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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

Estate of RODNEY LOUIS BOCK, deceased, by and through CYNDIE DENNY BOCK, as Administrator; KIMBERLY BOCK; KELLIE BOCK; HILLARY BOCK; MORGEN BOCK; LAURA LYNN BOCK; and Estate of ROBERT BOCK,

Plaintiffs,

v.

COUNTY OF SUTTER; COUNTY OF YUBA; J. PAUL PARKER, Sutter County Sheriff's Department Sheriff; LEWIS MCELFRESH, Sutter County Jail Division Commander; NORMAN BIDWELL, Sutter County Jail Corrections Lieutenant; JOHN S. ZIL; CHRISTOPHER BARNETT; BOBBY JOE LITTLE; DAVID CALAPINI; SHAUN FLIEHMAN; RAINBOW CRANE; KATY MULLIN; DONICE MCGINNIS; BALJINDER RAI; and Does I through XL, inclusive,

Defendants.

Case No. 2:11-cv-00536-MCE-KJN

PLAINTIFFS' NOTICE OF FILING OF RECOMMENDATIONS TO IMPROVE CARE AND TO AVOID PREVENTABLE DEATHS AT SUTTER COUNTY JAIL

On May 20, 2014, the parties reached a settlement agreement at a Settlement Conference before the Honorable Magistrate Judge Edmund F. Brennan. Pursuant to that agreement, Plaintiffs have agreed to assemble written recommendations for changes to improve the Sutter County Jail's medical and mental health system, based on investigation and discovery that has been completed. Counsel for Defendants has agreed to provide Plaintiffs' recommendations to County officials, and the County has agreed to give them serious consideration. *See* 5/20/14 Hr'g Tr. at 4:22-5:1.

Plaintiffs attach as **Exhibit A** their Recommendations to Improve Care and to Avoid Preventable Deaths at Sutter County Jail, which was provided to counsel for Defendants on July 2, 2014.

DATED: July 2, 2014

Respectfully submitted,

ROSEN BIEN GALVAN & GRUNFELD LLP

By: */s/ Aaron J. Fischer*
Aaron J. Fischer

Attorneys for Plaintiffs

EXHIBIT A

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July 2, 2014

Sheriff J. Paul Parker
Sutter County Sheriff's Office
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Yuba City, CA 95993
c/o John Whitefleet (via email)
Counsel for County of Sutter

Dr. Lou Anne Cummings, Health Officer
Sutter County Public Health Division
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c/o John Whitefleet (via email)
Counsel for County of Sutter

Re: Recommendations to Improve Care and to Avoid Preventable Deaths at Sutter County Jail
Bock v. County of Sutter, Case No. 2:11-cv-00536-MCE-KJN (E.D. Cal.)
Prasad v. County of Sutter, Case No. 2:12-cv-00592-TLN-CKD (E.D. Cal.)
Our File Nos. 1137-1, 1175-1

Dear Sheriff Parker and Dr. Cummings:

We are counsel in two recently-settled lawsuits brought against the County of Sutter, *Bock v. County of Sutter* (Case No. 2:11-cv-00536-MCE-KJN) and *Prasad v. County of Sutter* (Case No. 2:12-cv-00592-TLN-CKD). Extensive discovery was done in the two cases. As part of the settlement agreement in the *Bock* case, the parties agreed that our office would assemble recommendations for changes to improve the Sutter County Jail's medical and mental health system. We agreed to provide those recommendations to defense counsel, who in turn has agreed to provide them to you. We understand that the County of Sutter has agreed to give serious consideration to these recommendations. *See* Appendix A, 5/20/14 Court Hearing Tr. at 4:22-5:1.

In assembling these recommendations, our office has obtained input from some of the nation's most distinguished experts on prison and jail medical and mental health care, who have completed careful reviews of the County's system and the circumstances of recent Sutter County Jail inmate deaths.[1] In the last few years, several inmates have died

[1] These experts include: Pablo Stewart, M.D., a psychiatrist who has served as a federal court-appointed monitor of psychiatric care in jails and prisons, and has been cited by the United States Supreme Court, *see Brown v. Plata*, 131 S. Ct. 1910, 1933 n.6, (footnote continued)

at Sutter County Jail, including Rodney Bock (April 2010), Nathan Prasad (January 2011), Erica Ness (September 2011), and Nelson Figueira-Silva (March 2013).

The Sutter County Grand Jury has repeatedly identified serious deficiencies in the jail's medical and mental health care system, both generally and as related to specific deaths. *See, e.g.*, Final Report of the 2007-2008 Sutter County Grand Jury (July 1, 2008) at 134; Final Report of the 2010-2011 Sutter County Grand Jury (July 13, 2011) at 8-11; Final Report of the 2011-2012 Sutter County Grand Jury re: Sutter County Jail Death (Apr. 9, 2012); Final Report of the 2011-2012 Sutter County Grand Jury (July 29, 2012) at 49-50; Final Report of the 2012-2013 Sutter County Grand Jury (July 12, 2013) at 1-5. *See also* May 11, 2009 Memorandum from Sutter County Health Officer to Sutter County Board of Supervisors, available at http://www.co.sutter.ca.us/agenda/bos/2009/3097, Item No. 22 (identifying needs with respect to suicide prevention, mental health treatment, and 24/7 nursing coverage).

