Santa Clara County Office of Correction and Law Enforcement Monitoring

Report to the Board of Supervisors regarding the August 2019 In-Custody Incident Involving J.N.

May 16, 2023

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Introduction

In August 2019, J.N.[1] was a 28-year-old in the custody of the Santa Clara County Sheriff's Office, serving a short sentence on a misdemeanor offense. He initially was placed in a minimum-security housing module, but was moved to the Acute Psychiatric Unit (APU) of the Main Jail following an attempt to harm himself. Within hours of arriving at that unit, he again tried to harm himself by running headfirst into the door of his cell, which caused him to fall backward and land on the floor, unable to move. He spent the next 24 hours in his cell without medical care. Even though he repeatedly reported his injury to deputies and medical staff, they acted as though they believed he was "faking" and failed to even assess his condition or take necessary precautions when moving him from the floor to his bunk shortly after his fall.

J.N. laid in the same awkward position through three shift changes while both custody and medical staff ignored his claims. Meals that deputies delivered accumulated in the sink and on the floor of his cell; a nurse falsely documented that he had gotten up and eaten one of those meals; other nurses fabricated records of assessments they hadn't performed; deputies performed "welfare checks" every 15 minutes but apparently only to confirm J.N. was breathing. No one identified his injury for over 24 hours. When he was finally transported to the hospital, doctors confirmed he was paralyzed – consistent with what J.N. had repeatedly told personnel at the jail.

The inexcusable treatment of J.N. led to an independent investigation and swift action by Custody Health Services (CHS); none of the nurses who were responsible for J.N.'s care continue to be employed by the County. The Sheriff's Office likewise conducted a thorough Internal Affairs

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[1] Though this individual has been named in other public documents, including a claim and lawsuit he filed against the County, we use only initials in this report when identifying him to respect his privacy.

investigation and made appropriate disciplinary decisions. J.N. filed a lawsuit that the County quickly settled for $7 million.

Beyond individual accountability and County liability, though, important questions linger. What explains the shocking gap between the critical care that J.N. needed and the disregard with which that need was met – in a special unit designed to provide round-the clock nursing care? And, more significantly, what can be done to reduce the likelihood of a similar incident happening again?

This report is intended to further set out the abysmal conduct of jail staff that day, as well as the larger cultural issues and dysfunctions from which it arose. We also address the question of future prevention by assessing any changes made by the Sheriff's Office's Custody Bureau and CHS since 2019, and by making recommendations intended to help ensure that no other individuals in the Santa Clara County jails will have an experience like J.N.'s.

CHS leaders remain appropriately dismayed by the conduct of medical personnel revealed by J.N.'s ordeal. This event served as a type of wake-up call for CHS about the consequences of management and cultural deficits that had been previously identified but not adequately addressed. The implication is that as long as this incident lives in people's memory, its circumstances won't be repeated but it is critical to develop safeguards that outlast the memory of any particular staff member.

CHS has been involved in reform work necessary to institutionalize the painful lessons learned from this incident. A new Director addressed the interpersonal dysfunction and significant morale issues that had been hampering operations. Changes to the way the APU is staffed, as well as new training mandates, have brought a greater degree of consistency and professionalism to the unit.

It's not clear that J.N.'s case was a similar type of "watershed moment" for Custody Bureau, in large part because the investigation outcomes demonstrate the Sheriff's Office placed the greater part of the responsibility for J.N.'s poor treatment on nursing staff. This allocation of blame by sworn staff is not necessarily incorrect or inappropriate – CHS ultimately is responsible for the provision of medical and mental health health care. Nonetheless, while it may not have been deputies' *fault* that J.N.'s serious needs went unattended for so long, more attentive,

assertive deputies working in greater concert with nursing staff could have helped identify and address J.N.'s paralysis much earlier. Moreover, as detailed below, at least two deputies were untruthful: they were involved in falsifying a log entry and were subsequently dishonest during an investigative interview.

Our recommendations for Custody Bureau, then, center on creating a higher level of professionalism, experience, and maturity among deputies assigned to work in the APU. By improving the processes for selecting, training, incentivizing and compensating deputies in that unit, the expectation is that deputies will assume a greater degree of ownership of their responsibilities and contribute to a "care culture" which will result in improved treatment for the individuals housed there.

We also address communications issues and the ways in which personnel share information across shifts, and recommend a greater degree of supervisor engagement, both on a day-to-day basis and in the form of random, video-based performance audits. Certainly, this incident demonstrates a need to verify that employees are performing their responsibilities consistent with County expectations.

We recognize the importance of a team-based approach to providing effective mental health care and treatment to those in custody. We have been encouraged to see efforts by both CHS and Custody Bureau to promote a collaborative atmosphere between medical/mental health and sworn staff. But because these efforts seem largely focused on the supervisory and management levels, we recommend that CHS and Custody Bureau look for new ways to stimulate cooperation, communication, multi-disciplinary training, and collaboration among personnel at all levels.

Finally, efforts to reduce the jail population during the pandemic led to new alternatives and programs aimed at keeping those convicted of most misdemeanor offenses out of custody. Following today's guidelines, J.N. would not have served his sentence in jail. That is an encouraging development. Nonetheless, the County's responsibility to provide mental health care to many of those who remain in its custody presents ongoing challenges that it must meet with a higher level of care and professionalism than was evident in this case.

Scope of Review

On February 7, 2023, the Board of Supervisors directed the Office of Correction and Law Enforcement Monitoring (OCLEM) to review this incident and prepare a report with recommendations focused on policy, systems, and cultural changes aimed at improving the safety of those incarcerated in the County's jails.

OCLEM conducted an extensive review of documents, video, and other records provided by the Sheriff's Office and CHS, including the administrative investigations into involved personnel, reports generated by deputies, footage from both the jail's fixed camera system and deputies' body-worn cameras, and documents from the Root Cause Analysis meeting conducted by CHS. We also reviewed relevant policies and met with individuals in both the Sheriff's Office and CHS to discuss issues relating to the 2019 events and subsequent reform efforts.

We also reviewed publicly available information, including filings in the lawsuit against the County, the Board of Registered Nursing (BRN) documents published online, and media coverage.

Our analysis and recommendations reflect the full range of information we reviewed, but the factual detail in our report is tailored to protect confidentiality where required by law.

We are grateful for the complete cooperation of Sheriff's Office and CHS personnel and for providing us the materials we needed for this review. We appreciated the opportunity to speak with individuals in both offices, and this report is informed by their candor, insightfulness, and receptivity to our review.

We also take this opportunity to thank the Office of County Counsel for the assistance and guidance we received during our review process. We appreciate the ways in which we have been able to work in partnership with County colleagues, on this and other projects.

Factual Background and Summary of Events

Booking and Initial Events at Elmwood Correctional Facility

On July 19, 2019, J.N. entered Santa Clara County Jail to serve a short sentence on a misdemeanor charge.[2] He had never been jailed before, and was initially housed at Elmwood Correctional Facility, where the County detains individuals who pose the lowest level of security risk. Jail personnel were aware that J.N. had a history of mental illness.

On August 1, 2019, J.N. refused to return to his cell after programming, expressing fear that his cellmate and others were trying to hurt him. A deputy moved him to a private area to talk with him and asked him whether he felt suicidal. J.N. began stabbing himself in the face with a pencil. The deputy struggled with J.N. to seize the pencil and secure him. J.N. was sobbing and distraught. Jail personnel transported him to Santa Clara Valley Medical Center (VMC), where he was relatively quickly discharged.

