Court Expert's Report Regarding Treatment of People with Disabilities at Substance Abuse Treatment Facility (SATF)

Armstrong v. Newsom

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Introduction

This report outlines our findings following a year-long investigation into how the Substance Abuse Treatment Facility and State Prison – Corcoran (SATF) treats its disabled population. The findings are troubling. In recent years, SATF has been a difficult place to be an incarcerated person with disabilities. The moment class members arrive at SATF, they encounter a system that can cause them to lose the equipment, supplies, or medications they need to manage their conditions. They face obstacles obtaining durable medical equipment (DME) when their disabilities change or their DME break or need to be replaced. When they ask for basic supplies they need for their conditions, sometimes they are told, incorrectly, that those supplies are not available, and other times that they already have enough supplies. They often must file multiple requests to obtain a medical appointment, sometimes having to resort to the disability accommodation request process just to be seen by medical staff. Their interactions with those staff are frequently more challenging than at other institutions, with medical staff issuing inappropriate rules violation reports against their patients or treating them with impatience or disdain. Some class members have gone months or even years without receiving accommodations they require, all the while having to navigate a system that can seem indifferent to their needs.

The result is an environment that is negative for both class members and staff. Some class members respond to the obstacles at SATF by filing multiple requests for care, followed by disability accommodation requests, grievances, and appeals. That has resulted in SATF having to process a disproportionately high number of requests for disability accommodations. And processing those requests takes staff time—time that could be spent on other important work in the prison. Other times, the class members have just given up and try to get by with inadequate accommodations.

Much of what we focus on in this report are breakdowns in individual processes at SATF—processes designed to ensure people keep their prescribed DME during transfer, to respond to requests for medical appointments, to provide DME when requested, and the like. Each one of these breakdowns, standing alone, may seem like an inconvenience or a small problem not worthy of the Court's attention. But that is not so. For the person with disabilities, each problem, standing alone, is an obstacle to their being able to live a life that is on a par with their fully abled companions. A person with a disability who loses a DME when they are transferred and cannot get it replaced, or who cannot get a medical appointment or even submit a slip requesting one, or who cannot get the only food they can eat, or who cannot get an accommodation that allows them to use the phones—all of those people are living diminished and needlessly difficult lives. They face harsher prison conditions, and thus greater punishment, than their peers. And it is not the case that each problem stands alone; they compound. The class member who loses his DME on transfer is then unable to get a timely appointment to replace it. The class member who is not given an accommodation that allows him to communicate is then unable to get a job. These compounding problems can leave class members

hopeless. And all of this is occurring in a prison where class members report that staff often act like addressing the needs of the disabled population is not part of their job but an extra burden.

So, while each problem may seem minor taken alone, together they create a system that is failing its disabled population. They make SATF a particularly hard place to be a disabled person.

What is troubling is not just that it has been so difficult for class members at SATF to receive the accommodations and treatment they need, but also that the problems we learned about during our investigation were problems the leadership at SATF could have identified on their own. It is true that some of what we learned came from confidential survey responses and interviews with class members, and it is possible that class members may have been more willing to share such information with us than with SATF staff. But everything we heard directly from class members was also reflected in information that was available to staff and management. The failures with the DME process, the breakdowns in scheduling medical appointments, the repeated requests and inappropriate denials of accommodations and supplies—all of this information and more was well-documented. Whether through receipt of disability accommodations requests, review of healthcare grievances, or observation of class members who were plainly not receiving the accommodations they needed, management had before it evidence of real problems at SATF for people with disabilities.

However, it was not management that identified these problems; it was Plaintiffs' counsel. The question then is why SATF did not identify and remedy such problems on its own. One explanation could be the institution does not have the capacity to do so; SATF may be simply too consumed by managing the needs of its large and complex population to be able to recognize when there are systemic failings in the treatment of its disabled population and to fix those failings. Another could be that there are inadequate measures to monitor systemic failures, and so there are not the mechanisms in place for SATF management and staff to recognize patterns or widespread problems. And a third explanation could be that the needs of disabled incarcerated people are simply not sufficiently prioritized. Whatever the causes for this deficiency, the result is that SATF has not demonstrated that it is able to self-monitor and self-correct in the manner that would justify a lesser level of scrutiny by the Court and other outside monitors. Self-correction has to be the goal, and our investigation showed it is a long way off.

We acknowledge SATF has made real strides since Plaintiffs' counsel raised these issues. SATF has new leadership in key positions, it has hired additional staff, it has changed several practices in ways that will help the disabled population, and it has shown an openness to change and improvement. We also spoke with many staff members, from correctional officers to individuals in management, whose dedication to treating the disabled population at SATF with dignity was truly impressive. Prisons are a very difficult place to work, and a prison like SATF, with its enormous size and complex population, is particularly difficult. We acknowledge and admire the hard work of many of these staff members.

However, much at SATF has to change. First, there are many specific changes that must be made to ensure the disabled population is receiving the accommodations and care it needs. We identify suggested changes below, all of which are intended to bring SATF into compliance with the *Armstrong* Remedial Plan (ARP) and the Americans with Disabilities Act (ADA). Second, SATF needs to adopt processes to enable it to identify and remedy these sorts of problems on its own. And third, SATF, and CDCR as a whole, needs to consider why SATF has become such a problematic institution for people with disabilities. It is not because the staff at SATF are any less considerate or professional than their counterparts at other institutions. Rather, it appears to be a combination of a lack of guidance from SATF leadership regarding the importance of providing disability accommodations and a sense of overwhelm in dealing with the needs of its population. The former problem can be addressed through SATF's leadership demonstrating the importance of treating the disabled population with dignity. The latter problem may require changing the makeup of the population at SATF or the staffing model at the institution.

However these problems are addressed, SATF must become a place where the institution understands from the top on down that *Armstrong* class members are not just prisoners with problems; they are human beings who are in SATF's care. They have disabilities, and accommodating those disabilities often requires extra attention and assistance. But that should not be seen as a burden. Taking care of these class members with dignity must be understood as part of SATF's job.

Executive Summary

In a May 2021 case management conference statement, Plaintiffs' counsel in *Armstrong* reported that class members at SATF were experiencing significant discrimination and that SATF staff members celebrated the murders of *Armstrong* class members at SATF on social media.[1] In addition, Plaintiffs' counsel in *Plata* reported, following a remote site visit of SATF, that they heard reports of healthcare staff treating class members in a dismissive and unprofessional manner.[2] Plaintiffs' counsel also reported that healthcare staff at SATF were issuing Rules Violation Reports (RVRs) against patients and that healthcare leadership at SATF had not been aware staff were doing so.

In response, on November 8, 2021,[3] the Court ordered the Court Expert to investigate:

- Whether class members were being denied appropriate supplies;
- Whether class members were being treated disrespectfully when seeking accommodations;
- Whether class members were otherwise being discriminated against on the basis of their disabilities;

[1] Dkt. No. 3266.
[2] Dkt. No. 3717.
[3] Dkt. No. 3338.

- Why four nurses were responsible for seventy-five percent of all RVRs issued in 2021 by medical staff at SATF and whether those RVRs were properly issued;
- Whether medical leadership was unaware of any RVRs being issued by medical staff before being informed by Plaintiffs' counsel, and, if so, why;
- What investigation had been done to determine if the deaths of class members at SATF were in any way connected to a lack of concern by SATF staff members for *Armstrong* class members;
- What, if any, disciplinary action had been taken against any staff member in relation to the deaths of class members beyond placing on leave nurses who posted offensive comments; and
- The response of SATF's management to the incidents cited by Plaintiffs' counsel.[4]

This report documents our findings. In Part I, we discuss the method of our investigation and problems we encountered with collecting information as a result of the SATF mail room inappropriately opening mail from the Court Expert. In Part II, we review relevant background about SATF, including data that contextualizes the challenges faced by the institution, as well as the results of recent audits of healthcare at the prison.

Part III, our factual findings, is divided into sections discussing each of the issues we uncovered in our investigation. First, we find that class members at SATF have been denied disability accommodations in several ways:

- Class members have lost previously ordered accommodations when transferring into SATF.
- Class members have been denied accommodations due to an ineffective process of handling requests for medical attention, which is the first step in receiving DME and medical supplies necessary to accommodate many disabilities.
- Providers have denied DME for inappropriate reasons, leadership has failed to correct that denial through the Reasonable Accommodation Panel (RAP) or healthcare grievances, and the prison has had no functioning system to repair or replace broken DME.
- Incontinence supplies have been improperly denied to class members.
- Deaf class members who cannot sign have been improperly denied accommodations that would allow them meaningful access to programs, and they have thus been denied effective communication.
- Class members have been improperly denied non-medical assistive devices necessary to accommodate their disabilities.

[4] *Id.* at 2-3.