There are several steps that the County of Sutter can and should take right away to avoid future tragedies similar to those suffered by Mr. Bock, Mr. Prasad, Ms. Ness, Mr. Figueira-Silva, and the loved ones who survive them. Some of our recommended changes require the provision of additional resources, but are nonetheless essential to prevent future deaths and the costly lawsuits that may follow. Other recommended changes are remarkably inexpensive and entail simple, common-sense steps that can save lives.[2] We provide our recommendations below.

1935 (2011); Lindsay Hayes, Project Director of the National Center on Institutions and Alternatives, a nationally recognized expert in the field of suicide prevention within jails, prisons, and juvenile facilities who has served as a federal court-appointed monitor and suicide prevention consultant to the U.S. Department of Justice's Civil Rights Division; and Robert L. Cohen, M.D., an expert in prison health care (*see Parsons v. Ryan*, Case No. 12-16396, ___ F.3d __, 2014 WL 2523682, at *6 (9th Cir. June 5, 2014)) who has served as court-appointed monitor in cases regarding the provision of medical care in prisons and jails in cases in throughout the country, and served as a member of the Board of the National Commission on Correctional Health Care for seventeen years.

[2] Attached as **Appendix B** is Lindsay Hayes' "Guide to Developing and Revising Suicide Prevention Protocols within Jails and Prisons," which offers further detail and guidance regarding the implementation of an adequate suicide prevention program.

Recommendations to Improve Care and Avoid Preventable Deaths at Sutter County Jail

1. Update Jail Intake Procedures to Identify Prisoners with Serious Psychiatric or Medical Conditions. The intake screening process for newly booked prisoners is antiquated and grossly inadequate. Without adequate screening, prisoners at risk are all too likely to be missed, with unnecessary and tragic outcomes. If done appropriately, screening can be extremely effective in identifying inmates with serious mental illness or medical problems. The jail's screening questions need to be updated and should include meaningful questions regarding an inmate's mental illness and risk for suicide. *See, e.g.*, Appendix B at 2-3. Medical intake screening should be designed to identify medical problems that may require urgent or emergent evaluation by a physician, including but not limited to diabetes, hypertension, epilepsy, asthma, HIV infection, and heart disease.

Screening of inmates needs to be done in a confidential setting, not in the central booking area where other new inmates are just a few feet away. Medical or mental health personnel should conduct the screenings, not custody staff. If licensed vocational nurses ("LVNs")—or any other staff not licensed to diagnose or treat medical or mental illnesses—conduct the screenings, they must be trained to urgently or emergently refer patients with chronic illnesses who are receiving medications or those who have questionable vital signs to the facility physician or mid-level provider, and to obtain immediate telephone consultation for inmate-patients as needed.

Medical intake screening should also include enhanced screening for alcohol and drug withdrawal, both common and extremely serious conditions for men and women entering jail. Patients screened who are found to be at risk for withdrawal should receive immediate medical evaluation and require close monitoring or transfer to a facility equipped for treatment of these conditions.

2. Provide 24/7 Medical Coverage at Sutter County Jail to Ensure Timely Access to Medical Care. During the period from 12:00 midnight to 4:30 a.m. each day, there are no medical staff on site at the jail, and no physicians on call. It was during this four-and-a-half-hour overnight period on January 28, 2011 that the infection Mr. Prasad had developed took a serious turn for the worse. In these critical hours, Mr. Prasad was coughing up blood and sweating profusely, and his vital signs were plummeting. With no medical staff available, Mr. Prasad's condition went from likely treatable to fatal.

This issue—and Sutter County's knowledge of the problem—dates back several years, including a 2007-2008 grand jury report that recommended 24/7 medical staffing at the jail. Sheriff Parker, Jail Commander David Samson, and Lieutenant Norman

Bidwell have all stated, including in sworn testimony, that they believe that the jail needs to have round-the-clock medical staff. Even the County's one-time jail nurse manager made repeated requests for 24/7 medical staffing, but was told that there was simply "not money in the budget." By ignoring these repeated requests and leaving inmates without access to medical care for over one-sixth of every day, the County creates a predictable risk of serious and even lethal consequences for inmates.

To date, the County has not agreed to provide funding for this needed continuous coverage. We recommend that the County reconsider this decision; in the long run, 24/7 on-site medical coverage will save both lives and money. If on-site coverage for any period is provided exclusively by personnel not licensed to diagnose medical conditions (*e.g.*, LVNs), those personnel must have specific and concrete guidance about the signs, symptoms and complaints that should trigger an immediate referral to a higher-level provider and/or the emergency room.

3. Increase Licensed Mental Health Staffing at Sutter County Jail to Ensure Timely Access to Mental Health Care. Other than a psychiatrist (Dr. John Zil) who is on-site for no more than four hours per week, the Sutter County Jail currently does not staff any qualified, licensed mental health professionals. The "crisis counselors" who work at the jail are required to have little more than a valid driver's license. A minimally adequate standard of care requires that a qualified mental health professional be involved in any decision to place an inmate on suicide precautions, to discharge inmates from suicide precautions, and to make other significant treatment decisions related to mental health care.[3]

Shockingly, Mr. Bock went directly from round-the-clock hospital-level psychiatric care at the County's Psychiatric Health Facility to essentially no care at all at the jail. Dr. Zil saw Mr. Bock only one time during his month-long detention, and not once in the approximately 19 days preceding his suicide. Consequently, the jail did not provide necessary and potentially life-saving psychiatric attention to Mr. Bock in those critical days. The jail must increase its staffing of qualified, licensed mental health

[3] *Qualified mental health professionals* include psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and others who by virtue of their education, credentials, and experience are permitted by law to evaluate and care for the mental health needs of patients.

professionals. Those providers need to be notified of and follow up with inmates showing signs of serious mental illness. Otherwise, more deaths are inevitable.

