JMS:LES:CST:KKD:RMLM:JH:EJ:PZ
DJ 168-12C-43

June 4, 2014

VIA ELECTRONIC AND FIRST-CLASS MAIL

Anthony Peck, Esq.
Deputy County Counsel
4700 Ramona Blvd.
Monterey Park, CA 91754

Stephanie Jo Reagan, Esq.
Principal Deputy County Counsel
Los Angeles County Department of Mental Health
550 South Vermont Avenue
Los Angeles, CA 90020

RE: Mental Health Care and Suicide Prevention Practices at Los Angeles County Jails

Dear Mr. Peck and Ms. Regan:

We write to report our conclusions with regard to Los Angeles County's compliance with the Memorandum of Agreement ("MOA") that requires adequate mental health care and suicide prevention at the Los Angeles County Jail System ("Jails"). Since the entry of the MOA twelve years ago, there has been significant improvement in the delivery of mental health services. However, serious systemic deficiencies remain with regard to some aspects of the Jails' mental health program. Based on our review, we conclude that the County violates the Eighth and Fourteenth Amendments of the United States Constitution by failing to provide adequate mental health services and protect prisoners from serious harm and risk of harm at the Jails due to inadequate suicide prevention practices. Consistent with the practice of our long-standing investigation of the Jails pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, we write to update our conclusions of September 5, 1997 regarding mental health treatment and suicide prevention at the Jails and to discuss the minimum remedial steps necessary to address the identified deficiencies.

We notified the County of continuing weaknesses in the Jails' mental health services during the 12-year tenure of the MOA, including through numerous reports from the Department of Justice's long-standing experts, Joel Dvoskin, Ph.D., and Jeffrey L. Metzner, M.D. In the face of these ongoing problems and the ineffectiveness of the MOA to ensure that prisoners with mental illness are protected from suicide and other harms, we propose to enter into negotiations with the County regarding a court enforceable agreement to substitute for certain critical terms of

the MOA. The affected MOA provisions are: Suicide Prevention (§§ IV.G.25-29), Intake (§ IV.A.5), Referrals (§ IV.C.9), Treatment (§ IV.D.12 & 15-19), Medication Administration (§ IV.E.22), Environmental Conditions (§ IV.F.23-24), and Quality Assurance (§ IV.J.42). We are prepared for the following provisions related to mental health care and treatment to continue as part of the MOA: Evaluation (§ IV.B.7), Referrals (§§ IV.C.10-11), Treatment (§§ IV.D.13), Medication Administration (§ IV.E.21), Staffing and Training (§§ IV.I.34-35), and Quality Assurance (§ IV.J.41). As discussed below, the Department of Justice will cease monitoring those MOA provisions with which the County has achieved and maintained substantial compliance: §§ IV.A.1-4, A.6, B.8, D.14, D.20, H.30-33, and I.36-40. Despite our conclusions regarding constitutional violations at the Jails, we wish to commend the County on the considerable progress it has made in terms of mental health services at the Jails, especially with respect to increased mental health staffing, since our initial review in 1997.

The Department of Justice acknowledges that many of the prisoners confined to the Jails who have mental illness were failed by other systems. The delivery of mental health services in the corrections environment is difficult and presents unique challenges. Many of the prisoners may well be safely and more effectively served in community-based settings at a lower cost to the County. The remedies that we seek in order to ensure that the conditions in the Jails meet the minimum required by the Constitution – that ensure that prisoners are safe and that staff are not placed at an unreasonable risk of harm – can be implemented more effectively if the number of prisoners needing mental health services is reduced.

In considering solutions to this problem, we strongly encourage the Sheriff, the Mental Health Director, and the County to consider alternatives to incarceration for those prisoners with mental illness who can be supervised in the community without compromising public safety. We understand that the County Board of Supervisors recently voted unanimously to undertake an analysis of diversion programs for arrestees with mental illness in the County and the availability of beds in a non-jail setting to support the population.[1] The United States applauds the County's interest in increased community-based treatment and alternatives to incarceration for individuals with mental illness. While the United States cannot require measures to address the population pressures, we would consider any steps taken voluntarily as an important part of the solution to the issues we address in this letter. These measures would also be consistent with meaningful steps the County is taking to increase rehabilitative options for youth in the community as part of our amended MOA with the County involving its youth probation camps.

Our conclusions with regard to suicide prevention and mental health treatment at the Jails are summarized below, followed by our compliance assessment of the remaining MOA provisions.

I. SUMMARY OF CONCLUSIONS

We made the following factual determinations:

[1] Abby Sewell, *L.A. County Supervisors Vote to Move Forward on $2-billion Jail Plan*, L.A. Times, May 6, 2014, available at http://www.latimes.com/local/lanow/la-me-ln-jail-plan-vote-20140506-story.html#.

- There is inadequate mental health care to prevent prisoners from becoming suicidal, to identify suicidal prisoners, or to prevent prisoners from going into crisis.

- The County has failed to take necessary steps to address a dramatic increase in the number of suicides and suicide incidents in the Jails. In 2012, there were four completed suicides. In 2013, there were ten prisoner suicides and one more suicide in January 2014. Based on our review, many of the suicides that occurred in the last two years were preventable. In addition, the Jails reported a more than 20 percent increase in suicide "incidents" in 2013, when a total of 366 suicide "incidents" were recorded. While the Jails' characterization of self-harm is undefined and inconsistent, it appears that "incidents" includes suicide attempts evidencing a discernible intent to commit suicide and those requiring a certain level of medical intervention after the suicidal behavior is discovered. Indeed, one of these critical incidents occurred at the Jails at least *every seven days* from January through September 2013. The number of suicides and self-harming behaviors, together with the numerous procedural and policy lapses surrounding many of these incidents, give us reasonable cause to believe that prisoners remain at significant risk of serious harm.

- The Jails do not provide appropriate custodial supervision for prisoners, including those on the mental health caseload and those who have been identified as having a heightened risk of suicide. Remarkably, about 44% of those who self-harmed were housed in mental health housing at the time of the incident, indicating a lack of adequate custodial supervision for even those prisoners who require higher levels of attention. We found repeated lapses in the Jails' safety checks, which evidence a serious risk of harm to prisoners from suicidal behavior, as well as violence and other prohibited behavior.

- Prisoners with mental illness do not receive adequate supervision and are housed in conditions that present, rather than prevent, a risk of suicide. Deputies do not consistently perform timely, thorough safety checks. Living conditions in general are deficient (dimly lit, vermin-infested, noisy, unsanitary, cramped and crowded), most acutely at Men's Central Jail but also at the Century Regional Detention Facility and in certain areas of the Twin Towers Correctional Facility, and create an environment that may contribute to prisoners' mental distress. Often, suicide precautions are punitive in nature, even depriving some prisoners of a mattress to sleep on.

- Custody staff, the Medical Services Bureau, and the Department of Mental Health often operate in silos when addressing suicide incidents and risks, maintaining separate charts and even separate investigatory reports. The lines of communication between these entities are flawed, and at times non-existent. Our review of the Jails' suicide incidents demonstrated that this lack of communication, or miscommunication, between medical, mental health, and custody staff resulted in critical breakdowns in the custody and care of prisoners at the Jails.

- In spite of the increase in suicides in the Jails, there remains a persistent failure on the part of the Jails' command staff to critically review and appraise the contributions, intended or not, of its policies, staffing, and custody practices, to the suicides and suicide

attempts that are occurring. Fifteen suicides in 25 months produced almost no discernible change in the Jails' custodial practices. Critical incident reviews related to suicides are replete with inaccurate and incomplete information and do not identify or seek to remedy systemic problems. This failure to review, appraise, revise, and ultimately, to enforce the Jails' own policies, is reflected in the overall escalation of suicide incidents and preventable prisoner deaths. This is a system failure that negates the Jails' good custody policies and increases the risk of harm to prisoners.

These factual determinations provide us with reasonable cause to conclude that the Jails violate prisoners' constitutional rights to be protected from harm, *Farmer v. Brennan*, 511 U.S. 825, 833 (1994), and serious risk of harm, *Helling v. McKinney*, 509 U.S. 25, 33-35 (1993).[2]

II. BACKGROUND

The County entered into the MOA with the United States following an investigation by the Civil Rights Division pursuant to CRIPA. CRIPA authorizes the Department of Justice to seek equitable relief where jail conditions violate the constitutional rights of prisoners in state and local detention facilities. Because a monitor was not selected to oversee the implementation of the MOA, the Department of Justice continued its investigation into conditions at the Jails with expert consultants to ensure compliance with the MOA. *See* MOA § V.46. The MOA does not preclude the Department of Justice from initiating a civil action under CRIPA to protect the constitutional rights of prisoners at the Jails. MOA § V.52.

As discussed below, during the 12-year tenure of the MOA, the County has achieved sustained, substantial compliance with certain provisions of the MOA. However, our compliance reviews have identified grave concerns with regard to the Jails' suicide prevention practices and mental health treatment.[3]

On March 25-28 and June 25-28, 2013, we conducted on-site inspections at the Jails with our long-standing experts, Drs. Dvoskin and Metzner, to assess the County's MOA compliance. We determined the need to conduct additional review with regard to suicide prevention at the Jails. On September 23-26, 2013 and January 7-10, 2014, we conducted on-site inspections with Margaret E. Severson, our expert consultant in suicide prevention. In conjunction with each visit, we reviewed an extensive number of documents, including policies and procedures, the Jails' quality improvement documentation, investigative reports, incident reports, population data, staff training materials, and the Jails' suicide review files. Consistent with our pledge of transparency and to provide technical assistance where appropriate, we conveyed our preliminary observations to County and Jail officials and legal counsel for the County and Sheriff's Department at the close of the first three visits. At the conclusion of the January 2014 visit, we

[2] Additional information and detail supporting our conclusions is included in the attached expert report of expert Margaret E. Severson and monitoring report from Drs. Dvoskin and Metzner.

[3] This letter does not address provisions in MOA § IV.K, Abuse and Mistreatment, as that subject will be discussed in a separate letter related to our investigation of use of force and protection from harm at the Jails.

informed County officials that we would provide detailed conclusions to the County in writing. This report details our assessment of the Jails' MOA compliance, and non-compliance, as well as separately highlighting our conclusions on the Jails' suicide prevention practices.

III. CONCLUSIONS OF INADEQUATE MENTAL HEALTH CARE AND SUICIDE PREVENTION PRACTICES

We conclude that Los Angeles County, including the Sheriff's Department and the Department of Mental Health, violates prisoners' constitutional right to adequate suicide prevention practices, which is required as a part of the Jails' legal obligation to meet the serious mental health care needs of all prisoners. These deficiencies pose a substantial risk of serious harm to prisoners in violation of the Fourteenth Amendment's due process protections for pre-trial detainees, as well as the Eighth Amendment's protections for those convicted of a criminal offense.[4] *Farmer*, 511 U.S. at 832-834. In defining the scope of prisoners' Eighth and Fourteenth Amendment rights, the Supreme Court has held that corrections officials must take reasonable steps to guarantee inmates' safety and provide "humane conditions" of confinement. *Id.* at 832; *Bell v. Wolfish*, 441 U.S. 520 (1979) (holding pre-trial detainees protected by Fourteenth Amendment). Conditions must satisfy prisoners' basic needs, including their needs for mental health care. *Farmer*, 511 U.S. at 832-834; *Estelle v. Gamble*, 429 U.S. 97, 103-05 (1976); *Hoptowit v. Ray*, 682 F.2d 1237, 1253 (9th Cir. 1982), *abrogated on other grounds by Sandin v. Conner*, 515 US 472 (1995); *Gibson v. County of Washoe, Nev.*, 290 F.3d 1175, 1187-1188 (9th Cir. 2002). These obligations include the duty to protect prisoners against reasonable risk of self-harm. *Helling*, 509 U.S. at 32-34 (right to care extends to preventing "unreasonable risk of serious damage to [a prisoner's] future health"); *Conn v. City of Reno*, 591 F.3d 1081, 1095–96 (9th Cir. 2010), *vacated*, 131 S. Ct. 1812 (2011), *reinstated in relevant part*, 658 F.3d 897 (9th Cir. 2011) ("A heightened suicide risk or an attempted suicide is a serious medical need."); *Cabrales v. County of Los Angeles*, 864 F.2d 1454, 1461 & n. 2 (9th Cir. 1988) (applying the "deliberate indifference" standard to a § 1983 claim by the mother of a pretrial detainee who committed suicide in detention, and explaining that "the fourteenth amendment due process rights of pretrial detainees are analogized to those of prisoners under the eighth amendment"), *vacated on other grounds*, 490 U.S. 1087, 109 S.Ct. 2425, 104 L.Ed.2d 982 (1989), *opinion reinstated*, 886 F.2d 235 (9th Cir. 1989).

