissible and impermissible use of force, de-escalation techniques, alternatives to isolation and discipline, and use of force on prisoners with mental illness.
4. Ensure that staff adequately and promptly report all uses of force.
5. Consistent with *Garrity v. New Jersey*, and applicable law, require that any officers who have used or witnessed force submit a report or statement immediately after an incident occurs and before leaving for the day. The Jail should take measures to ensure that statements are prepared independently by affected staff, and not in consultation with anyone else.
6. Require that all incident reports describe any use of force, including what precipitated the event, the level of resistance encountered, and any attempts at de-escalation.

7. Prohibit use of the WRAP when a prisoner is not resisting or is compliant.
8. Require the creation of a use-of-force report for every WRAP placement.
9. In every use-of-force report for a WRAP placement, describe with specificity the behaviors leading to the use of the WRAP.
10. Develop a manual on how to conduct sergeant-level use-of-force investigations and train sergeants on conducting those investigations.
11. Ensure that use-of-force investigations include timely, thorough, and documented interviews of all relevant staff and prisoners who were involved in or who witnessed the incident in question, to the extent practicable.
12. Ensure that use-of-force investigations include all supporting evidence, including logs, witness and participant statements, references to policies and procedures relevant to the incident, physical evidence, body charts, photographs, and video or audio recordings.
13. Ensure that use-of-force investigations thoroughly document the basis for the investigator's finding, based on application of a preponderance-of-the-evidence standard.
14. Ensure that the Jail has a fully functioning objective classification system that reliably assesses a prisoner's risk of becoming either an aggressor or a victim of harm, including periodic review based on behavior within the Jail.
15. Develop and implement a system to track all uses of force by custody staff and any complaints related to the use of excessive force designed to alert the Jail administration to any potential need for retraining, problematic policies, or supervision lapses. The system shall be used to identify trends such as rates of use of force in general, as well as by unit, shift, time of day, prisoner, and staff member. The system should include an early-intervention component to alert administrators of potential problems with staff.
16. Conduct systemic reviews of use of force at least quarterly, in order to identify patterns or trends. The Jail should incorporate such information into quality management practices and take necessary corrective actions.
17. When there is evidence of staff misconduct related to excessive force against prisoners, initiate personnel actions and implement systemic remedies, as appropriate.
18. Develop procedures that will reduce reliance on chemical agents, electronic control devices, and the WRAP while still ensuring officer and prisoner safety.

E. Compliance with the Americans with Disabilities Act

1. Ensure that policies, procedures, and practices are reasonably modified and maintained so that prisoners with disabilities including mental illness are not unnecessarily placed in restrictive housing based on their disabilities.
2. Ensure that prisoners with mental illness who are in restrictive housing have the opportunity to participate in and benefit from services, programs, and activities available to prisoners without disabilities consistent with significant health or safety concerns.
3. Ensure that the Jail does not apply eligibility criteria that screen out or tend to screen out prisoners with disabilities from fully and equally enjoying the Jail's services, programs, or activities, unless the Jail demonstrates that such criteria are necessary for its provision of those services, programs, or activities.

VI. CONCLUSION

We have reasonable cause to believe that the Jail has engaged in a pattern or practice of resistance to rights protected by the Eighth and Fourteenth Amendments because it fails to provide prisoners with constitutionally adequate medical and mental health care, places prisoners with serious mental illness in restrictive housing for prolonged periods of time under conditions that violate prisoners' constitutional rights, and does not protect prisoners from use of excessive force. We also have reasonable cause to believe that the Jail violates the ADA by not providing individuals with mental health disabilities equal access to programming and services, and by placing prisoners with mental illness in restrictive housing because of their disability. We are obligated to advise you that 49 days after issuance of this letter, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies identified in this letter if State officials have not satisfactorily addressed our concerns. 42 U.S.C. § 1997b(a)(1). The Attorney General may also move to intervene in related private suits 15 days after issuance of this letter. 42 U.S.C. § 1997c(b)(1)(A). Please also note that this Report is a public document. It will be posted on the Civil Rights Division's website. We look forward to working cooperatively with the San Luis Obispo County Jail and its administrators and staff to ensure that these violations are remedied.