[2] We learned from the District Attorney's Office that if a circumstance similar to that in J.N.'s case was presented today, it likely would result in the same charges, but the sentence would be served in the Sheriff's Work Alternative Program (SWAP) in lieu of actual jail time. This was largely a consequence of the County's efforts to drastically reduce the population of offenders who are required to serve jail terms initially in response to the Covid-19 pandemic. Now, most misdemeanor offenders are serving time in either SWAP or doing community service, with only certain categories of misdemeanors ineligible for SWAP (such as convictions requiring sex offender registration).

After his release from VMC on August 1, J.N. was taken back to County Jail. Considering his recent self-harming behavior, J.N. was ordered to be housed at the Main Jail's APU, where inmates receive the highest level of mental health care in the jail facilities.

Initial Hours within Acute Psychiatric Unit

J.N. arrived at the APU – in module 8C[3] of Main Jail – just after midnight on August 2, 2019. In this unit, both nursing staff and sworn staff are required to complete safety and security checks on each individual at least four times each hour. As a result of his self-inflicted injury, CHS personnel ordered J.N. to receive regular neurological assessments.

Upon J.N.'s arrival at the APU, Nurse 1 met with him, and then deputies escorted him to his cell. J.N. walked without difficulty or assistance. Between around 1:00 AM and 7:30 AM, both deputies and nurses performed regular safety checks[4] roughly every 15 minutes. Just after 6:30 AM, Deputy A attempted to deliver breakfast to J.N., but he refused to come to his cell door and asked Deputy A about his criminal charges.

Just before 7:45 AM, J.N. ran headfirst into the window on his cell door and fell backward. This moment is captured on the fixed camera system in the jail.[5] The collision or the fall caused a serious injury to J.N.'s spine.

The 24 Hours Following J.N.'s Injury

Between 7:45 AM and 8:30 AM, personnel continued to do regular welfare checks every 15 minutes and documented that J.N. was lying on the floor of his cell during each of these checks.

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[3] Typically, the APU is located in module 8A. Because of construction and maintenance, this unit was located in module 8C at the time of this incident.

[4] Safety or welfare checks require direct physical observation of each inmate to assess their general well-being. They are conducted by looking through a window in a locked cell to assess whether an individual is in any distress or shows any signs of self-harm.

[5] The fixed camera system is not monitored in real time, but video footage is maintained and available for later review.

During “pill call” (regular rounds where deputies accompany nurses as they administer medications) at around 8:30 that morning (45 minutes after the injury occurred), J.N. did not get up off the floor to receive his medication, nor would he have been able to do so because of his injury. Deputy B accompanied Nurse 2 on rounds and opened the door to J.N.’s cell to facilitate a conversation. J.N. was lying on the floor of the cell with his feet facing the door and his hands over his chest in an unusual position. Deputies A and C and eventually, a supervising nurse, Nurse 3, responded. Personnel tried to convince J.N. to get up to take his medication, reassuring him that he was safe and would feel better if he took his medication. J.N. responded: “I cannot get up.”

Personnel persisted in trying to get him to take the medication, telling him his charges were minor and he wouldn’t be in jail much longer, and that if he took the medication, he would be able to relax and feel better. This dialogue – captured by deputies’ body-worn cameras – followed:

> J.N.: “I crashed myself into the window and I think I’m paralyzed sir. . . . Please help.”
>
> Deputy C: “So can the nurse give you some medication real quick?”
>
> J.N.: “I cannot get up.”
>
> Deputy A: “The medication is going to help with that.”
>
> J.N.: “You don’t understand.”

The conversation continued with personnel trying to convince J.N. to get up. J.N. repeated “I can’t get up. . . . I’m broken. . . . Please call the doctor. Please.”

Deputy B then told the nurses, “He says his back is broken.” Nurse 3 replied, “His back is broken, he, he is just acting, let’s put him, put him on to the bed.”

Eventually, at the direction of Nurse 2 and with the assistance of Nurse 3, Deputies A, B and C moved J.N. off the floor and onto the bunk by rolling him onto his side and then into a seated position. During that movement, J.N. screamed out in pain. Deputies A, B and C then hoisted him onto the bed, where he was laid on his back with his lower legs dangling over the

end of the bunk. Once on the bed, J.N. continued to complain that "everything hurts" and pleaded with deputies to return his arms to the position they had been in while his was on the floor. Deputy C moved his arms into the position he requested. As deputies were closing the cell door, Deputy A and B told J.N. that a doctor would be there soon to examine his back. Consistent with their normal practice and understanding of their own responsibilities, it appears the deputies believed one of the nurses would request a physician. In fact, neither deputies nor nursing personnel requested a doctor to assess J.N.'s condition. Neither Nurse 2 or 3 reentered J.N.'s cell or had further direct contact with him for the rest of their shifts.[6]

After J.N. was moved onto the bunk, numerous deputies and nurses continued to document welfare checks every 15 minutes. However, as discussed more fully below, video showed that nurses were documenting checks and assessments they frequently had not performed. For the next nearly 23 hours, deputies and nursing staff combined to log over 180 "welfare checks" on J.N. while he laid on the bed in cell without moving. Nurses did not conduct neurological assessments or check J.N.'s vital signs throughout this time.[7]

In addition to the regular welfare checks, in the several hours after J.N. was lifted onto his bunk, both a psychiatrist and a County social worker spoke to him through the cell door, without entering the cell. In conversations captured on the jail's fixed camera system, he informed both that he was paralyzed. The social worker reported the complaint of paralysis to Nurse 5, who took no further action. Video reflects that the psychiatrist never entered J.N.'s cell, while the facts suggest the psychiatrist took no further action in response to J.N.'s assertion.

In other interactions with deputies and medical personnel throughout that day, J.N. continued to insist that he could not move because he was

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[6] Nurses in the APU work eight and a half-hour shifts with 30-minute overlaps between each shift: 7:00 AM to 3:30 PM; 3:00 PM to 11:30 PM; and 11:00 PM to 7:30 AM.

[7] Nurse 4 documented having performed the neurological assessment, but video showed she never entered J.N.'s cell, which would have been required to conduct the evaluation. Further, because J.N. was later found to be paralyzed, her positive assessment could not have been accurate.

paralyzed, while personnel either openly disagreed or simply decided not to believe him. For example, in one interaction, Deputy D accompanied Nurse 4, who intended to do a blood pressure check:

> Deputy D: "He said he is paralyzed."
>
> Nurse 4: "Let me check his blood pressure, he ain't paralyzed."
>
> …
>
> J.N.: "My neck is broken."
>
> Deputy D: "You don't need your neck to walk. You just need your legs to walk. Get up!"
>
> J.N.: "My legs are broken, too."
>
> …
>
> Nurse 4: "He was walking when he came in here."

Later, during a routine pill call, Deputy E and Nurse 4 interacted outside J.N.'s cell. Nurse 4 said she wanted to go into the cell to take J.N. his medication, but Deputy E refused to open the cell door, telling the nurse that he was "walking yesterday," and "he was sleeping on the ground last night, so he can do anything."[8] The deputy later explained her refusal to let the nurse into the cell was based on her unfamiliarity with J.N. (since he had recently arrived to the unit) and her concern that he might be assaultive.

