Review of the Inmate Reception Center Intake Evaluation Process

November 2019

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Introduction

The Inmate Reception Center (IRC) of the Los Angeles County Sheriff's Department (LASD) is the entry point for all male prisoners into the County's jail system.[1] The IRC is responsible for receiving, searching, evaluating, and classifying incoming prisoners.[2] As a central component of the nation's largest jail system, the IRC processes an average of 250 prisoners each day. On busy days, the IRC may process as many as 500 prisoners in a twenty-four-hour period.

For over a decade, oversight agencies and advocates have reported on substandard conditions and excessive wait times for prisoner/patients at the IRC. In 2004, the Office of Independent Review[3] recommended that LASD "locate resources so that inmates seeking medical attention and housing in the jail do not languish in the holding areas of IRC."[4] In 2007, the U.S. District Court for the Central District of California held, in part, that absent exigent circumstances, prisoners "must be processed within a reasonable amount of time" which, "including any initial medical evaluation, should not take more than twenty-four hours, and, as technology improves, the time should decrease."[5]

In 2017, the County completed the consolidation of medical and mental health care under the Department of Health Services and created Correctional Health Services (CHS) in efforts to improve patient care in the jails, including the IRC. The Office of Inspector General (OIG) has repeatedly raised concerns about wait times and conditions in the IRC, and in July 2017, also reported on these issues.[6]

Substandard conditions largely arise in the clinic area of the IRC (IRC Clinic), where health care practitioners from CHS, with the assistance of Custody Division personnel for security and escorts, screen and evaluate patients for medical and mental health needs. Patients that require medical evaluations in the IRC Clinic may

[1] The term "prisoner" refers to male prisoners. Prisoners seeking or receiving health care services are referred to as "patients."

[2] The IRC is also responsible for processing releases, as well as maintaining court records, clothing, and property.

[3] The Office of Independent Review is a civilian oversight group that was contracted by the Los Angeles County Board of Supervisors from 2001 to 2014 to conduct comprehensive oversight of LASD and its jail facilities.

[4] Office of Independent Review, *Fourth Annual Report*, 51, October 2005, https://oig.lacounty.gov/LinkClick.aspx?fileticket=-DMz64DyZMY%3d&portalid=18.

[5] *Thomas v. Baca*, 514 F. Supp. 2d 1201, 1219 (C.D. Cal. 2007) (finding the existence of a custom of requiring prisoners to sleep on the floor in LASD jail facilities, and that this custom violated constitutional rights).

[6] *See* Los Angeles County Office of Inspector General, *Reform and Oversight Efforts Quarterly Report*, July 2017, at https://oig.lacounty.gov/Reports.

encounter excessive wait times that have exceeded forty-eight hours in cramped and crowded quarters, resulting in sleep deprivation and posing safety risks for patients and staff.

Some of the patients subjected to the worst conditions are those who display the most serious medical or mental health symptoms. Patients who are at risk of or exhibit acute mental health distress are tethered with handcuffs to fixed chairs for the duration of the intake process.[7] Despite the reporting, recommendations, and frequent warnings by the OIG against long-term tethering, patients continue to encounter excessive wait times in unsanitary conditions while tethered to chairs.[8] At times, patients have remained tethered for nearly twenty-four hours.

Since the July 2017 report, OIG personnel have conducted approximately seventy site visits to the IRC and spoken with hundreds of prisoners/patients and LASD and CHS personnel. OIG personnel have analyzed relevant CHS and LASD policies, reviewed force incidents, and closely monitored intake procedures, including wait times at each stage in the process. OIG personnel have also met with LASD and CHS executive leadership and communicated in detail OIG recommendations for improvement and concerns about the danger to patients and staff if deficiencies are not remedied.

