Santa Clara County

OFFICE OF CORRECTION AND LAW ENFORCEMENT MONITORING

Report on Audit of Jail Reform Recommendations

Interim Report #5

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Introduction and Background

As this Board is aware, 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.

On December 15, 2020, this Board directed OCLEM to take over the role of auditor of these Jail Reforms Recommendations. This is our fifth report on those efforts. In our prior four reports, we have reviewed Summarized Recommendations as the Jail Reforms Workgroup presents them to us as completed and ready to be audited. Our previous four reports addressed a total of 17 Summarized Recommendations and 93 Master List Recommendations.

This report covers an additional three Summarized Recommendations (encompassing 28 Master List Recommendations) deemed to be completed and for which Custody Health and Custody Bureau submitted materials for our review and verification.

In addition, following direction provided by this Board during the May 2, 2023 Jail Reform Study Session, we evaluated the remaining Master List Recommendations to see whether any could be considered completed or no longer necessary because they are outdated, no longer applicable, or for which the objective of the recommendation could be better achieved through other means, including ongoing monitoring by OCLEM.[1] In response and as detailed below, we identified 52 Master List Recommendations to remove from the list of pending recommendations for one of these reasons.

With the 80 Master List Recommendations detailed in this report, plus the 93 Master List Recommendations we reported as audited and completed in our prior four reports, we have deemed 173 Master List Recommendations to be "completed" in one manner or another. Of the original 623 recommendations, then, 450 remain to be audited by OCLEM.

[1] Another category of recommendations which may no longer be applicable are those that are subject to monitoring pursuant to the federal consent decrees in the *Chavez* and *Cole* cases. We intend to evaluate and report back on this category of recommendations in spring 2024.

Jail Reform Recommendations Audited by OCLEM

OCLEM Report	Summarized Recommendations	Master List Recommendations
1 – Sept 2021	8	34
2 – April 2022	2	15
3 – June 2022	3	28
4 – Jan 2023	4	16
5 – Oct 2023	3*	80*
Total	20	173

*The Master List Recommendations which we determined to be completed or no longer applicable, or for which we conclude the objective can be achieved by ongoing monitoring by OCLEM, are considered separately from their "Summarized Recommendation" designation.

We appreciate the assistance and cooperation of the County Executive's Office in coordinating and facilitating the production of documents and other responses to our audit requests. We are also grateful for the cooperation of the Custody Bureau and Custody Health Services 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.

Audit Findings:
Completed Recommendations

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.

Many of our findings reference conclusions made by the monitors of the *Chavez* and *Cole* remedial plans. Pursuant to a federal court order, the monitors are neutral experts selected by the parties and approved by the federal court. The monitors are experts in their respective fields (psychiatry, psychology, medicine, dentistry, nursing, for example) and as part of their monitoring work under the consent decrees, they have broad access to individuals, staff, and records, and regularly perform onsite tours of the jail facilities. Their reports to the federal court are confidential.

OCLEM has access to the monitors' reports and other confidential materials consistent with the County Ordinance Code and information-sharing protocols. Where we rely on findings made by the monitoring teams to conclude in this report that a particular recommendation has been completed, it is after our review of the monitors' confidential reports and with an understanding of the basis for their findings. In our next report, we will look more comprehensively at the overlap between the Master List Recommendations and provisions of the *Chavez* and *Cole* remedial plans, with the goal of identifying recommendations whose intent and purpose have been met by the ongoing work of the monitoring teams.

Recommendation		Description	OCLEM Finding
Summarized: SUI 7		CHS should develop suicide prevention policy that enhances communication between suicidal inmates and staff and incorporates the following factors: - Screening process at intake booking should include referral to medical or mental health staff - Permit both DOC and CHS staff to initiate suicide precautions, and the CHS can discontinue precautions only after conducting an assessment - Ensure inmates on suicide precautions are located in close proximity to staff - CHS staff perform an assessment before the scheduled release of an inmate on suicide precautions - Implement a continuous quality improvement plan - The behaviors that warrant an appropriate level of observation - Description of appropriate clothing for inmates on suicide precautions, and avoid if possible the use of restraints and cancellation of privileges - Training and mock drills for resuscitation with appropriate equipment available	Completed
Master List	222	The intake screening process should include procedures for referral to mental health and/or medical personnel.	Completed
	225	SCVHHS officials should initiate a continuous quality assurance plan to periodically audit the intake screening process to ensure that nursing staff are asking all questions to newly admitted detainees as required.	Completed
	228	SCVHHS should conduct a continuous quality improvement audit to determine whether the 12 current criminal offenses that automatically result in a "charge-based mental health referral" are effective in preventing suicides.	Completed
	229	Procedures that enhance communication at three levels: 1) between the sending institution/arresting-transporting officer(s) and correctional staff; 2) between and among staff (including medical and mental health personnel); and 3) between staff and the suicidal inmate.	Completed
	230	Isolation should be avoided. Whenever possible, house in general population, mental health unit, or medical infirmary, located in close proximity to staff.	Completed