Second, we discuss safety issues for class members at SATF. We find that recent murders of class members at SATF were not due to specific animus or disregard for class members by staff, and that staff who made disrespectful comments about the murders were disciplined. However, we also find that the current policies and procedures regarding the process for housing class members whose disabilities pose safety concerns for class members are not sufficiently clear.

Third, we discuss RVRs issued to class members at SATF. We find that healthcare staff were inappropriately authoring RVRs, which created an adversarial relationship between healthcare staff and incarcerated people.

Fourth, we discuss the culture at SATF and the response of leadership to known problems with disability accommodations at the institution. We find that SATF leadership failed to proactively identify and correct several systemic problems at the institution that they either knew or should have known of. We also find that staff and leadership need additional support to be able to identify and remedy such systemic problems and to adequately accommodate class members. We find that leadership has not been effective in self-monitoring the institution for ADA compliance and self-correcting when failures are identified.

Finally, in Part IV of the report, we offer several recommendations for remedying the problems we identified.

I. Methodology of the Investigation

During our investigation, we visited SATF on four occasions, during which we toured SATF and observed various yards, healthcare clinics, housing units, education buildings, the medical supply warehouse, and the prison's hospital. As discussed in more detail below, we reviewed survey responses from over 200 incarcerated people regarding conditions at SATF. We conducted more than 70 interviews with incarcerated people at SATF, both in person and via video. We interviewed incarcerated people who had responded to our surveys and asked to be interviewed, incarcerated people who responded but did not ask to be interviewed, and incarcerated people who did not receive or respond to our survey. We interviewed incarcerated people with a wide variety of disabilities. We appreciate the time and openness of the class members who spoke with us or responded to our survey.

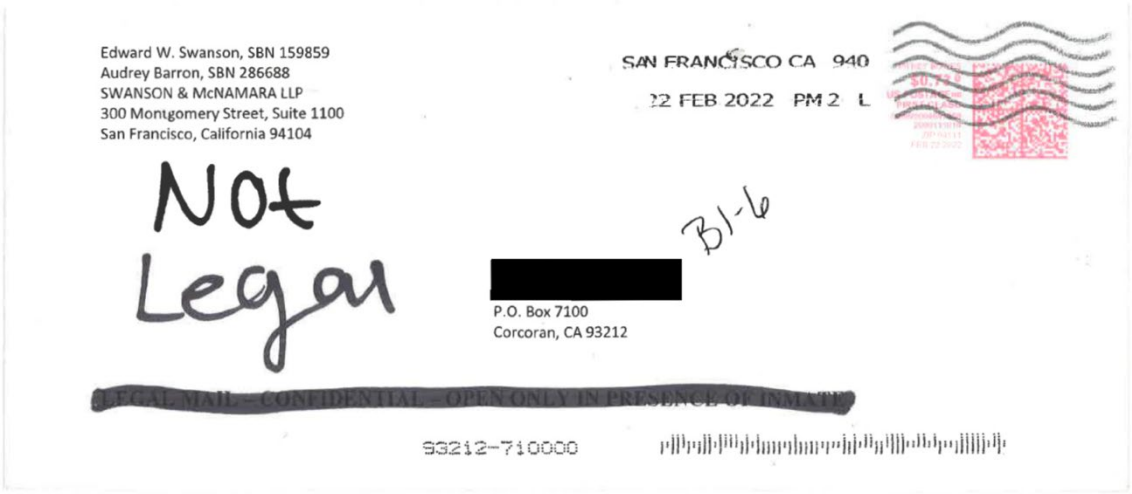
We conducted over 30 interviews with staff at SATF. We interviewed custody staff members, including housing unit officers, counselors, sergeants, lieutenants, and captains. We also interviewed healthcare staff members, including licensed vocational nurses (LVNs), registered nurses (RNs), primary care providers (PCPs), and psychiatric staff. We interviewed members of the ADA Office staff and other administrative staff of the prison. We interviewed leadership at the prison, including the Warden and Chief Deputy Warden, the Chief Medical Executive (CME) and Chief Nursing Executive (CNE), and the then-interim Chief Executive Officer (CEO). We appreciate the time and candor of the SATF staff who spoke with us. We also appreciate the assistance of SATF leadership in arranging our tours of the facility and interviews with

incarcerated people and staff, and in particular we appreciate the efforts of the then-ADA Coordinator (ADAC) in accommodating our many requests.

We received the cooperation of CDCR and CCHCS in providing us with a large amount of documents and information. We especially appreciate the significant efforts of the Office of Legal Affairs (OLA) in managing and responding to our document requests, as well as the efforts of Corrections Services of CCHCS in responding to requests for medical information. We also appreciate the assistance of Plaintiffs' counsel and their staff in providing us with requested documents and information.

Before we interviewed incarcerated people, we sent a survey to approximately 400 class members at SATF. We selected survey recipients who had a wide variety of disabilities. The survey sought information about class members' experiences obtaining disability accommodations and healthcare at SATF, their interactions with custody and healthcare staff, their experience with the RVR process, and their experience with the staff misconduct complaint process, among other topics. We received more than 200 responses to our survey.

Unfortunately, our ability to gain insight from class members via surveys was hindered by actions taken by SATF staff members. We mailed the surveys to class members in envelopes marked as "legal mail – confidential – open only in presence of inmate" and indicating the surveys were from the law office of the Court Expert. This process was adopted in consultation with CDCR. Mailing the surveys in this way should have resulted in mail room staff treating the surveys as confidential legal mail and leaving the envelopes unopened, and in custody staff opening the envelope in the presence of incarcerated recipients without reading the mail's contents.[5] Instead, shortly after we sent the surveys, we received calls from class members at SATF informing us that they received our surveys already opened and with the designation of "legal mail – confidential – open only in presence of inmate" crossed out, as shown in the example below:



[5] *See* Cal. Code Regs. tit. 15 § 3141-43.

We also heard from class members that in some cases it appeared the contents of the envelopes had been removed by custody staff and reinserted in the envelopes, sometimes with pages missing.

Once informed of the issue, SATF leadership investigated why the surveys were handled inappropriately. SATF determined that a mail room employee had improperly opened an envelope containing the survey, had reviewed the contents of the envelope—which contained a cover letter from the Court Expert and the survey—and had decided it was not in fact confidential legal mail. The staff person made this judgment on their own, without consulting a supervisor or legal counsel, as required.[6] The staff member then applied that judgment to all 400 surveys and instructed fellow employees to open all the envelopes and mark them as "not legal" mail. We understand that SATF initiated discipline proceedings against the mail room employee.

The mail room employees' actions had the effect of dissuading class members from sharing information with us. After the survey tampering was discovered, our office sent a letter to all survey recipients informing them that we were aware of the issue, and that SATF staff had been instructed to treat survey responses as confidential legal mail, even if they had not treated the delivery of the survey in that fashion. Nonetheless, and understandably, many class members called our office and informed us they would not be returning the survey because they believed their responses would not be kept confidential. We also heard from incarcerated people whom we interviewed that they received the tampered surveys and did not feel comfortable returning them because they believed staff would read the survey responses.

While we do not find that SATF staff intentionally interfered with our investigation by handling the surveys in this way, we are concerned that mail room staff did not follow the regulations regarding confidential legal mail. Staff's handling of the mail corroborates concerns we have heard from Plaintiffs' counsel and from class members that they believe that legal mail at SATF is being mishandled. We understand that CDCR is investigating system-wide problems with the confidentiality of legal mail and is working to strengthen training for mail room and custody staff regarding the proper treatment of confidential legal mail. We recommend retraining of mail room staff at SATF regarding the proper handling of legal mail.

II. Background on SATF

Located in Kings County, SATF is a medium-to-high-security and maximum-security institution. SATF is the largest prison in California both by physical size and by population, hosting between 4,300 and 5,100 incarcerated people at any given time in 2021.[7]

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[6] *See* Cal. Code Regs. tit. 15 § 3141(d) ("Institution mailroom staff shall contact the CDCR Office of Legal Affairs Division at Headquarters if there is any question regarding the legitimacy of a legal service organization.").

[7] *See* Statistical Report (SB601) for 2021 California Substance Abuse Treatment Facility, *available at* https://www.cdcr.ca.gov/research/reports-and-statistics-satf/.

SATF has been designated as a basic care institution, which means it has "the capability to provide limited specialty medical services and consultation for a generally healthy incarcerated person-patient population."[8] Basic care institutions are located in "rural areas away from tertiary care centers and specialty care providers whose services are likely to be used frequently by higher-risk patients."[9]

In 2020 and 2021, SATF was especially hard hit by outbreaks of COVID-19. At one point during 2020, SATF was managing nearly 2,000 positive cases of COVID-19, or nearly half the incarcerated population. COVID-19 also seriously affected healthcare and custody staff at SATF, as well as the availability of outside medical providers to treat patients at SATF.