The IRC Intake Process

The IRC receives prisoners from various locations throughout the state, most of whom are transported to the IRC from Los Angeles County courts. When the courts recess each day, the LASD Court Services Transportation Bureau transports newly remanded prisoners on buses, which typically arrive at the IRC in the late afternoon and evening hours. Other incoming prisoners arrive directly after arrest or are transported from local law enforcement station lockups, state prisons, and local hospitals. Upon arrival, prisoners are searched, booked, and classified based on security and institutional needs.[9] Prisoners are then required to shower and are issued jail clothing before proceeding to the IRC Clinic for a health screening.

At the IRC Clinic, nurses administer a screening questionnaire to identify any urgent, emergent, or continuing medical and mental health needs. The screening questionnaire is also used to identify several risk factors such as suicidal ideation, intoxication, and medication or street drug use. Patients who are identified as

[7] Bathroom breaks are permitted as discussed below.

[8] *See* Los Angeles County Office of Inspector General, *Overview and Policy Analysis of Tethering in Los Angeles County Jails*, June 2016, at https://oig.lacounty.gov/Reports.

[9] Prisoners that are not in stable medical condition upon arrival will not be admitted to the IRC and are instead transported to a local hospital for immediate medical care.

requiring urgent medical care or who are at risk for life-threatening withdrawals are diverted for immediate attention. Patients with no apparent medical or mental health needs who answer "no" to all screening questions are placed in holding cells pending transfer to permanent housing. All other patients are required to remain in the IRC Clinic for medical and/or mental health evaluations.

Since the IRC was designed to serve as a temporary holding facility, only narrow metal benches and plastic chairs are available for seating in the clinic area. Patients routinely encounter excessive wait times and substandard conditions at this stage in the intake process.

The high volume of incoming patients and long wait times resulted in the creation of Module 231, a dedicated IRC Clinic overflow located in the Twin Towers Correctional Facility (TTCF). CHS and Custody Division personnel make efforts to transfer patients to Module 231 when IRC Clinic wait times exceed sixteen hours or when additional clinical attention is required. While Module 231 is considered temporary housing, it nonetheless offers patients access to beds, showers, and limited programming for the duration of the intake process. A team of medical and mental health providers is assigned to Module 231 to complete intake evaluations.

Conditions in the IRC Clinic and Module 231

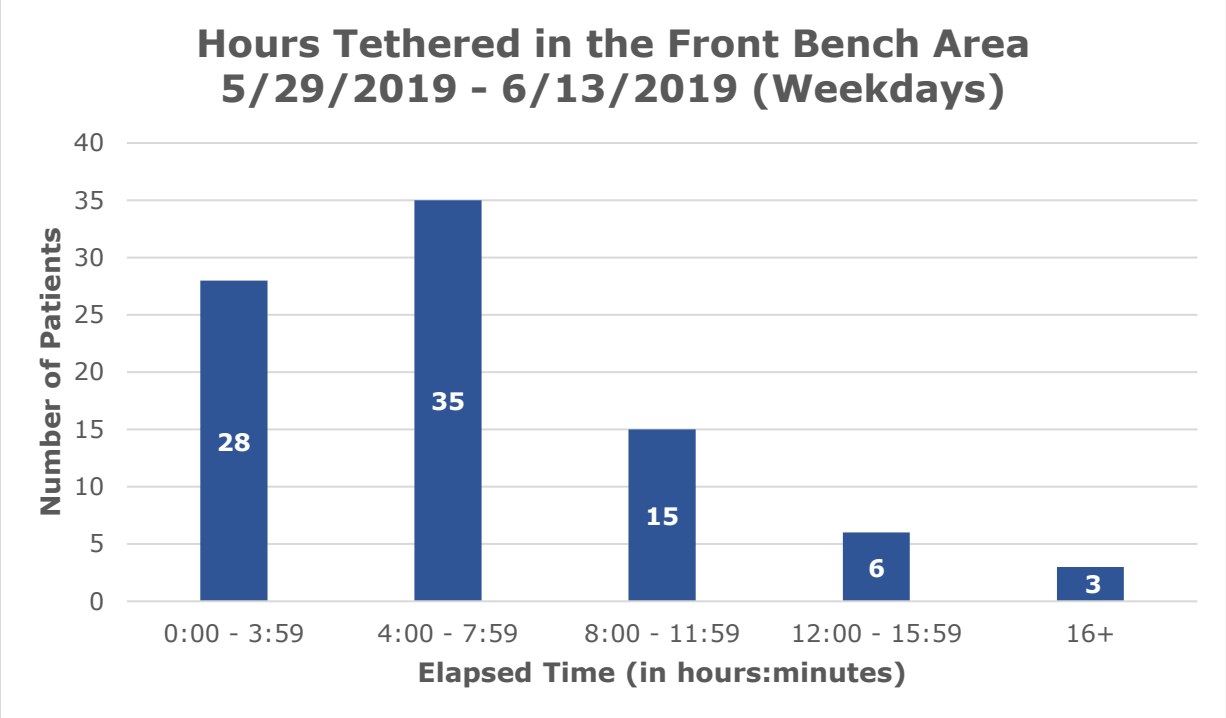
Over the course of the last two years, the OIG has frequently encountered patients who were required to wait in the IRC Clinic for more than twenty-four hours. On multiple occasions, patients waited for more than forty-eight hours. Most patients who experienced excessive wait times were pending medical evaluations; however, some were pending mental health evaluations or transfers to permanent housing locations.