4. Ensure Inmate Treatment Planning and Adequate Communication Between Sutter County Jail Custody Staff, Medical Staff, and Mental Health Providers. Section 1210 of Title 15 requires that, for every inmate treated for a mental illness or major medical problem in a jail, "treatment staff shall develop a written [individualized] treatment plan" and "custody staff shall be informed of the treatment plan when necessary, to ensure coordination and cooperation in the ongoing care of the inmate." We were troubled to discover that inmates at Sutter County Jail, including Mr. Bock and Mr. Prasad, do not receive the treatment plans required by state law. Meanwhile, custody staff repeatedly testified that they never receive information about inmates' medical and mental health needs, including relevant hospital discharge instructions, even though custody officers are the sole personnel in the inmate housing units able to observe and respond to inmate health needs for much of each day.

HIPAA specifically authorizes the sharing of protected inmate health information with correctional staff when needed to protect "the health and safety of such individual[,] … other inmates[,]" or "the officers or employees of or others at the correctional institution." 45 C.F.R. § 164.512(k)(5). Policies, procedures, and practices at Sutter County Jail must be modified to ensure that inmates receive written individualized treatment plans and that staff—including custody staff—have the information they need to implement those plans. The risk to inmates' health and safety absent adequate treatment planning and cross-discipline communication is simply too great.

5. Transfer Sutter County Jail Prisoners with Serious Mental Illness to a Hospital Setting. Mr. Bock committed suicide after being moved directly from the County's inpatient psychiatric facility (on a Section 5150 involuntary psychiatric admission) to the jail. Sutter County Jail does not have the licensing, staffing, or resources to safely house or treat prisoners with serious mental illness. Your County's citizens who require Section 5150 psychiatric hospitalization, or have been found incompetent to stand trial by reason of mental illness, or otherwise suffer from serious mental illness should not be admitted to or housed at the jail. As the federal judge in the *Bock* case found, the superior court judge's order for Mr. Bock to be transferred to a state psychiatric hospital "could have saved his life" if only the County had followed it.

6. Do Not Place Prisoners with Mental Illness in the Jail's Solitary Confinement Cells. Sutter County Jail has a dangerous, longstanding policy and practice to house inmates with mental illness in solitary confinement, meaning that they are kept in their cell for 23 hours per day and have no normal social contact with others

outside of their cell. There is now widespread recognition of the substantial risk of harm to inmates with mental illness housed in such a setting. *See, e.g.*, National Research Council-National Academy of Sciences, *The Growth of Incarceration in the United States: Exploring Causes and Consequences* (2014) at 186-188; American Psychiatric Association Position Statement on Segregation of Prisoners with Mental illness (2012) ("[P]rolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates.")

Sutter County Jail staff members themselves recognize that inmates with mental illness (like Rodney Bock) should not be housed in isolation units. Captain Lewis McElfresh, who served as Jail Division Commander from 2006-2010, testified that "[t]he jail, A-Pod [an isolation unit], is not a place for mental health patients." A sheriff's deputy working in the isolation units (A- and B-pods) expressed to our experts during a recent jail tour that prisoners with mental illness "shouldn't be here, in my opinion."

Moreover, many of these cells are themselves unsafe and pose undue risks to the safety of prisoners with mental illness. For example, the County placed Mr. Bock in a single-man cell in the solitary confinement A-Pod unit that was on the second floor and out of custody staff's and surveillance camera's line-of-sight. Mr. Bock's cell also was not protrusion-free, meaning that there were attachment points for an inmate to attach a suicide noose (as Mr. Bock did). Such hazards must be identified and eliminated in order to prevent predictable harm.

Prisoners with mental illness should be housed and clustered in a non-isolation unit that provides for adequate supervision, access to treatment, out-of-cell time, and suicide-resistant features. Prisoners with mental illness should be promptly moved to hospital-level care when clinically indicated.

7. Provide Suicide Prevention Training for Both Custody and Non-Custody Staff. Dr. Zil testified that he used to provide suicide prevention training to custody staff at Sutter County Jail annually, but this training was ended many years ago. Sound correctional practice requires all staff—both custody staff and non-custody staff (*i.e.*, nursing)—to receive detailed live training, at least annually, on recognizing and responding to inmate suicide risks, as well as emergency response procedures. *See, e.g.*, Appendix B at 1.

8. Implement a Method for Inmates' Family Members to Convey Concerns about Their Loved Ones. A major failure surrounding Mr. Bock's death was that his daughters, who visited him weekly and saw his condition getting worse and worse, had no idea if or how they could communicate their concerns about their father to

jail staff. The jail's crisis counselor testified that there is no procedure for family members to alert jail officials about serious concerns regarding inmates' physical and mental health.

We recommend that you follow the lead of El Dorado, Santa Clara, and at least a dozen other California counties that have systems in place—including posted and online guidance, contact information, and forms—for family members to communicate information about an inmate's mental health or medical needs, histories, and medications to jail staff. (Forms already in use are available at www.namicalifornia.org/criminal-justice.php?page=jail-resources&lang=eng.) This is a simple, low-cost way to help ensure that prisoners with serious illness get the care they need while in custody.