The most recent suicide demonstrates the Jails' failure to take reasonable steps protect prisoners with mental illness from the risk of suicide and illustrates the systemic deficiencies in the Jails' suicide prevention practices detailed in this letter. "Alan"[5] was assessed as actively suicidal upon intake to the Jails in early 2014; he acknowledged a history of medical and mental health problems and a previous suicide attempt. The next morning, he underwent a mental health evaluation and was housed in the Twin Towers high observation unit with an order for no mattress, no sharps, and 15-minute checks. At 11:45 a.m., Alan met with a mental health supervisor and voiced thoughts of suicide, including: "I just feel like dying … I won't care if I

[4] For the sake of clarity, in this letter we refer to all individuals housed in the Jails, including pre-trial detainees and individuals who have been convicted of a criminal offense, as "prisoners."

[5] We use pseudonyms to protect against disclosing personally-identifying information.

die. If I had a rope I would just hang myself." Corrections officials have an obligation to act when there is a strong likelihood that a prisoner will engage in self-injurious behavior, including suicide. *Funtanilla v. Rubles*, 5 Fed. Appx. 590, at **1 (9th Cir. 2001) (finding allegations that, while he was in suicide prevention cell, prison guard observed prisoner cutting his arm and left him there for two hours covered in his own blood, were sufficient to allege deliberate indifference on part of prison officials); *Van Orden v. Caribou County*, 546 Fed.Appx. 647, 649 (9th Cir. 2013) ("Because Bannister actively manifested her suicidality in the hours immediately preceding her suicide, we hold that the district court erred in concluding that no reasonable jury could find that Downs and Long were subjectively aware of a substantial risk of serious harm to Bannister."). However, when Alan was apprised of potential interventions, including the punitive restrictions of suicide watch at the Jails, it was noted that he "changed his mind."

Immediately following Alan's interview, mental health staff noted in his electronic medical record that he should be housed with a cellmate in double-man housing and a psychiatric note reads "no longer having suicide thoughts." Mental health staff relayed the order for double-man housing verbally to custody staff, who then documented the order. Alan hanged himself later that day from the top bunk in his solely occupied double-man cell. When Alan was discovered, safety checks had not been completed for nearly three hours. *Lemire v. California Dept. of Corrections and Rehabilitation*, 726 F.3d 1062, 1076-77 (9th Cir. 2013) (holding that fact issues precluded summary judgment on Eighth Amendment failure to protect and substantive due process claims against warden and captain who knowingly withdrew all floor staff from prison building which housed mentally ill inmates, leaving inmates unsupervised for over three hours, during which time an inmate committed suicide). The Assistant Sheriff over the Jails recently indicated that several Jail practices were not followed with regard to Alan's suicide.[6] However, as discussed below, our investigation concluded that the circumstances of Alan's death, including inadequate mental health care, deficient suicide precautions, and lax custody supervision, are far too common in the Jails.

The Jails are in the midst of a trend of ongoing systemic problems, which include: (1) supervision lapses and violations of security check policies and procedures; (2) incomplete information collection and communication in intake assessments and evaluations; (3) poor documentation in the medical records, in the deputies' incident reports, and in the Jails' critical incident reviews; (4) inadequate mental health treatment; (5) inattention to custody-related contributors to the suicides; and (6) an overall failure to adequately investigate and respond to the suicides that have occurred and the system failures that repeatedly come to light after a suicide.

A. Inadequate Intake Screening and Identification of Individuals with Mental Illness and at Risk for Suicide.

Constitutionally minimum standards require jails to have a program to "identify, treat, and supervise" prisoners at risk of suicide. *Coleman v. Wilson*, 912 F. Supp. 1282, 1298 n.10 (E.D. Cal. 1995) (noting that identifying prisoners at risk of suicide is one of the six basic

[6] Rina Palta, *Suicidal LA Jail Inmate, Later Found Dead, Was Left Alone for Hours*, Southern California Public Radio, May 5, 2014, available at http://www.scpr.org/news/2014/05/05/43961/la-jail-inmate-who-committed-suicide-was-not-check/.

components of a minimally adequate prison mental health care delivery system). Identification of persons at risk for suicide and self-injury can and does occur at any point during their incarceration. However, formal mechanisms to identify suicidal prisoners must be in place and a regular part of the custodial process that begins at the pre-booking phase of a person's detention and extends through the initial screening, classification, the history and physical examination, and the prisoner and staff sick call request process. *Madrid v. Gomez*, 889 F. Supp. 1146, 1256-57 (N.D. Cal. 1995) ("While a functioning sick call system can be effective for physical illnesses, there must be a 'systemic program for screening and evaluating prisoners in order to identify those who require mental health treatment.'") (internal quotations omitted).

After years of consultation with and technical assistance from Drs. Dvoskin and Metzner, the Jails' mental health and suicide prevention policies and procedures are largely adequate as written, including intake forms for screening for mental health needs and prisoners' suicide risk. However, implementation and practice diverge from the written policies in a manner that poses a risk to prisoners.

1. The Jails' Screening Process Inappropriately Excludes Some Prisoners.

The Department of Justice did identify at least one particularly critical deficiency with regard to the Jails' intake screening policies. It appears some prisoners are excluded or delayed from the Jails' screening process by policy when they are held in one of the Jail system's lockup facilities. In 2012, two days after his arrest, "Brian" hanged himself in the Century Regional Detention Facility ("CRDF") lockup. As a matter of policy, Brian did not receive a mental health screening upon his arrest or admission to a pre-arraignment housing unit in CRDF. The official arrest report indicates that Brian was detained on domestic violence charges for reportedly choking his victim and stating "you don't think I won't kill you right now, right here? I have nothing to live for!" However, it is unclear if any of this information was actually passed on to the Jails' staff when he was admitted, as the arresting/transporting officer's space for comments on the Jails' *Arrestee Medical Screening Form* is blank and the questions about mental health and suicide conditions are marked "no." Brian had the word "Suicidal" as part of two tattoos, the significance of which is unknown because there is nothing in the death review documents that refers to or attempts to explain these tattoos. The Jails' electronic medical record includes information from a previous intake screening two months prior to Brian's death, which states that he reported a history of medical, mental health, and substance abuse problems, including diagnoses of schizophrenia and depression, and auditory hallucinations. The Jails' policy omitting Brian from the screening is constitutionally deficient. *Coleman*, 912 F. Supp. at 1298. In this case, given Brian's significant mental health history and the suicidal statements he made upon his arrest, an adequate screening may have prevented his death.

2. The Jails Do Not Obtain or Disseminate Complete Information Upon Intake.

There are a series of screenings upon intake to the Jails, which are designed to identify prisoners who are in need of medical or mental health care or who may be at risk for suicide or self-harm. Unfortunately, often they are not filled out completely or adequately incorporated into the prisoners' electronic medical record. As a result, intake screening is insufficient to identify and protect individuals at risk for suicide.

When a prisoner is brought into the Jails, the arresting or transporting officer is asked to complete the "Outside Agency Medical Declaration" on the *Arrestee Medical Screening Form* by answering three questions, including: "Is any person in your agency aware of any medical or mental condition, prescribed medication taken by or in possession of this arrestee, or any medical problem or injury regarding this arrestee?" In reality, an answer to this question is rarely found on the form. Out of a sample of 26 suicide incidents reviewed by the Department of Justice, 16 of these Agency Declarations are entirely blank, and an additional seven only list the prisoner's name. While the instructions for completing this portion of the form have changed slightly over time, the rate of completion does not appear to have changed. It appears there is no enforcement of the requirement that arresting or transporting officers fill out this form.

The *Arrestee Medical Screening Form* also asks the arresting officer to describe the prisoner's behavior, whether medical treatment was sought, and whether the prisoner has a history of mental illness or suicidal behavior. It is unclear exactly who is expected to give all of the information and who actually completes the form. Importantly, this form is not made part of the Jails' electronic medical record; instead, it is placed into a "hard chart" that becomes part of the Medical Services Bureau's property. The Jails' mental health staff are not automatically informed of the contents of the hard chart and the breakdown of communications can contribute to the trajectory of prisoner self-injury. Our review of completed suicides from 2012 and 2013 indicates that arresting officers often have information that could prove valuable to the Jails' custody and mental health staff in their suicide prevention efforts. Moreover, when the arresting officers do have information that indicates a prisoner is at a heightened risk of suicide, the officers have a legal obligation to report such information. *Conn*, 591 F.3d at 1097 (finding that officers' failure to report to jail that prisoner wrapped a seatbelt around her neck and made suicidal statements en route to the jail constituted a factual issue as to whether the officers' omissions caused the eventual suicide).

For example, "Christopher" committed suicide at the Jails in 2013. Christopher was admitted to the Jails, six days before his death, after being arrested at his home while reportedly drunk, combative, and actively suicidal. Christopher hanged a noose in his garage but was stopped from hanging himself by a family member and, before finally being subdued by officers after a series of forceful attempts to control him, reportedly said he was going to "commit suicide by cop." The police report states that he was placed on a suicide watch at a local police lockup, where he was taken immediately after his arrest. Christopher's *Arrestee Medical Screening Form* reads "no" throughout the first page, but the second page references his suicidal thoughts. This form was not placed into or referenced in the electronic medical record; instead, it was filed in the hard chart. It appears that the Jails' mental health staff also did not receive the *Behavioral Observation and Mental Health Referral* form filled out by lockup staff. Like the arresting agency screening, that form was placed in the hard chart. Therefore, the Jails' mental health staff were apparently not aware of the critical circumstances of Christopher's arrest at the time of his mental health intake evaluation. Later that day, a nurse made an entry into the electronic medical record that Christopher "made statements that he wanted to kill himself," referencing the arrest report, but mental health staff never received the full arrest documentation relating Christopher's recent suicidal actions and statements. Christopher denied suicidal ideation, past and present, on intake. He was initially assigned to high observation mental health housing, but

was transferred to a medical isolation cell three days later due to a tuberculosis scare. Shortly thereafter, he was found hanging from a light fixture during a security check.[7]

In addition, our review of the Jails' suicide incidents revealed that when these forms are filled out, there are often inconsistencies between information on the *Arrestee Medical Screening Form* and the *15 Questions Screening Form* that is used upon intake at the Inmate Reception Center. This may be a testament to the importance of multiple screenings, but it may also be evidence of the arresting agency's rush to leave the prisoner at the Jails, poor training, a lack of accountability in making sure the forms are complete when the prisoner is formally accepted into the Jails, and communication lapses. In the case of "Dean," the *Arrestee Medical Screening Form* was marked "yes" for risk of suicide, but the *15 Questions Screening Form* was marked "no" for currently suicidal. In response to *15 Questions Screening*, Dean answered "yes" to having a history of mental health problems, to the use of psychotropic medications, and to having a history of suicidal behavior. Dean also had a history of at least seven psychiatric hospital admissions, including a hospitalization for anxiety and depression just two months before his intake screening. Dean had also been previously incarcerated in the Jails about two months prior to his intake screening and he was housed in mental health housing at that time. But at intake, mental health staff found that Dean did "not meet the criteria for mental health services" or suicide precautions. Eleven days after his admission to the Jails, Dean hanged himself in his single cell in non-mental health housing.