Since most arrivals occur in the late afternoon and evening hours, patients who require evaluations are likely to face long wait times that extend through the night. As a result, these patients must either remain awake throughout the intake process or sleep while sitting upright on narrow metal benches and plastic chairs or lying down on the concrete floor. During regular site visits, OIG personnel have observed patients lying or sleeping on concrete floors.

Patients who exhibit or verbalize suicidal ideation, are in the midst of a mental health crisis, or who require direct observation are identified as "high risk" and are tethered with handcuffs to fixed chairs in the Front Bench Area of the IRC Clinic for

the duration of the intake process.[10] Wait times for patients in the Front Bench Area have regularly exceeded eight hours and at times twelve hours. In August 2019, at least two tethered patients remained in the Front Bench Area for nearly twenty-four hours. Although prisoner-workers clean the Front Bench Area, and LASD has installed padded chairs for Front Bench Area patients, OIG personnel have observed unsanitary conditions, including urine and feces, on multiple occasions.

The OIG collected wait time information for some tethered patients on twelve days between May 29, 2019, and June 13, 2019.[11] For the days reviewed, at least twenty-eight patients were tethered up to four hours. At least thirty-five patients were tethered up to eight hours. At least fifteen patients were tethered up to twelve hours. At least six patients were tethered up to sixteen hours. Finally, at least three patients were tethered for over sixteen hours. The following chart reflects the number of tethered patients in the Front Bench Area by elapsed time on the days reviewed:



[10] *See* Custody Services Division Inmate Reception Center, Unit Order 8-40/002.00, Fixed Restraint of an Inmate.

[11] LASD does not retain aggregate wait time information due to data system limitations. As a result, the information collected reflects point-in-time snapshots of Front Bench Area wait times that were retrieved on weekdays between 6:00 a.m. and 3:00 p.m. Values reflect the number of hours patients had remained tethered to chairs in the Front Bench Area as of the time the snapshot was generated. They do not reflect the total number of hours patients remained tethered after the snapshot was generated, and they do not reflect all patients who were tethered in the Front Bench Area during the twelve days.

Patients who are classified with special housing needs may face additional wait times as a result of jail overcrowding. OIG personnel have identified several instances where patients with special housing needs, such as High Observation Housing (HOH) or administrative segregation, were required to remain in the IRC until appropriate housing is available. For example, on June 3, 2019, OIG personnel observed a patient who had been cleared for housing and was waiting in the Front Bench Area for transfer to HOH. Custody Division personnel reported that the HOH modules had reached capacity, and that the patient was required to remain tethered in the Front Bench Area for several additional hours until appropriate housing cleared.