9. Improve Communication Between Sutter-Yuba Mental Health Services and Sutter County Jail. Sutter-Yuba Mental Health Services (SYMHS) is the designated provider of psychiatric services at the jail. Many inmates, like Rodney Bock, have been treated for mental illness at SYMHS's Psychiatric Health Facility (PHF) at some point prior to their jail detention. Yet Dr. Christopher Barnett—the clinical director of SYMHS's PHF and psychiatric emergency services—testified that he had no idea what mental health services are provided at the jail, where prisoners with mental illness may be housed, or what policies and procedures exist for treating prisoners with mental illness. It is deeply troubling that, beyond Dr. Zil and the handful of SYMHS crisis counselors at Sutter County Jail, SYMHS staff and leadership are entirely disconnected from the mental health services at the jail. Better communication is essential.

All SYMHS staff should be trained on what services are available to SYMHS patients housed at the jail. Communication between the jail and SYMHS's community facilities regarding mental health histories, discharge summaries, and treatment plans for inmates with mental illness must be improved, to ensure adequate continuity of care. Proper written and telephone communication between clinical staff is necessary so that inmates with known mental illness do not fall through the cracks as Mr. Bock did.

10. Fix the Jail's Broken Death Review Process. The County of Sutter never completed a full investigation or death review for the deaths of Mr. Bock and Mr. Prasad. Dr. Zil testified that he was informed by the County's director of mental health that attorneys had directed the County not to conduct any death review for Mr. Bock. Similarly, Dr. Cummings directed medical staff not to discuss Mr. Prasad's case, and did not share her personal post-mortem chart review for Mr. Prasad with anyone. These failures violate Sutter County's own Jail Policy Manual, as well as Section 1046 of Title 15 of the California Code of Regulations.

Sound correctional practice requires a mortality-morbidity review for every death, suicide, or serious suicide attempt. This allows for a critical inquiry into the incident, facility procedures, training practices, available medical and mental health services, and the possible need for system improvements to avoid similar outcomes in the future.

11. Ensure Meaningful Training and Accountability to Maintain a Competent, Qualified, and Effective Staff. Actions of County personnel in both the Prasad and Bock deaths reveal a troubling lack of training and appropriate supervision. Likewise, the County's post-incident discipline and follow-up were horribly deficient. Adequate training (at the front end) and discipline (at the back end) are essential ingredients of a minimally adequate jail health care system. Written policies, however improved, are not enough on their own.

By way of example: on the last morning of Mr. Prasad's life, he was displaying alarming medical symptoms, yet the vocational nurse on duty confined him to a jail office for hours rather than summoning emergency care. Following Mr. Prasad's death, her supervisor told her that she "did a good job and handled it well" and that there was "nothing more [she] could have done." Neither of these staff members was ever disciplined or counseled by the County. Yet their respective licensing boards have moved to revoke both of their licenses for the "incompetence" and "unprofessional conduct" they displayed in failing to address Mr. Prasad's medical emergency. *See* http://www.bvnpt.ca.gov/public/vn104567.pdf; http://rn.ca.gov/public/rn530916.pdf.

In Mr. Bock's case, the psychiatrist at SYMHS charged with caring for Mr. Bock appears to have violated state law by approving Mr. Bock's discharge from a Section 5150 hospitalization and transfer to the jail while Mr. Bock was still psychotic, delusional, and in need of hospital-level care. *See* Cal. Welf. & Inst. Code § 5152. Just days before his death, a jail crisis counselor documented that Mr. Bock was unstable, refusing medication, delusional, and having auditory hallucinations, but did not convey this information to anyone. Neither employee was counseled, disciplined, or held accountable by the County in any way.

The County's failure to properly train or supervise these and other employees involved in the deaths of Mr. Prasad and Mr. Bock—or to counsel, discipline, or otherwise address their conduct—is deeply problematic. The County must implement appropriate measures to ensure that staff understand and implement appropriate policies and practices. The County must also hold staff accountable when their conduct contributes to a serious injury or death at the jail—including, at a minimum, re-training and re-evaluating their skill sets to ensure that they meet the minimum standards to be entrusted with the lives of inmates under their care.

We trust that the County will make good on its commitment before the judge who oversaw the *Bock* settlement to seriously consider these proposals. We would be happy to discuss these recommendations or to facilitate communications with the experts whose analyses informed them. On behalf of our clients, we look forward to seeing improved conditions at Sutter County Jail, and to helping the County fulfill its constitutional, legal, and moral responsibility to provide for the care and safety of those in its custody.

Sincerely,

ROSEN BIEN
GALVAN & GRUNFELD LLP

Aaron J. Fischer

Kathryn G. Mantoan

AJF/KGM:cg

Enclosures: **Appendix A**: 5/20/14 Hearing Transcript, *Bock v. County of Sutter*;
Appendix B: Lindsay Hayes, Guide to Developing and Revising Suicide Prevention Protocols with Jails and Prisons

cc: Stan Cleveland, Chairman, County of Sutter Board of Supervisors,
c/o John Whitefleet, Counsel for County of Sutter (via email)

APPENDIX A

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

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CYNDIE DENNY BOCK, et al., Plaintiffs, vs. COUNTY OF SUTTER, et al., Defendants.	Case No. 2:11-cv-00536-MCE-KJN Sacramento, California Tuesday, May 20, 2014 12:23 P.M. Hearing re: further settlement conference.