A. Data Regarding SATF

During our interviews with staff and leadership at SATF, we frequently heard that the reason SATF struggled to provide adequate healthcare and accommodations for people with disabilities was because of the sheer number of *Armstrong* class members at SATF and the disproportionately low number of custody and healthcare staff to accommodate that population. We also heard that SATF was unusual in that it housed not only *Armstrong* class members, but also people in the Enhanced Outpatient Program (EOP), people in the Developmental Disability Program (DDP), high-risk medical patients, and people on high security yards. Thus, staff believed SATF was uniquely strained because it was focused on serving several different prison populations, all of which had significant needs that custody and healthcare staff were tasked with managing.

To understand whether this was the case, we obtained data regarding population and staffing levels for the last four years at SATF as well as at seven comparison institutions: ASP, CMF, LAC, MCSP, PVSP, RJD, and VSP ("the comparison institutions"). We selected comparison institutions that were similar in size and had a significant number of *Armstrong* class members, as well as some institutions that were much smaller and had significantly fewer *Armstrong* class members. We also requested and received data regarding the number of 1824s (requests for disability accommodations), 602s and 602HCs (complaints by incarcerated people against custody or healthcare staff), and 7362s (requests for medical attention) filed at SATF and the comparison institutions for the last four years.

While it may be the case that that the staffing levels at SATF are inadequate to properly support the size and needs of its *Armstrong* population, it is not accurate to say that SATF has a uniquely large population of class members or uniquely low staffing. SATF does not currently have the highest population of *Armstrong* class members and has not in the last four years. Nor does SATF have the highest number of people designated Security Level 4, high risk medical patients, or people in the EOP program. Of the comparison institutions, SATF did have the highest number of people in the DDP program. SATF was also not alone in serving these various

[8] Office of the Inspector General (OIG) Cycle 6 Medical Inspection Report, September 2021 at 2, *available at* https://www.oig.ca.gov/wp-content/uploads/2021/09/SATF-Cycle-6-Medical-Inspection-Report.pdf.
[9] *Id.*

populations simultaneously; five of the seven comparison institutions also housed significant numbers of incarcerated people who were in the EOP program, the DDP program, high risk medical, Level 4, and *Armstrong* class.

Regarding staffing, we assessed the level of custody and healthcare staff in relation to the total population and the *Armstrong* population. In 2022, SATF had more healthcare staff per *Armstrong* class member than any of the comparison institutions. It had more custody staff per *Armstrong* class member than four of the comparison institutions and fewer staff than three of the comparison institutions. In the last four years, SATF has never had the least staffing per *Armstrong* class member of the comparison institutions.

Nor is SATF uniquely burdened by 602s, 602HCs, or 7362s. Of the eight institutions, SATF ranked sixth or seventh for total 602s filed over the last four years, meaning that most of the comparison institutions handled more staff complaints than SATF did. SATF also did not rank towards the top in terms of total numbers of 7362s, 602s, or 602HCs per capita.

However, although SATF does not have the greatest number of class members, SATF does appear to receive more requests for disability accommodations (1824s) than other institutions. SATF received significantly more 1824s than the comparison institutions in 2021 and was on track to receive the most 1824s in 2022. SATF received the second most 1824s of the comparison institutions in 2019, and the third most in 2020. As discussed in greater detail below, we believe that SATF could reduce the number of 1824s that it processes by instituting clear procedures for the procurement, replacement, and repair of DME, as well as by communicating with patients regarding pending appointments.

In short, SATF is not unique in the makeup of the population it manages or in the staffing levels the institution has to serve that population. Thus, the issues at SATF cannot be explained *alone* by the size of the institution or the staffing levels. That said, we have not reviewed conditions at the comparison institutions, and thus we do not know if the problems we identified at SATF are present at other institutions as well.

B. Recent Healthcare Audits of SATF

SATF has performed poorly in several recent audits of its delivery of healthcare services. Healthcare at SATF is subject to auditing by a variety of external oversight bodies, including the Office of the Inspector General (OIG), multiple units of CCHCS, and county and licensing bodies. Audits in 2021 and 2022 revealed serious and recurring problems with healthcare at SATF.

A September 2021 OIG Inspection Report found SATF's delivery of medical care to be "Inadequate" in every category measured except for emergency services and specialized medical housing.[10] Many deficiencies identified in the OIG report had carried over from the prior report

[10] OIG Cycle 6 Medical Inspection Report, September 2021 at 3, *available at* https://www.oig.ca.gov/wp-content/uploads/2021/09/SATF-Cycle-6-Medical-Inspection-Report.pdf.

in 2017, including a continued inadequate rating for access to care, the healthcare environment, and medication management.[11] Other aspects of SATF's healthcare performance were found to be worse than during the prior OIG inspection, including transfers, nursing performance, and provider performance.[12]

An October 14, 2022 operations monitoring audit report by the CCHCS Health Care Access Unit found that SATF struggled with several unresolved critical issues for two or more audits and therefore referred the institution for division/region level review. The audit also showed several new critical issues, including custody staff failing to effectively monitor therapy medication distribution, nurses failing to document collection of 7362 forms from units under lockdown or modified program, and custody staff failing to deliver all priority ducats to patients prior to their scheduled health care appointments.

Finally, a September 29, 2022 audit report from the CCHCS Health Care Facility Support Compliance Monitoring Unit found very serious deficiencies at SATF regarding the safety and cleanliness of healthcare facilities. The report concluded:

> The institution was found to be severely out of compliance in all components. The assessment team observed a full system failure to maintain regulatory and industry standards as contractually required. Many of the deficiencies identified by the assessment team involve Health and Safety concerns, security concerns, licensing concerns, and in more than one instance, concerns of patient welfare. Multiple findings required immediate collaboration and action by HFM,[13] custody, and clinical staff to remedy. The assessment team observed poor communication, a lack of cohesive partnership, and no mutual accountability between the disciplines.

Among other recommendations, the audit report recommended that SATF's healthcare leadership "conduct regular and frequent tours of the facility to inspect the condition of the institution."

The Court Expert finds it concerning that during a period when SATF was aware it was under close scrutiny, it not only failed to improve from its already inadequate performance on various healthcare metrics, but that it failed so dramatically to maintain safe and clean facilities during this period.

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[11] *Id.*
[12] *Id.*
[13] HFM stands for Healthcare Facilities Maintenance.

III. Factual Findings

The following findings are based on our interviews of staff and incarcerated people at SATF, as well as our review of documents and other evidence.

A. SATF Is Failing to Deliver Accommodations to Class Members

Our first finding is that SATF is failing to provide reasonable accommodations for people with disabilities in a timely manner, or sometimes at all. In this section, we discuss in detail the experiences of some incarcerated people who have tried to get accommodations for their disabilities. The experiences of these individuals are representative samples, rather than isolated occurrences, and they are illustrative of systemic failures at SATF.

As will be discussed in greater detail below, Person A advocated for six months for the return of DME that was lost during his transfer to SATF, including by filing 7362s, an 1824, and requesting the DME in healthcare encounters. His lost DME was not replaced until he attempted suicide and was moved to the Correctional Treatment Center (CTC), where providers quickly remedied the problem. Person B was transferred to SATF twice, and each time he was denied prescribed nutrition that was his primary source of food due to his inability to swallow most solids. During his second transfer, he was also abruptly cut off from antidepressant medication. These failures were not corrected until the Court Expert intervened directly with CCHCS. Person C, who is blind in one eye and has glaucoma in the other, was denied a tapping cane for six months despite filing 7362s, an 1824, and a 602HC, and despite a request by Plaintiffs' counsel. It was not until CCHCS intervened that he received the DME. Person D was denied incontinence supplies by healthcare staff, and no reasonable explanation for the denial was provided. Person E, who is deaf but does not know sign language, has been denied access to programs at SATF for over a decade and also does not receive consistent written communication from custody staff. His problem remains unsolved. Finally, Person F, who has a disability that affects his hands, has been requesting an assistive device to help him write for approximately three years. Despite three years of advocacy through 7362s, 1824s, 602s, and requests by Plaintiffs' counsel, Person F still has not received an assistive device to accommodate him in writing.

We discuss these examples in more detail below, but the problems these individuals experienced are representative of broader problems at SATF with continuity of care during transfer, requests for medical attention that are mishandled, DME being denied or not repaired, denial of incontinence supplies, denial of accommodations and effective communication for deaf people, and denial of assistive devices.

i. Denial of Accommodations During Transfer into SATF

For many class members, the challenges with receiving adequate healthcare and disability accommodations at SATF begin the moment they arrive. We heard from class members in both

interviews and surveys that upon arrival at SATF, they lost access to DME, had chronic conditions erased from their medical charts, or did not receive daily nutritional supplements or medication necessary to treat their disability. Our investigation confirmed that class members encounter these problems frequently at SATF.

a) DME

As discussed in this section, SATF lacks a clear process for replacing DME that are lost during an incarcerated person's transfer into SATF. We describe the current procedure and practice at SATF for documenting and replacing missing DME, as well as an illustration of how SATF's confusing process results in incarcerated people having to advocate for months to replace the DME that they were previously prescribed. While the following description of the policy is admittedly dense, we feel it is necessary to set out the current policy in order to understand its deficiencies.