This breakdown may be a further reflection of the "silo approach" that divides the Sheriff's Department from the County Department of Mental Health's Jail Mental Health Services. The two entities have separate policies and procedures and such policies do not consistently reference each other or the Jails' "unit orders." The Department of Mental Health's policy on suicide prevention reads, in part, "Inmates booked into the [ ] Reception Centers are initially screened … through observation, interview, administration of a screening tool, 15 Questions (15Q), review of pertinent medical records from prior incarcerations, *and reports from arresting or transporting officers regarding potential suicide risk*." Policy 70.7, Suicide Prevention §4.1.1 (emphasis added). Based on our review, this policy is not enforced with regard to arresting or transporting officers. Further, it is unclear who has the authority to enforce this mental health policy, given that the arresting or transporting officers do not report to the mental health staff. A better approach would be to integrate medical and mental health related policies and procedures into the relevant Sheriff's Department unit orders, by merging or explicitly cross-referencing them.

B. Insufficient Supervision of Prisoners with Mental Illness and Suicide Risk.

Prisoners with mental illness and those who are identified as being at risk for suicide do not receive adequate supervision and are housed in conditions that present, rather than prevent, a risk of suicide. Correctional facilities have a duty to ensure that the conditions of confinement

[7] In contrast to most critical incident reviews, which do not indicate any remedial measures, the review for Christopher's death includes both a recommendation for a review of the policies and procedures regarding safety checks "to ensure that procedures were followed" and a recommendation for refresher training regarding completing a *Behavioral Observation and Mental Health Referral* form. The Sheriff's Department also issued Information Bulletin #2013-09, entitled "Handling of Suicidal Inmates," to all custody staff.

do not pose a substantial risk of serious harm to prisoners by heightening the risk of suicide. *Van Orden*, 546 Fed.Appx. at 648.

Due to changes in State law, the prisoner population of the Jails has increased dramatically in recent years: from 14,500 prisoners in October 2011 to approximately 19,000 in September 2013. While population levels of this number are not historically unusual for the Jails, the result has been an increase in both the number of prisoners on the mental health case load and the acuity of the prisoners' mental illness. The Jails' mental health staff reported significant increased severity of mental illness among prisoners generally, which has affected all areas of service. While it is commendable that the Jails have seen a significant increase in the number of mental health staff during this time, it is clear that the custody deputy staffing level is not sufficient to provide adequate supervision for prisoners, including those at heightened risk for suicide. "Inadequate staffing can create an objective risk of substantial harm in a [correctional] setting that is sufficient to satisfy the objective prong of the deliberate indifference test." *Lemire*, 726 F.3d at 1076 (citing *Hoptowit*, 682 F.2d at 1251).

1. Deficient Prisoner Supervision Policies and Practices.

Perhaps as a result of understaffing, poor supervision is apparent throughout the Jails, which increases the risk of harm to prisoners from suicidal behavior, as well as violence, sexual assault, and the inability to access medical care in a timely manner. This runs afoul of the Jails' obligation to provide a reasonable level of safety to prisoners. *Farmer*, 511 U.S. at 832. The lack of supervision is evident even in the "safer" housing units of the Jails, such as the open units at CRDF, that are more amenable to good supervision and prisoner management. Some areas of the Jails reported frequent lockdowns as a result of staffing shortages. In various areas of the Jails, which house general population as well as prisoners on the mental health case load, general security checks are conducted only every 60 minutes, as opposed to every 30 minutes. This is contrary to generally accepted correctional standards and allows ample time for prisoners to engage in suicidal behavior, as well as violence and other prohibited activities. In general, prisoners should not be left unsupervised for 60 minutes at a time, regardless of their classification level. *See Lemire*, 726 F.3d at 1077 (citing *Hoptowit*, 682 F.2d at 1249) (noting that prisoners should not be left unsupervised for more than 30 minutes and that those with mental illness are at heightened risk to suffer harm when left unsupervised for extended periods).

Custody supervisory staff and deputies repeatedly mentioned the inconsistent operation of the Title 15 scanner system, which is supposed to verify that regular security checks are made as required. In the suicides we reviewed, we observed a repeated failure over the last two years to complete the mandated Title 15 safety checks. For example, the Jails' critical incident review revealed that the Jails' electronic scanners were not working on the day that "Frieda" committed suicide by hanging in 2012, thus there is no confirmation of when custody safety checks were completed in Frieda's unit. No documents contain a clear statement about the probable time of Frieda's death and, due to the lack of clarity about the security checks that may have been completed on the day of her death, it cannot be determined how long Frieda was hanging before being discovered. When the electronic system is not operational, written documentation of safety checks indicates that the checks are not consistently made. When checks are documented, the name of the deputy making the check and the time of the check completion are frequently

missing. We also noted some instances of handwritten checks documented at exact time intervals throughout a housing unit, which calls into question the veracity of the documentation and violates generally accepted correctional standards requiring staggered checks.

In many of the recent suicides, the security checks are not even documented on an hourly basis. For example, the documentation surrounding "Gary's" 2013 suicide show that he was last seen at 6:21 p.m. and then discovered hanging at 8:30 p.m. There are also units of the Jails where deputies do not actually walk through the unit to complete their security checks, such as the dormitories in Men's Central Jail, and other units where supervision is accomplished by walking along the enclosed guard walk rather than along the halls of the cellblocks. In many areas of the Jails, when the security checks, including suicide checks, are conducted, they are not staggered, which facilitates the possibility of a planned suicide occurring during the known period without observation between checks.

The "K6G" housing units house gay, bisexual, transgender, and intersex ("GBTI") prisoners. Jail officials indicated that there were more suicide attempts among this population when housed in single cells and that since designating these dormitories for GBTI prisoners, suicide behaviors have decreased. Despite this explanation and an apparent acknowledgment that GBTI prisoners may be at a heightened risk for suicide, deputies not only register security checks only at 60 minute intervals in the K6G dormitories, but checks are "completed" from the vantage point of the control room, rather than actually walking through the housing areas. As there are 140 persons housed in each of the two dormitories, it is virtually impossible to see very deep into the bunk areas, which take up the majority of the space within the dormitories. Consequently, without direct supervision or actual walkthrough security rounds, the deputies must rely on the prisoners to report problems within the units. In another 2013 death, "Henry" committed suicide in K6G module 4400, which is an administrative segregation cell rather than a dorm, by hanging himself with a noose fashioned from a county issued shirt. Prisoners on the B row of module 4400 informed deputies of a "man down," in D row. Ten minutes later, deputies requested assistance for a "possible suicide attempt." The Jails conducted a "safety check audit" that found only 43% compliance with safety check requirements in this module on the day of Henry's death.

2. Inadequate Supervision for Individuals on Suicide Precautions.

The problems of inadequate supervision extend even to those prisoners with most demonstrated risk of self harm. In 2012, "Elliot" committed suicide at the Jails. During his intake screening five weeks before his death, Elliot reported suicide attempts a few months prior and treatment with anti-psychotic, anti-anxiety, and anti-depressant medication. A Jail psychologist referred him to the forensic in-patient program. After a deputy reported that Elliot was "covered with feces and urine" and had "unpredictable behavior," a Jail psychiatrist determined Elliot to be incoherent, and he was sent out to the hospital for treatment and observation. Elliot returned from the hospital six days later, was placed in medical housing in Twin Towers, and received a sheet, two blankets, and a shirt and pants, even though he was identified as being at risk for suicide. Approximately three weeks later, he was found with a sheet tied around his neck.

The timing and frequency of safety checks is not clear from any documentation provided for Elliot's suicide. The Medical Services Bureau incident review suggests that at the time of Elliot's suicide, he was housed in a room monitored by cameras, but the responsibility for watching monitors had not been established nor assigned to any specific employee. According to medical staff, the current practice is that "everyone" looks at the monitor. It is important to note that there are cell areas not captured on the video monitor, even though "close observations" are ordered on all patients housed in a monitored room. Accordingly, even if a specific employee is assigned to monitor the camera constantly, video monitoring may not be enough to prevent the recurrence of a similar suicide event. Video monitoring is never an adequate substitute for live staff supervision, especially when a prisoner requires direct supervision due to a medical, mental health, or suicide risk.

The command staff in some instances looks to solve custody problems by using mental health staff to perform security functions like watching monitors and assisting with safety checks. Following the 2014 suicide of Alan, the suggestion was made to have mental health staff present on the high observation housing units 24 hours a day to provide supervision of prisoners. This is inappropriate. While we commend the Jails' commitment to increased mental health coverage, mental health staff are not a substitute for corrections staff. Custody deputies have primary responsibility for the safety and security of the prisoners and the institution; mental health staff is responsible for the identification of mental health needs and the provision of services and treatment to address those needs. Custody and mental health staff must work collaboratively in the effort to operate a safe and secure Jail system, and do so with a healthy dose of respect for their respective expertise and responsibilities.

C. Custodial Disregard for Clinical Recommendations on Suicide Precautions.

Clinical staff also expressed some frustration that their clinical opinions are ignored or overruled, for example, when they have completed suicide risk assessments and recommended no change in housing. Housing decisions must always be a collaborative effort based on information provided by custody, medical, and mental health staff. When clinical staff determines an inmate is suicidal, the first line of intervention is generally to increase restrictions, including moving the prisoner to "suicide housing," instituting full suicide precautions, and providing medication. However, if there were opportunities for mental health staff to suggest and consider other and ancillary treatment alternatives, it may be that less physical movement in the system could be realized. At present, threats of suicide and actions of self-harm result in a prisoner's movement to suicide precautions in designated areas of the Jails, and subsequently to a brief stay in moderate or high observation housing. Finding a space for a highly suicidal prisoner can be challenging in part because of all this movement.

A lack of appropriate housing for suicidal prisoners and a disregard of housing recommendations by mental health staff may have contributed to Elliot's suicide, discussed above. The Jails' electronic medical record reveals inconsistencies about the use of suicide precautions with Elliot. Upon his return from the hospital, a note in the record indicates that a suicide blanket was ordered, and then cancelled. A week later, a nurse noted that he is on suicide watch. Six days before his death, a psychiatrist, who diagnosed him with Schizoaffective Disorder, wrote that Elliot would be transferred to high observation psychiatric housing, and

noted many warnings had been given about his psychiatric condition and risks for violence. The transfer did not occur and there is no explanation for this failure in the documents we reviewed. On the day prior to his suicide, Elliot was seen at his cell by mental health staff, who noted that Elliot was naked and his clothes were not in his cell. There is no documentation or follow up, but at some point he was given a sheet, which he used to carry out his suicide the following day.

It is especially significant that even though mental health staff should be able to insist that safety checks be completed at intervals not longer than five minutes for prisoners in need, there seems to be little commitment by custody staff to seeing that these enhanced checks are accomplished. As discussed above, housing and supervision decisions must take into account information from mental health staff. When a mental health clinician finds that a prisoner is suicidal and recommends enhanced monitoring, disregard for such a recommendation can be evidence of deliberate indifference to a prisoner's safety. *Clouthier v. County of Contra Costa*, 591 F.3d 1232, 1244-45 (9th Cir. 2010). In a jail system with an increasing number of suicides and suicide incidents, the need for more intensive levels of prisoner supervision is critical. *Madrid*, 889 F. Supp. at 1259 (emphasizing the need for "adequate monitoring . . . on far more than just isolated occasions, particularly in the [isolation units]"). Inadequate custody staffing is not an excuse for refusing to provide more intense levels of prisoner surveillance.

