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To: Board of Supervisors
Public Safety and Justice Committee
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Cc: Jeffrey V. Smith, County Executive
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From: Michael Gennaco, OCLEM Project Manager
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Date: November 4, 2021

Subject: OCLEM Report on Custody Health's Review Process for In-Custody Deaths, Suicide Prevention Efforts, and Handling of Inmate Grievances

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Pursuant to the Work Plan approved by this Board in December 2020, OCLEM submits the following report on our work reviewing some areas of operation of Custody Health Services. We developed the plan for this work following this Board's direction to focus on those County offices with whom we have been able to reach an information-sharing agreement.

This report focuses on three areas of review that have significant implications for inmate welfare and operational effectiveness in the custody environment: Review process for In-Custody Deaths, Suicide Prevention efforts, and handling of Inmate Grievances related to medical service or care.[1] Our review centered on Custody Health's processes, which are generally thorough and impressive. For the inmate deaths and attempted suicides we reviewed, we found the identification of issues

[1] In our initial Custody Health work plan, we advised that we would be looking into discharge management systems as well. We intend to examine this important function as part of our 2022 work plan.

and areas for potential improvement to be laudable, with corresponding action plans and compliance measurement strategies that are specific and inclusive. We noted this applies more commonly to remedial measures impacting Custody Health policy and personnel than to Custody Bureau staff, and make a couple of recommendations aimed at improving the specificity with which those non-medical or mental health matters are identified and evaluated.

With respect to grievances regarding medical, dental, and mental health care, we were impressed with how quickly staff was responsive to inmates' concerns, often within just a few days, depending on the urgency of the expressed need. We also found the tone of Custody Health's written responses to be remarkable for their politeness, expressed concern for individual's wellbeing, and willingness to show humility and apologize where appropriate.

We appreciate the cooperation of Dr. Daye and Custody Health personnel, as well as County Counsel, for their timeliness in providing us the documents and information needed for preparation of this report.[2] We also appreciated the opportunity to attend a Suicide Prevention Committee meeting and an RCA/Death review following the recent death of an inmate. We look forward to attending future meetings as part of our monitoring responsibilities.

## Review of In-Custody Deaths

Each time an individual dies in custody, Adult Custody Health Services leads a Root Cause Analysis (RCA) review that includes, at a minimum, the Custody Health Medical Director, Psychiatric Director, Quality Improvement Manager, Nurse Manager, the jail facility Commander, and health care professionals directly involved in the inmate patient's care.[3] The purpose of the review is to evaluate the

[2] We provided an earlier draft of this report to Custody Health and the Sheriff's Office, and this final report reflects the input provided by both. We had a substantive conversation with Custody Bureau personnel regarding the Sheriff's Office internal processes for investigating and reviewing in-custody deaths, but did not review any documents pertaining to those processes due to the standoff regarding OCLEM's access to Sheriff's Office information.

[3] The Custody Health Quality Improvement team serves as coordinators for these reviews, with an assigned manager conducting a preliminary review of the incident and then leading the RCA review team to evaluate the circumstances around each incident, relevant procedures and training, or other factors. The QI manager is also responsible for following up on corrective actions identified by the RCA review and reporting back to Custody Health executive management. The Quality Improvement team is made up of medical professionals and analysts.

root cause of an incident so that staff can identify and implement prevention strategies. We reviewed the documentation from three recent RCAs following in-custody deaths and attended (virtually) a fourth RCA/death review. We generally are impressed with the level and depth of the process.

Three of the in-custody deaths we reviewed involved people in custody hanging themselves with ligatures fashioned from clothing or bedding; another involved an apparent accidental overdose. Learning the details of each incident – including background, circumstances, and timelines – was critical to our review because it provided needed context and permitted us to make a substantive assessment of the review processes associated with each event. While we don't discuss the factual underpinnings of each of the deaths we reviewed out of concern for the privacy and confidentiality of the underlying medical records, our assessment and recommendations were necessarily informed by those details.

The focus of our review of these incidents was on process – not, for example, on whether the mental health intake decisions were appropriate, but whether the RCA review thoroughly evaluated the decisions to identify issues and potential learning opportunities and systemic change to reduce the likelihood of future inmate deaths. At the outset, we sought answers to questions like:

- Are the RCA meetings consistently held in a timely way?
- Are all relevant players and stakeholders invited and actively participating?
- Are systemic issues and potential concerns about performance raised by the incident identified and discussed?
- Are existing accountability measures sufficient?
- Are "action items" devised to remediate issues identified?
- Is there an effective system to ensure that "action items" are completed and systemic recommendations implemented in a timely way?
- Is there a mechanism to ensure that involved personnel are advised of any issues identified by the reviewing body?