Recommendation		Description	OCLEM Finding
	231	Removal of an inmate's clothing (excluding belts and shoelaces), as well as use of physical restraints (e.g. restraint chairs/boards, straitjackets, leather straps, etc.) and cancellation of routine privileges (showers, visits, telephone calls, recreation, etc.), should be avoided whenever possible, and only utilized as a last resort for periods in which the inmate is physically engaging in self- destructive behavior.	Completed
	232	SCVHHS safety smocks should be implemented only by medical and/or mental health staff and only when a clinician believes that the inmate is at high risk for suicide by hanging, not as a default or behavior management plan.	Completed
	233	SCVHHS should develop suicide prevention policies to address procedures for deciding which possessions and privileges are provided to inmates oni suicide precautions.	Completed
	235	SCCSO and SCHHS suicide prevention policies should include two levels of observation (close observation and constant observation) that describe with specificity the behavior warranting each level of observation.	Completed
	237	SCVHHS should revise any suicide prevention policy to permit both custody and medical staff to initiate suicide precautions and require that only mental health staff can discontinue suicide precautions after a comprehensive suicide risk assessment.	Completed
	243	SCVHHS should extend the current “psych hold" or “K-Hold” to include those inmates on suicide precautions at the time of their scheduled release from custody. DOC staff should also inform mental health personnel of the scheduled release of inmates on suicide precautions so mental health staff can conduct a brief mental health assessment to ensure the inmate’s stabilization for release.	Completed
	244	A facility’s policy regarding intervention should be threefold: 1) all staff who come into contact with inmates should be trained in standard first aid and cardiopulmonary resuscitation (CPR); 2) any staff member who discovers an inmate attempting suicide should immediately respond, survey the scene to ensure the emergency is genuine, alert other staff to call for medical personnel, and begin standard first aid and/or CPR; and 3) staff should never presume that the inmate is dead, but rather initiate and continue appropriate life-saving measures until relieved by arriving medical personnel.	Completed

Recommendation		Description	OCLEM Finding
	245	In addition, all housing units should contain a first aid kit, pocket mask or mouth shield, Ambu bag, and rescue tool (to quickly cut through fibrous material). All staff should be trained in the use of the emergency equipment. Finally, in an effort to ensure an efficient emergency response to suicide attempts, “mock drills” should be incorporated into both initial and refresher training for all staff.	Completed
	396	Review best practices for suicide prevention for custodial facilities.	Completed

The *Chavez* remedial plan contains 28 provisions addressing suicide prevention. Each of the 14 Master List Recommendations contained within Summarized Recommendation SUI 7 are covered by one or more of these 28 provisions. The monitoring team has found the County to be compliant with each of these provisions. To reach that conclusion, the monitors conduct inspections, tours, and interviews, make observations, and review extensive documents. Some specific findings are noted below.

222: The intake screening process should include procedures for referral to mental health and/or medical personnel.

The screening process and referral procedures are covered in four separate remedial plan provisions.

225: SCVHHS officials should initiate a continuous quality assurance plan to periodically audit the intake screening process to ensure that nursing staff are asking all questions to newly admitted detainees as required.

The *Chavez* remedial plan requires detailed Quality Improvement reviews of the intake screening process; monitors found the County in compliance with these provisions. Specific to this recommendations, the 2022 audit of the process found near 100% staff compliance with asking the requisite suicide prevention questions.

228: SCVHHS should conduct a continuous quality improvement audit to determine whether the 12 current criminal offenses that automatically result in a "charge-based mental health referral" are effective in preventing suicides.

Custody Health now uses the Columbia Suicide Risk Assessment tool, which takes into account an individual’s charges, among a number of other factors. This audit had been completed in the past, but is no longer relevant.

229: Procedures that enhance communication at three levels: 1) between the sending institution/arresting-transporting officer(s) and correctional staff; 2) between and among staff (including medical and mental health personnel); and 3) between staff and the suicidal inmate.

Communication is a key element in nearly all of the 28 remedial plan provisions on suicide prevention, and a factor in the monitoring team's assessment. The spirit of this recommendation has been implemented.

230: Isolation should be avoided. Whenever possible, house in general population, mental health unit, or medical infirmary, located in close proximity to staff.

Several provisions of the remedial plan provide detailed instructions about housing suicidal individuals, including a preference for avoiding isolation. Accordingly, the goals of this recommendation have been achieved.[2]

31: Removal of an inmate's clothing (excluding belts and shoelaces), as well as use of physical restraints (e.g. restraint chairs/boards, straitjackets, leather straps, etc.) and cancellation of routine privileges (showers, visits, telephone calls, recreation, etc.), should be avoided whenever possible, and only utilized as a last resort for periods in which the inmate is physically engaging in self- destructive behavior.

232: SCVHHS safety smocks should be implemented only by medical and/or mental health staff and only when a clinician believes that the inmate is at high risk for suicide by hanging, not as a default or behavior management plan.

233: SCVHHS should develop suicide prevention policies to address procedures for deciding which possessions and privileges are provided to inmates on suicide precautions.

Provisions of the remedial plan provide:

> *All decisions regarding the removal of an inmate's clothing, bedding, possessions (books, slippers/sandals, eyeglasses, etc.) and privileges shall be commensurate with the level of suicide risk has determined on a case-by-case basis by mental health staff and is documented in the EMR;*
>
> …

[2] The State legislature continues to consider further limits on isolation for those incarcerated.

