Santa Clara County

OFFICE OF CORRECTION AND LAW ENFORCEMENT MONITORING

Report on Audit of Jail Reform Recommendations

Interim Report #2

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Introduction and Background

Beginning in 2016, 15 separate entities issued recommendations for reform of the County's jails. A total of 623 recommendations (referred to as "Master List Recommendations") were catalogued as part of these various review processes. Several years ago, the Finance and Government Operations Committee received numerous reports from the Office of the County Executive that grouped all the recommendations by subject area and created a list of 80 Summarized Recommendations. Despite efforts by County departments over the years, verifying implementation of these recommendations has proven to be a challenging task.

On December 15, 2020, this Board directed OCLEM to take on the role of auditor of these Jail Reforms Recommendations. In March 2021, the Jail Reforms Workgroup provided us with a list of 10 of the 80 Summarized Recommendations it deemed to be completed and ready to be audited. We published our first interim report in September 2021, covering eight of these 10 Summarized Recommendations, while we awaited further information on the remaining two. This report covers those last two recommendations from the initial batch (which encompass 15 Master List recommendations).

The first group of Recommendations discussed in detail below were proposed with the objective of ensuring that inmates are receiving adequate dental care. As detailed below, Custody Health has either implemented each of the specific recommendations or the intent of the recommendation has been met in a way such that the specific recommendation is either no longer applicable or advisable. When we were able to tour Main Jail last year, we observed the new dental clinic and were impressed with the upgraded facility.

The second group of Recommendations deals with the use of restraints and monitoring of inmates who are ordered into them. As detailed below, we found that for the most part Custody Health and the Custody Bureau of the Sheriff's Office (referred to as "Custody" or "Custody Bureau") have either implemented the specific Recommendations or implemented reforms that address the objective of the Recommendations. However, regarding the Recommendation relating to the use of the restraint chair and the frequency of monitoring restrained inmates, we found that Custody has not implemented the

specific Recommendation, nor has it advanced a rationale for not yet modifying its policies to align with that Recommendation.

We appreciate the cooperation of Custody Health Services and the Custody Bureau in providing us the necessary documentation and access to personnel necessary to complete this review. Both were given a draft version of this report and opportunity to provide feedback or further clarification. We look forward to our ongoing work and collaboration to complete our audit of the remaining Recommendations.

Feedback from Individuals in Custody

As we move forward with our audits of Custody and Custody Health's implementation of jail reform recommendations, we also look forward to receiving input from individuals in custody about the impact of the jail reform measures. We have had several constructive, collaborative meetings with personnel from the County Executive's Office, along with Custody Health and Custody Bureau staff, to discuss the most effective ways to gather this feedback.

We have developed a plan to post our audit reports on the inmate tablets, along with a summarized introduction, and then pose a few questions to those in custody on specific topics from each report, via both the tablets and paper surveys. We also will be exploring ways to interact with Inmate Advisory Councils, when COVID-19 protocols are sufficiently eased to allow those groups to resume meeting. The goal of all these efforts will be to learn about the experiences of those in custody, relative to objectives of the jail reform initiatives, to further inform our priorities in addressing these recommendations.

We will regularly update the Community Correction and Law Enforcement Monitoring Committee about these efforts and seek its members' input on additional, meaningful ways to reach out to those in custody.

Audit Findings

Each of the audited recommendations is listed below, by both Summarized Recommendation and its associated Master List Recommendations. OCLEM's findings regarding each recommendation follows.

Recommendation		Description	OCLEM Finding
Summarized: HLC 2		For dental care, broaden the scope of services for longer term inmates based on categorizing treatment as Urgent Care, Interceptive Care, Routine Rehabilitative Care, No Dental Care Needed, and Special Needs Care. Revise policy related to: • Dentures for inmates who are in custody for a long time that addresses when soft diets are prescribed • Dental prosthesis and fixed orthodontic appliances • Developing wider scope of services (such as denture fabrication) and clinical administrative procedures (such as record keeping) • Dental floss and when it will be denied for security reasons. Change the principal evaluation metric for the dental program from number of patient encounters to number of procedures per day.	Implemented
Master List	55	Provide regular preventative care for detainees who are housed for a year or longer in the facilities, such as dental cleanings and x-rays, physicals, immunizations and other standard care that would be received outside. To reduce the loss of teeth and the cost of trips to the emergency room, institute more preventative care for detainees and improve response to requests for care. Consult medical professionals for typical standards of recommended care.	Implemented
	548	The scope of services should be broadened for longer-term inmates and be based on the dental priority codes used by CDCR which categorize treatment needs as Urgent Care, Interceptive Care, Routine Rehabilitative Care, No Dental Care Needed, and Special Needs Care.	Not specifically implemented, but substitute measure in place