TRANSCRIPT OF PROCEEDINGS
BEFORE THE HONORABLE EDMUND F. BRENNAN
UNITED STATES MAGISTRATE JUDGE

APPEARANCES:

For Plaintiff:	MICHAEL BIEN AARON J. FISCHER Rosen Bien Galvan & Grunfeld 315 Montgomery Street, 10th Flr. San Francisco, CA 94104 (415) 433-6830
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Transcription Service:	Petrilla Reporting & Transcription 5002 - 61st Street Sacramento, CA 95820 (916) 455-3887

Proceedings recorded by electronic sound recording; transcript produced by transcription service.

SACRAMENTO, CALIFORNIA, TUESDAY, MAY 20, 2014, 12:23 P.M.

(Call to order of the Court.)

THE CLERK: Calling Civil Case 11-00536-MCE, Bock, et al v. County of Sutter, et al. Your Honor, this is on calendar for a further settlement conference.

THE COURT: All right. Let's go ahead and state everybody's appearance on the record. For the plaintiffs?

MR. BIEN: Good morning, Your Honor. Michael Bien and Aaron Fischer on behalf of the plaintiffs.

THE COURT: All right. Mr. Bien, Mr. Fischer.

MR. WHITEFLEET: Good morning, Your Honor, or it's close to afternoon. John Whitefleet for the defendants and with me is Ken Miley of the Risk Management Authority.

THE COURT: All right. And I think you're right. It is afternoon now.

All right. The record will reflect that we've been in further settlement conference this morning. I believe this is now the third conference that we've convened. Substantial progress was made over the first two. We set a further settlement conference for today's date and the morning has been productive. We have -- we appear to have reached a full and final settlement of this matter.

And counsel, I'm going to ask each of you to confirm the terms of the settlement. Mr. Whitefleet, why don't we have

you recite your understanding of the terms of the settlement.

MR. WHITEFLEET: And thank you, Your Honor. My understanding is defendant County has agreed to pay a sum total of $800,000 subject to the approval of the CSAC EIA Committee, and a signing of a standard settlement and release in exchange for dismissal with prejudice.

THE COURT: All right. And that committee meets on June 4, is that correct?

MR. WHITEFLEET: The next scheduled meeting is for June 4th, correct.

THE COURT: All right. And it's your intention to recommend to the committee that they approve this settlement in the amount of $800,000?

MR. WHITEFLEET: Yes.

THE COURT: All right. Now, as to the -- we had some discussion about recommended procedural changes and policy changes. What's your understanding as to that?

MR. WHITEFLEET: Your Honor, if I may, I understand that there have been implemented changes already performed. We can offer a list of those, if you'd like.

THE COURT: Yes. Why don't we have those -- have that list read.

MR. MILEY: Your Honor, this is Ken Miley. There's seven items that the County has implemented to improve the healthcare delivery system at the jail, and I'll go over them

one by one.

They are providing ASIST program training to all current jail medical staff and this training will also be given to all new staff. ASIST stands for Applied Suicide Intervention Skills Training. It's a recognized program.

Secondly, they've hired a new medical director.

Third, they've updated the policies and procedures and included that in all manuals giving priority to inmate safety. An example of one of the policies and procedures that they've changed and updated is when an inmate refuses medication, after three days in a row notices are given to the medical providers for appropriate intervention.

Number four, they've increased staff. They've hired two registered nurses with ER experience, emergency room experience. They've hired one public health nurse, and one LVN, and these are all additions to staff.

They've also added an extra health nurse practitioner as a cover position for vacations and off hours. They've improved the sick call response time. And lastly, they've trained staff on documentation for care of inmates in the safety cells, sobering cells, and medical cells, and that's an increase in training.

And those are the seven items that the County has implemented. And they're also reviewing and looking at additional ways to improve the system.

THE COURT: All right. Now, Mr. Bien -- well, first of all, let me just have you confirm your understanding as to the monetary part of the settlement.

MR. BIEN: Your Honor, we agree that the parties have reached an agreement to -- the plaintiffs will accept a total payment of $800,000 in return for dismissal with prejudice of the lawsuit.

THE COURT: All right. Now, as to the procedural changes and the policy changes the plaintiffs, in addition to this list of seven items that Mr. Miley just read for the record, in addition to that, the plaintiffs intend to submit some sort of a written proposal with recommendations, is that correct?

MR. BIEN: Yes, Your Honor, and defense counsel has agreed that we -- if we provide such a writing to him, he will provide it to the sheriff and the medical director, and we have recommendations from our experts in this case, and a related case, Prasad, which also involved a death at Sutter County Jail in an applicable time period. We have various ideas and recommendations for additional changes, and the County has agreed to hear that from us.

THE COURT: All right. And Mr. Miley, Mr. Whitefleet, it's your understanding that the County will serious consider those proposals?

MR. WHITEFLEET: That's correct, Your Honor.

MR. MYELINI: That's correct, Your Honor.

MR. WHITEFLEET: And just as one point of clarification, just so we can make sure everything is clear and expressed. That the monetary amount of the resolution is of all claims to all parties and requires all parties to bear their own fees and costs.

MR. BIEN: Yes, Your Honor. We agree.