Long wait times, cramped quarters, unsanitary conditions, and sleep deprivation frustrate waiting patients and appear to increase the risk of prisoner-on-prisoner and prisoner-on-staff violence. OIG personnel have reviewed multiple use-of-force incidents from the IRC Clinic, several of which reportedly stemmed from frustration by patients with excessive wait times. The OIG has also reviewed use-of-force incidents involving returning prisoners who refused to enter the IRC Clinic due to previous encounters with lengthy wait times.

Patients who are transferred to Module 231 must regularly wait for days before being evaluated. The OIG learned of several patients who had recently waited for more than four days before receiving evaluations. In one instance, a paraplegic patient was evaluated and ordered housing in the Correctional Treatment Center (CTC). Because no CTC beds were immediately available, the patient waited in Module 231. The patient suffered from serious pressure ulcers and was reportedly unable to transfer between a bunk and a wheelchair or to operate a wheelchair on the patient's own. The patient was confined to a regular jail bunk and can be seen on CCTV laying virtually still for much of the four days. When the patient required transfer to court or other movement, the patient was assisted by prisoner-workers. Otherwise, the patient would remain on the bunk, including during mealtimes when the patient can be seen eating while lying on the patient's stomach.

Medical Evaluation Issues

The increasing population of patients who suffer from medical and mental health conditions poses substantial challenges to managing the IRC Clinic. As of December 2018, CHS reported that approximately eighty percent (80%) of incoming prisoners are initially identified as having medical or mental health issues, the majority of which require medical evaluations. Yet, there are several identified systemic and

operational deficiencies that hinder the pace of medical evaluations.[12] Since LASD does not transfer patients to permanent housing until all required evaluations are completed, the medical evaluation process is currently the primary point of congestion in the IRC intake process.

Medical Provider Staffing Shortages and Accountability Issues

Both CHS and Custody Division personnel frequently cite insufficient medical provider staffing as the chief cause of backlogging, excessive wait times, and overcrowding in the IRC Clinic. The medical providers, consisting of medical doctors, nurse practitioners, and physician assistants, are responsible for conducting medical evaluations and clearing patients for housing based on identified medical needs. CHS reports that the IRC Clinic maintains four stations that may be used to conduct medical evaluations. Despite space for four, CHS has staffed most shifts with two medical providers. At times, more than 200 patients await evaluations in the IRC Clinic with more arriving throughout the day. Two medical providers are inadequate to evaluate and clear the new arrivals, let alone clear the backlog of patients from previous shifts. In addition, CHS does not have a contingency plan for medical provider leaves and unexpected absences. Because CHS does not staff on-call providers, absences exacerbate backlogging that may take several days to clear.

In August 2019, the IRC Clinic was staffed with only one medical provider for four consecutive shifts spanning nearly two days, reportedly due to leaves. By the end of the fourth shift, twenty patients were tethered in the Front Bench Area. One patient's wait time in the Front Bench Area exceeded twenty-four hours, approximately nineteen of which were pending medical evaluation. As backlogging in the IRC Clinic worsened, CHS nurses attempted to send patients with excessive wait times to Module 231, which reportedly reached capacity. As a result, CHS requested that small batches of patients be transferred to Urgent Care in TTCF to receive medical evaluations from Urgent Care providers. LASD reports that IRC leadership had concerns but agreed to dedicate personnel for the moves, despite greater staffing needs in the dangerously crowded IRC Clinic. Approximately five patients were transported to Urgent Care accompanied by Custody Division