Recommendation		Description	OCLEM Finding
	549	Urgent Care should be sub-divided based on a condition's acuity. Conditions characterized with sudden onset and severe pain should be treated within 24 hours. Urgent Care should be made available to all inmates.	Not specifically implemented, but substitute measure in place
	550	Inmates requiring Interceptive Care should be treated within 120 days. Interceptive Care should be available to inmates who have six months or longer left in their sentences or inmates who are not adjudicated but who are likely to be in custody for at least six months.	Not specifically implemented, but substitute measure in place
	551	Routine Care should be provided to inmates within 12 months. It should be available to inmates who have 12 months or longer left in their sentences or those who are not adjudicated but likely to be in custody for at least 12 months.	Not specifically implemented, but substitute measure in place
	553	Dental policies and procedures should be rewritten to address a wider scope of services (e.g., oral self-care, periodontal diagnosis and non-surgical treatment, denture fabrication and repair, restorations, and routine care), and clinical administrative procedures (e.g., record keeping and workload reporting). The Policies and Procedures should be modeled on those used by CDCR, especially with respect to the DPC system.	Not specifically implemented, but substitute measure in place
	554	The policy regarding prescribing inmates dental prosthesis should be rewritten.	Implemented
	556	A policy should be developed to address dental floss and other interdental cleaning devices. The policy should also address the circumstances when use of such devices will be denied for security reasons.	Implemented
	557	A policy should be developed to treat inmates who have fixed orthodontic appliances.	Not specifically implemented, but substitute measure in place
	560	A policy should be developed to address when inmates who are expected to remain in custody for six months or more will be provided dentures. The policy should also address when soft diets will be prescribed to inmates who experience chewing difficulty due substantial tooth loss.	Implemented

Recommendation		Description	OCLEM Finding
	568	Dr. Shulman recommends that the principal evaluation metric for the dental program be changed from the number of patient encounters to the number of procedures (using CDT codes) that dentists do on a daily basis. Consequently, it is critical that any EDR be designed with the capability to produce management and productivity reports using CDT codes. In addition, the EDR should be sufficiently flexible to track DPC codes. Dr. Shulman notes that this can be done initially using a manual (paper) system that is completed after each appointment and totaled at the end of the day. This system can be migrated to Microsoft Excel, and later be produced by the EDR.	Not specifically implemented, but substitute measure in place

55: Provide regular preventative care for detainees who are housed for a year or longer in the facilities, such as dental cleanings and x-rays, physicals, immunizations and other standard care that would be received outside. To reduce the loss of teeth and the cost of trips to the emergency room, institute more preventative care for detainees and improve response to requests for care. Consult medical professionals for typical standards of recommended care.

Custody Health provided its policies on dental services, including emergency, urgent, and routine care. We also reviewed its patient advisory on scope of dental services, and find that significant changes have been made to policies on provision of dental services in the past several years.

The CHS Standards Manual addresses the Scope and Timeliness of Dental Services. It includes a provision on dental examinations for those incarcerated for a year or more. It defines routine dental care and describes the process for oral screenings that are to be performed on all those entering the jail. The policy, which includes timelines for various types of care, was developed and approved as part of the *Chavez* remedial plan.

548: The scope of services should be broadened for longer-term inmates and be based on the dental priority codes used by CDCR which categorize treatment needs as Urgent Care, Interceptive Care, Routine Rehabilitative Care, No Dental Care Needed, and Special Needs Care.

Custody Health uses dental priority codes that are similar but not precisely the same as the CDCR codes. CHS developed its priority codes based on community standards, taking into account the Santa Clara County jail population. CDCR codes were developed for a prison population, which consists of sentenced inmates with a clear and longer length of stay.

Dental care has been broadened for longer-term inmates, including specific provisions for eligibility for dentures, and dental examinations for those incarcerated for more than a year. CHS reports that it is continuing to refine its standards with the dental monitors in the *Chavez* remedial plan.

549: Urgent Care should be sub-divided based on a condition's acuity. Conditions characterized with sudden onset and severe pain should be treated within 24 hours. Urgent Care should be made available to all inmates.

550: Inmates requiring Interceptive Care should be treated within 120 days. Interceptive Care should be available to inmates who have six months or longer left in their sentences or inmates who are no adjudicated but who are likely to be in custody for at least six months.