Our review consisted of reviewing the documents provided to us – PowerPoint slides that guided the meetings and "minutes" from the review that function as a

summary of the issues and outcomes rather than an actual account of what took place during the meeting – and attendance at one RCA/death review.

## Timeliness

All four of the death reviews we assessed were completed fewer than 30 days from the inmate's death. Because long delays between an incident and a review render constructive feedback and corrective action almost meaningless, the attention to timeliness by Custody Health is commendable and noteworthy.

## Attendance and Participation

The list of attendees at the RCAs is inclusive, with stakeholders from Custody Bureau as well as Medical and Mental and Behavioral Health Divisions joining the meetings. The extent to which any particular individual or entity is called on to answer questions, provide explanations, or offer solutions is not something evident from the written documentation. In the one RCA meeting we attended, part of the presentation was led by an Custody Health physician, who walked the group through the inmate's medical history and treatment relative to the issue that caused his death, and part was led by a Sheriff's Office Captain, who discussed security measures and other circumstances surrounding the inmate's death. The tone of the meeting was collaborative and constructive, though participants largely deferred to the speakers and did not interject with questions or challenges. It is hard to know the extent to which this is a product of the virtual format (in this case, on the Teams platform), and how the dynamic might be different for in-person meetings.

## Issues Identified and Addressed

Some of the issues identified, discussed, and addressed during the death review meetings we reviewed include the following:

- Possible communication gaps between classification and mental health, where the inmate provided different information in two separate interviews;
- Review of video of the CPR performed to provide opportunities for improvement through further training;
- Questions about the clothing allotment issued to newly-booked inmates;
- Ideas for improving the housing situation for inmates designated for 15-minute checks, to address concerns about isolation;

- Degree of privacy available in area used to perform mental health screening at intake;
- Potential improvements to the suicide risk assessment tool used by mental health staff and need for updated training opportunities for providers;
- Addressing an inconsistent use of translation services;
- Communications issues surrounding the officers' decisions about when to initiate mental health referrals;
- Issues relating to an inmate's release from the Acute Psychiatric Unit in the days prior to his death.

Some of these issues were raised as questions that could be resolved through discussion between Custody officials and Custody Health; many resulted in specific action plans. We note them not to identify individual flaws in performance or systems but as indicators of a robust review mechanism.

## Accountability Measures

The extent to which Custody Health's system for reviewing inmate deaths contains sufficient accountability measures is not a question we can easily judge from the documentation provided. Throughout the Action Plans, we see numerous references to standards and principles being "reinforced" with either particular individuals, or an entire group. In the 11 RCAs we reviewed, we saw one instance (related to a suicide attempt) where a matter was referred for an investigation and potential discipline. For Custody Health, though, it seems, consistent with the "root cause analysis" philosophy, that documented "reinforcement" by a Director or Manager is the most frequent form of individual accountability.

With regard to accountability measures relating to Sheriff's Office personnel, we saw references to "corrective action" being taken, but specific issues relating to performance by Custody staff are merely referenced at the meetings without further elaboration. This is not always inappropriate, given the privacy concerns surrounding formal Internal Affairs investigations and the overall emphasis of the RCA process: to drive change rather than find fault or assign blame. Nonetheless, some system for ensuring accountability should exist. Without meaningful access to Sheriff's Office information, we cannot determine whether meaningful corrective action is being taken to address performance issues or policy violations by Custody staff. This is an issue OCLEM hopes to address in the future.

## Development and Implementation of Action Plans

The resolution of issues identified in the RCAs involved specific plans of action and designation of staff responsible for implementation, along with anticipated date of completion and a strategy for measuring compliance. Some examples of action plan items identified in the incidents we reviewed included:

- Quality Improvement audits of the intake screening process;
- Updates and redistribution of relevant policies;
- Documented reinforcement of communication protocols;
- Feasibility study of possible changes to housing practices for potentially suicidal inmate and improvements in the mental health intake interview spaces;
- Development and dissemination of new training material;
- Random audits of encounters with medical, dental and mental health staff to determine compliance with policy governing language services;
- Documented reinforcement of policies and processes related to patient assessment and standards for initiating mental health referrals.

