

2017-2018 GRAND JURY REPORT

Riverside County Sheriff's Department Corrections Division

Booking-Process – Clinical Assessments and Medical Care Observations

Background

The Riverside County Sheriff's Department (RCSD) has varied responsibilities of meeting and upholding state and federal laws to its citizens, including those citizens detained or incarcerated under its supervision. All persons detained or incarcerated in RCSD correctional facilities must be provided basic and emergency medical care pursuant to *California Title 15 – Minimum Jail Standards*, §3351. Corrections staff must not interfere, delay, or deny an inmate/detainees access to medical care. When arrested persons (inmates) arrive at a Riverside County (County) detention facility, they go through a booking process (intake) to properly assess the person's safety, security, and identify and address any medical, dental, or mental health concerns.

During intake, an inmate/detainee is interviewed and examined for medical, dental, or mental health conditions which might require immediate treatment. A medical professional conducts a private screening to determine if an inmate/detainee is injured or in need of any urgent treatment.

A second clinical examination is conducted later during intake to record and properly evaluate an inmate/detainee's medical and mental health history, and schedule any appropriate subsequent appointments with appropriate clinical staff.

This report addresses concerns with proper annotation of information and continuity of content on various clinical/custody forms.

Methodology

Informal Interviews:

- Various RCSD medical personnel – Medical Director, LVNs, RNs
- Various RCSD Staff

The Grand Jury reviewed the following documents:

- *California Title 15 – Minimum Jail Standards for Local Detention Facilities – §3351 – Inmate Refusal of Treatment*
- *Riverside County Sheriff’s Department Policy 502.10 – Security Logs/Checks*
- *Riverside County Sheriff’s Department Policy 508.06 – Inmate Medical Care*
- *California Penal Code §296.1(a)(2) and (3) – DNA requirements*
- *Sheriff’s Department Policy 504.06 – DNA Sample Requirements*
- *Various police reports*
- *Supplemental incident reports*
- *Coroner’s investigative reports*
- *Critical Incident Logs*
- *Sobering Cell Logs and Continuation Sheets*
- *Supplemental Intake Questionnaire forms*
- *DNA Tracking Worksheets*
- *Health Insurance Portability and Accountability Act (HIPAA)*
- *Various newsfeed articles related to lawsuits/cameras*

Findings

Initial Medical History/Suicide Assessment form

1. The *Initial Medical History/Suicide Assessment* form lacks pertinent medical questions for clinical staff to determine medical concerns of the inmate/detainee screened for booking. The title of the form indicates that a medical history will be assessed. However, the form only addresses five medical issues: exposure to a contagious disease, current drug use and type, any withdrawal symptoms, suicidal ideations and if the inmate/detainee is transgender. There are no other comprehensive medical questions on the form pertaining to the health of the individual that identify any concerns clinical staff should be aware of during the inmate’s stay.

The form contains a “Statement of Consent to Medical Treatment” which states:

I (do) (do not) authorize the attending physician and medical staff to provide such services and treatments as deemed reasonable and necessary for my health and well-being while in the custody of the Sheriff.

This form includes a place for the inmate/detainee's signature with date and a place for a witness signature with date. There is a place for the inmate/detainee to print their name. There is no place for a witness to print their name.

In several of these forms where the inmate/detainee refused to sign, the witness signature line contained a staff identification number, not a signature, meaning that the form was not completely filled out as designated.

Because staff are not properly completing the form, it makes it difficult to determine who authenticated the form.

On one form utilized by the Desert Regional Medical Center titled *Leaving Hospital Against Medical Advice*, it was noted that an inmate signed a refusal of medical treatment. There is no subsequent refusal form signed by the inmate at the jail that the Riverside County Grand Jury (Grand Jury) could locate. Per *California Title 15, §3351 – Inmate Refusal of Treatment*, the *Inmate Refusal of Treatment* form must be signed for each subsequent clinical treatment, or appointment, whether at a detention facility or at an outside hospital. Refusal of treatment forms are not universally transferable from one area to another.

There is no statement on the form to inform the inmate/detainee that lifesaving measures will be performed to preserve life. Clinical staff has a mandate to intervene in performing lifesaving measures. There is no place for the inmate/detainee to print and sign their name acknowledging that they understand this information. The Medical Department does have a policy for refusal of treatment and the inmate is required to sign each time, but it is not reflected on this form.

Supplemental Intake Questionnaire

2. The current *Supplemental Intake Questionnaire* form states:

Swallowing or concealing any type of drug or substance inside your body poses a serious risk of harm and could lead to sudden death. We are concerned with your health and safety and want to provide you necessary medical attention if you are concealing any drug or substance inside your body. Are you concealing any drugs or other substances inside your body?

There is no acknowledgment section that the inmate/detainee read the statement and/or acknowledged that they understood.

The form does not contain a statement informing the inmate/detainee that the Sheriff will, with medical intervention, take X-rays or perform a body cavity search if an inmate/detainee is suspected of smuggling a controlled substance or other contraband into the facility. The Sheriff must take all precautions to maintain safety and security of its facilities. There is no provision for a witness signature and printed name if the inmate refuses to sign the form.