Meals Delivered to JN's Cell

Shortly after he arrived at the APU, J.N. accepted a food tray from deputies through the tray slot in his cell. At around 6:30 AM on August 2, Deputy A offered J.N. a breakfast tray but reported that J.N. declined to take it.

[8] This statement was apparently based on the faulty assumption that J.N. moved himself from the ground to the bunk.

Around noon on August 2, Deputy A delivered lunch to J.N.'s cell by leaving the boxed meal on the inside ledge of the tray slot while J.N. laid on his bunk.

At around 6:20 PM, Deputies E and F brought dinner to J.N.'s cell. Deputy F reached through the tray slot and tossed the tray toward the sink.

Just before 6:30 AM, Deputy D served breakfast to J.N. attempting to toss the tray into the sink area, but it fell onto the floor of the cell.

All four meals delivered to J.N. while he was in 8C were later found in his cell, uneaten. One (that had been accepted by J.N. just after his arrival at the unit) was on the back table; one was found in the sink; two were on the floor.

Delayed Discovery of Injury and Transfer to Hospital

Just after 7:00 AM on August 3, Deputy A and E approached J.N.'s cell to inform him that he had a visitor. At that time, Deputy A (who had moved J.N. to the bed the morning prior) realized that J.N. was still in the same awkward position he'd been in the day before.[9] Deputy A summoned nursing personnel to assess J.N.

Nurse 2 called a Code 2 medical emergency[10] and initiated a transfer to VMC via ambulance. At 8:10 AM, County paramedics arrived on scene to medically assess J.N. They at first requested deputies' assistance to move J.N. to a gurney. J.N. again screamed out in pain when deputies tried to move him into a seated position. Paramedics then retrieved and applied a neck brace and a backboard to transfer J.N. to a gurney. At 8:37 AM, paramedics escorted J.N. out of his cell for transport to VMC.

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[9] Deputies in the APU work 12-hour shifts, with shift changes at: 6:00 AM and 6:00 PM.

[10] "Code 2" means a response is urgent but not a medical emergency requiring an ambulance to respond immediately with lights and sirens (as in a "Code 3" response).

False Documentation of Interactions

J.N.'s records[11] are notable both for the absence of information – neurological assessments, vital signs, and progress notes that were never completed – and for the presence of some information that is demonstrably false. For example, remarkably, and inexplicably, Nurse 3 documented that J.N. ate his lunch, did not require assistance in eating, that he got up from his bunk, used the toilet, and was walking around in his cell. Video shows that Nurse 3 had no contact with J.N. and no basis for making these observations. Moreover, the evidence is clear that J.N. was in fact paralyzed during most of his time in the APU after his injury and could not have engaged in the activities Nurse 3 reported seeing him do.

As noted above, Nurse 4 documented that she had completed a neurological assessment of J.N., which included evaluation of, among other things, his motor responses. However, the video record shows Nurse 4 never went into J.N.'s cell or had any interaction with him. Had she done the assessment she claimed to do, she would have noted his paralysis and – presumably – would have taken action to get J.N. the help and care he needed.

And Nurse 5 documented completing welfare/suicide prevention checks on J.N. even though video shows she was also never at his cell. She also documented observations about his mental status, including remarks indicating she'd had a conversation with J.N., and noted that he was compliant with his medications and had eaten his entire dinner without assistance. In fact, in direct conflict with that entry, Nurse 4 had documented that J.N. had refused to take his medications, and his uneaten dinner was later found on the floor of the cell.

Nurse 6 documented that she had also completed the required neurological assessment on J.N. despite the video evidence that she never entered his cell or had other interaction with him during her entire shift. Nonetheless, she recorded normal results on her assessment. Her

[11] This section reflects factual information about nursing documentation that is publicly available on the website for the State of California's Board of Registered Nursing and which OCLEM independently confirmed based on our extensive review of records and video as described above.

documentation acknowledges J.N.'s claim that he is paralyzed, but casts doubt on this assertion by noting (apparently without any factual basis) that he moved while he was sleeping.

With the notable exception of one welfare check that was documented but not actually completed, and concerns about the lack of documentation of observations that should have been noted but weren't (discussed more fully below), the written record of deputies' interactions with J.N. were accurate (as evidenced by video recordings).

Investigations and Individual Accountability

About three hours after paramedics transported J.N. to Valley Medical Center, a detective from the Jail Crimes Unit (JCU) was notified and began an investigation into the incident, following protocol for any inmate suicide or suicide attempt.[12] The detective took statements from Deputy A and Nurse 2, as well as the psychiatrist who interacted with J.N. while he was in 8C. He gathered evidence – log books and other documentation from the jail – and reviewed video from surveillance and body-worn-cameras. He also went to VMC to speak with J.N., who was unable to make a fully coherent statement but did tell the detective, "I was being ignored throughout everything, and nobody believed me."

Custody Bureau leaders learned of the incident that day, and on August 5, the Sheriff's Office formally directed its Internal Affairs Unit (IA) to conduct an administrative investigation into the actions of the involved deputies. Concurrent with the IA investigation, the County engaged an independent firm to investigate the conduct of nursing personnel.[13]

During the IA investigation, the assigned IA sergeant worked closely with a lieutenant at Main Jail to gain insight into the jail's policies and practices, and to frame potential allegations relating to various deputies' conduct. The investigator reviewed extensive video footage, gathered employees' reports of the incident, reviewed records, and interviewed deputies

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[12] The purpose of this – and other suicide investigations by the JCU – generally is limited to ensuring that the incident was properly classified as an attempted suicide and did not involve criminal conduct, but does not examine questions of whether personnel violated any policies. Following the same protocol, a different JCU detective had responded to Elmwood on August 1, following the incident in which J.N. injured himself with a pencil.

[13] The professional conduct of physicians is typically assessed through a confidential peer review process.

involved in the incident. We reviewed all the materials associated with this investigation, and found it to be thorough, complete, and objective.

The investigation evaluated the actions of all the involved deputies and addressed a number of potential policy violations. It considered the fact that J.N. was housed in the APU, where individuals exhibit symptoms of severe mental illness and often engage in bizarre behavior. Ultimately, the Sheriff's Office concluded that the deputies reasonably relied on the medical professionals to make decisions about J.N.'s medical needs.

The IA investigation did find violations of policies, however, related to Deputy E and F's untruthful statements related to the completion of a welfare check; Deputy E's denial of Nurse 4's entry into J.N.'s cell; Deputies E and F's missed welfare check; and Deputies E and F's failure to conduct a formal class card count[14] during their shift. In addition to the serious integrity violations for the two deputies, two additional deputies were found to have committed less serious policy violations and received appropriate remediation. Deputy E is no longer employed by the Sheriff's Office.

The administrative actions taken to address the conduct of nursing staff likewise were thorough, complete, and objective. In addition to commissioning an independent firm to conduct an investigation that would guide its employment decisions surrounding the nurses, the County referred five of the involved nurses to the Board of Registered Nursing (BRN) for investigation and appropriate disposition.

According to documents available on the BRN's public website, the BRN filed formal Accusations against Nurses 2, 3, 4, 5, and 6. Nurse 2 did not challenge the Accusations, and the BRN revoked his nursing license. Nurses 3 and 4 agreed to voluntarily surrender their licenses. BRN proceedings against Nurses 5 and 6 are still pending. The psychiatrist who interacted with J.N. in Main Jail was a contracted psychiatrist who no longer works at the jail.