If mental health staff determine that an inmate's clothing needs to be removed for reasons of safety, the inmate shall always be issued a safety smock and safety blanket;

…

All inmates on suicide precautions shall be allowed all routine privileges (e.g., Family visits, telephone calls, recreation, etc.), unless mental health staff have determined otherwise based on clinical judgment unless the inmate has lost those privileges as a result of the disciplinary sanctions.

The County is in compliance with these provisions.

235: SCCSO and SCHHS suicide prevention policies should include two levels of observation (close observation and constant observation) that describe with specificity the behavior warranting each level of observation.

These two levels are expressly addressed by provisions of the remedial plan, including descriptions of behavior warranting each level.

237: SCVHHS should revise any suicide prevention policy to permit both custody and medical staff to initiate suicide precautions and require that only mental health staff can discontinue suicide precautions after a comprehensive suicide risk assessment.

Custody Health has revised its policies and practices to align with this recommendation. The monitoring teams have made findings confirming compliance.

243: SCVHHS should extend the current "psych hold" or "K-Hold" to include those inmates on suicide precautions at the time of their scheduled release from custody. DOC staff should also inform mental health personnel of the scheduled release of inmates on suicide precautions so mental health staff can conduct a brief mental health assessment to ensure the inmate's stabilization for release.

Custody Health's current policy and protocols align with this recommendation. Practices relating to "K-Holds" are also included in provisions of the remedial plans that the monitors regularly review.

244: A facility's policy regarding intervention should be threefold: 1) all staff who come into contact with inmates should be trained in standard first aid and cardiopulmonary resuscitation (CPR); 2) any staff member who discovers an inmate attempting suicide should immediately respond, survey the scene to ensure the emergency is genuine, alert other staff to call for medical personnel, and begin standard first aid and/or CPR; and 3)

staff should never presume that the inmate is dead, but rather initiate and continue appropriate life-saving measures until relieved by arriving medical personnel.

Custody Health Policy 5.2.6 (Medical Emergencies), which OCLEM has reviewed, addresses each of the requirements of this recommendation.

245: In addition, all housing units should contain a first aid kit, pocket mask or mouth shield, Ambu bag, and rescue tool (to quickly cut through fibrous material). All staff should be trained in the use of the emergency equipment. Finally, in an effort to ensure an efficient emergency response to suicide attempts, "mock drills" should be incorporated into both initial and refresher training for all staff.

396: Review best practices for suicide prevention for custodial facilities.

These recommendations are covered by provisions of the remedial plan and the monitoring teams have found the County to be in compliance.

OCLEM finds this Summarized Recommendation and all its sub-part Master List Recommendations have been implemented.

Recommendation		Description	OCLEM Finding
Summarized: SUI 8		With regard to suicide precautions, develop a triage system for mental health referrals. Length of stay on suicide precautions should be determined by CHS staff. Establish levels of supervision for suicidal inmates. Inmates discharged from suicide precautions get a treatment plan and follow-up assessments by CHS staff.	Completed
Master List	227	SCVHHS officials should develop a triage system for mental health referrals based upon acuity of behavior, including emergent, urgent, and routine. Any inmate expressing current suicidal ideation and/or current suicidal/self-injurious behavior should result in an emergent mental health referral.	Completed

Recommendation		Description	OCLEM Finding
	234	Two levels of supervision are generally recommended for suicidal inmates- close observation and constant observation. Close observation is reserved for the inmate who is not actively suicidal, but expresses suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed under close observation. This inmate should be observed by staff at staggered intervals not to exceed every 10 minutes. Constant Observation is reserved for the inmate who is actively suicidal, either by threatening or engaging in self-injury. This inmate should be observed by a staff member on a continuous, uninterrupted basis. Other supervision aids (e.g., closed circuit television, inmate companions/watchers, etc.) can be utilized as a supplement to, but never as a substitute for, these observation levels. Inmates on suicide precautions should be reassessed on a daily basis.	Completed
	236	SCVHHS should eliminate the minimum and maximum length of stay on suicide precautions for inmates identified as suicidal and instead use clinical judgement on a case-by-case basis to determine the length of stay.	Completed
	241	SCVHHS mental health clinicians should develop treatment plans for inmates discharged from suicide precautions. Those plans should describe signs, symptoms, and the circumstances in which the risk for suicide is likely to recur; how recurrence of suicidal thoughts can be avoided; and actions the patient or staff can take if suicidal thoughts occur.	Completed
	242	SCVHHS should ensure that all inmates discharged from suicide precautions remain on mental health caseloads and receive regularly scheduled follow-up assessments by mental health staff until their release from custody, in order to safeguard the continuity of care for suicidal inmates.	Completed

The 28 provisions addressing suicide prevention in the *Chavez* remedial plan likewise address each of these 5 Master List Recommendations and Summarized Recommendation SUI 8. The monitoring team has found the County to be compliant with each of these provisions. Specific findings are noted below.

227: SCVHHS officials should develop a triage system for mental health referrals based upon acuity of behavior, including emergent, urgent, and routine. Any inmate expressing current suicidal ideation and/or current suicidal/self-injurious behavior should result in an emergent mental health referral.