When an incarcerated person transfers to SATF from another institution, their first encounter with custody and healthcare staff is typically at the Receiving and Release (R&R) office.[14] There, custody staff review Strategic Offender Management Systems (SOMS)[15] to assess what DME the incarcerated person is supposed to have, as well as what DME they actually have in their possession.

The SATF Local Operating Procedure (LOP) establishes the process, albeit an unclear process, for how to inventory DME during transfers.[16] The LOP instructs that if SOMS indicates the incarcerated person has DME, "the sending facility shall inventory the inmate's [DME] and complete the CDCR 128B, Intra-facility Health Care Appliance Inventory Chrono (Attachment H)."[17] [18] The LOP then states that "[i]f there is a discrepancy between the [DME] listed on SOMS and the [DME] is [sic] actually in the inmate's possession, the sending facility staff shall document the discrepancy on the CDCR 128B."

[14] Incarcerated people who transfer to SATF on the weekends or holidays are processed through the Triage and Treatment Area (TTA).
[15] SOMS is database software that centralizes an array of information about incarcerated people.
[16] LOP 403(VI)(C)(4)(e).
[17] LOP 403(VI)(C)(4)(e)(2).
[18] Transfer from one institution to another is really "inter-facility" transfer, but the SATF LOP has no procedures specific to "inter-facility" transfer, and DME is inventoried on a form referring to "intra-facility" transfer. The LOP appears to envision R&R as the "sending facility," in that R&R sends an incarcerated person to the receiving yard where they will reside. Thus, R&R is the sending facility that fills out the Intra-Facility Health Care Appliance Inventory Chrono form and "inventory the inmate's [DME]" and "document [any] discrepenc[ies]" regarding DME.

The "Intra-Facility Health Care Appliance Inventory Chrono" form is not a model of clarity.[19] Although it appears the form's checkboxes are meant to inventory DME that the incarcerated person actually has in their possession at the time of transfer, when we spoke with custody staff at SATF's R&R, they told us they used the check boxes to mark DME that the person was *supposed to have* according to SOMS. They then used the "discrepancies/comments" section to note what DME the incarcerated person was missing, or what DME they had that was not listed in SOMS. Based on our review of a small sample of these forms, it appears staff fill them out inconsistently, with some using the check boxes to mark what DME appear in SOMS and others marking what DME the incarcerated person possesses. In addition, it appears staff use the discrepancies section to note both what DME the incarcerated person is missing and what DME they have that do not appear in SOMS.

It is unclear what custody staff are required to do to address discrepancies between what DME the incarcerated person has and what they are supposed to have. The LOP first instructs that "the sending facility staff shall attempt to resolve the issue by querying the inmate and notifying the facility clinic of the discrepancy."[20] By referring to "the sending facility," and not particular staff, the LOP is not clear as to whether custody staff in R&R, the R&R RN, or both are required to notify the facility clinic of missing DME.

The LOP then instructs, "[u]nder non-emergency situations, if staff discover an inmate is without his prescribed [DME], prior to movement custody staff shall coordinate with medical and immediately provide an interim accommodation (loaner cane, walker, wheelchair, etc.)."[21] But the LOP does not explain what a "non-emergency situation" is that requires staff to obtain a loaner item, much less what an emergency situation is or what staff are required to do in such an emergency. Custody staff in SATF's R&R told us that if someone arrived without a wheelchair or something they needed to ambulate, staff would attempt to get a replacement or loaner for the new arrival. But for most other missing DME, custody staff understood that it was up to healthcare staff to prescribe and distribute replacement DME, and that it was not their responsibility to contact medical staff on the yard where the incarcerated person would be housed to notify them of the missing DME.

After custody staff finish their intake with a newly arriving incarcerated person, the incarcerated person next meets with an R&R RN. The R&R RN completes an initial health screening, during which the R&R RN checks the electronic health records system to see what DME the patient has been prescribed and compares that with what DME the incarcerated person has in their possession. Although the Health Care Department Operations Manual (HCDOM) states that "the Receiving and Release Registered Nurse shall be responsible for ensuring that patients are provided with prescribed DME and/or medical supplies upon arrival," it does not establish a

[19] *See* Appendix B.
[20] LOP 403(VI)(C)(4)(e)(3).
[21] LOP 403(VI)(C)(4)(e)(4).

procedure that R&R RNs follow to replace prescribed DME that are missing.[22] Nor does SATF's LOP establish a clear process for how the R&R RN, or some other staff person, replaces missing DME. The R&R RN with whom we spoke at SATF told us that they will generally replace a missing DME if it is something they have on hand in the R&R office, like a vision impairment vest or cane. But most items (like hearing aids, custom dentures, eyeglasses with a particular prescription, or C-pap machines) are not kept on hand in R&R, and in that case, the R&R RN told us that they send a message noting the discrepancy to healthcare staff on the yard where the person will be housed. It is then up to the clinic on the yard to correct the DME discrepancy.

When the R&R intake is complete, the R&R nurse sends a message to healthcare staff on the yard where the incarcerated person will live, including to the PCP, to inform them of the new patient arriving.[23] Once the incarcerated person is moved to the yard where they will be housed, PCPs are required to complete a process called reconciliation, in which the PCP reviews the patient's medical information and ensures that appropriate medication, DME, nutritional supplements, and pending appointments continue to appear in the patient's orders. PCPs are required to complete order reconciliation by the close of the next business day after the incarcerated person's arrival.[24] Our understanding is there is no automated notification in the electronic medical system to remind a PCP to reconcile DME, or to alert PCPs or their supervisors if a provider fails to reconcile within the required time frame.

The PCP is next required to complete an initial assessment within seven calendar days if a newly arriving patient is "High Risk/Complex Care," within 30 calendar days if the patient is "Medium/Low risk … with one or more chronic conditions with prescribed medications," or "as needed, or based on applicable care guides" if the patients is "Medium/Low risk … without known chronic conditions with prescribed medications."[25]

The process just described can help identify when an incarcerated person's DME is lost during transfer, but it does little to correct the problem. There is no policy requiring the R&R RN to order the replacement DME from the medical supply warehouse, or to message the yard clinic to inform them that their newly arriving patient is missing DME, and even if they do so, it is not clear what action that would trigger in a clinic to correct the problem; neither the LOP nor HCDOM discuss what the yard clinic is required to do once they are informed that a newly arriving patient is missing DME. Once the new patient arrives on the yard, the provider must reconcile the patient's DME, but they do so before they evaluate the patient, so they may not be aware of what DME the patient is missing unless they received notification by the R&R RN or other healthcare staff. And after arrival, the new patient may not see the PCP for a week, 30 days, or indefinitely if they are low risk. Unless the incarcerated person seeks care proactively,

[22] HCDOM 3.6.1(e)(8).
[23] HCDOM 3.1.9(c)(3)(B)(3).
[24] HCDOM 3.1.9(c)(3)(B)(5).
[25] HCDOM 3.1.9(c)(3)(B)(4).

he or she could go weeks or months before seeing a provider and having an opportunity to raise concern about missing DME.

Thus, the system is not designed to require custody or healthcare staff to promptly replace DME that was lost during transfer, and it relies on incarcerated people to advocate for themselves and request, either through a 7362 or 1824, to have their missing DME replaced. As discussed below, even when incarcerated people do so, SATF is not quickly replacing missing DME. Indeed, we repeatedly heard from class members that their DME was lost during transfer to SATF and that they had to engage in lengthy advocacy to get back DME that had been prescribed to them at previous institutions. We confirmed this to be the case through a review of records.

We outline in detail here one example of how the system fails to replace lost DME during transfer. While this is a particularly egregious case of DME being lost and not replaced, it was one of many that we learned of in our investigation. This class member, who we will refer to as Person A, arrived at SATF in October 2021 from Salinas Valley State Prison. During his reception at SATF, custody staff checked boxes on the Intra-Facility Health Care Appliance Inventory Chrono for various DME including a wheelchair, wheelchair cushion, wedge pillow, wheelchair gloves, foot orthoses, insoles, and partial dentures. But in the "discrepancies" section, the custody staff noted that Person A "arrived without partial denture." Thus, partial denture was listed both as a DME that was "transferred with the inmate to receiving facility" and also as missing. The discrepancies section also noted that the wheelchair cushion, wheelchair gloves, and wedge pillow were not listed in SOMS. During the initial health screening, the R&R RN noted that, contrary to what custody staff wrote, SOMS did indicate orders for wedge pillows, a wheelchair cushion, and wheelchair gloves, as well as several other DME. The R&R RN noted several DME missing, including DME that custody staff had not identified as missing, like wedge pillows, a TENS unit (a battery-powered device that delivers electrical impulses meant to treat pain), and a cervical pillow. There is no indication whether the R&R RN sent a message to the yard clinic noting the missing DME.