In October 2019, J.N. filed a claim against the County as a precursor to a lawsuit. The County settled the lawsuit for $7 million in early 2022.

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[14] Class card counts are conducted at the beginning and end of every shift to ensure that all inmates in a housing module are accounted for.

Systems, Policy, and Culture Issues

Staffing Issues in Acute Psychiatric Unit

The APU in module 8A[15] of Main Jail functions as an inpatient mental health unit with around 40 beds, housing those with serious mental illness in need of acute inpatient care. Nurses staff the module 24 hours a day, seven days a week, with the goal of stabilizing these individuals through medication and programming so they can eventually transition to less restrictive environments.

Fully addressing the needs of those housed in the APU in module 8A requires unique sets of skill and levels of patience and understanding by both deputy and nursing personnel. Hiring qualified nurses and identifying those deputies who are temperamentally well-suited to the job – and then training them appropriately – are key to a successful operation.

Custody Bureau: Selection Processes and Incentives

Because of the challenges presented by those with acute mental illness and the necessary degree of cooperation with medical and mental health staff, positions on 8A are unique within the jail. Supervisors at Main Jail reported to us that deputies are specially selected to work this assignment based on their work history, demeanor, and skill sets. Some deputies request the assignment. But there are no specific criteria and no formal

[15] As noted previously, at the time of this incident, module 8A was out of service for maintenance issues and the APU was located in module 8C.

selection process for this position. Supervisors just "hand-pick" those who they think are a good fit.

A better model for staffing 8A would be to establish a list of qualifications and a formal application and selection process to ensure that those assigned to work the module have the appropriate disposition, experience, and motivation to meet the challenges of the position. We understand that the Sheriff's Office currently employs a formal selection process for its Multi-Support Deputies (MSDs),[16] including a written application in which deputies must, among other things, describe why they want to work in a specialized, mental health-focused role. Custody Bureau should consider folding the selection for 8A deputies into that process, since the qualifications and criteria share many similarities.

> Recommendation 1: The Sheriff's Office should develop a list of qualifications and other criteria for deputies who wish to be assigned to work the Acute Psychiatric Unit on 8A.

> Recommendation 2: The Sheriff's Office should utilize a formal application and selection process for deputies assigned to the Acute Psychiatric Unit on 8A, to ensure that personnel in that unit have the appropriate experience, temperament, and motivation.

The Sheriff's Office should also strive to make these positions more competitive and coveted in order to attract deputies with more experience and maturity. One way to accomplish this is to establish an assignment to 8A as a positive step for career advancement within the organization.

Another way to encourage the development of a cadre of deputies with the skill and temperament to effectively address the dynamics of mental illness in the custody setting is to establish a bonus classification that would provide increased salaries for deputies assigned to the APU. This

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[16] Multi-Support Deputies are specially selected to assist other deputies and mental health professionals to address the needs of the seriously mentally ill. They work closely with CHS throughout the jail facilities, responding to requests for assistance with inmates who are in crisis or who need care and attention that a module deputy may not be able to provide. Unfortunately, there is no record indicating whether the MSDs working the APU on the date of the J.N. incident were apprised of the situation by the deputies assigned to the unit.

type of “bonus” position would promote a greater sense of professionalism and concern for the welfare of those in custody than what we saw among those assigned to the APU while J.N. was housed there. It would recognize the difficulties and heightened stress levels associated with the assignment to 8A while also establishing a higher set of expectations for the position.

> Recommendation 3: The Sheriff’s Office should reinforce the critical importance of positions in the Acute Psychiatric Unit by working with the County to establish a bonus classification that would provide increased salaries for deputies assigned to work there.

> Recommendation 4: To further reinforce and recognize the critical importance of the Acute Psychiatric Unit assignment, the Sheriff’s Office should view successful service as a deputy in this unit as a positive attribute for career advancement opportunities.

Custody Bureau: Training for 8A

Beyond their typical security function, deputies who work in the APU on 8A are required to address a range of difficult situations, with individuals who are often a danger to themselves or others, are heavily medicated, behave bizarrely, and need to more frequently interact with medical and mental health personnel. An understanding of mental illness and specialized training around how to address the behavioral implications of those illnesses is essential in order for deputies to best perform the functions required in the APU.

We learned that the jail does not require deputies to complete any specialized training program before beginning work on 8A. Custody Bureau leaders referenced a training program for 8A, but deputies who worked in the unit reported they received little formal specialized training to work this assignment. Instead, they described a type of progressive and repetitive, learning-on-the-job training in which more tenured deputies told or showed them how the unit operates. Certainly, this type of “field” training program has value and is essential to gaining practical skills needed for work in 8A, but on its own is not enough to optimally prepare

deputies for the challenges of keeping acutely mentally ill individuals safe and promoting their stabilization and recovery.

All deputies receive some mental health training in the Academy,[17] and the Sheriff's Office in-service training regularly features classes on addressing mental health crises. But the Sheriff's Office should develop a specialized course of training to develop, on a practical level, better comprehension of the day-to-day functions of the APU, to foster a deeper understanding of the illnesses those housed there live with and how it impacts their behavior, and to introduce deputies to effective strategies for providing a safe custodial environment for those in the APU.[18]

> Recommendation 5: Custody Bureau should develop a training program for deputies assigned to work in the Acute Psychiatric Unit, to address specific operational issues as well as instruction on serious mental illness, its implications for individuals' behavior in a custody setting, and expectations for how deputies will address those behavioral issues.

Following the incident involving J.N., Custody Bureau recognized the disconnect between supervisors' expectations and deputies' practices, and that the failures here likely were indicative of broader problems. In response, Main Jail leaders convened a Squad Meeting Training on September 30, 2019, to remind personnel of their expectations. Training topics included:

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[17] We were told that all deputies now get 40 hours of Crisis Intervention Team training in the Academy, though this is a relatively recent development, and not all of the more tenured deputies have been through this mental health-focused training curriculum. We understand the challenges of complying with training requirements while also contending with the staffing shortages the Sheriff's Office (and most law enforcement agencies nationwide) is currently facing. We also know that ongoing annual training for deputies on mental health issues is a requirement of the *Chavez* remedial plan that the Sheriff's Office is currently struggling to comply with due to staffing shortages.

[18] We understand that training on mental health issues in a correctional setting – and training for deputies in the APU specifically – are addressed in provisions of the *Chavez* consent decree and remedial plan. Our recommendations are meant to facilitate compliance with those provisions and not to establish conflicting benchmarks.

- The role of deputies working in the APU, to assist with the stabilization and treatment of those housed there by facilitating the work of nurses, psychiatrists, and other clinicians;
- Instruction that deputies should "interact with the inmate as often as possible" and "investigate each inmate's allegations or claims";
- The role of supervisors and the expectation that deputies reach out to a supervisor if they have a concern that an inmate is not receiving proper care;
- The importance of communication, especially between shifts.

This training was a necessary response to concerns about the treatment of care of J.N., but the importance of these subjects warrants regular updates and ongoing emphasis, not just a one-time briefing. In addition to specialized training as a precursor to assignment to the APU, deputies should receive regular, ongoing training or briefings specific to their work in that unit.