This recommendation is mirrored by a provision in the remedial plan. Based on their review of mental health records, the monitors found compliance with this provision.

234: Two levels of supervision are generally recommended for suicidal inmates- close observation and constant observation. Close observation is reserved for the inmate who is not actively suicidal, but expresses suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed under close observation. This inmate should be observed by staff at staggered intervals not to exceed every 10 minutes.

Constant Observation is reserved for the inmate who is actively suicidal, either by threatening or engaging in self-injury. This inmate should be observed by a staff member on a continuous, uninterrupted basis. Other supervision aids (e.g., closed circuit television, inmate companions/watchers, etc.) can be utilized as a supplement to, but never as a substitute for, these observation levels. Inmates on suicide precautions should be reassessed on a daily basis.

As with Master List Recommendation 235, two different provisions of the remedial plan define these two levels of supervision, with appropriate descriptions and regulations covering each.

236: SCVHHS should eliminate the minimum and maximum length of stay on suicide precautions for inmates identified as suicidal and instead use clinical judgement on a case-by-case basis to determine the length of stay.

The remedial plan provides: *Length of stay on suicide precautions for inmates identified as suicidal shall be determined by mental health clinician based on clinical judgment on a case-by-case basis.*

The monitoring team found compliance with this provision.

241: SCVHHS mental health clinicians should develop treatment plans for inmates discharged from suicide precautions. Those plans should describe signs, symptoms, and the circumstances in which the risk for suicide is likely to recur; how recurrence of suicidal thoughts can be avoided; and actions the patient or staff can take if suicidal thoughts occur.

242: SCVHHS should ensure that all inmates discharged from suicide precautions remain on mental health caseloads and receive regularly scheduled follow-up assessments by mental health staff until their release from custody, in order to safeguard the continuity of care for suicidal inmates.

The treatment plans and discharge procedures described in these recommendations are included in provisions of the remedial plan and are regularly subject to monitoring as part of the ongoing compliance measures.

OCLEM finds this Summarized Recommendation and all its sub-part Master List Recommendations have been implemented.

Recommendation		Description	OCLEM Finding
Summarized: SUI 9		CHS staff should be trained on Suicide Risk Assessment form and development of treatment plans. Training should be developed for new and existing custody and custody health employees, along with regular refresher training. Training should include avoiding negative attitudes, impact of correctional environments on suicidal behavior, predisposing factors, high-risk time periods, warning signs, suicide prevention policy and liability issues. Any staff involved in a critical incident should be offered a stress debriefing. Custody Administration should ensure a compliance rate for CPR/AED training for custody staff.	Completed
Master List	246	DOC should ensure that the compliance rate of CPR/AED training for custody personnel (excluding those who might be out on disability or other leave) be maintained at a minimum of 90 percent.	Completed
	249	Further, all staff involved in the incident should be offered critical incident stress debriefing.	Completed

Recommendation		Description	OCLEM Finding
	252	All SCVHHS mental health personnel (including psychiatrists) should receive additional training on: 1) how to complete the Suicide Risk Assessment form, which should include examples of adequate and inadequate assessments; and 2) how to complete a reasonable treatment plan that contains specific strategies for reducing future suicidal ideation, which should include examples of adequate and inadequate treatment plans.	Completed
	304	All correctional, medical, and mental health staff should receive 8 hours of initial suicide prevention training, followed by 2 hours of annual training.	Completed
	305	At a minimum training should include avoiding negative attitudes to suicide prevention, inmate suicide research, why correctional environments are conducive to suicidal behavior, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, identifying suicidal inmates despite the denial of risk, components of the agency's suicide prevention policy, and liability issues associated with inmate suicide.	Completed
	306	DOC and SCVHHS should only utilize classroom-instructed suicide prevention training.	Completed
	307	DOC and SCVHHS should collaborate on the development of a new 4 to 8 hr. pre-service suicide prevention curriculum for new employees.	Completed
	308	DOC and SCVHHS should collaborate on the development of a two-hour annual suicide prevention curriculum for all custody, medical and mental health staff.	Completed
	309	SCVHHS mental health personnel (including psychiatrists) should receive additional training on comprehensive suicide risk assessments and how to develop a reasonable treatment plan that contains specific strategies for reducing future suicidal ideation.	Completed

As with SUI 7 and 8, the recommendations included in SUI 9 are the subject of multiple provisions of the *Chavez* remedial plan.

246: DOC should ensure that the compliance rate of CPR/AED training for custody personnel (excluding those who might be out on disability or other leave) be maintained at a minimum of 90 percent.

Custody Bureau reports its compliance with various training requirements to the California Board of State and Community Corrections Training on an annual basis. According to the last audit, for the period that ended June 30, 2023, 96% of 720 Custody Bureau personnel were up-to-date on CPR/AED training. Accordingly, this recommendation has been achieved.

249: Further, all staff involved in the incident should be offered critical incident stress debriefing.

The two recommendations preceding this one related to the internal review of any in-custody death by suicide or serious suicide attempt. Custody Health Policy 5.2.2 (Critical Incident Debriefing) provides staff and inmates with an opportunity to debrief after a traumatic event. This recommendation has been achieved.