The mechanisms for following up on action items are laid out well in the Action Plan accompanying each RCA. Each specific task is delineated, along with staff responsible for implementation, planned completion date, and a measurement strategy to ensure compliance. The measurement strategy generally requires a written report back to Quality Improvement. A failure to follow up on recommended improvements is a frequent issue in our audits and systemic reviews of law enforcement agencies: This level of specificity in the Custody Health documentation is the most likely way to ensure completion of identified tasks and avoid this critique.

We also found the identified actions to be forward-thinking and significant. For example, in one incident where there was a concern about accessibility of an interpreter for a non-English speaking inmate, one identified plan of action was for Quality Improvement to conduct random monthly audits of health records to test

compliance with relevant policies on language services.[4] In another, the death review attendees discussed the possibility of providing wider access to Narcan, and agreed to meet with a public health expert to explore options and best practices in a custody setting. That degree of proactivity is commendable.

The documents we reviewed were all focused very heavily on medical and mental health care and largely related to performance of Custody Health staff. Of course, Custody Health is not the only entity with a role to play in the review of in-custody deaths. Systemic issues related to Sheriff's Office operations or performance by Custody Bureau personnel were sometimes mentioned, but not typically addressed in a substantive way. In the one death review we attended, Custody Bureau personnel were active participants, engaging with medical staff in productive, cooperative ways.

Nonetheless, fewer than one-quarter of all identified action items in the written documentation listed custody staff as among those responsible for implementation, and even fewer of the measurement strategies involved a report-back by any Sheriff's Office personnel. In the death review we attended, Sheriff's personnel referenced some corrective actions or systems modifications being considered or effected. These seemed like positive steps, but few details were provided and no specific implementation plan was discussed. In order to ensure that all deaths in custody are thoroughly and inclusively reviewed, Sheriff's Office issues should be addressed as part of the holistic RCA review process that includes meaningful accountability measures and adequate systems for measuring implementation, in the same way we found Custody Health issues handled.

One example of an area that may perhaps need greater scrutiny is the required welfare checks of inmates' cells. The notes attached to each of the death review presentations we reviewed contained some reference to welfare checks, and in one case Custody personnel noted the absence of a timely welfare check while reporting that the Sheriff's Office is taking corrective action to address the issue. Still, the records we reviewed contained no documented, comprehensive audit of the history of cell checks.

Because, for example, an individual could make preparations for hours prior to an actual suicide attempt (perhaps fashioning a ligature out of available materials),

[4] Quality Improvement is conducting the monthly audits as part of an overall six-month audit that will be completed and reported on in September 2021. Custody Health has committed to providing us with a copy of that audit report.

jail managers should review the record of welfare checks in the hours leading up to the death, and not just immediately prior to the discovery of the individual. Further, the review should involve more than simply looking at documentation but should also include an audit or review of available video, to ensure deputies did not just log checks at the required intervals, but meaningfully performed those checks.

We are not suggesting that Sheriff's Office staff are not diligently performing substantive welfare checks at the required intervals. Because we have so frequently seen outright neglect of this responsibility in other jail systems, though, we recommend that Custody Bureau take every opportunity to fully explore this issue.

In recent conversations, a Sheriff's Office official reported that security checks (including video review) are an important part of significant investigative efforts that follow every inmate death. Both the Jail Crimes Unit and Internal Affairs respond to each death in custody to begin, respectively, any potential criminal investigation and a thorough administrative review. If Internal Affairs identifies potential policy violations or performance issues warranting a full investigation, that process begins immediately. Otherwise, a facility lieutenant is assigned to gather all evidence – including video, radio calls, logs, deputies' reports, and other documents – to be assembled into an investigative packet that goes to the facility captain and others in the chain of command. The packet reportedly includes identification of any potential remedial issues or other concerns and memorializes any plan to address those issues.

We have not had access to these investigative materials to make our own assessment of their thoroughness and inclusivity in any given case. We look forward to expanding our review of in-custody deaths to include these Custody Bureau issues in the future.

> RECOMMENDATION 1: Custody Health should ensure that all remedial measures involving Custody Bureau are specifically identified in Root Cause Analysis reviews as a plan of action, assigned to specific personnel, with a defined completion date and measurement strategy.

RECOMMENDATION 2: Custody Health should work with Custody Bureau to develop a mechanism to ensure that the Root Cause Analysis review process includes a comprehensive evaluation of the timeliness and thoroughness of welfare checks performed by Custody Bureau staff in the hours preceding an inmate death.