[12] On September 3, 2015, the U.S. District Court for the Central of California approved a stipulated agreement between the U.S. Department of Justice and the LASD requiring, in part, adequate mental health care and related services, which includes several provisions related to the IRC intake process. An independent monitor assesses and reports on implementation progress. As a result, LASD and CHS have made significant progress in addressing systemic issues in the IRC Clinic's mental health screening and evaluation process. *See United States v. County of Los Angeles*, Case No. 2:15-cv-05903-DDP (C.D. Cal. 2015).

personnel throughout.[13] Because Urgent Care providers prioritize care of patients with more urgent medical needs, Custody Division personnel reported that only three patients were evaluated in the span of approximately four hours. CHS and LASD have since implemented a pilot program to transfer certain patients to Urgent Care for medical evaluations. The OIG has ongoing concerns about the pilot program, discussed in more detail below.

Adequate medical provider staffing in the IRC Clinic would alleviate significant backlogging in Module 231 also. If the IRC Clinic is sufficiently staffed, most patients would receive timely medical evaluations and be cleared for permanent housing without requiring transfer to Module 231. This would allow the module to function as a proper overflow area for unexpected surges in incoming patients rather than as a de facto extension of the IRC Clinic.

CHS reports there are substantial barriers to achieving ideal staffing levels of medical providers in the IRC Clinic and system-wide. CHS leadership reports that existing staffing needs cannot be met without an approved staffing model and increased departmental budget and that it has ongoing challenges with recruitment and retention of quality medical providers.

CHS leadership maintains that it cannot staff the IRC Clinic based solely on peak patient load. However, it does not appear that CHS has completed a demand-capacity analysis or determined or met staffing needs based even on daily average patient load. Despite frequent discussions regarding poor medical care and substandard conditions, current provider staffing levels remain inadequate to accommodate current patient loads. Determining what constitutes a sufficient number of medical providers in the IRC Clinic for each shift to ensure an optimal pace of evaluations may require additional analysis, which CHS must prioritize. CHS is working to improve system-wide patient care, but it should not allow current patients to suffer in the interim.

Finally, there is a large discrepancy between the number of evaluations conducted by individual medical providers per shift. Some medical providers are reported to regularly see fewer than six patients in an eight-hour shift, while one provider regularly sees more than forty and recently saw sixty-four patients in a single shift. On several occasions, the OIG has recommended that CHS conduct additional analysis to determine whether the providers who see many patients are providing adequate care and whether those who see few patients are truly inefficient. Either

[13] When Custody Division personnel transport IRC patients to Urgent Care for evaluations, they are required to remain with the patients until they are seen and then escort them to their next or final housing locations.

way, the discrepancy suggests inconsistent care that varies in efficiency, and inadequate CHS quality control and accountability mechanisms.

Medical Evaluation Prioritization Issues

CHS lead nurses are ultimately responsible for determining the order in which medical providers conduct evaluations, yet, several lead nurses each utilize differing methods for prioritizing waiting patients. All lead nurses reportedly account for patient acuity (patient care needs based on the severity of illnesses) in prioritizing evaluations, however, some reported prioritizing factors that others do not. One lead nurse reported printing a list of all patients in the IRC Clinic arranged in order of wait time at the beginning of the shift and assigning them to medical providers in descending order. Patients who require expedited evaluations were moved to the front of the line on case-by-case bases. Other lead nurses reported prioritizing all patients based on such factors as individual provider efficiency, patient wait time, acuity of patients in the Front Bench Area, and special handle classifications.

CHS reported that no formal policy or guidelines exist for prioritizing medical evaluations, and that nurses rely on clinical acumen to prioritize patient evaluations. While it is important that lead nurses have discretion to account for the dynamic needs of the IRC Clinic, CHS policy should guide that discretion in accordance with generally accepted practices, and the medical standard of care must be met. Sufficient supervision is necessary to ensure that clinical acumen is properly exercised.