252: All SCVHHS mental health personnel (including psychiatrists) should receive additional training on: 1) how to complete the Suicide Risk Assessment form, which should include examples of adequate and inadequate assessments; and 2) how to complete a reasonable treatment plan that contains specific strategies for reducing future suicidal ideation, which should include examples of adequate and inadequate treatment plans.

The particular form referenced has been discontinued and replaced by the Columbia suicide prevention inventory, as encouraged and approved by the monitoring team. The Columbia tool is integrated into HealthLink, and staff have been trained in its use. Accordingly, this recommendation has been implemented.

304: All correctional, medical, and mental health staff should receive 8 hours of initial suicide prevention training, followed by 2 hours of annual training.

305: At a minimum training should include avoiding negative attitudes to suicide prevention, inmate suicide research, why correctional environments are conducive to suicidal behavior, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, identifying suicidal inmates despite the denial of risk, components of the agency's suicide prevention policy, and liability issues associated with inmate suicide.

306: DOC and SCVHHS should only utilize classroom-instructed suicide prevention training.

307: DOC and SCVHHS should collaborate on the development of a new 4 to 8 hr. pre-service suicide prevention curriculum for new employees.

308: DOC and SCVHHS should collaborate on the development of a two-hour annual suicide prevention curriculum for all custody, medical and mental health staff.

309: SCVHHS mental health personnel (including psychiatrists) should receive additional training on comprehensive suicide risk assessments and how to develop a reasonable treatment plan that contains specific strategies for reducing future suicidal ideation.

Suicide prevention training is a significant emphasis of the remedial plan. Monitors have been examining the training curriculum and attendance records since 2020, and they have found the County to be in compliance while offering praise for the content of the training materials.

OCLEM also has reviewed the suicide prevention training materials for Custody Bureau personnel, including both the initial Academy training and the two-hour in-service training. The training encompasses all of the topics included in these Master List Recommendations, and represents positive collaboration between Custody Bureau and Custody Health Services.

This Summarized Recommendation and its sub-part Master List Recommendations have been implemented.

Master List Recommendations: Outdated or Otherwise Not Applicable

We recommend that the following recommendations be removed from the list of those being audited, because they are either outdated, too vague to be effectively audited, their intent has been met through some other means, or they are no longer applicable for some other reason, as detailed in the following table.

Recommendation		Description	OCLEM Finding
Master List	Summarized List		
358	CLS 5	Move low security level, pre-trial inmates to the Elmwood Facility and create a minimum camp for protective custody inmates.	The concept of building a minimum camp for individuals in protective custody should be tied into any discussions around the feasibility or advisability of building a new facility, but these recommendations do not need to be independently monitored for compliance. In addition, many of the lower security level individuals who may have been sent to a "minimum camp" at the time these recommendations were written in 2016 are no longer being held in custody.
359	CLS 5	Evaluate where protective custody inmates can be assigned to a secure area on the minimum camp. If feasibility is determined, the planning and construction will be in collaboration with the FAF.	
77	ISV 4	The Board of Supervisors should re-constitute the membership of the IWFC to include two members from the Office of the Sheriff, one member from the Office of the Public Defender, and six community members with an accounting background, two behavioral health professionals, two with mental health experience, nonprofits, family members, and one former inmate).	These recommendations are not currently applicable, as there is no longer an Inmate Welfare Fund Committee. The Inmate Welfare Fund does not have any new funding added to it, and any expenditure of the money that remains in the Fund is approved directly by the Board of Supervisors.

Recommendation		Description	OCLEM Finding
Master List	Summarized List		
78	ISV 4	The Board of Supervisors should assign a staff person who will oversee a formal application process to re-constitute the IWFC and who will ensure that information about the application process is widely disseminated to the public.	
79	ISV 4	The Board of Supervisors should set terms for service on the IWFC.	
80	ISV 4	Notices of IWFC meetings should be distributed to maximize attendance by the public; and meetings should be held on days and at times that maximize public attendance.	
81	ISV 4	Require IWFC members to tour all jail facilities annually.	
82	ISV 4	Require the IWFC to convene two public forums each year to present information about the programs and services provided to inmates, to present information about the vendors who provide those services and programs, and to receive community input about new and/or alternative programs and service for possible implementation. The forums should be held at dates and times to maximize public attendance.	
83	ISV 4	The IWFC should assess and verify all purchases, usage, and access provided by the funds.	
89	ISV 4	The IWFC should review contents of the kits and ensure that all kits (hygiene, stationery) have adequate supplies, and recommend changes to the kits.	