Thus, after the R&R encounter, the picture of what DME Person A was prescribed and what he actually possessed was unclear. For example, wedge pillows were marked as being in Person A's possession on the Inventory Chrono, noted as not being prescribed in SOMS on the Inventory Chrono, listed as being prescribed in the initial health screening, and listed as missing in the initial health screening.

Almost immediately upon arriving on the yard on October 22, 2021, Person A filed an 1824 requesting a TENS unit and cervical pillow, because they were "confiscated" at Salinas Valley, the institution from which he transferred to SATF. A few days later, on October 25, the PCP evaluated Person A as a new high-risk arrival. At that appointment, notes indicate the class member again requested the replacement of his cervical pillow, which he said was lost during his transfer. The provider noted that Person A's DME "mention cervical pillow," but instead of simply reissuing the pillow that was previously prescribed to the class member and lost during

transfer, the provider decided to reassess whether there was a medical necessity for the cervical pillow. Person A had a documented history of cervical spinal stenosis, cervical pain, and "degenerative joint disease, cervical" so severe that he was offered neck and spine surgery two years prior. Nonetheless, the provider reviewed the person's documented medical history and determined that there was "no medical necessity this time for such issue of accommodation [sic]." And despite Person A's 1824 stating his TENS unit had been taken from him, the PCP noted that Person A had all other DME in his possession, including his TENS unit. The PCP's note that Person A had his TENS unit also contradicted the R&R RN, who had only a few days earlier documented that Person A's TENS unit was not with the incarcerated person at the initial evaluation.

Two days later, on October 27, the RAP met to discuss Person A's 1824 requesting a cervical pillow and TENS unit. Despite the intake notes stating the TENS unit was missing upon Person A's arrival to SATF, the CME relied on the notes from the PCP's evaluation, stating that Person A had a TENS unit. The CME also deferred to the provider's assessment that the cervical pillow was not medically indicated, despite Person A's documented history of significant cervical conditions. The RAP therefore denied Person A's request to replace his previously prescribed DME that were lost in transfer.

Two days later, on October 29, Person A was seen by a different PCP to "[d]iscuss TENS unit and cervical pillow." It is not clear if this encounter was prompted by Person A submitting a 7362, at the behest of the RAP, or for some other reason. This care provider reviewed Person A's medical records, including his history of cervical degenerative disease and cervical arthrosis, and referred Person A to physical therapy to "[e]val if cervical pillow and TENS unit are appropriate devices for the pt's chronic neck and back pain."

Two months later, on December 29, Person A submitted a 7362 again requesting a TENS unit and wedge/cervical pillow.[26] Person A was seen for this request 13 days later on January 11, 2022. At that appointment, the same provider who had referred Person A to physical therapy to evaluate whether he needed a cervical pillow or TENS unit this time "[o]rdered Cervical pillow/Wedge pillow from his previous institution." It is not clear what it means to order an item from a previous institution, or if any order was actually placed.

Despite notes indicating the provider would refer Person A to physical therapy in October 2021, he was not evaluated by a physical therapist until February 18, 2022, nearly four months after he arrived at SATF with missing DME and nearly four months after the PCP referred him to physical therapy to evaluate whether his previously prescribed DME was medically necessary. The physical therapist stated in medical notes that they believed the cervical pillow and TENS units were "accommodations [that] will benefit [the] patient."

[26] The records indicate the class member and medical staff sometimes referred to the cervical pillow as a wedge pillow, although we understand that cervical pillows and wedge pillows are different DME.

Following this opinion of the physical therapist, Person A again submitted a 7362 requesting an update on the status of his requests for a cervical pillow and TENS unit. A few days later, he was seen by the PCP, who put in a Request For Service (RFS) nonformulary order for the cervical pillow and TENS unit. Despite the RFS, Person A did not receive the DME and continued to ask for replacements in two encounters with the provider in March 2022. Medical notes indicate that on March 8, 2022, the provider again placed a RFS nonformulary order for the TENS unit and cervical pillow. But by April 20, 2022, when Person A was transferred to CTC after a suicide attempt, he had still not received the replacement DME.

Thus, after approximately six months of advocacy by Person A, including making requests in at least five encounters with PCPs, one 1824 that was denied by the RAP, one physical therapy evaluation, and at least four 7362s, Person A still had not received the DME that were lost during transfer.[27] It was not until he attempted suicide and was placed in a mental health crisis bed that Person A received the replacement DME, thanks to providers in that department calling the medical supply warehouse and insisting that the DME be replaced urgently. To be clear, Person A told us that he did not attempt suicide *because of* his difficulty obtaining DME, but he said that the difficulty he encountered contributed to his overall feelings of hopelessness and negative mental health.

This example is representative of a system-wide deficiency in replacing DME lost in transfer that we learned of in our investigation. We heard from class members and saw documentary evidence of DME being lost in transfer and not being timely replaced. And our interviews with staff demonstrated their confusion about the processes for identifying and replacing lost DME. As discussed in greater detail below, SATF healthcare leadership had an opportunity, particularly through its participation in the RAP, to identify this systemic problem and did not do so. It is the responsibility of leadership to devise a local operating procedure that implements the process for prescribing, replacing, and repairing DME at SATF.[28] As discussed in greater detail below, we therefore recommend that SATF revise its LOP to clarify requirements for custody and healthcare staff when they discover during the transfer process that an incarcerated person is missing DME.

b) Medication and Nutritional Supplements

In its most recent medical inspection report from September 2021, the OIG found SATF performed poorly in ensuring continuity of care for people transferring into SATF. For example, compliance testing found that SATF "did not administer or deliver medications without interruption" approximately half of the time it transferred in new patients. About half of keep-on-person medications "were not administered timely or were not administered at all."[29]

[27] A review of online retailers indicates that cervical pillows typically cost approximately $10 to $20, and TENS units typically cost approximately $15 to $35.
[28] *See* HCDOM 3.6.1(f).
[29] OIG Cycle 6 Medical Inspection Report, September 2021, at 41.

Similarly, OIG found a failure to provide medication and follow-up appointments for patients who returned to SATF following an off-site hospitalization.[30]

Although we reviewed a relatively small sample of class members who transferred into SATF, our investigation confirmed that failure to provide continuity of care upon transfer into SATF is a serious and ongoing problem. We provide as an example the experience of one class member, Person B, who transferred into SATF twice in the last year, and on both occasions experienced lapses in medication and nutritional supplements due to SATF's failure to properly handle his transfer into the institution. As with the example above, the details of this individual's experience are illustrative of problems in continuity of care that many class members experience, which we learned of through interviews and document review.

Person B used a wheelchair and had a history of mental health diagnoses as well as several chronic medical conditions. Relevant here, Person B had a history of difficulty swallowing solid foods, such that he had been prescribed a nutritional supplement prior to his arrival at SATF. We interviewed him on March 28, 2022, when he told us that he went approximately 10 days without the nutritional supplement after he arrived at SATF, and that he was continuing to have difficulty consistently getting the supplement. He explained that his inability to receive the nutritional supplement was a serious cause for concern, since it was difficult for him to swallow solid food, and he relied on the supplement for nutrition. He also explained that many of the medications he took for chronic medical conditions were to be taken with food, so he had stopped taking some critical medications out of concern for taking them on an empty stomach. At the time of our interview, we reported these concerns to the ADAC who took immediate steps to ensure Person B received the nutritional supplement.

A subsequent review of Person B's records corroborated what he told us in his interview. Person B arrived at SATF on March 12, 2022, which was a Saturday. On weekends, TTA is responsible for receiving new patients, since R&R is closed on weekends and holidays. It is not clear whether the TTA RN performed an initial evaluation or messaged the yard where Person B would be housed regarding the need to reconcile his orders. But it is clear that once Person B arrived on C yard at SATF, the PCP on that yard failed to reconcile his orders for nutritional supplement or incontinence supplies. On March 16, 2022, Person B put in a 7362 requesting to renew his nutritional supplement, and he noted on the form that it was his second request. There is no record of his first request. The next day, he was seen by the PCP on the yard who noted in the medical records that they would order incontinence supplies and order a dietician's evaluation for nutritional supplement. The PCP did not document any reason for second-guessing the appropriateness of the existing order for nutritional supplement. The PCP did not renew the order for the nutritional supplement pending the dietician's evaluation, and it is not clear that the PCP actually placed a referral to a dietician to evaluate Person B, as there is no evidence the evaluation was ever scheduled.

[30] *Id.* at 42.