THE COURT: All right. It does then appear that we do have a full and final settlement of the case. The -- I will be entering what we refer to as the drop dead order. It's an order that will vacate all dates in the case. It will vacate the trial date, and any remaining due dates for filing of documents, discovery, et cetera. And it will set a new deadline, and that deadline will be the filing of the dispositional document, that is the stipulation for dismissal in this case.

Is 30 days enough time for that, or do you need more than 30 days?

MR. WHITEFLEET: Just to ensure that we meet the Court's set deadline, once it is set, we would prefer 45 days.

THE COURT: All right.

MR. BIEN: That's fine, Your Honor.

THE COURT: All right. Then we'll -- it will be a 45-day deadline then, assuming that the committee approves the $800,000 settlement, and it sounds like that's likely to

happen. You anticipate that a check would issue within a few weeks after that date, is that correct?

MR. WHITEFLEET: Yes, Your Honor.

THE COURT: All right. We do have a final settlement.

I want to compliment counsel for both sides, or for your diligence and also your patience. We've achieved a settlement in a case where when we began the conference, I didn't think a settlement would be possible. So my compliments to each of you.

And to the family, I want to also commend you for your patience. You've achieved not only what I tink is a very reasonable and fair monetary settlement, but it's also had the result of some important and significant changes that are being made at the jail that are much needed. So my compliments to you as well.

All right. Thank you.

MR. BIEN: Thank you, Your Honor.

MR. WHITEFLEET: Thank you, Your Honor.

(Whereupon the hearing in the above-entitled matter was adjourned at 12:31 p.m.)

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CERTIFICATE

I certify that the foregoing is a correct transcript from the electronic sound recording of the proceedings in the above-entitled matter.

_____ May 21, 2014

Patricia A. Petrilla, Transcriber

AAERT CERT*D-113

APPENDIX B

GUIDE TO DEVELOPING AND REVISING SUICIDE PREVENTION PROTOCOLS WITHIN JAILS AND PRISONS

Lindsay M. Hayes

All correctional facilities, regardless of size, should have a comprehensive suicide prevention program that addresses the following critical components.

Staff Training

The essential component to any suicide prevention program is properly trained staff, who form the backbone of any correctional facility. Very few suicides are actually prevented by mental health, medical or other professional staff because suicides are usually attempted in housing units, and often during late evening hours or on weekends when they are generally outside the purview of program staff. These incidents, therefore, must be thwarted by correctional staff who have been trained in suicide prevention and have developed an intuitive sense about suicidal inmates. Correctional staff are often the only personnel available 24 hours a day; thus, they form the front line of defense in preventing suicides.

All correctional, medical, and mental health personnel, as well as any staff who have regular contact with inmates, should receive eight (8) hours of initial suicide prevention training, followed by two (2) hours of refresher training each year. The initial training should include administrator/staff attitudes about suicide and how negative attitudes impede suicide prevention efforts, guiding principles to suicide prevention, inmate suicide research, why the environments of correctional facilities 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 facility's suicide prevention policy, and liability issues associated with inmate suicide. The two-hour refresher training should include a review of administrator/staff attitudes about suicide and how negative attitudes impede suicide prevention efforts, predisposing risk factors, warning signs and symptoms, identifying suicidal inmates despite the denial of risk, and review of any changes to the facility's suicide prevention plan. The annual training should also include general discussion of any recent suicides and/or suicide attempts in the facility.

In addition, all staff who have routine contact with inmates should receive standard first aid and cardiopulmonary resuscitation (CPR) training. All staff should also be trained in the use of various emergency equipment located in each housing unit. 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.

Identification/Referral/Evaluation

Intake screening and on-going assessment of all inmates is critical to a correctional facility's suicide prevention efforts. It should not be viewed as a single event, but as an on-going process because inmates can become suicidal at any point during their confinement, including the initial admission into the facility; after adjudication when the inmate is returned to the facility from court; following receipt of bad news or after suffering any type of humiliation or rejection; confinement in isolation or segregation; and following prolonged a stay in the facility.

In addition, although there is no single set of risk factors that mental health and medical communities agree can be used to predict suicide, there is little disagreement about the value of screening and assessment in preventing suicide. Research consistently reports that approximately two-thirds of all suicide victims communicate their intent some time before death, and that any individual with a history of one or more suicide attempts is at a much greater risk for suicide than those who have never made an attempt.

Intake screening for suicide risk may be contained within the medical screening form or as a separate form. The screening process should include inquiry regarding: past suicidal ideation and/or attempts; current ideation, threat, plan; prior mental health treatment/hospitalization; recent significant loss (job, relationship, death of family member/close friend, etc.); history of suicidal behavior by family member/close friend; suicide risk during prior confinement; and arresting/transporting officer(s) belief that the inmate is currently at risk. Specifically, inquiry should determine the following:

- Was the inmate a medical, mental health or suicide risk during any prior contact and/or confinement within this facility?

- Does the arresting and/or transporting officer have any information (e.g., from observed behavior, documentation from sending agency or facility, conversation with family member) that indicates inmate is a medical, mental health or suicide risk now?

- Have you ever attempted suicide?

- Have you ever considered suicide?

- Are you now or have you ever been treated for mental health or emotional problems?

- Have you recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)?

- Has a family member/close friend ever attempted or committed suicide?

- Do you feel there is nothing to look forward to in the immediate future (expressing helplessness and/or hopelessness)?

- Are you thinking of hurting and/or killing yourself?