Recommendation		Description	OCLEM Finding
Master List	Summarized List		
91	ISV 4	The IWFC should be provided a full accounting of the incentive meal/beverage program (2010-2016), how it has been administered at all jail facilities including the profits (from mark-ups) to vendors.	
95	ISV 4	Diversify IFW revenue beyond commissions collected from phones and the commissary to increase revenue to the recommended level of 8.3%.	
96	ISV 4	Create a grant program to pursue funding.	This recommendation is vague and lacks sufficient context or detail to be effectively audited.
97	ISV 4	Conduct a comprehensive review of the sources and uses of the inmate welfare fund, to be conducted by an independent auditor as requested by the IWFC at least every other year.	This recommendation is not currently applicable, as there is no longer an Inmate Welfare Fund Committee. The Inmate Welfare Fund does not have any new funding added to it, and any expenditure of the money that remains in the Fund is approved directly by the Board of Supervisors.
98	ISV 4	Report on the status of the Harvey M. Rose audit recommendations and set a date for completion of recommendations not yet implemented.	It is unclear which Harvey M. Rose audit this recommendation refers to, or whether any of the recommendations from that audit remain relevant or applicable. The auditors at Harvey M. Rose would be in a better position to address this.
171	ISV 6	Ensure that men and women receive an equal opportunity to participate in direct-service programs funded by the IWF including education and vocational opportunities.	Taken literally, this recommendation is no longer applicable, as no direct-service programs are currently funded by the IWF. More broadly, the recommendation speaks to the need for equity in programming opportunities. OCLEM, together with the Community Correction and Law Enforcement Monitoring Committee, will continue to play a role in the monitoring programming efforts and encouraging equity in opportunities provided.

Recommendation		Description	OCLEM Finding
Master List	Summarized List		
510	JAF 4	The jail must update its data systems with 21st century technology.	This is a true statement, but it is overly broad and not amenable to auditing. To the degree that the recommendation suggests the need for an automated Jail Management System, the Sheriff's Office acknowledges this is a critical outstanding task that has yet to be completed. Without an effective JMS, Custody remains limited in its ability to address a number of important reforms.
426	JAF 5	Complete identified improvement and modernization projects at Main Jail and Elmwood.	This recommendation lacks sufficient specificity to be effectively audited.
428	JAF 5	Request immediate funding for facility improvements at Elmwood to move low-level, pre-trial inmates to Elmwood and create a minimum camp for Protective Custody inmates.	The concept of building a minimum camp for individuals in protective custody should be tied into any discussions around the feasibility and advisability of building a new facility, but this recommendation does not need to be independently monitored for compliance. In addition, many of the lower security level individuals who may have been sent to a "minimum camp" at the time this recommendation was written in 2016 are no longer being held in custody.
520	JAF 5	The jail should take immediate measures to meaningfully improve conditions, enhance supervision, and alleviate crowding in Main Jail South.	Moot. Main Jail South was closed and torn down in 2018-2019.

Recommendation		Description	OCLEM Finding
Master List	Summarized List		
251	SUI 10	DOC representatives to the Death Review Committee should become active participants and partners on the SCVHHS-run Death Review Committee.	This recommendation is outdated. The Death Review Committee has been replaced by a process to conduct Root Cause Analysis meetings following in-custody deaths (which OCLEM regularly attends). The suggestion to merge the in-custody death review process with a hospital-based Death Review Committee is neither practical nor necessary, given the impressively thorough work done by Custody Health Services in leading RCA meetings.
104	JAF 1	The Department needs to reopen an "Assessment and Observation" unit. This is an important unit to house inmates in the first 24 hours after arrest. During the first 24 hours, the module officer will monitor inmates' behavior and can render medical or mental health services promptly.	This recommendation is outdated. Any plan to reopen the "Assessment and Observation" unit was set aside because of discussions about a new jail facility and alternate, non-custodial treatment centers. In addition, Custody Health's development of an Acute Psychiatric Unit meets the goal of an "Assessment and Observation" unit in providing more inclusive medical and mental health treatment to a unique subset of patients. These developments were discussed in detail in an April 8, 2022 off-agenda report to the Board from the Deputy County Executive & Director, County of Santa Clara Health System and the Director of Custody Health and Behavioral Health Services.
547	HLC 4	The Office of the Sheriff should retain an experienced correctional health care administrator to monitor the provision of health services and coordinate the interaction between health care and custody	This recommendation seems to be based on a misunderstanding of the County's structure. In many California Counties, provision of medical services is within the authority of the Sheriff's Office. In Santa Clara County, Custody Health Services – a separate County department – is responsible for providing health care to individuals in custody.

Recommendation		Description	OCLEM Finding
Master List	Summarized List		
598	HLC 4	The DOC should require that all health care staff who interact with patients wear a standardized uniform with respect to color and presentation.	Custody Health Services utilizes name badges that are color coordinated based on position (for example, nurses, doctors, and administrators have different color ID badges). This alternate way of identifying staff is sufficient to meet the intent of these recommendations.
599	HLC 4	The DOC should require that the health care staff uniforms be embroidered in a standardized location with the staff member's first name, last initial and job title within the institution.	
620	HLC 10	Dr. Gage also recommended review of the limited use of temporary and permanent conservators, which he opined were likely underutilized. Related to this is a need for thorough examination of policies and practices related to the evaluation of competency and securing informed consent. This should include examination of the current practice of permitting incompetent patients to refuse any health treatment including medical, dental, and mental health treatment.	This recommendation is outdated. It applies to standards relevant when the jail operated a designated unit pursuant to the Lanterman-Petris-Short Act ("LPS"). Custody Health has transitioned to an Acute Psychiatric Unit ("APU") for provision of equivalent mental health care, with different standards than those in effect at the time this recommendation was written. Further, the policies and practices in the APU are subject to regular monitoring pursuant to the *Chavez* remedial plan.
101	HST 5	The Women's Facility needs to establish a mental health unit to provide adequate care for the female mentally ill inmates. Female mentally ill inmates should not be transferred to module 8A.	This recommendation is not feasible. While mental health services are provided at the women's facility at Elmwood, the population of women in need of the level of mental health care provided in the APU (module 8A) is not sufficiently large to warrant creation of a second, women-only APU.
3	OVR 4	The Board of Supervisors should take immediate steps to change the leadership of the operation of the jails.	These recommendations are outdated. Leadership has changed, including at the very top of the organization.