D. Unsafe Housing of Prisoners at the Jails.

The general lack of adequate supervision is especially troubling given the hazardous conditions that exist in nearly every housing unit in the Jails, including bars, open bunks, wide mesh vent covers, hidden corners, small cell windows, and other known suicide risks. Living conditions in general are deficient (dimly lighted, vermin-infested, noisy, unsanitary, cramped and crowded) and create an environment that may contribute to prisoners' mental distress. The County has a constitutional duty to ensure that conditions in the Jails constitute adequate shelter and to maintain sufficient sanitation for prisoners. *Johnson v. Lewis*, 217 F.3d 726, 731-32 (9th Cir. 2000). While these rights are guaranteed for all prisoners, hazardous environmental conditions can pose a particularly significant threat for prisoners who are vulnerable to mental health decompensation or suicide risk. *Redman v. County of San Diego*, 942 F.2d 1435, 1443 (9th Cir. 1991) (citing *Colburn v. Upper Darby Township*, 838 F.2d 663, 669 (3d Cir.1988) (holding that corrections officials may be constitutionally liable when they "know or should know of a particular vulnerability," such as a prisoner in severe emotional distress, and fail to protect the prisoner from that vulnerability).

Mental health line staff complained that many of the cells are very dirty and that steam cleaners were not routinely being used to clean feces-smeared cells. Contraband that can be used for self-harm (plastic bags, broken plastic spoons) is readily visible throughout the housing areas. These conditions provide ample opportunity for suicidal actions. For example, the Supplemental Assessment Team Area in the Twin Towers Correctional Facility houses prisoners who require additional evaluation for mental health challenges within 24-72 hours of their admission or identification. Although these areas are designated as high observation housing, with single and two-man cells intended to house prisoners who are in crisis, the cells are not suicide resistant.

E. Suicide Precautions at the Jails are Unnecessarily Punitive and Clinically Inappropriate.

Prisoners on suicide precautions often face arguably punitive restrictions, regardless of whether they are clinically indicated. When on a suicide watch, prisoners are not allowed to have pencils, combs, and other potentially harmful instruments, including paper, which some inmates have reportedly used to choke themselves. Prisoners placed on suicide watch are generally issued suicide resistant gowns, one or two suicide resistant blankets, and a mattress, absent explicit instructions to withhold one or more of these items. However, prisoners and line mental health staff reported that in practice, it was very common for prisoners to be denied access to mattresses, ostensibly because they were too easily torn. It was also reported by mental health staff that prisoners in high observation housing were not consistently permitted eyeglasses, hairbrushes, or thermal underwear, though custody staff disputed some of these allegations. The Jails should allow prisoners to retain their eyeglasses unless there is a documented and adequate clinical reason for removal, such as if the prisoner recently used eyeglasses to injure himself. In general, property restrictions should be individualized, documented, and necessary.

Suicidal gestures and comments are commonly countered with the threat of housing changes, the use of restraints, and limitations on privileges until the prisoner denies suicidal ideation, at which time the mental health staff lower the prisoner's risk level precipitously and virtually ignore the prisoner's risk history. The danger of moving quickly from high observation housing to merely bi-weekly contact with mental health staff is demonstrated by numerous recent suicides at the Jails. When Jail staff discontinue suicide precautions despite a reasonable inference that the prisoner is still at risk for self-harm, the staff demonstrate deliberate indifference to the prisoner's suicide risk. *Clouthier*, 591 F.3d at 1244-45. Even in some of the Jails' designated "step-down units," it was reported that prisoners are allowed out of their cells only one to two hours per day and are required to eat in their rooms. This is grossly inappropriate. In the absence of an individualized and documented clinical reason, inmates in the step-down unit should spend the majority of the day out of their cells, including therapeutic programming, organized activities, meals, and unstructured time in the day room. When suicide precautions are unnecessarily harsh, it raises the risk that some prisoners who are actually suicidal will be hesitant to admit their suicidality. These prisoners report that they would prefer to "take their chances" rather than experience what they regard as the punitive conditions of suicide watch. This was true in the previously cited example of Alan's death.

F. Therapeutically Inappropriate Environment for Prisoners with Mental Illnesss.

Severe restrictions are not confined to prisoners on suicide watch (or disciplinary sanctions). In some of the high observation housing units for female prisoners, women moved into the day room for treatment groups or other functions have one arm restrained with handcuffs extended from a chain secured to the floor while seated individually at tables. This approach to prisoner management may be a reflection of the low level of security staffing throughout the women's housing units rather than a necessary safety-structural requirement for delivering appropriate assessment and treatment services. Well-regarded and evidence-supported women-centered treatment approaches would support the delivery of services in an environment that

allows for group interaction, the building of connections, and the minimizing of the kinds of physical and emotional restraints that prove counterproductive to women's health. *See, e.g.*, Covington, S.S. & Bloom, B.E., *Gender-Responsive Treatment and Services in Correctional Settings*, Women and Therapy, 29(3/4), 9-33 (2006); Epperson, M., Wolff, N., Morgan, R., Fisher, W., Frueh, B.C., and Huening, J., *The Next Generation of Behavioral Health and Criminal Justice Interventions: Improving Outcomes by Improving Interventions*, New Jersey: Rutgers (2011). Similar restrictive handcuffing policies are followed at Twin Towers. While specific prisoners may at certain times require a higher degree of restraint in order to participate in therapy, such determinations must be made and documented on an individualized basis in accordance with the prisoners' specific mental health and safety needs.

Additionally, prisoners have inadequate access to recreation on many high observation housing units. Prisoners who exhibit mental illness are frequently housed in their own single cells, which increases their isolation and opportunity for self-harm. Despite the fact that they are not in any high-custody or segregation status, many prisoners with serious mental illness in Men's Central Jail spend as many hours per day in their small, four-man cells as segregation prisoners spend in single-man cells. Isolation or extended 22-hour cell confinement of prisoners with serious mental illness is not appropriate.[8]

Finally, the unacceptable, unsanitary, and unsafe conditions at the Jails, including the punitive nature of suicide precautions, are exacerbated by inappropriate and unprofessional behavior by deputies. The Eighth Amendment's prohibition on the unnecessary and wanton infliction of pain includes the intentional infliction of psychological pain. *Jordan v. Gardner*, 986 F.2d 1521, 1525 (9th Cir. 1993). We received reports, from both prisoners and staff, of deputies using obscene and derogatory language towards prisoners with mental illness. Verbal abuse of prisoners is unacceptable and can contribute to increased mental distress and suicidal ideation, especially for prisoners with mental illness. It is impossible to establish a therapeutic milieu if prisoners with mental illness are harassed and disrespected consistently by the deputies assigned to supervise them.

G. Deficient Tracking, Reporting, Investigations, and Suicide Reviews Contribute to Sustained Deficiencies in Suicide Prevention Practices.

The suicide prevention sub-committee review process is broken and ineffective. At present, nowhere in the review process are custody personnel or practices effectively scrutinized. In most of the cases reviewed, that scrutiny should have been focused on: (1) the repeated

[8] As one court noted, long periods of isolation for those with serious mental illness can be "the mental equivalent of putting an asthmatic in a place with little air to breathe." *Madrid*, 889 F. Supp. at 1265-66; *see also Brown v. Plata*, 131 S. Ct. 1910, 1933 (2011) (acknowledging the concern that prolonged isolation may result in inappropriate delays of mental health care); *Wilson v. Seiter*, 501 U.S. 294, 304 (1991) (holding that when conditions of confinement combine to "have a mutually enforcing effect that produces the deprivation of a single, identifiable human need" they violate the Eighth Amendment); *Hoptowit v. Ray*, 682 F.2d 1237, 1247 (9th Cir. 1981) ("[T]he court must consider the effect of each condition in the context of the prison environment, especially when the ill effects of particular conditions are exacerbated by other related conditions."); *Coleman*, 912 F. Supp. at 1320-21; *Casey v. Lewis*, 834 F. Supp. 1477, 1547-49 (D. Ariz. 1993) (describing the inappropriate use of isolation for prisoners with serious mental illness because "[d]uring lockdown, inmates are provided improper mental health care or no mental health care").

violation of suicide and safety check procedures; (2) the adequacy of the custody staffing in the units where the suicides occurred; (3) the placement of suicidal inmates into single cells, which can be done by custody staff without consulting prisoner classification or mental health staff; (4) the persistent submission of incomplete and poorly documented incident reports; and (5) the continued accessibility of instruments (plastic bags, plastic spoons, razor blades) that can be used to complete a suicide or effect a suicide attempt. The obfuscation inherent in not seeking and critically examining all the documentation around a death, the absence of corrective measures taken to add custody staff to housing units, the unwillingness to monitor and enforce policy adherence, and the lack of insistence on precise and accurate reports of critical incidents all signal a system destined to experience more of these incidents. The escalation in suicides and suicide attempts between 2012 and 2013 are evidence of this trajectory. An increased rate of suicides without meaningful change or remedial measures to address significant and known inadequacies in suicide prevention practices is evidence of on-going constitutional violations. *Coleman v. Brown*, 938 F. Supp.2d 955, 974 (E.D. Cal. 2013) (finding an "ongoing violation of the Eighth Amendment" where the suicide rate has not declined and majority of prison suicides involve longstanding, known deficiencies).

1. Inadequate Tracking and Documentation of Suicides and Suicide Attempts.

First, the labeling and recording procedures used to document suicide incidents are not consistent, which creates uncertainty about the nature of the suicide incidents that occurred system-wide. When asked for clarification as to who characterizes the type of self-harm behavior (as threats, gestures, attempts, and completions) when they occur, the Jails' mental health authorities acknowledged that they do not have clear working definitions for attempts, gestures, and threats. At present, the categorization appears to be done on the basis of discernible intent to commit suicide and on the level of medical intervention required after the suicide behavior is discovered. Thus, a prisoner caught in the process of creating a noose may not be classified as having made a suicide attempt or gesture. The fact that a suicide attempt or gesture did not result in actual, physical harm does not negate the Jails' obligation to take precautions against the heightened risk evidenced by suicidal behavior. *Conn*, 591 F.3d at 1095 (citing *Doty*, 37 F.3d at 546). All suicidal or self-injurious events must be taken seriously and included in the Jails' data collection, review, and response to critical incidents. Tracking and analysis of attempts and gestures enables correctional facilities to identify and correct system weaknesses. It is unclear if the Jails have any data or analysis of suicidal gestures that occur in the Jails system.

Moreover, there is a sustained failure to adequately report the details of suicide incidents, including attempts, that occur in the Jails. Even with completed suicides, deputies' reports lack substantive detail and are rarely signed with the time of completion noted. For example, "Jack" committed suicide by hanging in 2013. A prisoner worker found Jack hanging from an air vent in his cell at 10:15 p.m. After the worker reported the suicide, the events thereafter were apparently recorded on a video, but the video has been lost. There are no relevant times listed on the reports detailing this critical incident, beginning with the notification of the hanging until Jack was pronounced dead. The suicide critical incident review contains a note that the Title 15 scanner was "not available" to log security checks. The autopsy report states that Jack was last checked at 9:00 p.m. It appears some time was wasted during the intervention period when the

responding officer had to open the housing door for other officers to enter, but none of the documentation is clear with regard to any times. None of the reports written by the many responding deputies are time stamped or dated, nor are the times of report completion noted. All of the deputies' reports look very similar in detail and in language. There are no photographs of the suicide scene in the critical incident review or in the other materials reviewed, although our review revealed that such photographs are routinely taken by the Sheriff's Department and Coroner's investigators.