## Suicide Prevention Efforts

Suicides are a particularly troubling subset of jail deaths, both because the desire to harm oneself is a predictable aspect of the circumstances of incarceration and because the means of self-harm are often within the control of those running the facility. Accordingly, suicide prevention efforts have been a key piece of the class action litigation and Custody Health has revised policies and procedures in this area as part of its efforts to achieve compliance with various elements of the resulting consent decree. All of these are being tracked by independent monitors in coordination with County Counsel.

For example, in the spring of this year, pursuant to the remedial plan in *Chavez v. County of Santa Clara*, Adult Custody Health Services significantly revised its policy governing its Suicide Prevention Program and Services. Prior to implementation, County Counsel provided OCLEM a draft of the new proposed policy, which we found to be thorough and inclusive of relevant concerns. The detailed policy, which had been developed with the assistance of the experts engaged in the litigation and approved by the independent monitor, covers a host of procedures that constitute the Custody Health suicide prevention program, from guidance about when and how to conduct a suicide screening and risk evaluation, communication with Custody Bureau staff, and circumstances under which interventions are available and appropriate.

Our observation about the policy is that it references many areas of crossover and needed collaboration with Custody Bureau staff. We do not currently have a frame of reference or meaningful way to measure to what extent that collaboration is occurring, but note that the review processes we discuss in this report are led by Custody Health, and the analysis and corrective action is very much focused on Custody Health issues. This is appropriate and commendable in many ways, but raises questions for us about the extent to which the Sheriff's Office Custody Bureau is a meaningful and supportive participant in this arena. Those are

questions we look forward to examining as we move forward in our role with the County.

As with all in-custody deaths, Custody Health leads a Root Cause Analysis of all serious suicide attempts or other self-injurious behavior.[5] Our review involved a request for documents relating to the RCA or any meetings or evaluations conducted following a significant suicide attempt by an inmate within the County's jails during 2019 and 2020. We received a list of 20 RCAs for serious self-harm or suicide attempts[6] from this time period and, from those, selected seven – representing a range of locations, method, and significance of injury – for which we requested further documents relating to the Custody Health review.

We made a couple of observations based on review of the list alone. First, over half of the incidents included were determined not to be suicide attempts, but other types of self-harm – the distinction being the inmate's intent or expectation that the self-injury would lead to death. We see the fact that Custody Health is engaging in analysis of such a number of non-suicidal self-harm incidents as a positive sign of the organization's efforts to intervene and treat these individuals before their behavior escalates. Second, all but one of the seven RCAs we examined were conducted within a month of the last incident reviewed (the one outlier was conducted within 10 weeks; three others were conducted within two or three weeks), a commendable level of timeliness, given the number of documents and personnel involved.

An attempted suicide can reveal the same issues in inmate care, screening, and security measures as a completed one, and warrants the same type of scrutiny. We were encouraged to see that Custody Health recognizes this, and conducts Root

[5] The criteria for inclusion in an RCA are:

1. Any near-lethal or serious suicide attempts based on psychiatric/medical record review, which requires discussion about systems and processes that failed or did not support safe patient care, analysis or significant adverse events or system deficiencies that require improvement by implementing corrective action plan/risk reduction strategies should be referred for RCA.
2. Any suicide attempts or self-injurious behavior in which patient required extensive treatment in Emergency room (Ex: required sutures or required additional diagnostic studies) or required hospitalization.
3. If record review indicates system issues or significant incidental finding should be referred for discussion in RCA.

[6] These 20 meetings included review of 35 separate incidents involving 20 distinct individuals.

Cause Analysis meetings for suicide attempts and other serious self-harm incidents. As with reviews of in-custody deaths, the goal of these meetings is to learn the details of each incident, examine why it happened and how it can be prevented, and to develop a corrective action or risk reduction plan based on the lessons learned.

We reviewed the PowerPoint presentations and meeting minutes from seven recent RCAs and were impressed by the level of detail in the documentation of these meetings and the issues addressed. Medical, Mental Health, and Behavioral Health staff look closely at intake screening, treatment orders, and communication and follow-through issues to provide a good picture of what happened in each incident, where things went wrong, and how systems can be improved. The reviews also include a record of the inmate's mental health history and family/social history as part of a broader evaluation of both chronic and acute risk factors.