SATF's records show that Person B first started receiving nutritional supplement on March 22, 2022, ten days after he arrived at the institution. Thus, this person went ten days without receiving his primary source of nutrition. It is not clear in the medical records how Person B started receiving the supplement, since the medical provider did not reconcile or renew his previous order for it.

Less than two months after he arrived at SATF, Person B was transferred to California Health Care Facility (CHCF) after he requested via 1824s to be transferred to different housing due to his incontinence. Person B explained in the 1824s that his housing on B yard at SATF was not adequate to accommodate his incontinence, in part because the design of the bathrooms made it difficult for him to transfer from his wheelchair to the toilet. It took several weeks and three 1824s until he was transferred to different housing.

While at CHCF, Person B was prescribed a pureed diet due to his ongoing struggle to swallow solid food. Apparently because he began receiving a pureed diet, his order for nutritional supplement was discontinued.

For reasons that are not clear, Person B was transferred back to SATF on September 12, 2022. Unfortunately, this second transfer into SATF went even more poorly than the first. Person B was processed through TTA, rather than R&R, because he was considered to be a transfer from a higher level of care. The TTA nurse failed to send a message to the receiving yard's care team regarding the new patient and his pending orders, although they were required to do so. The receiving yard's PCP failed to reconcile Person B's medications, active medical conditions, DME, and nutritional supplement order by the close of the next business day, although required to do so. The PCP saw Person B a few days later, on September 15, but failed to conduct a comprehensive evaluation and again failed to reconcile the patient's pending orders or active medical conditions. As a result of the provider's failure to reconcile, Person B was abruptly cut off of several medications, including a medication taken for depression. Person B's medication for depression was not re-ordered until October 9, 2022, nearly a month after he arrived at SATF.

The provider also failed to reconcile or request an order for pureed diet, or to order a nutritional supplement in lieu of a pureed diet. Person B provided us with a carbon copy of the 7362 he submitted on September 20, 2022, asking to have his pureed diet restored and noting he had not received it and had been unable to eat since he arrived on September 12. This 7362 was not scanned into the medical records, and, as a result, Person B's request went unanswered.[31] On September 30, 2022, our team became aware of Person B's transfer to SATF and learned that he had, yet again, been denied prescribed nutrition. We informed CCHCS of the issue and, as a

[31] A Field Training Sergeant (FTS sergeant) did check on Person B when he was moved to the yard, but Person B did not tell the FTS sergeant about the problems he was experiencing with medication and nutritional supplement. Person B told us that he did not think the FTS sergeant would have been able to help, since it was a medical issue.

result of CCHCS's intervention, SATF healthcare leadership at that point took steps to ensure Person B received adequate nutrition.

Thus, in the span of one year, Person B was transferred into SATF twice, and on both occasions, staff failed to follow protocol for transfer by not reconciling his medications, nutritional supplements, and conditions. As a result, Person B experienced two separate ten-day or longer periods of receiving little to no nutrition[32] after arriving at SATF, and during his second transfer, he had to go cold turkey off of an anti-depressant, which was not restored for nearly a month and only after intervention by the Court Expert's team, CCHCS, and Plaintiffs' counsel. It is particularly alarming that this second transfer failure happened at a time when SATF should have been aware that it was under close scrutiny, and that the Court Expert's team was investigating what had occurred with Person B's first transfer into SATF. Again, while this individual's experience was particularly troubling, his experience was not unique. In the course of our investigation, we spoke with multiple class members who had interruptions in medications, some of which relate to their disability, during transfer into SATF. And as noted above, OIG has also identified continuity of care during transfer as a systemic problem at SATF.

The problem here appears to be that existing prescriptions for medication and DME do not automatically continue upon transfer, and instead, PCPs must remember to reconcile a new patient's medications, DME, conditions, nutritional supplements, and appointments before the provider ever sees the patient. There do not appear to be any checks in the system to alert a provider when they have failed to complete reconciliation. And the consequences when human error inevitably occurs and a provider fails to reconcile can be dire, as the previous example demonstrates.

We understand that CCHCS is investigating ways to automate the reconciliation process. We encourage that effort and recommend that CCHCS also investigate whether the electronic records system can alert providers when they have failed to reconcile orders for a new patient.

ii. Problems with the 7362 Process

We repeatedly heard from class members at SATF, both in surveys and in interviews, that they often received no response or very delayed responses to 7362s requesting medical attention or to be seen regarding DME or supplies. Delays in the provision of healthcare affect all incarcerated people, but they disproportionately affect *Armstrong* class members who rely on healthcare staff to provide DME and supplies to accommodate their disabilities. As discussed below, we find that there are problems at SATF with the timely collection and response to 7362 forms.

When an incarcerated person requests medical, dental, or mental health care, they submit a 7362 form and explain the reasons they are requesting health care services. The incarcerated person

[32] Person B told us he subsisted on mashed bananas and peanut butter, as well as some soft vegetables he was able to mash.

can keep a carbon copy of the form they filled out, but they do not receive a receipt or other paperwork showing that the 7362 was received or entered by healthcare staff. Incarcerated people submit the 7362s to locked boxes on the yard or in their housing unit, and healthcare staff collect the 7362s from the locked boxes daily.[33] When an incarcerated person does not have access to the locked boxes because they are confined to a cell, such as during lockdowns or modified programming, healthcare staff is responsible for making rounds to cells to collect 7362s.[34] The rounds and collection of the 7362s "shall be documented by nursing staff in the housing unit logbook."[35]

On normal business days, a health care staff member on each yard collects 7362s, documents the date and time of pickup, and delivers the forms to the Primary Care RN for review.[36] The Primary Care RN then triages the forms to identify "those that describe symptoms of a medical, mental health, or dental condition."[37] The RN identifies patients who describe urgent or emergent health care needs and refers them to be seen by the PCP either immediately in the case of an emergency, or within 24 hours in the case of urgent needs.[38] Those patients who describe symptoms that are not considered urgent or emergent "shall be seen by the Primary Care RN within one business day."[39] For 7362s that contain a request for care but do not report symptoms needing treatment, such as a form that requests a medication renewal or eyeglasses, the RN must "rout[e] them to appropriate staff" on the same business day.[40]

On non-business days, all 7362s are routed to the TTA RN. The TTA RN triages the forms to "direct action to coordinate care for patients with emergency or urgent conditions."[41] For non-urgent or emergent needs, the TTA RN routes the 7362s to the Primary Care RN assigned to the patient to address the request through the normal process the following business day.[42]

Once the RN sees the patient, they determine if the patient should be seen by the PCP. If the RN determines the patient's issue is an emergency, the patient must be seen by the PCP immediately.[43] If the RN determines the issue is not an emergency but is urgent, the patient must be seen by the PCP within 24 hours.[44] All other issues are "routine," and the patient must be seen by a PCP within 14 calendar days.[45]

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[33] HCDOM 3.1.5(c)(2)(B)(2)(d); HCDOM 3.1.5(c)(2)(B)(3).
[34] HCDOM 3.1.5(c)(3)(D)(3).
[35] *Id.*
[36] HCDOM 3.1.5(c)(2)(B)(3)(a)(1).
[37] HCDOM 3.1.5(c)(2)(B)(3)(a)(2).
[38] *Id.*
[39] HCDOM 3.1.5(c)(2)(B)(3)(a)(3).
[40] HCDOM 3.1.5(c)(2)(B)(3)(a)(5).
[41] HCDOM 3.1.5(c)(2)(B)(3)(b)(2).
[42] HCDOM 3.1.5(c)(2)(B)(3)(b)(1).
[43] HCDOM 3.1.5(c)(2)(B)(3)(a)(4).
[44] *Id.*
[45] *Id.*

a) 7362s Lost or Otherwise Not Entered

We repeatedly heard from class members that they had to submit multiple 7362s about the same issue in order to receive medical attention, because they often received no response. We reviewed records that confirmed that incarcerated people had carbon copies of 7362s they filled out but were never logged or entered in the person's medical chart, including instances where they were requesting urgent medical care. Although it is possible a class member could have filled out a 7362, kept the carbon copy, and never submitted the form, we find it highly unlikely that occurred, given the incarcerated people were often urgently seeking assistance; they would seem to have no motivation to fill out but not submit a form seeking medical attention. We find it more likely that incarcerated people at SATF are submitting 7362s that healthcare staff either lose or otherwise fail to enter.

b) 7362s Not Collected

In addition to 7362s being lost or otherwise not entered, some incarcerated people at SATF have been unable to submit 7362s at all due to a lack of 7362 locked boxes in housing buildings at SATF, and a failure by healthcare staff to collect and submit 7362s from housing units where class members were unable to access 7362 locked boxes on the yard. In June 2020, Plaintiffs' counsel in *Plata* informed Defendants of concerns that incarcerated people on D yard at SATF were unable to access locked boxes to submit 7362s. At that time, there was only one locked box where incarcerated people on D yard could submit a 7362, and it was located outside the housing buildings, on the yard next to the medical clinic. Because of restrictions on programming due to COVID, many incarcerated people on D yard were only let out of their housing unit to the yard, where the 7362 locked box was located, three times per week or less. On days they could not leave the housing unit and access the yard, nurses came to the buildings to conduct medication distribution. But Plaintiffs' counsel reported that nurses were not making rounds to each cell to collect 7362s as required,[46] and people who did not receive medication were not allowed to leave their cells to submit 7362s to the nurses distributing medication.