Recommendation		Description	OCLEM Finding
Master List	Summarized List		
7	OVR 4	Clearly establish who is ultimately responsible and accountable for all aspects of jail operations, including the treatment of inmates and employees in the County jail. Examine other departmental structures, including re-establishment of a separate, free-standing Department of Correction.	
315	OVR 4	The second is that we urge for new leadership in Custody Operations. The JRC has heard testimony recommending that the Sheriff's office be removed from administering the jails. In research we have done, it is clear that the DOC and the Sheriff's office have both operated the jails in prior decades. And it is common for a county Sheriff to be responsible for Custody Operations. But we feel that trust in leadership is a key mandate for this role and that trust has been grievously eroded. The community, staff, inmates and family and friends of inmates all attest to this to the HRC, JRC and to the Blue Ribbon Commission. We feel this trust has eroded to such a degree that we cannot move forward in making necessary changes under the current leadership. In setting up new leadership for Custody Operations, clear lines of authority and accountability need to be established. Currently, it seems to be an ineffective relationship and operation between the DOC.	
316	OVR 4	This may also take a committee to work on to reach significant reform. However, reform cannot occur with the current leadership in place.	

Recommendation		Description	OCLEM Finding
Master List	Summarized List		
58	OVR 4	Create a committee of knowledgeable experts and community stake holders to study and recommend effective models of independent over sight of the DOC. Committee will report it's findings and recommendations to the Board of Supervisors , including time lines and responsible parties, and oversee it's implementation.	This recommendation is completed. The Board of Supervisors enacted ordinances creating OCLEM and CCLEM following an extensive process of planning and deliberation to determine the best form of oversight for the County and the Sheriff's Office.
333	OVR 4	We recommend that a small committee work on the agency designation. The committee should be made up of representatives from the County Administration, JOP, JRC, and potentially members of the BRC, Silicon Valley Debug, and PACT.	This recommendation followed 332, which was included in Summarized Recommendation OVR 1 and stated: *Santa Clara County should create an independent oversight agency that will regularly audit the Santa Clara County Custody Division. . . . The County would need to decide on the type of agency that would best serve the community (such as a Solicitor General, Independent Auditor, Community Commission, Federal Oversight or any combination of the above).* As with 58 (above), this recommendation is completed by the creation of OCLEM and CCLEM following an extensive process that involved numerous community stakeholders.
60	OVR 4	Proactively request that the Santa Clara County Jail system be placed under federal oversight until sweeping reforms are put in place.	This recommendation is outdated. The *Chavez* and *Cole* remedial plans aim to achieve these sweeping reforms.
1	OVR 5	The Board of Supervisors should accept the report of Scott Emblidge and utilize it as major impetus for change in the operations of the jail.	This recommendation is unnecessary and redundant. Each of the individual recommendations made in the Emblidge report were adopted and included among the Master List Recommendations.

Recommendation		Description	OCLEM Finding
Master List	Summarized List		
6	OVR 5	Upon finalization of recommendations to the Board from the BRC, form an interim committee to ensure the recommended changes to culture and practice are being implemented. Ideally this committee would consist of people with experience or knowledgeable in best practices for ushering in such changes, in addition to several current members of the BRC who represent the community, advocacy groups, mental health experts and the incarcerated. The committee should report to the Board of Directors until such a time as significant progress is being made on the established goals.	This recommendation is outdated, in that any "interim committee" should have been created well before now. Nonetheless, the recommendation speaks to the creation and ongoing work of OCLEM and CCLEM.
517	OVR 5	The Jail should disclose Sabot's activities and recommendations regarding, among other things, use of force, mental health and medical treatment, staffing, security and safety, modification to policies and procedures (including use of force, discipline, and housing) for inmates with mental disabilities, and restrictive housing. It should ensure full review of each of these issues, as well as seek involvement and input of key community stakeholders.	This recommendation is overly broad and not able to be effectively or efficiently audited. Its numerous subjects are all being examined in a number of other ways, through other more specific jail reform recommendations and provisions of the *Chavez* and *Cole* remedial plans.
526	OVR 5	The Jail and the County should immediately, urgently, and thoughtfully work to implement the Blue Ribbon Commission's recommendations.	The work of implementing the Blue Ribbon Commission's recommendations has been ongoing. Specific auditing of this particular recommendation is not necessary.
5	OVR 6	The Board of Supervisors and County Counsel must protect civilian members who volunteer for its Commissions and Boards from retaliation and harassment from County employees.	This recommendation lacks sufficient specificity for effective and efficient auditing with regard to any specific actions of retaliation or harassment. Further, the County has, since 2003, had a Policy Against Discrimination, Harassment, and Retaliation (Board Policy 3.8).