The stated purpose of the meetings is not to assign blame but to address deficiencies in a constructive way. We did not attend any of these meetings and cannot offer an assessment of the tone or level of defensiveness among attendees. Nonetheless, we did not see – based on the documentation – a tendency for Custody Health leadership to shy away from acknowledging mistakes made by individuals and, in one of the seven cases we reviewed, noted a pending investigation and possible disciplinary action for involved mental health staff based on a failure to properly document an order.[7]

The following types of issues were among those identified in the RCAs we reviewed, as evidence of a thorough medical and mental health evaluation:

- Discrepancies noted between information recorded at intake by medical and mental health personnel resulted in an update to the screening instrument used.
- An individual's repeated self-injurious behavior led to an evaluation of the underlying causes of the behavior, and concern about a delay in addressing repeat incidents and resulted in a plan for coordination of communications regarding development of a behavior plan.

[7] We verified completion of this investigation, which resulted in a sustained finding and imposition of discipline.

- Detailed review of medical records revealed gaps in communication about critical lab reports and resulting orders and led to documented reinforcement with medical staff of these issues.

At the same time, we noted some questions raised in a number of incidents not fully addressed in the documents we received. These largely had to do with the role of Custody staff. For example, questions about the performance of welfare checks; an incident where an individual who had been ordered not to have access to sharps got a razor and swallowed it; or another where a person's behavior perhaps should have led to a referral to mental health but was not reported prior to a suicide attempt. These issues were identified in the RCA documentation but not as thoroughly explored or resolved in those documents as were those matters within the Custody Health realm.

While the RCAs we reviewed generally contain detailed reference to implementation and measurement strategies for identified plans of action, including the staff responsible and target/planned date for completion, along with an expectation that the responsible parties will provide documentation of completion to the Quality Improvement manager, this level of detail did not accompany those items for which Custody was responsible. Instead, the notations relating to Custody typically said something like, "Custody leadership will reinforce standards with Custody staff." This was true even where individual deputies would have been identifiable and more direct action might have been appropriate.

And some issues were not addressed at all in any of the RCAs we looked at: notably, the timeliness and thoroughness of welfare checks performed by Custody staff. For example, in one incident we reviewed, an individual was found down in his cell during a deputy's rounds. The deputy began life-saving measures, and the person survived. Nonetheless, the medical records indicate it was unknown how long the individual had been down, and the RCA did not reflect any documented effort to discover whether welfare checks had been completed at appropriate intervals (though, as we note below, the Sheriff's Office may document this information in its own files, to which we did not have access). As we noted above, the importance of jail cell welfare checks to the goal of protecting the security and welfare of inmates cannot be overstated, and we frequently have seen lack of diligence and outright neglect of these duties in other jail systems we have monitored. We are not suggesting that Santa Clara County Sheriff's Office staff are failing to perform this duty as expected. But each attempted suicide provides a

potential window into staff conduct that should be fully explored. The documentation we received indicates this is a potential missed opportunity to fully explore this issue.

Though it's possible these issues may have been addressed elsewhere by Sheriff's Office personnel, an analysis whose stated goal is to find the root cause of an incident – including any human or environmental factors, communication factors, and policy, procedure and practice concerns – should ideally look at all those who had responsibilities associated with the care and well-being of the inmates. As we discussed and recommend above, a complete review will have documentation in the review file demonstrating and detailing remediation of issues identified during the review process.

> RECOMMENDATION 3: Custody Health and its Quality Improvement team should work with the Custody Bureau to ensure identified issues relating to performance of Custody Bureau personnel are thoroughly addressed, with a mechanism for follow-up and verification of completion.

In addition to reviewing the RCA documentation, we also had the opportunity to attend (virtually, via Teams) a recent Suicide Prevention Committee meeting. Attendees included Custody Health staff, Custody Bureau leaders, and members of County Counsel's office. The meeting did not focus on specific incidents, but rather broader systemic issues that are responsive to identified risks (such as clarification of commissary items available to those on suicide watch, policies on suicide prevention gowns, and ordering new types of underwear to issue to at-risk women). The tone of this monthly meeting was collaborative and constructive, with open dialogue between Custody Health and Custody personnel, and we appreciated the opportunity to participate.

## Response to Grievances Related to Healthcare

Since the beginning of our work in Santa Clara County, we have heard frequently about frustrations with the way in the which the jail handles grievances from inmates. A healthy grievance process is, in our view, critical to the just and effective management of a jail system. Those incarcerated need a forum where their complaints can be fairly and transparently resolved. And a functional grievance process can serve as an important tool for all law enforcement agencies,

jail managers, and custody health care administrators to identify and rectify potential problems early.