551: Routine Care should be provided to inmates within 12 months. It should be available to inmates who have 12 months or longer left in their sentences or those who are not adjudicated but likely to be in custody for at least 12 months.

These three recommendations rely on the CDCR terminology referenced in Recommendation 548, which as noted above, Custody Health does not use. Instead, CHS has worked with the Prison Law Office as part of the *Chavez* remedial plan to establish time standards for the provision of various types of dental care. These standards are more relatable to the jail population than the prison population the CDCR standards were designed to serve.

The CHS standards outlined in the remedial plan are:

- Oral screening within 14 days of the intake/booking process to identify emergent and urgent care conditions.
- Emergency dental conditions (meaning requires immediate evaluation and treatment to prevent death, severe or permanent disability, and/or disabling pain) provided immediately.

- Urgent dental conditions (meaning prevents an inmate's ability to carry out essential activities of daily living; or the onset of severe pain, signs of infection, trauma, or fractures) seen by a licensed health professional within 24 hours for appropriate pain management and by the dentist within 5 days.
- Inmate who is in custody for one year may request a dental exam, which will be scheduled for not more than 120 days from the date the request was received.
- Inmate who is edentulous or essentially edentulous and has been incarcerated for at least 120 days may request a dental examination, which will be scheduled for a date not more than 120 days from receipt of the request.[1]

While these three recommendations have not specifically been implemented, substitute measures are in place sufficient to satisfy the goals of the recommendations.

553: Dental policies and procedures should be rewritten to address a wider scope of services (e.g., oral self-care, periodontal diagnosis and non-surgical treatment, denture fabrication and repair, restorations, and routine care), and clinical administrative procedures (e.g., record keeping and workload reporting). The Policies and Procedures should be modeled on those used by CDCR, especially with respect to the DPC system.

Dental policies and procedures have been rewritten and do address a wider scope of services. As noted above, though, they have not been modeled on those used by CDCR. Custody Health responded to this audit request by noting it understands and appreciates the CDCR standards, but cannot simply model its policies on them because those policies are designed to serve sentenced inmates who have defined and often significant periods of time left in custody. The County jail population is more transient and fluid, and Custody Health policies on dental care are written to address this. The new policies were developed in consultation with the Prison Law Office as part of the remedial plan.

While this recommendation has not been specifically implemented, substitute measures are in place sufficient to satisfy the goals of the recommendation.

[1] The Dental Director reported that these are the maximum times permitted under the new standards, but asserted that wait times are generally significantly shorter than these requirements.

554: The policy regarding prescribing inmates dental prosthesis should be rewritten.

The new Custody Health policy contains specifications relating to the provision of dentures to inmates who meet criteria relating to their length of stay in custody.

556: A policy should be developed to address dental floss and other interdental cleaning devices. The policy should also address the circumstances when use of such devices will be denied for security reasons.

The new Custody Health policy on dental services provides access to floss and interdental cleaners, but does not address when those devices will be denied for security reasons. Custody Health noted in response to this audit item noted that Custody Bureau is responsible for security issues. Applicable Custody Bureau policy provides generally for the restriction of certain items based on specific individual needs of a particular housing area to ensure safety and security.

557: A policy should be developed to treat inmates who have fixed orthodontic appliances.

Custody Health does not provide orthodontic care, and the recommendation does not call for general orthodontic treatment or care.[2] Rather than have a specific policy on fixed orthodontic appliances, the Dental Director believes that current policy provides for care of these inmates, without specific reference to orthodontics.

For example, if a patient is experiencing pain or discomfort from their fixed orthodontic appliance, Custody Health considers that part of pain management under its policy governing the Scope and Timeliness of Dental Services. If warranted, a Custody Health dentist would address the patient's pain by removal of all or a problematic portion of the patient's fixed orthodontic appliance, or will send the patient to an outside provider if necessary. Clinical decision making around the type of care provided to a patient with orthodontics will take into the account the level of pain and discomfort, but also how long

[2] Custody Health notes that even CDCR does not provide orthodontic care, and the CDCR policy referenced in support of this recommendation only provided for possible removal of orthodontic bands/brackets from inmates who arrived in custody with braces.

the patient is likely to remain in custody, as the preference would be for their device to be addressed by their treating orthodontist.

While this recommendation has not been specifically implemented, substitute measures are in place sufficient to satisfy the goals of the recommendation.

560: A policy should be developed to address when inmates who are expected to remain in custody for six months or more will be provided dentures. The policy should also address when soft diets will be prescribed to inmates who experience chewing difficulty due substantial tooth loss.