Even without any guidelines for categorization of incidents, mental health staff determined that 75 out of 281 suicide incidents from January 1, 2013 through September 21, 2013 qualified as "critical incidents." All but three of these incidents involved people who had been seen by the mental health staff sometime prior to the incident. Importantly, no more than seven days passed between critical incidents. This demonstrates a system replete with on-going problems related to suicide prevention, but also a system in which serious problems are not being effectively addressed. In short, there is a need to more accurately and systematically define and record information relative to the suicide attempts that occur in the Jails. Further, the opportunity for self harm and the influence of traumatic exposure (and the possibility of contagion effects) should be investigated as suicide risk reduction efforts proceed. Accurate information on the number, type, and facts surrounding "suicide incidents" must be available to the suicide review sub-committee so the members can recommend comprehensive and effective remedial measures in response to a prisoner suicide.

2. Ineffective, Inaccurate, and Incomplete Suicide Mortality Reviews.

Although the Jails have a system in place to review prisoner suicides, the process is incomplete and inaccurate. The review process is not managed by supervisory staff with sufficient authority to hold staff accountable and mandate change to remediate problems. Members of the review committee do not work collaboratively to ensure complete and accurate dissemination and analysis of information. The final reviews are missing critical information that could enable the review team to better formulate conclusions about the actions leading up to the prisoner's death.

Currently, the review process begins within 24 hours of a suicide and continues with meetings 7 days after the suicide and again at one month after the death.[9] For a suicide review process to yield life-saving benefits, a ranking official must lead the inquiries, some of which are (or should be) directed at other ranking officials. In contrast, the Jails' suicide review process, including the drafting of a written critical incident review, is largely led by a team of deputies and one sergeant, who have neither the rank nor the power to fully investigate and document their findings. These officers, good-intentioned as they may be, have neither the authority nor experience to question the supervision and security practices of employees of equal or higher rank. The sub-committee works as a trifurcated body, such that Sheriff's Department custody officials work separately from the Medical Services Board officials, who work separately from the Jails' mental health staff in compiling and reviewing the materials. Unfortunately, the three entities do not always share their materials with each other. A custody deputy compiles and

[9] Prior to approximately September 2013, a single suicide review was conducted approximately 30 days after a suicide.

writes the final critical incident review document, and mental health staff on the sub-committee do not see the file prior to the final review meeting at which it is discussed. Mental health staff have no input or involvement in the draft document. The sub-committee does not include interviews of, or direct input from, the clinical staff that actually saw or provided on-going services to the prisoner involved. This results in missing, incomplete, and potentially inaccurate information in the review process, and a sense of disenfranchisement among the clinical staff. There is a major gap in the communication between the custody and mental health divisions of the Jails, which should both play a critical role in mortality and morbidity reviews.

The written reviews are not completed in a timely manner, often taking eight months or more to complete. Indeed, two years after many of the prisoner suicides detailed in this letter, none of the critical incident reviews are complete because they still do not contain final signatures denoting approval. The Sheriff's Department attributes these delays to the wait for an autopsy report from the Coroner's Office. However, the Assistant Chief Coroner for the Los Angeles Coroner's Office confirmed that most autopsies are completed within a maximum of six weeks after the death. The autopsy report often contains critical information for the Jails' custody staff and mental health providers. Many of the autopsy reports are missing completely from the Jails' critical incident reviews. The Jails' inexplicable failure to obtain such reports in a timely manner impedes the ability to complete timely investigations of custodial suicides, which in turn delays the implementation of changes that might emerge from such investigations.

In addition to the missing autopsy reports, the critical incident reviews are missing other significant information. The specific interventions used when a suicide attempt was discovered and the timing of each phase of the intervention (*i.e.*, when CPR started, when medical and custody staff were notified, when they responded, when mental health staff were notified, when the paramedics were called, etc.) is obscure or absent from the review documentation. The fact that this information can often be found in separate records not available to the deputies completing the critical incident reviews further emphasizes the breakdown in communication during this process. In the end, assessing an accurate timeline of discovery-intervention-resolution is nearly impossible through the Jails' official review process due to missing, incomplete, or in some cases inaccurate documentation. In general, the County's documentation practices are inadequate.

The many errors in the critical incident reviews, errors of both omission and inaccurate recording, create suspicion with regard to their veracity. For example, the final critical incident review for the suicide of Dean is marked by errors in facts and appears to be the product of cutting and pasting from another suicide that occurred prior to Dean's death. Inconsistencies and errors in his age, his record of incarceration in the Jails, and in the dates of the critical incident review meetings make the entire review document questionable. Apparently none of these errors were noted by members of the review committee, as they remained in the critical incident review three months after Dean's death.

3. Lack of Remedial Response to Suicide Reviews.

Importantly, the Jails' suicide reviews fail to identify lapses in practice or policy and therefore do not result in comprehensive or effective remedial measures to correct identified

deficiencies. The critical incident reviews of suicides consistently end with the same or similar conclusions: a finding that no medical, mental health, or custody systems or practice issues contributed to the prisoner's suicide. Remedial measures, when advised, suggest custody briefings and written reminders to custody staff or revisions in policy - but the substance of these recommendations is not detailed. These conclusions and recommendations are rote, noncommittal, and cursory. Even where there is a clear contributory problem, such as when nursing staffing dropped to 20 personnel below the staffing level on the day of "Kyle's" 2013 suicide, the critical incident review did not include a recommendation to address the deficiency. Rarely are custody staffing deficiencies detailed in the files, even though there is a form (the Watch Commander's Incident Form) that requires this detail. Finally, the Jails' summary of the suicide reviews, compiled in an incomplete document called the *2012-2013 LASD Inmate Suicides Summary and Synopses*, is little more than a cursory view of the incidents and as such, is not a useful document to form the basis for action. The omission of critical reviews of custody responses to suicide incidents is suspect. The absence of recommendations geared toward enforcing existing policies and unit orders by (1) enhancing staffing levels, (2) providing effective training in report writing and documentation, and (3) taking definitive action when safety checks procedures are repeatedly violated, suggest that the critical incident review process, while perhaps well intended, amounts to little more than a bureaucratic exercise. The evidence of this is in plain sight: these same problems have happened repeatedly and more frequently over the 25-month period encompassing 15 suicides.

For example, in the case of Brian, discussed above, the documents we reviewed demonstrated numerous lapses. For instance, Brian was admitted into the Jails without undergoing the screening designed to prevent and identify acute health problems; the transporting officers failed to report his thoughts of having "nothing to live for;" and Jails staff failed to enforce its admission policy related to information from the arresting/transporting officer. There are gaps in the deputies' documentation of the suicide itself, including the response times of the three deputies who arrived on the scene, which make it difficult to evaluate the effectiveness of the response. A deputy's report notes that, on the shift prior to this suicide, Brian was "yelling, banging and kicking his cell door throughout the night," but it is not known if mental health staff were notified of Brian's level of agitation. In addition, even a cursory look at the electronic medical record would have revealed Brian's significant psychiatric history. Despite these deficiencies, the Jails' critical incident review of the suicide did not identify any remedial action regarding medical, mental health, training, and policy and procedures. The conclusions and recommendations in the critical incident reviews for Elliot, Dean, Henry, Kyle, and Michael are similarly lacking: no critical findings and no remedial action or training is suggested.

Even in the rare cases where the critical incident review actually includes or implies a critical finding, insufficient remedial measures are recommended. This is clear in the case of "Lily," who committed suicide in the Jails in 2013, on the anniversary of a family member's death, a year after she was charged with murdering family members. Lily had a significant history of mental illness and suicidal ideation. As the anniversary of the deaths drew near, her psychotic depression intensified, her auditory and visual hallucinations were more prominent, and her psychologist noted that Lily talked of her alleged victims' visits, of hearing their voices, and reminded the psychologist of the anniversaries of their deaths, but there is no apparent

increase in her level of supervision. At 11:00 a.m. the deputy completing cell checks in her unit noticed that Lily had not changed sleeping positions since the prior safety check, which is recorded as having occurred 38 minutes earlier, at 10:22 a.m. Lily, lying face down with blankets over her head, did not respond when called and, when the deputy entered the cell, Lily did not respond to the flashlight used to "nudge her left thigh." The deputy left the cell and requested that medical staff respond. Lily was found with a plastic bag over her head at 11:04 and pronounced dead at 11:20 a.m. The critical incident review reveals that the deputy, when observing that Lily had not moved, had a discussion with another deputy and with a prisoner prior to taking further action, and that when she nudged Lily with the flashlight, she realized she was "stiff." There are no times listed in the deputies' incident reports until Lily's death is pronounced. The unit activity log shows a Title 15 check completed at 9:20 and then not again until 10:22. The 15 minute safety check log sheets that relate to prisoners in certain cells are preprinted in quarter hours (*e.g.*, 11:00; 11:15; 11:30; 11:45) so that the deputy does not fill in the exact time of the safety check. Obviously, the deputy cannot observe all prisoners subject to these frequent safety checks at the same time, so the logs are necessarily inaccurate. A memorandum from a training officer indicated his findings that the deputy "failed to perform a thorough and complete assessment of the inmate as taught by the custody headquarters' training staff." However, in the end, no remedial actions were recommended for custody services, medical services, mental health, or for training. The critical incident review does recommend a policy and procedures review, related to: (1) the barcodes that accurately scan the time and location of a Title 15 check to ensure veracity and to create a record, and (2) plastic bags not being permitted in cells of those classified as high security or mental health risks. In fact, plastic bags have been removed from some housing areas, but there is no indication of a change with regard to tracking of required safety checks or any recommendations regarding Lily's insufficient level of supervision and the inadequate response by mental health staff to her worsening condition. Lily's death was preventable. As with the other suicides that have occurred in this system, there were specific points where therapeutic and security responses and interventions that could have saved her life should have happened and did not.

The suicide and critical incident reviews consistently evidence a complete neglect of critical analysis with regard to custody practices. Concerns about the timing, frequency, and adequacy of safety checks, while sometimes mentioned, at most result in referrals to the Internal Affairs Bureau for investigations. Unfortunately, investigations of suicides at the Jails are inadequate and untimely. The Sheriff's Department investigates its own jail suicides, using Sheriff's detectives to do so, and the resulting investigations are often incomplete and superficial. Assigning the investigation to an outside law enforcement or justice-system agency would not only avoid the appearance of bias in the investigation, but would open the door to a more critical and meaningful review of the circumstances of the death. Moreover, many Internal Affairs Bureau inquiries remain active even one year after a death, which negates the possibility for a timely impact that might prevent further suicides.

The lack of a comprehensive, self-critical, and remedial mortality and morbidity review process allows obvious and on-going deficiencies to continue unabated in violation of the Constitution. *Coleman*, 938 F. Supp.2d at 974. For example, on most days, the Sheriff's Department transports many prisoners to criminal (and presumably some civil) courts located throughout the complex Los Angeles County land mass. Sheriff's deputies indicated that suicide

incidents occur with some regularity in the court holding cells. In 2013, "Michael" hanged himself in the court holding area. While there is scant information about Michael, because he was held in a local lockup prior to his court appearance and had not been screened by the Jails, apparently he asked to see someone from mental health. Significantly, the Jails' mental health staff are not responsible for prisoners as they are transported to and from courts and held in court holding cells. Further, mental health staff indicated that they are not informed of self-harm incidents when they occur during court movement. Consequently, there is a large segment of the Jails' population that on any given day may be influenced or affected by self-harming behaviors and mental health staff, and perhaps custody housing staff as well, are unaware of it. This is a critical deficiency. Not only is intervention and follow-up warranted after any suicidal behavior, the behavior itself constitutes a risk for further suicide behavior. Moreover, the Jails' documentation of suicide attempts in 2013, not including any incidents in the court holding cells, revealed that 48 percent (174) of those incidents occurred within one week of a court date. These facts indicate that the Jails need to do an in-depth look at their court transport and holding procedures and communication practices regarding prisoners' behavior during such periods, as well as facilitating an appropriate alert or response to suicidal behavior that may be triggered by court proceedings. However, the Jails' dysfunctional critical incident review process has neither identified nor addressed these issues.