In a July 2020 response, CCHCS acknowledged that "the collection of CDCR 7362 . . . [was] not consistently documented in the logbook as is required per policy." CCHCS indicated that nursing supervisors at SATF would "provide refresher training to all nursing staff on D yard" regarding the issue, and that "[d]uring future lockdowns, compliance will be monitored." In addition, CCHCS stated that during future medication pass, "patients needing to turn in a CDCR 7362 [will] be released to submit their forms…."

However, during a site visit in August 2021, Plaintiffs' counsel in *Plata* reported that they continued to receive reports from patients on D yard at SATF that they were not being permitted to leave their housing units to submit 7362s, and nurses were not coming to the housing units to

[46] HCDOM 3.1.5(c)(3)(D)(3).

collect them. Plaintiffs' counsel asked that SATF install locked boxes for 7362s in each housing unit on D yard and instruct nurses to collect the forms from those boxes daily.

In response, in September 2021, the then-CEO of SATF presented a PowerPoint to Plaintiffs' counsel in *Armstrong* in which he represented that for C and D yards at SATF, "7362 drop boxes installed in each yard building, and Nursing will pick up 7362's daily."

However, in April 2022, Plaintiffs' counsel in *Plata* again informed CCHCS that they heard reports from patients on D yard that they continued to be unable to submit 7362s, and that no locked boxes for 7362s were actually installed in their housing units. In response in May 2022, CCHCS clarified that, contrary to the representations of the SATF healthcare CEO, locked boxes were not installed in each housing unit on D yard. The response included a memorandum issued by the SATF Warden in October 2021 that instructed custody staff to make an announcement "via the P.A. system or means necessary to inform inmates with a 7362, to flag their door for release." The memo stated that the Control Booth Officer would then release "those inmates needing to drop off a 7362." In addition, the memo stated that when any facility was on modified programming "and Medical staff is conducting pill pass in the housing units, medical staff will continue to collect the 7362's and log it in the unit logbook."

In June 2022, Plaintiffs' counsel in *Plata* again informed CCHCS of reports of patients on D yard not being permitted to leave their cells to submit 7362s and again requested that SATF comply with HCDOM policy and collect 7362s cell-side in the housing units when they were on restricted programming. CCHCS responded in July 2022 and stated that "[i]n the event that Facility D is on modified program, medical staff will distribute and collect CDCR 7362s at cell front." The response also stated, "there are currently no CDCR 7362 issues in Facility D, as SATF staff is handling the process effectively."

Despite these assurances, an audit of SATF documents from August 2021 to July 2022 by the Health Care Access Unit of CCHCS showed a 4.4% compliance rate when examining whether nurses were documenting that they collected 7362s from general population housing units under lockdown or modified program. Thus, despite two years of assurances that SATF nurses would comply with policy and collect 7362s cell-side during lockdown, and despite a promise in 2020 that compliance with the policy would be monitored, a CCHCS audit in 2022 showed that SATF nurses documented compliance with the policy only 4.4% of the time.

In our most recent visit to SATF in October 2022, we noted that 7362 boxes had been installed in housing units on D yard, but they were still not operational. We were told that the boxes needed locks installed, which was to happen soon. In other words, over two and a half years into the pandemic, and after repeated requests by Plaintiffs' counsel and repeated inquiries from the Court Expert, SATF had neither taken the simple step of installing operational 7362 locked

boxes[47] in buildings, nor had it ensured that its nurses were collecting 7362s from persons in housing units under lockdown or modified programming. This failure was not caused by ignorance of the problem but, in the Court Expert's view, by a lack of urgency to address a known problem.

c) Delay of Entry and Care After 7362s Are Received

In addition to the problems class members face in submitting 7362s, it appears many class members are not seen in a timely fashion once their 7362 is received. Plaintiffs' counsel in *Plata* identified a trend at SATF in which healthcare staff were reviewing 7362s immediately but then waiting several days to enter the 7362 in the system and schedule the face-to-face encounter with the RN. Thus, because of the gap between when a 7362 was submitted and when it was entered, it appeared in tracking measures that RNs were seeing patients within the required deadline of one business day from receipt of the 7362, but patients were actually not being evaluated by an RN for several days after they submitted a 7362. In responses to Plaintiffs' counsel in August and November 2022, CCHCS acknowledged that this practice of delayed entry of 7362s had indeed occurred at SATF. CCHCS indicated that scheduling support staff were being retrained to "improve adherence to the scheduling and access to care policies" and stated that "RN audits" would be taking place monthly, presumably to catch whether this issue continued.

It is troubling that nursing staff were either intentionally or negligently delaying entry of 7362s, resulting in the appearance of compliance when in fact care was delayed. It is also troubling that it was Plaintiffs' counsel, and not healthcare leadership, who identified these patterns of problems with access to healthcare.

d) Lack of Communication Regarding Appointments

For patients at SATF who submit a 7362 and are seen by an RN, the RN will inform the patient of next steps, including whether they will be scheduled to see a PCP. But for those who make a request but do not report symptoms, such as people requesting to be assessed for DME, they may not have a face-to-face encounter with an RN who can communicate what will happen next.[48] In those cases, the incarcerated person is left wondering whether their 7362 was received and whether they will be seen by a PCP or specialist. There is currently no system at SATF—or as we understand it, any institution—requiring healthcare staff to inform patients that their request for DME assessment or the like has been received, what response they can expect, and when they can expect it.

[47] We understand that, following our most recent visit, locks were installed, and the boxes are now operational.

[48] *See* HCDOM 3.1.5(c)(2)(B)(3)(a)(5) ("The Primary Care RN shall separately address CDCR 7362s that do not include symptoms, such as requests for eyeglasses or medication renewals, routing them to appropriate staff.").

This lack of communication results in frustration for incarcerated people who hear nothing, sometimes for weeks, about their requests. As a result, incarcerated people often seek information from healthcare staff during medication distribution, which can cause frustration for those staff who are under time pressure to distribute medication and who may not have time to look up the requested information. We also observed that in the absence of information about their request, patients often file 1824s seeking to know if their 7362 was received and how it is being addressed, causing unnecessary work for the RAP. [49] For example, an incarcerated person who submits a 7362 requesting DME may hear nothing for a week or more, assume his 7362 was not received or logged, and file an 1824 requesting the DME. The RAP must investigate and respond to the 1824, only to find that the 7362 was logged and the incarcerated person was scheduled to be seen by the PCP, but the fact of that upcoming appointment was not communicated to the incarcerated person.

We understand that with the rollout of tablets to incarcerated people, there may be an opportunity to use those devices to communicate healthcare information—such as the fact that an appointment has been scheduled—to incarcerated patients. We understand that CCHCS is investigating this issue. In the absence of a system that would notify patients via tablet, we encourage CCHCS to develop a system of notifying patients that their request was received and how it will be handled via letter.

e) Effects of Failures of the 7362 Process

The importance of the problems with 7362s cannot be overstated. As we heard repeatedly from incarcerated people at SATF, they doubted their 7362s were being entered into the system and responded to, and it appears their doubts were well-founded. The failure to respond to medical requests in a timely manner has created a cascade of problems. Most significantly, it has meant that incarcerated people are often not receiving treatment or being assessed for DME or supplies when they request them. It also has created a feeling of anxiety among many class members that they will not have access to health care when they need it. It has led to incarcerated people submitting multiple 7362s for the same issue and then filing 1824s in hopes of getting an appointment. And the filing of 1824s has contributed to the burden placed on the RAP at SATF. Simply put, SATF has done a poor job of handling the 7362 process, and the results can be seen throughout the medical and custody systems at SATF.

As discussed in the recommendations section below, we recommend that SATF leadership immediately ensure compliance with the requirement to collect 7362s in a timely manner, and that SATF be required to report their compliance to CCHCS staff. We also recommend that

[49] The RAP is a panel that reviews and responds to 1824s submitted by incarcerated people with disabilities. The RAP is led by the ADAC and includes representatives from the appeal/grievance offices, health care staff, mental health staff, and education staff. *See* LOP 403(VI)(C)(7)(x)(1).