We reviewed 36 grievances that were routed to Custody Health for action and response.[8] These were a representative sample of different types of grievances (related to dental, medical care, and accommodations) from the three different facilities (Main Jail, Elmwood Women, Elmwood Men). We focused on the processes related to reviewing and responding to these complaints, assessing the timeliness, thoroughness, and extent to which the response substantively addressed the inmate/patient's complaint.

It is important to emphasize that we did not delve into the medical records to judge the quality of medical staff's decision making related to patient care (whether correct diagnoses were made, proper medications prescribed or specific recommended treatment provided, for example). To the extent we continue to hear about inmate dissatisfaction with the way Custody Health handles grievances, it is likely driven more by disagreement with these *substantive* decisions than the more *process-driven* inquiry that was the subject of this review.

On the whole, we are impressed with the way Custody Health handles the inmate grievance process. Importantly, we found the grievances we reviewed to be resolved in a timely way. In many instances, the issue the inmate complained about was handled within a few days,[9] with a clear correlation between the level of urgency and time to response. The written responses took longer, but generally not unreasonably so, given the need for records assessment and supervisory review. The following table depicts the timing of responses for the grievances we evaluated:

[8] Grievances are tracked in the County's ACeS system. Custody Bureau personnel receive all grievances and make the initial entry, categorizing each grievance by (among other things) type of complaint, location, and unit assigned to respond.

[9] We considered a complaint to be "handled" or "addressed" when the individual was seen by a health professional. We understand that persons in custody may not always have been fully satisfied by the outcome of that visit, and possibly appropriately so, but specific issues of diagnosis or care are beyond the scope of this review.

## Custody Health Services Grievance Response

| | Facility | Days to Issue Addressed | Days to Written Response | | Facility | Days to Issue Addressed | Days to Written Response |
|---|---|---|---|---|---|---|---|
| 1 | Elmwood Women | 15 | 36 | 19 | Elmwood Men | 1 | 10 |
| 2 | Elmwood Women | 23 | 39 | 20 | Elmwood Men | 6 | 6 |
| 3 | Elmwood Women | n/a[10] | 14 | 21 | Elmwood Men | <1[11] | 4 |
| 4 | Elmwood Women | 3 | 10 | 22 | Elmwood Men | <1 | 18 |
| 5 | Elmwood Women | n/a | 3 | 23 | Elmwood Men | n/a | 40 |
| 6 | Elmwood Women | 23 | 27 | 24 | Elmwood Men | 2 | 28 |
| 7 | Elmwood Women | 2 | 11 | 25 | Main Jail | 2 | 29 |
| 8 | Elmwood Women | 2 | 9 | 26 | Main Jail | 8 | 40 |
| 9 | Elmwood Women | 2 | 8 | 27 | Main Jail | n/a | 13 |
| 10 | Elmwood Women | 11 | 21 | 28 | Main Jail | n/a | 17 |
| 11 | Elmwood Women | n/a | 12 | 29 | Main Jail | n/a | 6 |
| 12 | Elmwood Women | 1 | 23 | 30 | Main Jail | n/a | 21 |
| 13 | Elmwood Men | 5 | 29 | 31 | Main Jail | 7 | 8 |
| 14 | Elmwood Men | 1 | 19 | 32 | Main Jail | 20 | 33 |
| 15 | Elmwood Men | n/a | 13 | 33 | Main Jail | n/a | 18 |
| 16 | Elmwood Men | n/a | 18 | 34 | Main Jail | 10 | 42 |
| 17 | Elmwood Men | n/a | 37 | 35 | Main Jail | n/a | 6 |
| 18 | Elmwood Men | 1 | 10 | 36 | Main Jail | 7 | 11 |

[10] In a number of instances, a grievance asked a question, requested an explanation, or sought a change in policy instead of care or other services. The written response explained medical staff's position but did not actually provide the relief requested. These are designated "n/a".

[11] This was an urgent mental health referral that was addressed within hours, not days.

Often, the complaint was on its way to being addressed before the individual submitted a grievance. For example, in one grievance an inmate complained about a delay in getting an appointment with a mental healthcare provider and referenced numerous "white cards" that she had previously submitted. She saw mental health staff the next day, not in response to her grievance but pursuant to an appointment that had been scheduled following submission of the white card. (The internal note on the grievance stated she would have been seen immediately had it been a mental health crisis.) The written response to the inmate stated, "We apologize for delays in service at times due to […] triage order."