In July 2018, LASD created the lead deputy position to monitor wait times and notify the lead nurse of patients who are experiencing excessive wait times. However, lead deputies have expressed that effective Custody-CHS collaboration, and the resulting reduction in wait times and backlogging, depends largely on collaboration by and the resolve of the lead nurse on duty for a given shift. CHS personnel have lodged similar complaints, that some Custody Division personnel are more collaborative than others.

LASD Policy and Population Management Issues

LASD faces ongoing challenges ensuring the availability of special mental health housing locations for prisoners who present moderate and severe mental illnesses. Prisoners with moderate mental illnesses are housed in Moderate Observation Housing ("MOH") modules while prisoners with severe mental illnesses are housed in HOH modules. From January 2015 to June 2019, CHS estimates that the population of MOH prisoners has increased by thirty-four percent (34%) and the

population of HOH prisoners has increased by fifty-six percent (56%). During this same period, the average daily prisoner population increased by less than three percent (3%).[14] The steadily increasing populations of prisoners with moderate and severe mental illnesses have led to the MOH and HOH modules often nearing or reaching capacity. When these modules are full, new patients who present with moderate or severe mental illnesses—some of whom are tethered throughout the entire intake process—are required to remain in the IRC Clinic or Module 231 for several additional hours until appropriate housing becomes available.

In addition, effective population management requires adequate information technology infrastructure. LASD reports that its current information technology infrastructure relied upon to the manage the population of prisoners is outdated. This presents ongoing challenges with tracking the population in real-time and optimizing prisoner movement and housing availability.

Custody Division personnel report that staffing shortages may also create additional delays in the IRC intake process. Custody Division personnel transport patients from the IRC Clinic to permanent housing locations upon completion of all required evaluations. When the IRC Clinic is understaffed, Custody Division personnel are not always readily available to transport patients, resulting in additional delays.

Lastly, the influx of prisoners that arrive at the IRC in the late afternoon and evening hours adds to existing backlogs in the intake process. CHS contends that revising the bus schedule to conduct additional transports throughout the day could stagger the incoming prisoner population and potentially alleviate backlogging in the IRC Clinic. Given the complexity of court schedules and a variety of other factors, it is unclear whether the bus schedules could be modified, and if so, whether it would make a meaningful difference in reducing extreme wait times.

Front Bench Policy Issues

In 2016, LASD created new policies and procedures under section 7-03/000.5 of the Custody Division Manual (CDM) regarding the general use of fixed restraints (or the tethering of prisoners to fixed objects) in an effort to provide deputies with "reasonable tools to control prisoners while building safeguards to ensure proper supervision that will limit potential abuse."[15] The CDM allows for exceptions to the "notification/approval process" for the use of fixed restraints during certain "routine

[14] CHS reports that these figures are estimates that are derived from a point-in-time snapshot due to limitations with LASD's data systems.

[15] *See* Los Angeles County Office of Inspector General, *Overview and Policy Analysis of Tethering in Los Angeles County Jails*, June 2016, at https://oig.lacounty.gov/Reports.

procedures" so long as they are "clearly outlined in the facility's unit order."[16] Accordingly, IRC Unit Order 8-40/002.00 ("Unit Order") prescribes procedures for the application of fixed restraints in the IRC Clinic.[17] The medical delays, excessive wait times, substandard conditions, and current Custody Division practices necessitate review and revision of the Unit Order.

The CDM provides that when a prisoner is placed in fixed restraints, a supervising sergeant for that location must be promptly notified and is then responsible for among other requirements: (1) documenting pertinent information, including the reason for the application and all subsequent activities; (2) conducting hourly safety checks[18] to reassess whether the prisoner needs to remain in fixed restraints and ensure that the prisoner has been provided access to toilet facilities and drinking water; and (3) making certain that a medical evaluation is conducted by medical personnel at least once every two hours. If a prisoner remains in fixed restraints for more than four hours, notifications must be made up the chain of command in two-hour intervals until the facility's division commander is notified and consulted.