The new Custody Health policy provides that individuals who are edentulous or essentially edentulous and have been incarcerated for 120 days may request to be evaluated for dentures. The policy also provides: "In order to be eligible for dentures, the inmate must reasonably expect (as confirmed by defense counsel, if possible) to remain in custody for at least another 6 months after the dental exam." One goal of the plan of care is to allow the patient to "chew a regular diet."

568: Dr. Shulman recommends that the principal evaluation metric for the dental program be changed from the number of patient encounters to the number of procedures (using CDT codes) that dentists do on a daily basis. Consequently, it is critical that any EDR be designed with the capability to produce management and productivity reports using CDT codes. In addition, the EDR should be sufficiently flexible to track DPC codes. Dr. Shulman notes that this can be done initially using a manual (paper) system that is completed after each appointment and totaled at the end of the day. This system can be migrated to Microsoft Excel, and later be produced by the EDR.

The Dental Director disagrees with the source of this recommendation about the appropriate metric for measuring how effectively Custody Health is meeting the demands of its patient population. Custody Health argues that the number of patient encounters, coupled with careful tracking of wait times to confirm that patients are being seen in a reasonable time frame, is the more reasonable and reliable metric for measuring productivity.

Custody Health does capture the dental procedures (using CDT codes) in its HealthLink database and could generate reports using CDT codes. Therefore, should the Prison Law Office, or the court overseeing implementation of the *Chavez* remedial plan, request

Custody Health to produce data on the number of procedures dentists do on a regular basis, it could produce this information as a basis for further analysis and evaluation.

While this recommendation has not been specifically implemented, substitute measures are in place sufficient to satisfy the goals of the recommendation.

Recommendation		Description	OCLEM Finding
Summarized: HLC 7		With regard to use of restraints, refine policies around supervision, timing, and appropriate medical checks while in restraints for behavior or clinical reasons. Any time that exceeds the expert's recommendations should include a mental health assessment and special oversight by clinician. Clothing and personal items afforded to inmates should be individualized and based on assessment of risk.	Partially implemented
Master List	627	Dr. Gage recommended that inmates in restraints, whether in the restraint chair for behavioral reasons or clinical restraints on 8A, should be on constant watch rather than periodic checks (or constant video monitoring with direct visualization every 15 minutes). Nurses must check inmates in restraints at least every two hours for vital signs (the current policy specifies hourly), neurovascular assessment (under current policy only vascular assessment is specified and the frequency is not specified), and limb range of motion and movement, including the legs (which custody can do).	Implemented by Custody Health, but not implemented by Custody Bureau
	628	Dr. Gage further recommended that the County modify its policy on prone restraint, which should be avoided absent clear evidence that prone restraint is indicated for certain medical conditions.	Implemented
	629	Dr. Gage also recommended that restraint chairs be utilized for no more than four hours. Additional restraint should involve mental health assessment and include consideration for placement in a mental health setting. Similarly, clinical restraint should be ordered every four hours for the first twelve hours. The current limitation of 24 hours is reasonable. Exceptions for longer restraint may be necessary in some cases but this should require special oversight and in-person evaluation by the ordering clinician and authorization by a supervisor.	Implemented

Recommendation		Description	OCLEM Finding
	630	Dr. Gage recommended that the type of clothing afforded inmates in restraint and seclusion be individualized and based on an assessment of risk. As those in restricted settings improve, it is important to restore items noted to be potentially risky to ascertain their readiness to manage themselves in less restrictive settings.	Implemented

627: Dr. Gage recommended that inmates in restraints, whether in the restraint chair for behavioral reasons or clinical restraints on 8A, should be on constant watch rather than periodic checks (or constant video monitoring with direct visualization every 15 minutes). Nurses must check inmates in restraints at least every two hours for vital signs (the current policy specifies hourly), neurovascular assessment (under current policy only vascular assessment is specified and the frequency is not specified), and limb range of motion and movement, including the legs (which custody can do).

This recommendation addresses both behavioral restraints (which are Custody-driven) and clinical restraints (which are Custody Health-driven). Therefore, two sets of policies may apply, depending on the reason for the restraint.

The applicable Custody Health policy for the use of clinical restraints, Policy 6.1.12, enacts the specific monitoring requirements contained in this recommendation. It requires nursing to perform a 1:1 observation of the patient while they are on restraints (constant monitoring). It also requires that nursing check circulation and range of motion every two hours. In response to our question, Custody Health reported that this check is intended and interpreted by medical staff to be a neurovascular assessment. Nonetheless, Custody Health acknowledged this could stand to be further explained, and reported it plans to revise the policy soon, to streamline and clarify its mandates. (This policy was last revised in 2006.)