Although an inmate's verbal responses during the intake screening process are critically important to assessing the risk of suicide, staff should not exclusively rely on an inmate's denial that they are suicidal and/or have a history of mental illness and suicidal behavior, particularly when their behavior and/or actions or even previous confinement in the facility suggest otherwise.

The process should also include referral procedures to mental health and/or medical personnel for a more thorough and complete assessment.

The intake screening process should be viewed as similar to taking your temperature, it can identify a current fever, but not a future cold. Therefore, following the intake screening process, should any staff hear an inmate verbalize a desire or intent to commit suicide, observe an inmate engaging in any self-harm, or otherwise believe an inmate is at risk for suicide, a procedure should be in place that requires staff to take immediate action to ensure that the individual is constantly observed until appropriate medical, mental health, and/or supervisory assistance is obtained.

Finally, given the strong association between inmate suicide and isolation/special management (e.g., disciplinary and/or administrative segregation) housing unit placement, any inmate assigned to such a special housing unit should receive a written assessment for suicide risk by medical or mental health staff upon admission to the placement.

The screening and assessment process is only one of several tools that increases the opportunity to identify suicide risk in inmates. This process, coupled with staff training, will only be successful if an effective method of communication is in place at the facility.

Communication

Certain behavioral signs exhibited by the inmate may be indicative of suicidal behavior and, if detected and communicated to others, can reduce the likelihood of suicide. In addition, most suicides can be prevented by correctional staff who establish trust and rapport with inmates, gather pertinent information, and take action. There are essentially three levels of communication in preventing inmate suicides: between the arresting/transporting officer and correctional staff; between and among facility staff (including correctional, medical and mental health personnel); and between facility staff and the suicidal inmate.

In many ways, suicide prevention begins at the point of arrest. At *Level 1*, what an arrestee says and how they behave during arrest, transport to the facility, and at intake are crucial in detecting suicidal behavior. The scene of arrest is often the most volatile and emotional time for the individual. Arresting officers should pay close attention to the arrestee during this time; suicidal behavior may be manifested by the anxiety or hopelessness of the situation, and previous behavior can be confirmed by onlookers such as family members and friends. Any pertinent information regarding the arrestee's well-being must be communicated by the arresting or transporting officer to correctional staff. It is also critically important for correctional staff to maintain open lines of communication with family members who often have pertinent information regarding the mental health status of inmates.

At *Level 2*, effective management of suicidal inmates is based on communication among correctional personnel and other professional staff in the facility. Because inmates can become suicidal at any point during confinement, correctional staff must maintain awareness, share information and make appropriate referrals to mental health and medical staff. At a minimum, the facility's shift supervisor should ensure that appropriate correctional staff are properly informed of the status of each inmate placed on suicide precautions. The shift supervisor should also be responsible for briefing the incoming shift supervisor regarding the status of all inmates on suicide precautions. Multidisciplinary team meetings (to include correctional, medical and mental health personnel) should occur on a regular basis to discuss the status of inmates on suicide precautions. Finally, the authorization for suicide precautions, any changes in suicide precautions, and observation of inmates placed on precautions should be documented on designated forms and distributed to appropriate staff.

At *Level 3*, facility staff must use various communication skills with the suicidal inmate, including active listening, staying with the inmate if they suspect immediate danger, and maintaining contact through conversation, eye contact, and body language. Correctional staff should trust their own judgment and observation of risk behavior, and avoid being misled by others (including mental health staff) into ignoring signs of suicidal behavior.

Poor communication between and among correctional, medical, and mental health personnel, as well as outside entities (e.g., arresting or referral agencies, family members) is a common factor found in the reviews of many custodial suicides. Communication problems are often caused by lack of respect, personality conflicts and boundary issues. Simply stated, facilities that maintain a multidisciplinary approach avoid preventable suicides.

Housing

In determining the most appropriate housing location for a suicidal inmates, correctional facility officials (with concurrence from medical and/or mental health staff) often tend to physically isolate (or segregate) and sometimes restrain the individual. These responses might be more convenient for all staff, but they are detrimental to the inmate since the use of isolation escalates the sense of alienation and further removes the individual from proper staff supervision. To every extent possible, suicidal inmates should be housed in the general population, mental health unit, or medical infirmary, located close to staff. Further, removal of an inmate's clothing (excluding belts and shoelaces) and the use of physical restraints (e.g., restraint chairs or boards, leather straps, handcuffs, straitjackets) should be avoided whenever possible, and used only as a last resort when the inmate is physically engaging in self-destructive behavior. Housing assignments should be based on the ability to maximize staff interaction with the inmate, not on decisions that heighten depersonalizing aspects of confinement.

All cells designated to house suicidal inmates should be as suicide-resistant as is reasonably possible, free of all obvious protrusions, and provide full visibility. These cells should contain tamper-proof light fixtures, smoke detectors and ceiling/wall air vents that are protrusion-free. In addition, the cells should not contain any live electrical switches or outlets, bunks with open bottoms, any type of clothing hook, towel racks on desks and sinks, radiator vents, or any other object that provides an easy anchoring device for hanging. Each cell door should contain a heavy gauge Lexan (or equivalent grade) clear panel that is large enough to allow staff a full and unobstructed view of the cell interior. Finally, each housing unit in the facility should contain various emergency equipment, including a first aid kit, pocket mask or face shield, Ambu-bag, and rescue tool (to quickly cut through fibrous material). Correctional staff should ensure that such equipment is in working order on a daily basis.