After reviewing several *Intake Questionnaire* forms, the inmate/detainee's printed name with booking number was left blank. If this form was lost or detached from the booking file, it would be difficult to match the form with the correct inmate/detainee.

DNA Tracking Worksheet

3. The *DNA Tracking Worksheet* provides for the tracking of DNA samples in compliance with California Penal Code §296.1(a)(2) and (3) and Riverside County Sheriff's Policy 504.06 *DNA Samples*. Several *DNA Tracking Worksheets* in the booking packet were reviewed, but the form was left blank in all four sections except for the inmate/detainee's name and booking number.

Medical Attention/Observation

4. When an inmate/detainee is placed into a sobering cell for observation, the custody staff is required by Policy 502.10 – *Security Logs/Checks*, to conduct security checks at least once every thirty minutes. This was verified. However, there was no documentation obtained, from the Riverside County Correctional Health Care Administration, requiring clinical staff to make similar thirty minute checks for clinical observations.

One report indicated that an inmate/detainee was placed in a sobering cell at 0740 hours (7:40 a.m.) but was not observed by clinical staff until 1200 hours (12:00 p.m.), which was more than four hours later. There was no recorded entry in the computer of any clinical observation of the inmate/detainee during this time period, found in the documents, reviewed by the Grand Jury. If clinical observations were conducted, it was not recorded in any documents provided to the Grand Jury. If the inmate was in distress during this time, custody staff may have missed pertinent medical symptoms. Custody staff is not typically medically trained to recognize less-obvious medical or critical symptoms such as an escalating fever or dehydration, which a clinician could more easily identify.

There is no clinical protocol/policy provision the Grand Jury could find, nor any notation in submitted reports, requiring medical or psychiatric clinical staff to conduct routine rounds in holding/sobering cells, consistent or similar to custody staff mandates.

Critical Incident Logs

5. *Critical Incident Logs* are designed to give a synopsis of critical information concerning issues with crime scenes, critical incidents, search and rescue missions, Special Emergency Response Team (SERT) incidents, and critical aid operations as described on the form. The current *Critical Incident Logs* do not contain this pertinent information and are not completed accurately as required. Personnel listed on the logs require their printed name (last, first) and rank, as well as other pertinent information. The rank of clinical staff is not properly annotated. Medical staff use a generic “medical staff” designation which is not in compliance with the form. Proper clinical rank or position such as LVN, RN, or MD must be properly annotated as required on the form, the same as required by custodial staff such as Sergeant (Sgt.) or Corporal (Cpl.).

The form is not descriptive enough to give a true picture describing what the actual critical incident pertained to and the circumstances. The form only lists categories for staff, rank, ID, time in/out, name, and not the synopsis of the incident. In the incident section, it listed “non-responsive”; in another report in the incident section, it lists “10-44”. This does not reflect why this incident required special response.

Outside Hospitals “OK to Book”/Exclusion of Normal Medical Screenings

6. The standard booking protocol requires a non-correctional hospital to clear an inmate/detainee for formal booking at a detention facility if there is a medical concern, mental health concern, or injury at the time of arrest before the inmate/detainee will be accepted at a detention facility.

However, in reviewing documents provided to the Grand Jury from medical and custody staff pertaining to the “OK to Book” clearance from a non-correctional hospital, there were no additional documents indicating that a more thorough comprehensive clinical screening was conducted.

The non-correctional hospital may only focus on the immediate health issues to determine if the inmate/detainee is “OK” to be processed and accepted into the detention facility. If the detention clinical staff do not conduct a thorough medical screening in addition to the “OK to Book” clearance, the facility may not be aware of any

undiagnosed medical or mental health conditions or diseases until a later date.

Sobering Cell Logs

7. A review of several *Sobering Cell Logs* revealed they were not properly completed according to protocol codes listed on the form. Some of the notations were not legible. The only annotation listed was C-4, commonly known as “Code 4”, meaning that everything is OK. However, this code is not one of the authorized codes listed on the form.

Physician or Other Clinical Staff on Call

8. There is no process in place to identify the medical personnel or the physician on call for each shift in an easily accessible database. The Medical Director informed the Grand Jury that payroll would have to be contacted to ascertain this information.

Critical Incident Reports Completed by Custody and Clinical Staff

9. All reports start out as “I” as the person “writing” the report. There is no way to identify the person actually writing, or authoring, the report because there is no signature line, printed name line, or employee ID number line to connect the report to the author. The word “I” does not identify who actually wrote the report.

There is no indication a supervisor reviews any reports ensuring all information and issues of the incident are thoroughly addressed. There is no place for a supervisor to print and sign their name, affix their ID number and rank, or identify who reviewed the report.

Reports Not Properly Screened for Content Continuity

10. In a *Critical Incident Report* reviewed, custody and clinical staff observed a plastic bag secured to an inmate/detainee and the clinician removed the bag. However, there was no further mention of the bag, the disposition of the bag in the original report, or any subsequent or supplemental reports.