> Recommendation 6: Deputies working in the Acute Psychiatric Unit should receive ongoing training or briefings on subjects critical to their work, including reinforcement of Sheriff's Office expectations for cooperation with medical and mental health professionals, interaction with those in custody, and communication with supervisors and others.

Role of Multi-Support Deputies

In 2019, Custody Bureau had 24 designated Multi-Support Deputies to assist other deputies and mental health personnel in the management of mentally ill inmates throughout the jail facilities. Those positions were lost to budget cuts in 2020, but the items have since been reinstated and the Sheriff's Office is working to re-staff those positions.[19]

[19] Currently, eight of the 26 positions are filled, and this number grows by two with each Academy class graduation, as a new deputy fills a position vacated by a newly-assigned MSD.

MSDs are selected for their disposition, skill, and interest in working with those with mental illness. They meet weekly with mental health clinicians in the jail to establish and maintain clear lines of communication and address specific problems. They do rounds throughout housing areas for those with serious mental illness, and commonly respond to situations that module deputies do not have the time or capacity to manage effectively. For example, one common scenario in the jails is an individual who refuses to come out of his cell to shower or allow the cell to be cleaned. A housing module deputy who has multiple tasks to complete every hour may not have the time or patience to calmly talk that individual into leaving his cell. An MSD has that extra time to spend, and brings a level of experience, knowledge, and training to the situation, increasing the likelihood of successful resolution.

As the Sheriff's Office brings the MSD program back, it is worth exploring the possibility of coordinating – or perhaps even merging – the MSD program with a reinvigorated system for selecting and training deputies designated to work the APU. Because both assignments share many of the same ideal qualifications and attract deputies with similar interests, Custody Bureau could employ a single application and selection process for both positions.

Likewise, both MSDs and 8A deputies should have similar types of training to prepare them for addressing the needs of those with serious mental illness in the custody setting. Custody leaders responsible for MSDs are trying to develop a more robust training program for those newly assigned to the position; aligning that with an effort to design a training curriculum for those working on 8A may create efficiencies that make sense for both programs. The two positions – MSDs and 8A deputies – are a natural fit for cross-training, which could open up possibilities for flexibility in staffing across both positions.

> Recommendation 7: The Sheriff's Office should explore ways to coordinate the application, selection, and training of Multi-Support Deputies and those deputies assigned to work in the Acute Psychiatric Unit.

Custody Health Services: Staffing, Management, and Cultural Issues

The failures of the nursing staff so evident in J.N.'s care created a defining moment for Custody Health Services. While those failures were addressed on an individual level through reporting to the BRN and subsequent employment consequences, the level of deviation from acceptable nursing practices coupled with the brazen falsification of medical records pointed to a broader cultural issue.

CHS conducted a Root Cause Analysis (RCA)[20] meeting a little over a month after J.N.'s injury. The RCA acknowledged the individual performance issues but noted the ongoing investigation, instead focusing on a number of systems issues, many of which had previously been identified as concerns by CHS's Quality Improvement (QI) team, without adequate follow-up or implementation.

When a new Director of CHS joined the County one year after the incident involving J.N., she recognized that many of these issues had been addressed through various staffing changes, but without a plan for sustainability. She was particularly dismayed by the performance of the nurses in the J.N. matter and sought to address the larger morale and environmental concerns that seemed to contribute to the poor performance, including management dysfunction and a degree of interpersonal conflict that demanded immediate attention.

[20] The purpose of an RCA is to evaluate the root cause and any associated systems issues following an in-custody death or other critical incident so that personnel can identify and implement prevention strategies. The Quality Improvement team serves as coordinators for these reviews, with an assigned manager conducting a preliminary review of the incident and then leading the RCA review team to evaluate the circumstances around each incident, relevant procedures and training, or other factors. Managers from different disciplines are assigned responsibility for implementation of action items. The QI manager is responsible for following up on corrective actions identified by the RCA review and reporting back to CHS executive management. Other participants in RCAs include the Director of CHS and Custody Behavioral Health Services, Nurse Manager, the Commander and other personnel from the involved jail facilities, other medical or mental health professionals, and County Counsel. OCLEM is also a regular attendee at these meetings.

The CHS Director engaged conflict resolution specialists to address internal tensions and assist with team-building and sagging morale at all levels of the organization. The mediators worked directly with nursing leadership to provide communication support and other resources to enhance engagement and conflict resolution. Along with bolstering supervision by adding an assistant nurse manager to each shift, focusing on the internal discontent was, in the Director's view, step one in providing a higher level of care to individuals in the APU.

Many of the changes accomplished in CHS since then are tied to other reform efforts – generally, the *Chavez* remedial plan – and not explicitly linked to an action plan stemming from J.N.'s case. Regardless, significant shifts in the way CHS staffs and supervises the APU are consistent with the needs of the population served on the APU, giving current CHS leaders a high degree of confidence that J.N. would be treated with a higher level of care and greater compassion today than he was in 2019. Specifically:

- A dedicated care team is assigned to the APU, including psychiatrists, psychologists, clinicians, and nurses, along with a nurse manager with specific training and experience in working with mental health population. This team follows a consistent shift schedule to provide continuity and familiarity.[21]

- Given the 24/7 nature of the job and turnover among nursing staff, however, staffing challenges remain. CHS is aggressively hiring to fill vacant positions, but open positions as well as vacancies due to vacation or sick time are still intermittently being filled by per diem nurses.[22]

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[21] Efforts to provide greater continuity of care have been aided by changes to the admission and discharge criteria for the APU. In 2019, it operated as a unit intended to house people for 72 hours or less. Now, patients stay in the unit for as long as they need the level of care provided. Ending the constant churning of patients in and out of the unit allows and encourages staff to make therapeutic connections with individuals in ways they previously did not.

[22] In J.N.'s case, Nurses 4 and 6 were per diem nurses, meaning they were not regular County employees but were working on a per-day basis to cover staffing shortages.

CHS addressed our concerns about employing per diem nurses[23] on the APU by noting some key changes since 2019. Currently, per diem nurses that are scheduled to work on the APU unit are from a pool of nurses dedicated for that unit who have gone through the same "on-boarding" process and been through the same mandated training as any other APU nurse. Because there are no extra APU nursing positions available to backfill inevitable vacancies, it is our understanding that per diem nurses are necessary for the operation of the unit.[24] The commitment to predominantly staff the unit with experienced nurses who have mental health proficiency is intended to provide structure and accountability, even on shifts that may include less experienced nurses.

- The shift assignment form was revised in 2019 with input from nursing staff so that staff assignments are now clearly documented, with adequate details to maintain accountability and clarity of assigned tasks and roles.

- New training mandates, largely stemming from the *Chavez* consent decree, set out requirements for baseline training content that addresses the unique aspects of mental health care in a custody setting, as well as regular refresher courses covering a range of topics, including suicide prevention.

- Interpersonal conflict and low morale in the unit was addressed by conflict resolution specialists in 2020 and 2021, and the Director reports she does not and would not hesitate to bring them back if tensions begin to surface.

Clinical staffing shortages across all categories of CHS personnel remain an ongoing challenge and continue to impact the level of care medical and mental health professionals can provide. CHS has been making a

[23] A per diem nurse is not a County employee but contracts with the County on a day-to-day basis as needed.