H. Deficiencies in Mental Health Services Contribute to Inadequate Suicide Prevention.

Despite 12 years of monitoring by the Department of Justice, detailed reports by the Department's experts, and consultation with those experts on policies, practices, and plans of correction, the deficiencies and examples noted above demonstrate that significant weaknesses remain with regard to mental health services at the Jails. The Eighth and Fourteenth Amendments both guarantee prisoners' right to receive constitutionally adequate mental health care. *Doty v. County of Lassen*, 37 F.3d 540, 546 (9th Cir.1994). In addition to failing to comply with the Jails' constitutional obligation to provide for the serious mental health needs of its prisoners, these systemic problems contribute to and allow for the Jails' dangerous conditions for suicidal prisoners.

In addition, our meetings with the Jails' psychiatrists and direct service providers (clinical social workers and counterparts), suggest that mental health services, within the Jails, are offered within a fairly traditional medical model, focusing on diagnostic assessments, treatment with medications if indicated, and limited follow up, rather than on a public health model that includes a broader preventive agenda focusing on larger population issues in addition to individual pathology.[10] As we emphasized previously, we strongly encourage the County to embrace both alternatives to incarceration for individuals with mental illness and augment its efforts to provide a robust community care network to provide mental health services to the

---

[10] The 2012 Surgeon General's report *National Strategy for Suicide Prevention: Goals and Objectives for Action*, available at http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/index.html, speaks to the public health approach in suicide prevention. Also see, the 2001 publication: *Mental Health: Culture, Race, and Ethnicity A Supplement to Mental Health: A Report of the Surgeon General* available at: http://www.ncbi.nlm.nih.gov/books/NBK44243/.

public, which may decrease the number of individuals who are arrested as a result of behavior stemming from untreated mental illness.

Following their most recent review of the Jails, Drs. Dvoskin and Metzner expressed considerable concern with the Jails' inability to progress in some areas, particularly those related to providing adequate mental health treatment and programming to prisoners on the Jails' mental health caseload, especially for prisoners who are not in mental health housing. Breakdowns in mental health services are evident in the suicides we reviewed. For example:

- Elliot committed suicide after 61 days in custody. During his intake screening, he reported suicide attempts a few months prior and treatment with anti-psychotic, anti-anxiety, and anti-depressant medication. The coroner's report included significant mental health history, including diagnoses of schizophrenia and bipolar disorder, auditory hallucinations, panic and anxiety disorders, substance abuse, and the initiation of numerous 72-hour holds. However, even months after the suicide, the Jails' psychiatrists were not aware of the coroner's report or of this significant history for a prisoner who was their patient for two months.

- In the 2012 death of Frieda, the Jails' *15 Questions Screening Form* reflects a history of suicidal behavior and mental health problems. Although Frieda was referred for psychiatric evaluation on intake, she was not seen until four days later, and then only by a social work intern. The intern evaluated Frieda, noted her history of having a Post-traumatic Stress Disorder, but indicated that her "symptoms do not appear outstanding enough to warrant [moderate observation housing]." The medical notes do not indicate any supervisory review of the intern's evaluation. Frieda hanged herself, while housed alone, two weeks after admission to the Jails. The autopsy report reveals that Frieda had a significant history of depression and three or four suicide attempts over several years, yet there is no indication of any substantive contact with the Jails' mental health staff following her intake.

- In late 2012, Nicole committed suicide at the Jails with a lethal overdose of prescription psychotropic medications. Nicole was admitted to the Jails directly from a hospital emergency room after a serious suicide attempt on charges of murdering a family member. All of her screening interviews and documentation noted suicidal intent, with the *15 Questions Form* indicating "extremely suicidal." After telling the mental health staff at intake that she would be better off dead than alive, she was referred to the forensic in-patient unit. Shortly thereafter, Nicole was placed in four-point leather restraints and she remarked to the nurse on duty that she was "deeply sad." There is no indication in the medical record about why Nicole was placed in four point restraints, nor is there documentation of what, if any, other less restrictive alternatives were considered or tried prior to applying the four-point restraints. Ninety minutes after being placed in full-body restraints, Nicole insisted that she was not going to hurt herself, was released from the restraints, placed on a 30 minute close observation, and given a safety gown and blanket. This abrupt change in supervision and attention, without any sort of step-down or transition, is contrary to generally accepted professional standards. Nicole was diagnosed with Mood Disorder NOS, Depressive Disorder NOS, rule/out Major

Depressive Disorder, and rule/out Bipolar Disorder, and placed in a single cell. Over the next three months, there are only three instances of mental health staff notes found in the medical records and several group activity notations. These records note that Nicole is consistently depressed. On one occasion, Nicole was sent to a local hospital for complaints of "dizziness." While there, she was prescribed a psychotropic medication. The dosage of this medication was increased when she returned to the Jails. Nicole was noted to be "med compliant." Nicole saw a psychologist again a week before her death, who observed her to be depressed and evidencing "…a psychotic process." Despite this observation, Nicole was not scheduled to be seen again until two weeks later. However, she ingested a fatal overdose of her prescribed medication a week before her next appointment.[11]

These examples, and those discussed in the previous sections, demonstrate that, despite some significant improvement during the tenure of the MOA, the Jails are not providing adequate mental health treatment in a consistent manner. In addition to the areas detailed in the discussion above, such as deficient screening and crisis intervention, the Jails are failing to comply with their obligations to provide: adequate treatment and referrals for prisoners in general population; sufficient in-patient care for those in need; adequate treatment to prisoners refusing medication; sufficient discharge planning; appropriate therapy and clinical contacts; and appropriate medication administration practices.

1. Insufficient Treatment for Prisoners in General Population.

Due to the increase in the Jails' population overall, and the accompanying increase in prisoners with mental illness, there are now nearly 1000 male prisoners who are seriously mentally ill or otherwise in need of psychotropic medication who are currently housed in non-mental health housing in different areas of the Jails. In response, the Jails have increased mental health staffing and the hours of mental health coverage in these areas of the Jails. Unfortunately, each of the six full-time psychiatrists serving these areas requires an escort deputy to bring prisoners to and from their offices, or to escort psychiatrists to housing units, and to provide security supervision. Prior to July 2013, the deputies assigned to the Jail Mental Health Evaluation Teams were serving this function, which left six of the teams without a deputy for the majority of the day shift. As a result, we strongly recommended that the Jails consistently assign one full-time deputy or equivalent to each psychiatrist, in addition to the deputies assigned to the mental health teams, in order to maximize their productivity while adhering to the team model that has been so successful.

In addition, the threshold for custody referrals for prisoners in need of mental health care in the non-mental health housing units, particularly those in the Men's Central Jail, is too high, basically waiting until the prisoner is in psychiatric crisis. Custody staff should be alerted (*e.g.*, through shift briefing trainings) to look for less obvious signs of increasing emotional distress, so that mental health referrals can occur earlier.

[11] Despite the autopsy report finding of an overdose of prescription psychotropic medications, the Jails' critical incident review lists Nicole's cause of death as suicide from an overdose of "Tylenol/aspirin."

2. Insufficient Access to In-Patient Care When Clinically Appropriate.

The Jails do not have enough in-patient beds to provide appropriate licensed in-patient care to the current population of prisoners with mental illness. While it is commendable that the Jails' mental health staff is attempting to address the problem by mandating daily psychiatric contact for prisoners awaiting transfer to in-patient care, this is not an acceptable alternative to additional in-patient beds. The Jails' mental health staff estimate that the current population requires approximately 200 additional in-patient beds. The Jails do not have sufficient in-patient care capacity to provide an adequate level of care to prisoners with serious mental illness. As such, the County should explore alternative options for treating and housing these prisoners in a setting that can meet their needs.

3. Inadequate Mental Health Treatment for Prisoners Refusing Medication.

In some areas of the Jails, psychiatrists decline to order psychotropic medications or continue to meet with a prisoner if a prisoner discloses an intention to refuse medication, even if the prisoner appears to suffer from an obvious or previously diagnosed mental illness. Unfortunately, this can result in prisoners with serious mental illness failing to be entered onto the mental health caseload. It is important to note that prisoners might initially refuse psychiatric medication, but later agree to take it at the urging of the treatment team. Thus, it may be useful to consider either ordering medications that will be refused, or ordering a follow-up psychiatric evaluation. Regardless, all prisoners with serious mental illness should be routinely followed by mental health staff, even if they are refusing medication and other treatment.

As demonstrated by several of the suicide incidents, some prisoners in mental health crisis do not receive adequate intervention. Moreover, the County must examine the policies and practices with regard to involuntary medication when clinically indicated, including related guardianship issues. The increase in population has made it difficult to transfer all prisoners in need to appropriate housing.

4. Insufficient Discharge Planning.

In order to facilitate the provision of adequate mental health treatment, the County committed to Corrective Action Plan 4.7, which requires the Jails to improve discharge planning and linkage to Service Area mental health providers and aftercare services. While discharge planning for prisoners in male mental health housing appears reasonably adequate, discharge planning for prisoners with a serious mental illness in non-mental health housing is very scarce. We also received reports of inadequate discharge planning at CRDF. The Jails need to remedy this issue and ensure adequate discharge planning for all prisoners in need of mental health care in the community, regardless of their housing location, as part of the Jails' obligation to provide adequate mental health treatment.

5. Inappropriate and Insufficient Therapy and Clinical Contacts.

The MOA requires that prisoners with serious mental illness who are housed in the most intensive levels of outpatient mental health housing be offered at least 10 hours per week of structured out of cell therapeutic or programmatic activity and 15 hours of recreation per week. Meeting the 10 hours per week of structured therapeutic activity threshold remains a challenge,

related in part to medication noncompliance issues for a subset of high observation housing prisoners who are refusing to attend therapies. As discussed above, the Jails should explore potential avenues related to involuntary medication practices, including guardianship issues, and assessing the quality/relevance of certain offered group activities. Having the ability to involuntarily medicate prisoners on a nonemergency basis, where clinically indicated, could be clinically very beneficial to many prisoners who are significantly impaired due to their mental illness. The Jails must also improve efforts to provide the required weekly recreation time, particularly at CRDF, where women in the high observation housing unit reported that they were not offered any outdoor recreation time. Additionally, prisoners with mental illness should be allowed to participate in the Jails' educational and work programs, where appropriate.

Group treatments in some housing units are three hours in duration, which is too long for both the prisoners and for the therapists. This results in prisoners refusing to participate and also diminishes the effectiveness of group treatment. We recommend that structured out-of-cell group activities should generally be about 90 minutes in duration and not longer than two hours.

In some high observation housing units, most clinical contacts occur at cell front, and much less often in the dayroom. While frequent cell front contacts can assist in providing emotional support and creating a therapeutic alliance, they are no substitute for private and confidential mental health treatment. This is not adequate treatment and indicates both a lack of adequate treatment space and, potentially, a reflection of custody staffing deficiencies that limit the ability to safety transport prisoners for clinical contacts. These staffing deficiencies obstruct the prisoners' opportunities for unstructured out of cell time and outdoor recreation, which can negatively impact their mental health status.