The medical and mental health assessment requirements required for inmates placed in a safety cell or restraint chair are outlined in Custody Health Policy 5.1.16. That policy requires nurses to assess a patient every hour, exceeding the requirement of this recommendation.

The Custody Bureau policy regarding restraints (9.01 Use of Force (XIV) Use of Restraints) was last revised in August 2017. Currently, policy provisions do not comply with this recommendation regarding "*constant watch rather than periodic checks*." Rather, the policy requires that, "[a]t least once every fifteen (15) minutes, staff shall check the inmate and document any comments regarding the health and physical condition of the inmate." Custody personnel reported to us that they are in the process of modifying policies around the use of restraints and they are aware of this recommendation.

This recommendation has been implemented by Custody Health, but not Custody Bureau.

628: Dr. Gage further recommended that the County modify its policy on prone restraint, which should be avoided absent clear evidence that prone restraint is indicated for certain medical conditions.

Custody Health Policy does not contain this specific language, but does state: "If it is necessary to restrain a patient in a prone position for medical reasons, a psychiatrist's order must be obtained."

Custody Health acknowledges that the language can and should be clearer and pledged to modify it to accomplish this when it revises the policy. Nonetheless, it asserts the intent and practice is to not use prone restraint unless it is necessary for medical reasons. While not squarely in line with the language of Dr. Gage's recommendation, we find the language of the existing policy, and the requirement of an order from a medical doctor to be sufficient to satisfy the terms of this recommendation.

The recommendation seemingly applies to fixed restraints that hold an individual in a prone position in a clinical setting, and not to the law enforcement practice of temporarily restraining an individual on the ground in a prone position while gaining control of the individual. The Custody Bureau Use of Force policy has a provision relating to this that states: "Caution shall be used to guard against the risk of medical distress when using restraints, e.g. positional asphyxia, excited delirium, or other high risk medical conditions."

629: Dr. Gage also recommended that restraint chairs be utilized for no more than four hours. Additional restraint should involve mental health assessment and include consideration for placement in a mental health setting. Similarly, clinical restraint should be ordered every four hours for the first twelve hours. The current limitation of 24 hours is reasonable. Exceptions for longer restraint may be necessary in some cases but this should require special oversight and in-person evaluation by the ordering clinician and authorization by a supervisor.

Custody Bureau is in compliance with this recommendation. Policy 9.01 (XIV)(F)(8). provides: "The maximum time an inmate shall be secured in the Restraint Chair is two hours."

630: Dr. Gage recommended that the type of clothing afforded inmates in restraint and seclusion be individualized and based on an assessment of risk. As those in restricted settings improve, it is important to restore items noted to be potentially risky to ascertain their readiness to manage themselves in less restrictive settings.

This recommendation refers to a couple of different issues regarding *restraint* and *seclusion*. Inmates placed into restraints – clinical or behavioral as referred to in this group of recommendations – would only have articles of clothing removed that could prove problematic in the restraints, such as clothing that could restrict circulation.

To the extent that there is a concern about self-harm or suicide risk and an inmate is in seclusion, Custody Health may remove the clothing as a self-harm/suicide prevention tool under the suicide prevention policy and the mental health observation policy. That is based on an individualized risk assessment made by mental health staff and informed by the patient's behavior.

In all cases, Custody Health policy 6.1.12 (IV)(B)(13) specifies minimal clothing that will be provided, in either restraints or seclusion (briefs for men, and panties and a gown for women).

Conclusion

As detailed above, with regard to the Recommendations regarding dental care, Custody Health has either implemented the Recommendations or modified its protocols to address the objectives of each. Regarding the Recommendations relating to the use and monitoring of inmates placed in restraints, Custody Health has largely implemented them but clarification for some of the current policy provisions is warranted. And with respect to the specific Recommendation relating to the frequency of monitoring inmates placed in restraint chairs, Custody has not yet aligned its policy with the Recommendation. While we understand Custody is in the process of revising the relevant policy relating to use of restraints, we cannot certify Summarized Recommendation HLC 7 as complete until this specific provision has been addressed. We urge Custody Health to clarify its restraint policies as specified above to provide improved guidance to medical staff. Most significantly, we urge to Custody either adopt or otherwise address the Recommendation relating to monitoring of inmates in restraint chairs.