[24] That being said, per diem nurses do not provide the consistency in care that a permanent employee does and their use in the APU should be kept to a minimum.

concerted effort to fill vacant positions, with specialized recruitment efforts and retention bonuses, as well as pay differentials for psychiatrists.

For nurses, efforts include hiring other classifications of workers – Licensed Vocational Nurses and Psychiatric Technicians – to allow Registered Nurses (RNs) to work at the highest level of their credentials. Still, given the high demand for nurses in general, attracting nurses to the correctional setting is a perpetual challenge. CHS is looking at innovative ways to do so. It is our understanding that nurses receive shift differentials and "hazard pay", but not at a rate comparable to those available to physicians and psychiatrists. While we are not conversant in the intricacies of County funding models or employment classifications, compensating nurses for the danger and discomfort of working in a jail strikes us as a necessary measure for addressing staffing shortages.

> Recommendation 8: The County and Custody Health Services should explore all possible ways to attract additional nursing staff, including additional "hazard pay" bonuses meant to compensate for the unique challenges of working in a correctional setting, especially in the APU.

Communication between Custody Bureau and Custody Health Services

Effective treatment of mentally ill individuals in custody demands ongoing communication and cooperation between Custody Bureau personnel and mental health care providers. Ideally, sworn staff should work as a team with nurses, clinicians, and psychiatrists to manage inmates within the unit. This team approach is particularly important in the APU, which functions as a medical unit but is nonetheless under Custody Bureau's span of control.

Evidence of this type of collaborative approach was absent from the unit at the time J.N. was housed there. Even while a nurse and deputies were working together to move J.N. from the floor onto the bunk, there was virtually no communication about J.N.'s claims or the best course of action. Later, when Deputy E refused to open the cell door to allow Nurse 4 to assess J.N., there was no follow-up discussion; the nurse and deputy both moved on and J.N. remained in his cell. The way that interaction

transpired hints at a problematic regularity of discord between deputy and nursing staff. And it further suggests a pattern of conduct at the time completely inconsistent with the goal of stabilizing and treating the acutely mentally ill individuals housed in the APU.

This deficiency was acknowledged by leaders in both Custody Bureau and CHS, who report a shared commitment work collaboratively at every level. Some specific shortcomings have been addressed by both. Custody Bureau released an administrative directive following this incident which emphasized that deputies should not refuse a medical professional's request to enter an individual's cell, unless there is a security threat preventing the medical visit, in which case deputies should consult a supervisor, ensure that the event is captured on body-worn camera, and create an entry in the Post Log Book. And CHS implemented and trained its personnel on an "escalation protocol" to employ if a deputy declines to open a cell door, where a nurse reports the denial to a supervisor who will address the issue up the deputy's chain of command.

The improved partnership is evident in other ways as well. For example, the CHS Director was recently invited to participate in interviews for a new jail Captain. And we've been generally encouraged by the level of cooperation and collaboration at work between Custody Bureau leadership and CHS personnel during the RCA meetings we've attended. CHS is looking forward to the return of the full complement of MSDs, with a plan to introduce a new model for crisis intervention across the jail system once these positions are more fully staffed.

In the APU, CHS reports there is now daily "rounding," where both Custody Bureau and CHS personnel walk to each cell and discuss the needs and priorities of the individuals housed on the unit. And personnel conduct regular "care coordination meetings" that bring the treating psychiatrist and clinicians together with a Sheriff's Office sergeant or lieutenant to discuss the needs of individuals housed in the unit. Ideally, this level of cooperation would get pushed down to line-level personnel – deputies and nurses – so they approach day-to-day operations with a shared commitment to care and treatment.

Greater continuity among nursing staff should help to promote this type of collaborative atmosphere in the APU. The goal of our recommendations regarding the selection and training of 8A deputies, above, is to encourage a similar degree of continuity among sworn staff. Custody Bureau and

CHS should work together to find other ways to build and maintain a collaborative environment. The weekly meetings between MSDs and mental health personnel could serve as a model for similar regularly set meetings between 8A deputies and CHS personnel in the APU on given shifts. The meetings could be used to share pertinent information about particular individuals, including how to accommodate treatment needs in light of security concerns, and to promote greater familiarity with each other's protocols and operational issues.

Another possibility for team-building and collaboration is to plan joint trainings. CHS already does coordinated training with Custody Bureau on suicide prevention and requirements of the Americans with Disabilities Act (ADA). Leaders of both Custody Bureau and CHS should, to the extent possible, consider and plan future joint trainings with line-level sworn and medical/mental health staff on de-escalation, ways to better detect and respond to those asserting injuries or other types of crises, and other topics relevant to the provision of behavioral health treatment in the custody setting.

> Recommendation 9: Custody Bureau should adopt its administrative directive as a formal policy, clearly stating that that deputies should not refuse a medical professional's request to enter an individual's cell. If deputies have particular security concerns about a request from medical staff to see an inmate, they must notify or consult with a supervisor, who will consult with medical staff to decide how to provide care to the individual.

> Recommendation 10: Leaders from Custody Bureau and Custody Health Services should continually look for opportunities to promote a collaborative atmosphere in the APU, including establishment of regular meetings between deputies and medical/mental health staff and the development of joint training opportunities with the two groups.

Sharing Information across Shifts

J.N.'s time in the APU spanned a little more than 32 hours, and deputies and nurses across all shifts had the opportunity to interact and make

observations about his condition and behavior. Unfortunately, both sworn and medical staff failed to adequately convey information to their peers in a way that could have impacted J.N.'s care.

Custody Bureau: Failure to Log or Pass-Down Information

In the APU, deputies have three ways to convey information to those on subsequent shifts:

- The "Post Log Book" in which deputies are expected to record operational issues impacting the module;
- A verbal or written "pass down" to convey notable information about particular inmates to deputies coming on to work the next shift;
- An "8A Module Program Log" to document information about out-of-cell activities for each individual housed in the unit.

Between the time that J.N. injured himself in the APU and was carried out by paramedics roughly 24 hours later, deputies made no entries in the Post Log Book about his condition or claims of paralysis. Likewise, it seems no information was passed down to from shift-to-shift. And the 8A Module Program Logs simply document that J.N. entered the module on August 2, 2019, at 0014 hours and went to VMC on August 3, 2019.

Policy 9.37 of the Department of Corrections Policy and Procedure Manual states:

> *The Post Log Book shall include, but not be limited to the following information:*
>
> *. . .*
>
> *Unusual occurrences or events. The time and type of an occurrence such as a suicide attempt, an inmate under the influence, an inmate injury/accident, a fight, unusual inmate behavior . . .*
>
> *Special medical or psychiatric problems or needs. The time and type of problem; the time and name of the supervisor that was notified and the action taken to resolve the problem.*

Several aspects of deputies' interactions with J.N. and nursing personnel arguably fit within the scope of information to be reported pursuant to this policy. For instance, J.N.'s initial statement to deputies was, "I crashed myself into the window and I think I'm paralyzed sir." This should have been reported by deputies as a suicide attempt, or at least an injury resulting from another act of self-harm.

When Nurse 2 directed Deputies A, B, and C to move J.N. despite his claim of paralysis and cries of pain, deputies likewise should have recognized this as a reportable event. J.N. continued to complain of pain after personnel moved him, and Deputies A and B told him a doctor would come soon to examine him. While they understandably believed nurses would handle this request, they should have considered pain and paralysis a "special medical need" to include in the log. This is particularly true as they continued conducting welfare checks throughout their shifts and J.N. remained in the same awkward position they'd left him in.