Continuity of information and “chain of custody” evidence, if it was deemed evidence, was lost in subsequent documentation. Supervisory review would have caught this discrepancy and had it addressed in a supplemental report.

Automated External Defibrillators (AED)

11. In reviewing reports from the nursing staff, one report indicated that the AED was available and the AED electric pads were placed on the inmate to deliver a shock. However, the AED did not deliver a shock. There was no documentation clarifying whether the AED

malfunctioned or if the AED indicated a shock was not warranted and therefore did not deliver the shock. When reading the reports, it is not clear whether the AED was malfunctioning or if it was a proper reading by the machine.

Recommendations

**Riverside County Board of Supervisors
Riverside County Sheriff's Department
Riverside County Correctional Health Care Administration**

Initial Medical History/Suicide Assessment form

1. a. The *Initial Medical History/Suicide Assessment* form should contain additional medical questions and information to assist both medical and psychiatric staff in understanding the inmates/detainee's complete medical history.
- b. The title of the form should be renamed to better reflect the limited information it contains, if additional medical information is not requested on the form.
- c. A statement should be included informing the inmate that although they have a right to refuse medical treatment, lifesaving measures will be taken.
- d. There should also be a statement included which informs the inmate/detainee that subsequent refusals of clinical treatments will also require their signature each time. There should be a place for the inmate/detainee to sign and print their name acknowledging that they understand what they are signing.
- e. There should be a signature and printed name line of staff along with a place for their ID number and rank/title to clearly identify who witnessed the signing of this form.

Supplemental Intake Questionnaire

2. a. The form should be revised to include a statement informing the inmate that the Sheriff will take whatever precautions are necessary to preserve the safety and security of the facility. It should also include a place for the inmate/detainee to print and sign their name acknowledging they understand.
- b. The form should be revised to include a provision for the witness to print and sign their name with ID number if the inmate/detainee refused to sign the form.

- c. The inmate/detainee's printed name should be placed on the form, regardless, to correlate the inmate to the form being completed.

DNA Tracking WorkSheet

3. The *DNA Tracking Worksheet* should be completed as required in the booking packet. If sections of the *Tracking Worksheet Sheet* do not apply, then *Not Applicable* (N/A) should be clearly annotated in those sections indicating all sections were reviewed.

Medical Attention/Observation

4.
 - a. Inmate/detainees booked into detention facilities, who exhibit conditions/symptoms requiring placement into a sobering or safety cell, should receive periodic observation by both custody and medical staff. These rounds should continue every thirty minutes until it is determined that clinical monitoring is no longer necessary. This dual process would enhance timely clinical intervention for the care and treatment of inmates/detainees.
 - b. Video cameras should be installed in all sobering/safety cells. This would provide constant observation between the physical observation rounds at 30-minute intervals and would greatly enhance the monitoring process and assist clinical and custody staff for quicker response intervention.
 - c. Funding should be provided to purchase video monitoring equipment for sobering/holding cells.

Critical Incident Logs

5. The name of the incident should clearly define, and fully describe, specifically what the incident or situation was to obtain a full picture of what transpired. Clinical and custody staff should properly complete the *Critical Incident Logs* as designated on the form with their actual rank or title.

Outside Hospitals "OK to Book"/Exclusion of Normal Medical Screenings

6.
 - a. All detention facilities, regardless of whether the inmate was first screened at a non-correctional hospital for "OK to Book", should conduct a full medical and mental health screening and evaluation of inmates/detainees at the time of booking. This will ensure the facility is fully aware of any medical or mental health issues.
 - b. The booking form should note that a full medical and mental health screening was conducted and is recorded in the inmates/detainee's medical file in accordance with HIPAA.

Sobering Cell Logs

7. *Sobering Cell Logs* should be written legibly and clearly, and if a C-4 code is to be an acceptable code, then it should be included as an option on the form.

Physician or Other Clinical Staff on Call

8. There should be an easily accessible historical database in all duty stations to identify all clinical staff on duty who were on-call for a particular shift or who were physically working a particular shift on a particular date.

Critical Incident Reports Completed by Custody and Clinical Staff

9. All reports should have a signature line, printed name line, staff ID number line and rank line to properly identify and authenticate who authored the report. There should be a similar signature line, printed name line, staff ID number line and rank line to authenticate the supervisor reviewing the report.

Reports Not Properly Screened for Content Continuity

10. All information in reports should clearly and thoroughly address all issues described in the report. All reports should be reviewed by a supervisor for accuracy and completeness. The supervisor's printed name, signature, rank and date should be annotated on the report. When clarification or additional information is required after further review, a supplemental report should be prepared. All supplemental reports shall have the same original report linking them all together for reference.

Automated External Defibrillators (AED)

11. All reports regarding the use of an AED should clearly and accurately state the reason why an AED did not deliver a shock.

Report Issued: 06/21/2018
Report Public: 06/25/2018
Response Due: 09/25/2018