This type of response from medical staff was not atypical, and the thing we found most commendable in our review of grievances. We frequently evaluate a law enforcement agency's responses to complaints from members of the public, and regularly advocate for more detailed replies that display some humility, and thus were struck by the written responses we reviewed for this report. With only some exceptions, we found the written responses prepared by Custody Health staff to be remarkable for their politeness, expressed concern for inmate's wellbeing, and willingness to apologize (the exceptions themselves were not bad, but stood out for being more standard).

For example, in one submission, an individual wrote that he had been prescribed medication, but five days had passed and he had not yet started receiving it. The written response, 28 days later, noted that the individual had received the medication two days after his grievance, and included this statement: "Sorry for Mental Health's delay in getting you your medication. At times, it takes a little longer than expected for the medication to arrive to the jails. . . . I hope you are feeling much better."

In another, an inmate expressed frustration that he did not seem to be getting medications consistent with what the doctor had ordered. The detailed response from Custody Health staff noted he had seen the doctor shortly after the grievance and his medications had been updated. It stated, "There may have been a misunderstanding about what the doctor originally prescribed . . . . You are right to advocate for yourself and we do want to make sure you get the proper treatment while you are staying with us. Thank you."

Even when personnel do not take action with regard to a complaint, we often found the response delivered to the inmate to be thoughtful and considerate. For example, an individual whose grievance insulted his mental health care provider

and complained about her power to order medications received this response, along with an explanation about the complexities of his care: "Thank you for your feedback. We are sorry to hear you are frustrated with your current situation and treatment."

The language and tone of these responses is clearly intended to make people in custody feel they are patients, to be served and cared for by medical and mental health staff. The expectations set for how these notes are to be written also reinforces among staff a mindset of service that is commendable.

We did note a couple of areas of potential improvement. All of the grievances we reviewed had been routed to Custody Health for action and response, but there were some that also had a component involving conduct of Custody Bureau personnel. There is no apparent mechanism for looping those back for a Custody response. For example:

- An individual who complained about the length of time it was taking to get a medical appointment noted that a particular Correctional Officer had been "very helpful and accommodating." Recognizing positive individual behavior is a powerful tool for reinforcing agency expectations, and this sort of notation from an inmate ideally should lead to some sort of recognition for the officer.

- An individual complained that deputies "stole" her wheelchair. The grievance was understandably assigned to medical to assess the person's needs and ADA compliance. But the complaint also suggests that deputies might have handled the situation differently. At a minimum, the complaint should have prompted a discussion among Custody and Medical personnel about the best way to effectuate the removal of an inmate's wheelchair or other assistive device, and whether that would more appropriately be handled by medical staff.

A similar lack of crossover seems to exist between medical and mental health. We saw one grievance where an individual complained about his deteriorating mental state and need to see a mental health provider, but also discussed ongoing pain that could need medical attention. The grievance was routed to Mental Health, who responded by telling the individual he should submit a "white card" to Medical to get the care he requests. Particularly with an inmate who suggests his mental health is deteriorating, it would be helpful if Medical and Mental Health personnel

could make cross-referrals to streamline the process of getting individuals appropriate care.[12]

> RECOMMENDATION 4: Custody Health Services should work with Custody Bureau to develop a mechanism for referring back any grievances routed to Custody Health that also reference the impact of conduct or behavior by Custody Bureau personnel.
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> RECOMMENDATION 5: Custody Health Services should develop a mechanism for simultaneously handling grievances that contain complaints related to both Medical and Mental Health care.

[12] There are additional grievance-related issues that were not addressed during this review but we will consider in the future. For example, we did not explore in this review the overall trends and types of grievances and whether Custody Health uses the data collected in a meaningful way to identify systemic issues. For example we have been advised that while men's grievances decreased considerably during the pandemic, there was no similar decline among grievances from women. Nor did we review the grievance appeal process which is handled internally and has been reported as having a very small reversal rate. We also did not review the process whereby inmate grievances are received and entered into the inmate database and whether the grievances are miscatalogued or not fully captured during this process.

This report was only intended to be an introductory examination of the process and most significantly did not include grievances against Sheriff's staff because of our inability to obtain an information sharing agreement. All of these issues are deserving of additional scrutiny.