6. Inappropriate Medication Administration Practices.

Lack of adequate supervision is not only a problem with custody staff. During the Department of Justice's September 2013 on-site review of the Jails, we observed a nurse during medication rounds in a high observation housing unit, where medical staff are aware of the prisoners' heightened risk level. The nurse would bring a paper cup to the prisoner in her cell and tell the prisoner to fill the cup with water and bring it back to the cell window or trap door, after which the nurse gave the prisoner her medication(s). The prisoners could turn their backs and walk away without conversation, which makes "cheeking" or otherwise saving one's medications possible. In the case of Nicole, who likely stored up her medications to effect her overdose, the critical incident review contains no recommendations for, or even discussion of, potential remedial measures about the practices and protocols used for medication administration in the housing units. This practice is of concern not only because of the risk of suicide by medication overdose, but because Jails' staff report that in shakedowns, stockpiled medications are frequently found, and that medications are used as a commodity for "sale" or trade between prisoners at the Jails.

IV. MINIMUM REMEDIAL MEASURES FOR DEFICIENT MENTAL HEALTH SERVICES AND SUICIDE PREVENTION ISSUES

Suicides can be prevented and suicide incidents reduced when medical, mental health, and custody services act together and in accord with their policy directives. Insisting on complete arresting officer information before accepting an inmate into the Jails; sharing

information about prisoners' risk conditions across disciplines; resisting the inclination to house persons with mental illnesses and those who have suicide ideation in single cells; ensuring that security and safety checks are performed and increasing the frequency of such checks in those units where persons at elevated risk for suicide are likely to be found; having an accurate, participatory death review process; and scrutinizing the practices of all the Jails' divisions, including custody, will likely go a long way to reduce the rising number of suicide incidents in the Jails.

The above conclusions demonstrate how the Jails' non-compliance with the existing MOA provisions related to suicide prevention (§§ IV.G.25-29), including certain mental health provisions related to Intake (§ IV.A.5), Referrals (§ IV.C.9), Treatment (§ IV.D.12 & 15-19), Medication Administration (§ IV.E.22), Environmental Conditions (§ IV.F.23-24), and Quality Assurance (§ IV.J.42), poses a serious risk of harm to prisoners. These current MOA provisions roughly encompass the Jails' duties to provide adequate screening and suicide risk assessment upon intake, properly evaluate prisoners identified as suicidal, ensure appropriate crisis intervention and emergency response for prisoners who attempt suicide, properly monitor and observe prisoners who are at risk for suicide, provide safe housing for suicidal prisoners, administer medications in a manner that does not pose an unreasonable risk of suicide attempts, and ensure an adequate morbidity and mortality review to identify problems and potential remedial measures. In order to address the deficiencies outlined above, the existing MOA provisions must be replaced with a court-enforceable remedy that addresses these subject areas but provides greater detail and structure in order to ensure adequate suicide prevention practices at the Jails.

The reduction of the number of prisoners with mental illness confined to the Jails may be essential to the effective implementation of remedies. The United States welcomes the efforts that the County has begun to create diversion programs to keep people safely supervised in the community rather than confined to the Jail. We encourage the County to expand these programs.

In order to rectify the deficiencies identified in this letter, a court-enforceable agreement should require the Jails to implement, at a minimum, the following remedial measures:

A. Custody Practices and Staffing Related to Suicide Prevention and Safety of Prisoners with Mental Illness.

1. The Sheriff's Department must develop, implement, and enforce an effective policy and procedure for obtaining relevant and available information on prisoners' mental health status and suicide risk from the arresting or transporting officer upon intake to the Jails.

2. The Sheriff's Department must conduct an appropriate and objective assessment of custodial staffing needs throughout the Jails, with particular consideration of staffing in housing areas for prisoners with mental illness and high observation housing units, including suicide observation.

3. The Sheriff's Department must ensure that custodial safety checks are completed and documented in accordance with policy and legal requirements, at least every 30 minutes in general population and appropriately staggered, and more frequently as necessary due to the prisoner needs (including for prisoners on suicide watch), environmental challenges posed by the facilities, or requests by medical or mental health care staff.

4. Custodial safety checks must be completed in a manner that allows deputies to view each prisoner in a housing unit in order to assure prisoner well-being and security within the unit.

5. The Sheriff's Department must develop, implement, and enforce an effective policy and procedure for unit contraband searches on a regular but staggered basis.

6. The Sheriff's Department, in consultation with the Department of Mental Health, must develop advanced training curricula for special management housing, including moderate observation housing, high observation housing, and suicide watch, and ensure that deputies assigned to these areas receive adequate training in identifying mental health symptoms, assessing suicide risk, using appropriate communication strategies when dealing with prisoners in mental health crises, and in effective crisis intervention techniques.

7. The Sheriff's Department, in consultation with the Department of Mental Health, must revise the deputy suicide prevention training to include adequate training on response to suicide incidents, including a hands-on simulation experience that incorporates the challenges that often accompany a jail suicide, such as cell doors being blocked by a hanging body and delays in securing back-up assistance.

8. The Sheriff's Department must notify the Jails' medical and mental health staff of any crisis or suicide incident that occurs during court transport or in a court holding cell, including providing relevant incident reports.

9. Cameras cannot substitute for deputy staffing. However, if a cell is designated for constant monitoring by camera, then designated custody staff must be assigned to view the monitors in those areas where cameras have been placed in the cells.

10. Any prisoner brought directly to CRDF and held pre-arraignment must be screened by the Jails' medical and, if indicated, mental health staff prior to being placed in the pre-arraignment unit.

11. The Sheriff's Department must consider housing recommendations from medical and mental health staff, including recommendations for "no change in housing," when considering a change to a prisoner's housing unit or classification level following potential suicidal ideation, gesture, or incident, or other indication of mental health issues.

12. The Sheriff's Department must ensure that any relevant information regarding a prisoner's medical or mental health status or history (for example, from the arrest report) is communicated to medical and mental health staff for inclusion in the prisoner's electronic medical record.

B. Mental Health and Medical Care Treatment and Suicide Prevention.

1. The Department of Mental Health shall include deputies on the relevant housing units as members of the treatment team and shall advise such deputies of any prisoner's special handling needs.

2. Mental health staff and custody staff, working collaboratively, must ensure adequate crisis intervention for prisoners exhibiting signs of mental health crisis.

3. Mental health staff must consider, and revise as necessary and consistent with legal requirements, Jail policies and procedures related to involuntary medication of prisoners in acute stages of a mental health crisis.

4. Every prisoner seen for ongoing services by mental health staff must have a treatment and an individualized discharge plan in the electronic medical record. When services are discontinued, a brief discharge summary should also be made in the electronic medical record to allow for an expedient review of the prisoner's history should he or she be readmitted to the Jails at another time.

5. Excluding restraints used for transport (handcuffs), prisoners should only be subjected to mechanical restraint in response to a mental health crisis when necessary based on an individualized assessment: if the prisoner poses an immediate and serious risk of harm to him/herself or others; after a graduated range of less restrictive measures has been exhausted or considered in a clinically justifiable manner; for reasons other than as punishment, for convenience of staff, or in the absence of or as an alternative to treatment; and in accordance with applicable written policies, procedures, and plans governing restraint use.

6. If the Department of Mental Health subjects a prisoner to restraint in response to a mental health crisis, mental health staff must ensure the prisoner receives therapeutic services to remediate any effects from the episode(s) of restraint.

7. The Department of Mental Health must provide adequate mental health treatment to all prisoners with mental health needs, including those who refuse medication.

8. The Department of Mental Health must develop and implement an adequate policy and procedure for seeking involuntary medication of prisoners when clinically appropriate.

9. The Sheriff's Department must refer prisoners from general population who are demonstrating a potential need for mental health care to the Department of Mental Health for evaluation.

10. The Department of Mental Health must ensure adequate therapy and counseling for all prisoners with mental illness, including those housed in general population.

11. The Department of Mental Health must provide adequate 24 hour crisis intervention for prisoners, including transfer to special housing units, administration of psychotropic medications, provision of therapy treatment, and special observation.

12. Unless contraindicated, all prisoners with serious mental illness and housed in the most intensive levels of outpatient mental health housing must be offered at least 10 hours per week of structured out of cell therapeutic or programmatic activity and 10 hours of unstructured out of cell time, including recreation, per week.

13. Unless clinically contraindicated or the prisoner is in administrative segregation, no prisoner with serious mental illness shall be locked down more than 19 hours per day. Prisoners with serious mental illness in segregated placements shall be offered adequate therapeutic and recreational out-of-cell treatment, consistent with their security levels and treatment needs.

14. Prisoners with mental illness or housed in mental health housing shall not be denied jail privileges or programs based solely on their status as mentally ill or on their placement in mental health housing.

15. The Sheriff's Department must provide adequate space for treatment and individual and group therapy and programming.

16. The Department of Mental Health must ensure adequate access to appropriate licensed in-patient care when clinically appropriate, either in the Jails or in another appropriate facility.

17. The Department of Mental Health must provide adequate discharge planning and linkage to community mental health providers and aftercare services for prisoners on the mental health case load.

18. Mental health staff and custody staff, working collaboratively, must ensure that conditions of suicide watch are not unnecessarily punitive. Property restrictions must be individualized, documented, and necessary to accommodate the prisoner's mental state and behavior. Prisoners on suicide watch shall be provided mattresses, including suicide-resistant mattresses when warranted, unless providing a mattress is clinically contraindicated. Orders to remove a prisoner's mattress must be documented in the electronic medical record.

19. Intermediate steps between highly restrictive suicide precautions (*e.g.*, mechanical restraints, suicide protective gowns and blankets, and constantly monitored cells) and the discontinuation of suicide precautions shall be developed, knowing that "recovery" from depression and suicide ideation is a process that extends beyond the moment when an inmate no longer admits to suicide ideation.

20. The Medical Services Bureau and the Department of Mental Health must consolidate and manage prisoner medical and mental health records to ensure that all relevant information is available to all health service providers.

21. All intake forms, including the 15 Question screening form and the Arrestee Medical Screening Form, must be included in the electronic medical record.

22. Supervisors shall periodically review clinician notes and entries in the electronic medical records to independently assess and ensure accuracy and veracity of the notes.

23. Medication administration procedures must be adequate to prevent prisoners from hoarding medications or from deviating from the prescribed medication regimen without the knowledge of medical and mental health staff.

24. Relevant custody, medical, and mental health staff shall meet on a regular basis to ensure coordination and communication regarding the needs of prisoners in mental health housing.

25. Jails staff must ensure that prisoners in mental health housing have equal access to educational and work programs, and that adequate translation services are readily available for prisoners requiring mental health services.

C. Suicide Tracking, Investigation, and Review Process.

1. The Sheriff's Department, working collaboratively with the Department of Mental Health, shall develop and implement a consistent method for categorizing, documenting, and tracking suicide gestures and attempts. Information on all such incidents must be included in the prisoners' electronic medical records.

2. The Sheriff's Department, the Medical Services Bureau, and the Department of Mental Health must work collaboratively to review each prisoner death. Written mortality reviews shall be prepared by a Sheriff's Department official of appropriate rank.

3. Prisoner death reviews must include accurate and complete information surrounding the prisoner death, including time-stamped and signed reports from deputies and medical and mental health staff relevant to the incident.

4. Prisoner death reviews must be completed in a timely manner.

5. Autopsy reports shall be sought from the coroner's office within six weeks of a prisoner death, and Jails staff must conduct prompt and regular follow up to receive any reports still outstanding after six weeks. Findings from autopsy reports must be incorporated into the final written suicide review, including another subcommittee meeting to assess the autopsy report, if necessary.

6. Suicide review reports should include an approximate time of death and an accurate timeline regarding the discovery of the prisoner and any responsive actions or medical interventions.