Later, Deputies D and E interacted with J.N. and nursing staff and heard his claims of paralysis. The shared perception was that he was faking, but again, deputies arguably should have recognized this as reportable information.

If information about J.N.'s claims of injury and paralysis had been recorded in the Post Log Book, deputies on subsequent shifts could have seen the consistency of J.N.'s behavior and claims, perhaps prompting them to take some action. And if they had recognized J.N.'s situation as something that should be documented, they likewise would have been required to notify a sergeant.

Unfortunately, deputies did not document any of their actions or observations, and did not notify their supervisors.

Nonetheless, the Sheriff's Office determined that the Post Log Book policy did not provide clear enough guidance to the deputies involved in J.N.'s case. Indeed, deputies reported that it is difficult to determine "normal" behavior for inmates in the APU, and conversely, that there is no clear standard for "unusual" events on that unit. J.N.'s behavior did not stand out to them as uncommon. In these circumstances, the IA investigator concluded deputies' failure to document anything of J.N.'s situation did not violate the policy, as written. Given that, the policy should be revised to clearly state the Sheriff's Office expectations for documentation.

Recommendation 11: The Sheriff's Office should revise its policy on Post Log Book entries (Policy 9.37) to provide greater clarity and guidance to deputies working in the Acute Psychiatric Unit about what information must be included in the log.

Carrying this further, if deputies had recognized J.N.'s injury and claim of paralysis as something to be included in the Post Log Book, they likely would have conveyed this information about J.N. during a pass down to the next shift.

During training, deputies learn that the Shift Change Protocol[25] directs them to pass down information about inmate-specific behavior to the next shift of deputies coming on duty. Pass down information can be exchanged during jail-wide shift briefings or between deputies working in a certain module as they exchange their posts.

The type of information expected to be conveyed during pass downs is not dictated by policy but is meant to be guided by common sense and good judgment. In practice, 8A deputies typically record basic information on inmate behavior into an informal "Pass Down Log" – a document they type into a template and print for the next shift. These documents typically summarize the type of behavior of each inmate in the module during a given shift, and in the absence of notable behavior simply read: "No issues."

Pass Down Logs are intended to be informal, and are not retained past the next shift, so it is unclear whether any information about J.N. was conveyed in this manner during shift changes on August 2 and August 3, 2019. One deputy vaguely remembered some information being communicated to him about J.N. during pass down, but it was not specific and did not refer to an injury or claim of paralysis.

The failures to communicate with other deputies in this case should be addressed by some of the recommendations we make with regard to staffing, above. More tenured and well-trained deputies will be expected

[25] Within the Sheriff's Office Jail Training Program Manual is Critical Task #1: Shift Change Protocol. The manual directs deputies to conduct pass downs stating that at the beginning of each shift, a deputy must "ask for post details/information."

to exercise a higher degree of common sense and judgment than did the deputies who were responsible for J.N.'s care. A greater emphasis on communication we also discuss above – both among deputies and between sworn and medical personnel – should help alleviate these concerns as well. Nonetheless, we recommend that periodic briefings and/or training memos directed to deputies assigned to 8A should include regular reminders about the importance of sharing information with peers during routine shift pass-downs.

> Recommendation 12: Custody Bureau should use briefings and/or training memos to regularly remind deputies assigned to the Acute Psychiatric Unit of the importance of sharing information with other deputies about the condition and care of individuals housed on the unit during routine shift pass-downs.

It bears repeating that had deputies recognized the significance of J.N.'s injury, the expectation is that they would have taken action to get him adequate medical care. The failure to document was secondary to the failure to act. However, had deputies been more conscientious about following pass-down information protocol, J.N. may have received earlier intervention.

Custody Health Services: Falsification Impacts Future Assessment

Nurses likewise have a responsibility to communicate information about patients and their care across shifts. For medical staff, this documentation includes progress notes and various assessments and evaluations that together constitute a patient's medical record.

In this case, nurses did not just fail to document relevant information, but also affirmatively documented demonstrably false information that likely interfered with the assessments made and care provided by personnel on future shifts.

For example, Nurse 3's notation that J.N. ate his lunch, did not require assistance in eating, that he got up from his bunk, used the toilet, and was walking around in his cell may have impacted the perception of nurses on subsequent shifts when they considered whether J.N. may have been

"faking." Of course, nurses on later shifts should have independently assessed J.N.'s condition but instead likewise falsified documents, further perpetuating the baffling conclusion that J.N. was in fact not injured.

CHS leadership recognizes that the culture among CHS personnel at the time that tolerated this type of rampant falsification of medical records has to be addressed through strong leadership and supervision, coupled with strict accountability and auditing measures, which we discuss below.

Beyond documentation in the medical records, though, nurses also engage in change-of-shift hand-offs, similar to deputy pass-downs. At the time, those hand-offs were inconsistent and sporadic. In 2019, following this incident, CHS revised its process for shift-to-shift reporting in the APU, with renewed and ongoing instructions to staff that reinforce the importance of communication between shifts and during shifts, across all disciplines. CHS management developed a report template in the County's electronic medical records systems for nurses to maintain consistency in the way they document and track relevant information for shift hand-offs. CHS reports that change of shift reports have become a routine practice at APU and include a "safety huddle" at the beginning of each shift along with updates on the patient population (including new admits and discharges, appointments that require transportation, upcoming patient moves to other facilities, incidents that occurred on the prior shift, or any other pertinent patient information that the oncoming team needs to know for follow up).

Supervision, Management, and Ongoing Accountability

Custody Bureau: Supervisory Engagement

Sergeants are the first line of supervision in the jails. As supervisors, sergeants should typically act as risk-managers and cultural leaders while providing guidance and mentorship to line-level personnel. They respond to critical events such as use of force incidents and medical emergencies. Their supervisory role generally spans multiple modules.

In the Santa Clara County jails, sergeants perform "unannounced checks" at various times throughout a shift in all modules, including the APU.

During these “unannounced checks” sergeants approve welfare check logs[26] and are expected to inquire about and identify any issues or problems within a certain housing module.

During the time J.N. was housed in the APU, sergeants conducted three unannounced checks. During these visits, it seems they did little more than review and approve the module’s welfare check logs. Based on our review of video from the fixed cameras, these sergeants apparently did not substantively engage with the deputies in the module. Deputies did not report to sergeants any unusual events involving J.N. Had a sergeant inquired about recent events within the unit, or if deputies had meaningfully communicated with the sergeant about inmates in the module, J.N.’s paralysis may have been discovered much earlier than it was.

The primary purpose of sergeants’ unannounced checks should be to engage with deputies and to leave a module assured that all emergent issues have been handled, and not just to sign the welfare check logs. The Sheriff’s Office should reinforce with sergeants the importance of their role as first line supervisors and encourage them to communicate with deputies in each housing location with the goal of mitigating or managing potential issues. This will become especially important as Custody Bureau moves toward the digitalization of welfare check logs and the temptation may be for sergeants to spend more time in their offices than directly supervising the deputies in their command.