The Unit Order modifies tethering procedures beyond the scope of the CDM's notification/approval exception and loosens requirements related to basic human needs. For example, the Unit Order requires that the lead deputy offer tethered patients access to the toilet facilities at least once every four hours as opposed to every hour as required by the CDM; otherwise, it is patients' responsibility to request to use the toilet facilities. The Unit Order also requires that tethered patients are offered access to drinking water at least once every two hours as opposed to every hour as required by the CDM.

The Unit Order is also void of key safeguards that are outlined in the CDM. Under the Unit Order, Custody Division personnel are not required to document such information as the reason for the use of fixed restraints, opportunities to use toilet facilities, or access to drinking water. While both the CDM and the Unit Order require that prisoners/patients in fixed restraints be placed in a location where they are in direct and unobstructed visual observation of Custody Division personnel, the Unit Order does not require responsible sergeants to conduct the same safety checks and approve continued restraints as required by the CDM. The Unit Order

[16] Custody Division Manual, 7-03/000.05, Fixed Restraints.

[17] Custody Services Division Inmate Reception Center, Unit Order 8-40/002.00, Fixed Restraint of an Inmate.

[18] "Safety checks" in the CDM and Unit Order should not to be confused with more frequently referenced Title 15 safety check requirements. The CDM's fixed restraint safety checks require that supervising sergeants verify that the restraint is not causing undue pain, injury, or an obvious medical problem during.

does not require periodic medical assessments and first requires notification of a sergeant after four hours.

Typically, when a unit order is silent on protections or requirements that are addressed in the CDM, the CDM controls. However, because the IRC Unit Order covers both routine and non-routine restraint applications, it appears to be used instead as a stand-alone policy. Furthermore, in some instances, it does not appear that more permissive Unit Order requirements are being met.

LASD's failure to adhere to the CDM or the Unit Order has been largely the result of a consistent failure to timely evaluate and process patients through the IRC Clinic. LASD should immediately reevaluate and revise the Unit Order. However Custody Division personnel will likely not be able to comply, and additional safeguards will likely fail, until CHS remedies its own systemic deficiencies. The appropriate remedy for inability to provide for humane treatment is release.

Reported Remedial Measures

LASD and CHS report that they have taken steps to remedy some systemic deficiencies since 2017. For example, a two-step intake screening process was consolidated into a one-step questionnaire to eliminate redundancies and expedite processing. CHS reports that staff has been dedicated to processing pharmaceutical needs of incoming patients, and both LASD and CHS have dedicated staff to monitoring wait times for patients in the IRC Clinic, including the Front Bench Area. CHS and LASD implemented a pilot program in certain courts whereby patients are screened by nurses and classified by Custody Division personnel so that when they arrive at the IRC, they proceed directly to assigned housing locations. Unfortunately, both LASD and CHS agree that these measures did not result in substantially reduced wait times and backlogging.

The most significant improvement to patient care since the medical and mental health care consolidation is CHS's opening of its Urgent Care in June 2018. Urgent Care offers prisoner/patients with urgent medical needs immediate medical attention in a licensed care setting. This is particularly important given that LASD's CTC maintains only fifty-five licensed beds, which is inadequate for the size and needs of the population. Since its establishment, wait times for housed patients with medical needs have decreased substantially, quality of care has improved, and Urgent Care patients report feeling like they receive good care from Urgent Care providers. Currently, Urgent Care maintains hours of 6:00 a.m. to 10:00 p.m. daily. Urgent Care currently has the capacity to see more patients, and CHS and LASD should increase its staffing and hours of operation to twenty-four hours a day.

On September 23, 2019, CHS and LASD initiated a pilot program to transport certain patients from the IRC Clinic to Urgent Care for medical evaluations and clearance for transfer to permanent housing. Currently, only patients who are cleared by CHS and deemed safe by LASD may be transferred to Urgent Care. CHS reports that if/when additional providers are hired, patients with urgent medical needs will be transferred to Urgent Care for medical evaluations and patients with non-urgent medical needs will be transported directly from the IRC Clinic to permanent housing locations and placed in a medical evaluation queue at their respective housing locations.