Levels of Observation/Management

In regard to suicide attempts in correctional facilities, the promptness of the response is often driven by the level of supervision afforded the inmate. The planning of and preparation for suicide can take several minutes; brain damage from strangulation caused by a suicide attempt can occur within 4 minutes, and death often within 5 to 6 minutes. 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 (e.g., expressing a wish to die without a specific threat or plan) and/or has a recent prior history of self-destructive behavior. In addition, an inmate who denies 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. Staff should observe such an inmate in a protrusion-free cell at staggered intervals not to exceed every 10 minutes (e.g., 5, 10, 7 minutes).
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> *Constant Observation* is reserved for the inmate who is actively suicidal, either threatening or engaging in suicidal behavior. Staff should observe such an inmate on a continuous, uninterrupted basis. In some jurisdictions, an intermediate level of supervision is utilized with observation at staggered intervals that do not exceed every 5 minutes.
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> Other aids (e.g., closed-circuit television, cell mates) can be used as a supplement to, but never as a substitute for, these observation levels.

Because death from a suicide attempt can occurs within a short duration, observation of a suicidal inmate at intervals less frequent than continuous observation can only be successful if the observation is staggered and the cell is suicide-resistant.

In addition, mental health staff should assess and interact with (not just observe) the suicidal inmate on a daily basis. The daily assessment should focus on the current behavior, as well as changes in thoughts and behavior during the past 24 hours (e.g., “What are your current feelings and thoughts?” “Have your feelings and thoughts changed over the past 24 hours?” “What are some of the things you have done or can do to change these thought and feelings?,” etc.)

An individualized treatment plan (to include follow-up services) should be developed for each inmate on suicide precautions. The plan should be developed by qualified mental health staff in conjunction with not only the inmate, but medical and correctional personnel. The treatment plan should describe signs, symptoms, and the circumstances under which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the inmate and staff will take if suicidal ideation reoccurs.

Finally, due to the strong correlation between suicide and prior suicidal behavior, in order to safeguard the continuity of care for suicidal inmates, all inmates discharged from suicide precautions should remain on mental health caseloads and receive regularly scheduled follow-up assessments by mental health personnel until their release from custody. Although there is not any nationally-acceptable schedule for follow-up, a suggested assessment schedule following discharge from suicide precautions might be: 24 hours, 72 hours, 1 week, and periodically until release from custody.

Intervention

Following a suicide attempt, the degree and promptness of the staff's intervention often foretells whether the victim will survive. National correctional standards and practices generally acknowledge that a facility's policy regarding intervention should be threefold. *First*, all staff who come into contact with the inmate should be trained in standard first aid procedures and CPR. *Second*, any staff member who discovers an inmate engaging in self-harm should immediately survey the scene to assess the severity of the emergency, alert other staff to call for medical personnel if necessary, and begin standard first aid and/or CPR as necessary. If facility policy prohibits an officer from entering a cell without backup support, the first responding officer should, at a minimum, make the proper notification for backup support and medical personnel, secure the area outside the cell, and retrieve the housing unit's emergency response bag (that should include a first aid kit, pocket mask or face shield, Ambu-bag, and rescue tool). *Third*, correctional staff should never presume that the victim is dead, but rather should initiate and continue appropriate life-saving measures until relieved by arriving medical personnel. In addition, medical personnel should ensure that all equipment utilized in responding to an emergency within the facility is in working order on a daily basis.

Finally, although not all suicide attempts require emergency medical intervention, *all* suicide attempts should result in immediate intervention and assessment by mental health staff.

Reporting

In the event of a suicide attempt or suicide, all appropriate officials should be notified through the chain of command. Following the incident, the victim's family should be immediately notified, as well as appropriate outside authorities. All staff who came into contact with the victim before the incident should be required to submit a statement including their full knowledge of the inmate and incident.

Follow-Up/Mortality-Morbidity Review

An inmate suicide is extremely stressful for both staff and other inmates. Staff may also feel ostracized by fellow personnel and administration officials. Following a suicide, misplaced guilt is sometimes displayed by a correctional officer who wonders: "What if I had made my cell check earlier?" Inmates are often traumatized by critical events occurring within a facility. Such trauma may lead to suicide contagion. When crises occur in which staff and inmates are affected by the traumatic event, they should be offered immediate assistance. One form of assistance is Critical Incident Stress Debriefing (CISD). A CISD team, comprised of professionals trained in crisis intervention and traumatic stress awareness (e.g., police officers, paramedics, fire fighters, clergy, mental health personnel), provides affected staff and inmates an opportunity to process their feelings about the incident, develop an understanding of critical stress symptoms, and seek ways of dealing with those symptoms. For maximum effectiveness, the CISD process or other appropriate support services should occur within 24 to 72 hours of the critical incident.

Every completed suicide, as well as serious suicide attempt (i.e., requiring medical treatment and/or hospitalization), should be examined through a mortality-morbidity review process. If resources permit, clinical review through a psychological autopsy is also recommended. Ideally, the mortality-morbidity review should be coordinated by an outside agency to ensure impartiality. The review, separate and apart from other formal investigations that may be required to determine the cause of death, should include a critical inquiry of: 1) the circumstances surrounding the incident; 2) facility procedures relevant to the incident; 3) all relevant training received by involved staff; 4) pertinent medical and mental health services/reports involving the victim; 5) possible precipitating factors leading to the suicide or serious suicide attempt; and 6) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures.

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