Sergeants should also be required to conduct random audits of available video footage – both from the fixed camera system and deputies’ body-worn cameras – to ensure the integrity of log entries and monitor deputy performance (on issues, for example, like the delivery of meals). This will provide opportunities for more consistent and early identification and remediation of problems with inaccurate or false log entries, failures to conduct required welfare checks, or any other identified issues concerning

[26] Once Custody Bureau has completed the installation and implementation of its new Radio Frequency Identification (RFID) wristband system, we understand the role for sergeants with respect to oversight of deputies’ welfare checks will change considerably, with the ability to monitor dashboards and ensure compliance without having to visit the module and view the currently hand-written log books.

interactions with medical staff or poor treatment of individuals in custody. At the same time, audits which find deputies performing consistently with expectations should be positively recognized and their good performance reinforced.

> Recommendation 13: The Sheriff's Office should regularly reinforce with sergeants – through briefings and in training – the importance of engaging with deputies during their module checks to learn about any problems or unusual events.

> Recommendation 14: The Sheriff's Office should develop policy requiring sergeants assigned who supervise housing modules to conduct a set number of random audits per month of deputies' body-worn camera footage to both monitor performance issues and identify any concerns about deputy conduct and the accuracy of log entries.

Custody Health Services: New Approach to Management and Accountability

CHS leadership acknowledges there were significant concerns about the way the APU was managed in 2019, and that the level of dysfunction among personnel stemmed at least in part from a lack of adequate supervision. The addition of a Nursing Manager with demonstrated psychiatric leadership experience and an office in the APU – along with the consistency gained through the addition of dedicated care teams and other changes to the way CHS staffs the APU – is intended to address these concerns.

Other changes in CHS since the time of J.N.'s injury include a new emphasis on managerial engagement, including random leadership walks, where Chiefs, Managers, and supervisory personnel are encouraged to regularly visit units, talk to staff, make observations, and identify areas of potential improvement. CHS also now employs a "care team" approach to treatment that integrates physical and behavioral health care among providers across discipline and rank, introducing a new degree of collaboration between both supervisory and line staff and physicians, nurses, and other clinicians.

Nonetheless, concerns linger about the stunning misconduct of nurses who ignored J.N.'s needs while falsifying medical records – and about the culture that allowed those individuals to think their conduct was acceptable.

In the investigation that followed J.N.'s injury, investigators reviewed video from the fixed camera system in the APU and discovered that nurses had documented their completion of checks and assessments when the video showed they had never visited J.N.'s cell. The type of rampant falsification identified makes it highly likely that this was not a one-time occurrence and that similar behavior had been happening for some amount of time. As a safeguard against this type of future misconduct, CHS should develop a protocol requiring random audits of available video footage from the APU to verify the accuracy of nurses' progress notes, assessments, and welfare check logs. Ideally, the Nurse Manager, personnel from CHS's Quality Improvement unit, or some other designated individual or unit would be required to conduct a set number of audits each month. With appropriate access to the camera system,[27] supervisors would be able to verify the accuracy of records kept by staff and may identify other areas of concern.

Conducting regular audits of welfare checks, and other at-cell consultations, would complement goals of the new Director of CHS to reform the culture of nursing personnel. And again, when the audits detect optimal performance of medical and health staff, employees should be recognized for their good work.

> Recommendation 15: Custody Health Services should consider requiring supervisors to conduct a set number of random audits per month of available video footage from the Acute Psychiatric Unit to verify the accuracy of nurses' progress notes, assessments, and welfare check logs.

[27] This recommendation will require the cooperation of the Sheriff's Office, which controls access to the camera system.

Jail Population Management

The events that unfolded here began with the incarceration of J.N. for a misdemeanor offense that today would have resulted in a sentence to the Sheriff's Work Alternative Program and no time in jail. This is largely the result of efforts to reduce the County's jail population that took on new urgency during the COVID-19 pandemic and pushed institutions to embrace innovative ideas for safely keeping people out of custody. While the jail population has not remained at the lows seen during the pandemic, we understand the County – through Pretrial Services, District Attorney's Office, Sheriff's Office, and the Courts – is actively exploring alternatives to incarceration and options for community-based behavioral health care. We encourage these efforts to continue.

> Recommendation 16: County stakeholders should continue to engage in efforts to re-think jail population management and efforts to divert people from custody to community-based alternatives.

Recommendations

1: The Sheriff's Office should develop a list of qualifications and other criteria for deputies who wish to be assigned to work the Acute Psychiatric Unit on 8A.

2: The Sheriff's Office should utilize a formal application and selection process for deputies assigned to the Acute Psychiatric Unit on 8A, to ensure that personnel in that unit have the appropriate experience, temperament, and motivation.

3: The Sheriff's Office should reinforce the critical importance of positions in the Acute Psychiatric Unit by working with the County to establish a bonus classification that would provide increased salaries for deputies assigned to work there.

4: To further reinforce and recognize the critical importance of the Acute Psychiatric Unit assignment, the Sheriff's Office should view successful service as a deputy in this unit as a positive attribute for career advancement opportunities.

5: Custody Bureau should develop a training program for deputies assigned to work in the Acute Psychiatric Unit, to address specific operational issues as well as instruction on serious mental illness, its implications for individuals' behavior in a custody setting, and expectations for how deputies will address those behavioral issues.

6: Deputies working in the Acute Psychiatric Unit should receive ongoing training or briefings on subjects critical to their work, including reinforcement of Sheriff's Office expectations for cooperation with medical and mental health professionals, interaction with those in custody, and communication with supervisors and others.

7: The Sheriff's Office should explore ways to coordinate the application, selection, and training of Multi-Support Deputies and those deputies assigned to work in the Acute Psychiatric Unit.

8: The County and Custody Health Services should explore all possible ways to attract additional nursing staff, including additional "hazard pay" meant to compensate for the unique challenges of working in a correctional setting.

9: Custody Bureau should adopt its administrative directive as a formal policy, clearly stating that that deputies should not refuse a medical professional's request to enter an individual's cell. If deputies have particular security concerns about a request from medical staff to see an inmate, they must notify or consult with a supervisor, who will consult with medical staff to decide how to provide care to the individual.

10: Leaders from Custody Bureau and Custody Health Services should continually look for opportunities to promote a collaborative atmosphere in the APU, including establishment of regular meetings between deputies and medical/mental health staff and the development of joint training opportunities with the two groups.

11: The Sheriff's Office should revise its policy on Post Log Book entries (Policy 9.37) to provide greater clarity and guidance to deputies working in the Acute Psychiatric Unit about what information must be included in the log.

12: Custody Bureau should use briefings and/or training memos to regularly remind deputies assigned to the Acute Psychiatric Unit of the importance of sharing information with other deputies about the condition and care of individuals housed on the unit during routine shift pass-downs.

13: The Sheriff's Office should regularly reinforce with sergeants – through briefings and in training – the importance of engaging with deputies during their module checks to learn about any problems or unusual events.

14: The Sheriff's Office should develop policy requiring sergeants assigned who supervise housing modules to conduct a set number of random audits per month of deputies' body-worn camera footage to both monitor performance issues and identify any concerns about deputy conduct and the accuracy of log entries.

15: Custody Health Services should consider requiring supervisors to conduct a set number of random audits per month of available video footage from the Acute Psychiatric Unit to verify the accuracy of nurses' progress notes, assessments, and welfare check logs.

16: County stakeholders should continue to engage in efforts to re-think jail population management and efforts to divert people from custody to community-based alternatives.