The OIG has concerns about the feasibility and efficiency of the Urgent Care pilot program. Requiring personnel to transport severely mentally ill patients who require fixed restraints while in the IRC Clinic may increase the risk of force and is time and resource intensive. It seems that a more efficient approach would be to assign Urgent Care providers to the IRC Clinic as needed. Resolving the IRC Clinic processing issues is complex and requires close Custody-CHS collaboration and clear communication to all IRC personnel.

In the first week of October 2019, LASD and CHS reported improved conditions in the IRC Clinic and OIG personnel conducted a site visit on October 7, 2019. Indeed, OIG personnel observed only three patients tethered in the Front Bench Area and relatively few patients in the IRC Clinic overall. Most notably and for the first time, OIG personnel also observed four medical providers conducting evaluations. CHS and Custody Division personnel reported that additional providers were now regularly assigned to the IRC Clinic, and as a result, patient flow had improved significantly. The Urgent Care pilot program is also in effect and may be contributing to reduced wait times. However as of the October 7 site visit, relatively few patients had been transported to Urgent Care for medical evaluation, and CHS and Custody Division personnel consistently reported that the improved conditions were predominantly due to increased medical provider staffing. The OIG will continue to monitor wait times and conditions in the IRC Clinic.

Recommendations

Recommendation 1: CHS should consistently staff the IRC Clinic with four providers during each shift until it completes a comprehensive assessment of patient and staffing needs, after which it should maintain staffing at identified appropriate levels.

Recommendation 2: CHS should implement and maintain a twenty-four hour on-call medical provider staffing rotation for the IRC Clinic and Module 231 that compensates for leaves, unexpected absences, and patient load.

Recommendation 3: CHS and LASD should reevaluate the feasibility and safety of the plan to transport IRC Clinic patients to Urgent Care for medical clearance, unless patients otherwise require that level of care.

Recommendation 4: CHS and Custody should dedicate sufficient medical and Custody Division personnel to expand Urgent Care to twenty-four hours a day.

Recommendation 5: CHS should implement internal accountability mechanisms to ensure that all medical providers conduct evaluations efficiently and in accordance with the medical standard of care.

Recommendation 6: CHS should create and implement guidelines on prioritizing medical evaluations that account for all relevant factors, including the acuity of mentally ill patients tethered in the Front Bench Area, in order to standardize the methods utilized by lead nurses.

Recommendation 7: The County should increase efforts to divert qualified prisoners with mental illnesses to community-based mental health treatment programs in order to alleviate overcrowding in mental health housing locations. In addition, LASD should maintain adequate mental health housing for prisoners with moderate and severe mental illnesses.

Recommendation 8: CHS, in collaboration with LASD, should identify and implement a tracking mechanism that can generate real time and aggregate population data about mentally ill prisoners and their current mental health classifications.

Recommendation 9: LASD should work with the courts and other County partners to explore the feasibility of revising the bus schedule as necessary to conduct additional transports throughout the day and reduce IRC Clinic backlogging.

Recommendation 10: LASD should immediately implement and maintain adequate staffing of Custody Division personnel in the IRC Clinic during all shifts to transport patients as needed and without delay.

Recommendation 11: LASD should rescind the IRC Unit Order regarding fixed restraints or revise it to ensure it complies with LASD's CDM.

Recommendation 12: CHS should work closely with LASD leadership to identify and implement all additional strategies necessary to eliminate backlogging,

excessive wait times, long periods of patient tethering, squalor, and other potentially dangerous or inhumane conditions of confinement in the IRC.

Recommendation 13: LASD should identify a timeframe beyond which patients awaiting housing in the IRC Clinic or Module 231 are released from custody if safe, adequate housing remains unavailable.