7. If available, suicide review reports shall include and maintain any relevant video recordings of the incident or response, and photographs of the scene. The County shall document the chain of custody for all evidence related to a prisoner death, including relevant videos and photos.

8. The Sheriff's Department must ensure an accurate, complete, and unbiased investigation of suicides that occur in the Jails. This may involve an arrangement with a neighboring jurisdiction, district attorney's office, or private organization to conduct or facilitate the investigation.

9. Each suicide review shall identify any deficiencies in custodial, medical, or mental health practices or policies that may have contributed to the suicide and recommend remedial measures, including policy revisions, re-training, or staff discipline, to address the deficiencies. The subcommittee shall designate a member to follow up on each recommendation to ensure implementation.

10. The suicide review process shall result in data-driven efforts to identify and address systemic issues. The subcommittee shall collect data on suicide attempts and incidents, including location, method, and deficiencies (lack of staffing, missed security checks, inadequate mental health contacts, etc.) in order to target problems for remediation.

D. Environmental Conditions.

1. The Sheriff's Department shall conduct a systematic review of all housing, with particular emphasis on moderate observation housing, high observation housing, and areas in which suicide watch is conducted, and identify and address suicide hazards.

2. The Sheriff's Department shall revise and implement written housekeeping and sanitation plans to ensure the proper routine cleaning of housing, shower, and medical areas, in accordance with generally accepted correctional standards. Such policies should include oversight and supervision, including meaningful inspection processes and documentation, as well as establish routine cleaning requirements for toilets, showers, and housing units.

3. The Sheriff's Department shall implement a preventive maintenance plan to respond to routine and emergency maintenance needs, including ensuring that shower, toilet, and sink units are adequately maintained and installed.

4. The Sheriff's Department shall ensure adequate lighting in all prisoner housing, programming, and work areas.

5. The Sheriff's Department shall ensure adequate pest control throughout the housing units, medical units, kitchen, and food storage areas.

6. The Sheriff's Department shall ensure that all prisoners have access to needed hygiene supplies.

V. COMPLIANCE ASSESSMENT OF REMAINING MOA PROVISIONS

With regard to the remaining provisions of the MOA related to mental health care, and the associated Corrective Action Plans developed by the Jails in conjunction with Drs. Dvoskin and Metzner, the Jails have made considerable progress. The Jails have achieved and sustained substantial progress, meaning the Jails have achieved compliance with most, or all, components of those requirements, with the following MOA provisions: §§ IV.A.1-4, A.6, B.8, D.14, D.20, H.30-33, and I.36-40. As such, we will no longer conduct compliance assessments on those provisions and the Jails are not required to report on those areas. While our conclusions confirm continued problematic practices in certain areas connected to some of these MOA provisions, those concerns are discussed in our conclusions regarding mental health treatment and suicide prevention and shall be addressed with the remedial measures set out above.

The remaining MOA provisions related to mental health care, excluding those implicated by the suicide prevention conclusions, are in partial compliance and will require further monitoring and consultation. A brief review of the Jails' compliance status with regard to the remaining MOA provisions, §§ IV. B.7, C.10-11, D.13, E.21, I.34-35, and J.41, follows. The monitoring report from Drs. Dvoskin and Metzner contains a more detailed review of the Jails' MOA and Corrective Action Plan compliance, as well as additional recommendations for achieving compliance.

§ IV.B. Evaluation

7. Within 24 hours of admittance to IRC (excluding weekends and legal holidays as long as an urgent evaluation is not indicated), the County shall provide an adequate mental health care evaluation of inmates who screen positive for possible mental illness at IRC. Within 72 hours of admittance to IRC, the County shall provide a mental health care evaluation to inmates admitted to IRC on the weekends or legal holidays (unless an urgent evaluation is indicated). If the evaluation identifies a serious mental illness, the evaluation shall result in a brief initial treatment plan.

Partial Compliance.

Subject to the discussion above regarding screening issues identified in relation to our suicide prevention conclusions, much of the reception and screening process at the Jails continues to function well. There is some evidence, in an effort to avoid false-negative screening results, that mental health staff are now over-identifying too many prisoners for follow-up assessment. Any attempt to remedy this problem should be addressed carefully. Overcorrection could result in an increase in false negative conclusions, which have far more dangerous consequences.

§ IV.C. Referrals

10. Mental health staff shall make weekly rounds in locked down non-mental health housing modules (e.g. administrative segregation, disciplinary segregation) at the Jail to identify inmates who may have been missed during screening or who have decompensated while in the Jail.

Partial Compliance.

Currently, the mental health teams conduct rounds throughout the male non-mental health housing areas and respond to crises and referrals. Given the dramatic increase in the number of prisoners with mental illness living in non-mental health housing throughout the system, it is a challenge to provide adequate treatment to everyone in need. We identified many prisoners in non-mental health housing who were currently experiencing symptoms of serious mental illness, particularly in the Men's Central Jail. Every prisoner with mental illness housed in the Men's Central Jail non-mental health housing should be seen at least once every month by a psychiatrist to ensure that the prisoner's mental health status is not deteriorating in the difficult environment at Men's Central Jail. We also recommend consideration of creating a mental health housing unit for prisoners believed to be vulnerable due to the nature of their charge or other reasons, who are currently segregated in Men's Central Jail.

In addition, it is important that the Jails take into account any impact that a prisoner's mental health status may have on his or her actions that contributed on the behavior leading to an assignment to administrative or disciplinary segregation. To the extent that mental health staff identify individuals in locked down non-mental health housing who ought to be moved, either because segregation is having a negative impact on the prisoner's mental state or because the prisoner's disciplinary infraction was due to his or her mental health diagnosis, the Sheriff's Department must consider such mental health recommendations with regard to a prisoner's housing assignment. Custody staff must also consult with mental health staff when an inmate with mental health issues is subject to discipline.

11. The Jail will maintain a confidential self-referral system by which inmates can request mental health care without revealing the substance of their request to correctional officers.

Partial Compliance.

To address this MOA provision, the County committed to Corrective Action Plan 4.17, which requires the Jails to provide reasonable access to clinicians and psychiatrists through a self-referral process. The Jails' own data indicate compliance with regard to prisoners in most male mental health housing, but there is inconsistent information regarding compliance for

prisoners in CRDF and a need for a quality assurance initiative to track access for prisoners who are not in mental health housing.

§ IV.D. Treatment

13. The County shall ensure continuity of appropriate medicine to individuals identified as mentally ill who were receiving medicine prior to entering the Jail.

Partial Compliance.

While we found greater consistency with regard to medication continuity, a minority of prisoners continued to experience two- to three-day delays in receiving their medications following the initial orders by the psychiatrist.

20. Inmate trusties shall never be placed in a supervisory position or used as escorts for mentally ill inmates or inmates in mental health housing. Inmate trusties shall be carefully selected and screened before being assigned trustie positions. Where trusties are allowed to work in mental health housing, they shall be closely monitored.

Sustained Compliance.

While this provision is in sustained compliance, we note that in some areas of the Jails, such as the K6G dormitory units and CRDF, prisoners must use trustees to submit their medical and mental health request slips to designated deputies for collection. An alternative method of collection must be implemented so that other prisoners are not assigned the responsibility to collect and deliver these sensitive medical documents.

§ IV.E. Medication Administration

21. The County shall ensure that a full range of appropriate psychotropic medications is available at the Jail and that psychotropic medications are properly prescribed, monitored and documented by appropriately trained mental health professionals.

Partial Compliance.

The Jails' quality improvement initiatives demonstrate that policies and procedures have been successfully implemented with regard to bridging medication orders and timely renewal of psychotropic medications. Issues remain with regard to obtaining relevant laboratory studies, but the Jails are appropriately addressing the problem. The Jails' quality improvement studies were generally consistent with prisoner reports relevant to medication management issues. However, a minority of prisoners continued to experience two- to three-day delays in receiving their medications following the initial orders by the psychiatrist.

§ IV.I. Staffing and Training

34. The County shall provide sufficient mental health staffing to ensure timely access to adequate mental health treatment and meet the obligations and provide the services listed in this Agreement. Except for staffing for the women's case load population and the Forensic Inpatient Program, mental health staffing shall be no lower than one psychiatrist per 100 inmates who require medication. Staffing for the women's case load population shall be enhanced due to

higher utilization rates of mental health services. Staffing for the Forensic Inpatient Program shall ensure timely access to adequate treatment and shall minimally meet licensure standards currently governing such program.

Partial Compliance.

As mentioned above, in response to the increased population of the Jails due to changes in State law, the number of mental health services staff at the Jails has increased. The current mental health staffing is sufficient and the number of vacancies has remained low. In most areas, the Jails have attained full compliance with the staffing requirements for psychiatry, including an acceptable level of psychiatric staffing enhancement for the women's population. The psychiatrist-to-patient ratio in non-mental health housing is approximately 1:73, as compared to earlier finding of 1:350. However, we reiterate our concerns with regard to staffing in CRDF, especially the lack of a dedicated Jail Mental Evaluation Team.

35. A psychiatrist shall be available, at least by telephone, twenty-four hours per day to evaluate and prescribe psychotropic medications in emergency situations.

Partial Compliance.

Psychiatric coverage and the number of vacancies remain low. However, the low level of custody staffing is negatively impacting the psychiatrists' ability to evaluate and treat prisoners in a timely manner. Until this issue is resolved, psychiatrists will be hampered from providing adequate treatment.

§ IV.J. Quality Assurance

41. The County shall implement and document a continuous quality improvement program for mental health services in the Jail. The continuous quality improvement program shall monitor the quality of mental health care.

Partial Compliance.

The quality improvement process continues to improve. The Jails have implemented many quality improvement initiatives, some of which have yielded timely and effective results. For example, one quality improvement study regarding continuity of psychiatric medications on a particular unit revealed that a significant problem was being caused because of the need for an additional high-volume printer, and the problem was easily remedied. This is a wonderful example of how quality improvement projects are supposed to work; the team analyzed and identified the source of the problem and an inexpensive solution that had previously been missed, to the detriment of psychiatric care. As a result, medication continuity and psychiatric care was dramatically improved. However, the Jails need to broaden efforts not only to identify problem areas for additional quality improvement initiatives, but to ensure remedial actions are taken as a result of these studies. In addition, the discrepant information obtained relevant to the involvement by mental health line staff in the quality improvement process is very concerning.

VI. CONCLUSION

We applaud the cooperative and productive partnership the County has formed and continued with the Department of Justice with regard to reforms at the Los Angeles County Jail System. We also commend the strides made in most areas of MOA compliance. As discussed, this commitment and demonstrated improvement allows us to recommend removing the provisions in sustained compliance from further MOA monitoring by the Department of Justice. However, given the gravity of the conclusions with regard to the Jails' deficient suicide prevention program and the serious harm posed as a result, we recommend that the County negotiate with the Department of Justice regarding the terms of a court-enforceable settlement governing remedial suicide prevention measures at the Jails. We hope to continue working with County officials in an amicable and cooperative fashion to resolve our outstanding concerns regarding the Jails.

Please note that this assessment is a public document. It will be posted on the Civil Rights Division's website. We are obligated to advise you that, in the event that we are unable to reach a resolution regarding our concerns with regard suicide prevention, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter anytime following the date that is 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1).

We would prefer, however, to resolve this matter by working cooperatively with you. The lawyers assigned to this investigation will be contacting the County to discuss this matter in further detail. Please contact us if you have any questions. You may reach Jonathan Smith at (202) 514-5393, Luis Saucedo at (202) 598-0482, or Robby Monteleone at (213) 894-2458.

Sincerely,

Jonathan Smith
Chief, Special Litigation Section
Civil Rights Division

André Birotte, Jr.
United States Attorney
Central District of California

cc: Beong-Soo Kim, Esq.
Jones Day

Attachments