Recommendation		Description	OCLEM Finding
Master List	Summarized List		
404	OVR 6	Create an Office of Inspector General (IG) that serves the civilian oversight commission and is directed by the commission to provide monitoring of custody operations and facilities (including medical and mental health services) and provide recommendations for improvement.	These recommendations should be considered completed. The functions referenced are being performed by OCLEM.
516	OVR 6	Internal and external oversight should specifically prioritize these issues, in addition to serious incidents and allegations of staff misconduct.	
521	OVR 6	The County should establish an independent oversight entity that has (i) broad scope of authority regarding inmates' rights; (ii) with the cooperation of the Sheriff, full access to jail facilities, data, records, staff, and administrators; and (iii) full independence, reporting to the Board of Supervisors and engaging in outreach to the public.	
527	OVR 6	The jail should work with outside assistance to ensure proper planning and prioritization for implementation of the Commission's recommendations.	This recommendation is outdated. The suggestion to engage outside assistance to plan and prioritize implementation of these recommendations is obviously past any meaningful usefulness.
534	OVR 6	The Board of Supervisors should commission a thorough independent audit of the Custody Health Services organization to ensure best management practices are identified and employed.	The *Chavez* and *Cole* Consent Decrees – while not technically the result of an “audit” – are broadly scoped, and the work being done to comply with all provisions of the remedial plans will effectively achieve the goals of this recommendation.

Recommendation		Description	OCLEM Finding
Master List	Summarized List		
536	OVR 6	The Board of Supervisors should appoint a project manager to oversee the implementation of the multi-disciplinary teams to ensure their anticipated benefits are fully realized.	This recommendation is outdated. The appropriate time to appoint a project manager to oversee any aspect of the implementation of these recommendations is long past. While there may have been efforts to engage a project manager to address these recommendations at some point, there are currently individuals at Custody Health Services and Custody Bureau, as well as in the County Executive's Office who are fully engaged in working on these recommendations as well as implementation of the remedial plans.

Master List Recommendations: Subject to Monitoring by OCLEM

The following recommendations should be removed from the list of those being audited because they address issues that can be effectively monitored by OCLEM. These recommendations were submitted seven years ago, and the Sheriff's Office and its Custody Bureau have implemented numerous changes and reforms in those years. This Board created OCLEM to provide transparency and a level of oversight that did not exist at the time these recommendations were written. Given our access to Sheriff's Office records and personnel, we believe ongoing monitoring of the issues addressed in these outdated recommendations is a better mechanism for reform. We elaborate on each of these issues in the table below.

Recommendation		**Description**	**OCLEM Finding**
Master List	Summarized List		
601	OVR 4	The County needs multiple individuals overseeing quality of care in all of the jails. There should be regular meetings that include representatives from all levels of the organization, from all facilities, and from custody regarding quality improvement.	This recommendation is being addressed by various quality improvement measures implemented as part of the *Chavez* remedial plan. Given OCLEM's recently-signed information sharing agreement with the Sheriff's Office, we expect to learn more about the regular meetings that occur across all levels of the organization, and to be engaged in those meetings when feasible and appropriate.
524	OVR 5	The Jail should immediately publish its PREA audit and PREA data and engage outside assistance in responding to the PREA audits and ensuring PREA compliance.	This information should be published as part of a broader transparency effort. We will work with the Sheriff's Office and the Office of County Counsel to create a greater level of transparency around PREA data, as well as use of force and grievance data, and other information of public concern, as appropriate.

Recommendation		Description	OCLEM Finding
Master List	Summarized List		
472	UOF 1	Establish a custody review committee that will evaluate the force applied within custody facilities, the quality of the investigation and the effectiveness of the supervision.	Custody Bureau has a process for reviewing uses of force that includes a meeting of the Use of Force Review Committee. As part of its recent assignment from the Board regarding the use of chemical agents in planned use of force events, OCLEM was able to access information about this process. Now that we have more complete access to Sheriff's Office records, we anticipate regularly reviewing uses of force and participating in at least a subset of the Use of Force Review Committee meetings. We will review use of force incidents to evaluate deputies' use of de-escalation or force prevention strategies, proportionality of the force, and post-incident medical care. We also will evaluate Custody's review processes – the objectivity and thoroughness of investigative activities, the rigor of mid-level supervisor review, and identification of any needed training or accountability measures. We will regularly report to the Board and the public regarding our findings and any recommendations for improvement, as appropriate and allowable by law.
473	UOF 1	Members of the panel shall include command level personnel, representatives from medical and/or mental health (when applicable), a member of the independent Civilian Oversight Commission and additional support personnel.	
475	UOF 1	The committee will review the force incident including the events that precipitated, any prevention or de-escalation efforts as well as the quality of the force review.	
476	UOF 1	A report will be generated that includes their findings and recommendations. If the findings include any policy or other violations, it will be referred for further follow-up. Exemplary performance or conduct shall also be noted.	
477	UOF 1	In instances of use of force there will be an evaluation of an individual's performance that includes the strategies or tactics used leading up to, during and following a use of force incident. The evaluation will be a review of the performance to standards associated with the actions.	