SATF leadership take immediate action to end the problem of delayed entry of 7362s and that they be required to report their audit of this problem to CCHCS staff.

iii. Failure to Issue and Repair DME

People with disabilities at SATF rely on healthcare providers to issue DME they need to accommodate their disabilities as well as to order the replacement or repair of DME. There is currently not a well-functioning system at SATF to ensure that people consistently and quickly receive the DME that they need. This is causing significant problems for people with disabilities at SATF, as well as causing an unnecessary burden on the RAP.

a) Denial of DME

People with disabilities who are not incarcerated can purchase DME for themselves without a prescription or approval from a doctor. For example, they are free to purchase white canes to aid them with vision impairment, wheelchairs to aid them with a mobility impairment, and hearing aids to aid them with a hearing impairment.

But for incarcerated people with disabilities in CDCR, in order to obtain DME like canes, wheelchairs, and hearing aids, they must be evaluated by a provider, and the provider must determine that the DME is "medically necessary to ensure the patients have equal access to prison services, programs, or activities."[50] This means that to obtain DME, incarcerated people at SATF and other institutions must make an appointment with a provider, and that provider must agree that the person needs the DME.[51]

In determining whether a patient requires DME, providers consult the Durable Medical Equipment and Medical Supply Formulary,[52] which provides guidance on when equipment is medically necessary.[53] In addition, providers may order DME that is not listed in the Formulary but that the provider determines is medically necessary to accommodate the patient.[54] The CME at each institution reviews requests for these "nonformulary" DME.[55]

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[50] HCDOM 3.6.1(a)(1).
[51] As discussed in greater detail below, healthcare staff also issue DME to incarcerated people with disabilities when, even if a provider has determined it is not "medically necessary," the RAP determines to provide the incarcerated person with the DME as a reasonable accommodation. In that case, the provider must notate the decision made by the RAP in the electronic health records, and non-licensed clinical staff then issue the DME.
[52] CCHCS Durable Medical Equipment and Medical Supply Formulary, December 2020, *available at* https://cchcs.ca.gov/wp-content/uploads/sites/60/CR/DME-Medical-Supply-Formulary.pdf
[53] HCDOM 3.6.1(e)(1)(A).
[54] HCDOM 3.6.1(e)(4)(D).
[55] *Id.*

Because incarcerated people requesting DME must be seen by a provider who approves or denies the request, the timely provision of DME depends on the 7362 process functioning well, which as discussed above, is not the case at SATF. It also depends on providers being adequately trained on the DME-ordering process and on their responsibility to accommodate the needs of people with different disabilities. We find that providers at SATF have not consistently and timely provided DME to incarcerated people at SATF, due to both delays in patients being evaluated and providers appearing to misunderstand their responsibilities when ordering DME.

Incarcerated people we interviewed frequently told us that it took multiple 7362 requests to get assessed for or to receive DME at SATF. Our review of records verified this was often the case. We reviewed incidents where incarcerated people put in 7362s requesting DME, but health care staff never evaluated them for their request. We also reviewed incidents where incarcerated people were evaluated and a provider said they would order the DME, but the incarcerated person did not receive the DME until they filed additional 7362s to follow up on the request.

We also frequently heard from incarcerated people at SATF that healthcare staff told them some requested DME were "not available" or "not carried" at SATF, and we reviewed documents that confirmed that. For example, one incarcerated person requested via 7362 a TENS unit to assist with managing pain. The provider wrote a letter to the incarcerated person stating that TENS units were "not an approved durable medical equipment in CDCR." That statement was not correct; we understand that there are hundreds of incarcerated people across CDCR who have TENS units. TENS units are not among the DME listed in the Formulary, but as discussed above, there is a process for ordering nonformulary DME. It was certainly within the discretion of the provider to determine that the TENS unit was not medically necessary, but here it appears the provider did not even meet with the incarcerated person to evaluate him or discuss the request.

As discussed in our recommendations section below, we recommend that all providers at SATF be retrained on the nonformulary ordering process and the need to utilize it when individuals require a nonformulary device or supply to accommodate their disability.

b) Leadership Failed to Intervene when Providers Incorrectly Denied DME

On several occasions, we observed that the RAP and healthcare grievance process at SATF failed to intervene to ensure people with disabilities were provided with the DME they needed to accommodate their disability.

To give a sense of how frustrating and seemingly irrational the process is for requesting DME, both from providers and from the RAP, we will discuss one example in detail. This class member, Person C, who is blind in one eye and has poor vision in the other due to glaucoma, began requesting a white tapping cane in February 2021, stating that he was bumping into things due to his low vision. After submitting a 7362 regarding the request, Person C was seen by his

PCP who denied his request for the tapping cane, stating that the class member first needed to be evaluated by an optometrist for new glasses before he could request a tapping cane. This initial denial was a violation of procedure, since the DME Formulary indicated the only requirement for a tapping cane to be medically necessary was that the class member have a DPV code, which he did. The provider also offered no explanation for why the accommodation was not medically necessary.

Following this denial, Person C was seen by an optometrist in March 2021 and shortly thereafter submitted another 7362 and an 1824 requesting a tapping cane due to his inability to safely maneuver in the prison without bumping into things. The RAP, which included the CME and the ADAC, reviewed the 1824 and denied the request for the tapping cane. Inexplicably, the RAP advised Person C "to complete a 7362 to medical," even though the very reason Person C had submitted an 1824 was because the provider had denied his 7362 request. The RAP did not provide Person C with an interim accommodation to assist him while he awaited another evaluation by the provider.

Approximately two weeks after the RAP denied his request, Person C was again evaluated by the PCP, who again denied his request, stating that the provider was "deferring decision on the tapping cane until [the class member] gets the new glasses." The provider noted that the class member "has not been running into anything here today at this visit." This response failed to consider that walking a few feet into an exam room is not the same as navigating the buildings or yard of a prison.

Following this second denial, Person C filed a healthcare grievance in May 2021 appealing the denial of the RAP. While the healthcare grievance was pending, Plaintiffs' counsel submitted an advocacy letter to SATF in June 2021 regarding the denial of the tapping cane. Despite Plaintiffs' advocacy letter explaining the problems with the providers' repeated failure to provide the cane, on July 4, 2021, the then-CEO of SATF denied the health care grievance and upheld the RAP's decision to deny Person C a tapping cane. The then-CEO wrote that "review of your medical records support the primary care provider documented no current indication for a tapping cane." The then-CEO's response failed to identify that the provider's denial was not in line with policy and that the RAP's denial of the request, directing Person C to file a 7362 when he had already done so, failed to correct the provider's mistake.

Thus, after six months of Person C's self-advocacy through 7362s, an 1824, a healthcare grievance, plus an advocacy letter from Plaintiffs' counsel, Person C, who is nearly entirely blind, still had not received a white tapping cane.[56] The CME, ADAC, and then-CEO of SATF all had an opportunity to correct the failure to accommodate this incarcerated person and none did so. It was only after a headquarters' level intervention that the incarcerated person finally received the cane.

[56] A review of online retailers indicates that white tapping canes typically cost between $10 and $20.

As discussed in greater detail below, this was not the only incident we observed where healthcare providers denied DME without adequate explanation and where the RAP failed to correct the denial and provide the DME as a requested accommodation. Healthcare staff who sit on the RAP must be reminded that their job is to independently assess if a disability accommodation request for DME is reasonable. ADA staff who sit on the RAP should also be retrained on their independent duty to provide DME where it is a reasonable accommodation, regardless of whether providers believe it is "medically necessary."

c) Repair of DME

An incarcerated person whose DME needs repair or replacement must "utilize approved CDCR procedures for notifying health care staff of health care needs," which means they must file a 7362.[57] Although policy is clear regarding how incarcerated people at SATF must request DME repair, the fact that policy requires filing a 7362 means that class members seeking repair of DME will likely encounter many of the problems described above regarding the 7362 process.

Moreover, there is no clear policy regarding who is responsible for repairing or replacing DME, the process for repair and replacement, and the timeframes in which DME must be repaired or replaced. The relevant HCDOM provision states that once health care staff verify the need to repair or replace DME and it is determined that staff or workers cannot immediately repair it, "staff" shall "arrange for the DME to be repaired while the patient retains possession" or "issue appropriate replacement DME" or "issue appropriate loaned DME while the patient's owned DME is being repaired" or "provide another adequate accommodation."[58] The HCDOM does not clarify which "staff" are responsible for accomplishing this replacement or repair process.

The HCDOM requires institutions to "establish local operating procedures (LOPs) to implement the statewide procedure."[59] But SATF's LOP is equally vague as to who is responsible for repairing and replacing DME, how they do so, and in what time frames. The LOP simply reiterates that "staff" are responsible for arranging for DME to be repaired or replaced.[60] It also states that "DME items and their associated supplies deemed in need of replacement shall be replaced on a 1 for 1 exchange basis," but there is no explanation of which staff are responsible for exchanging DME, how they accomplish that exchange, or when they must do so.[61]

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[57] HCDOM 3.6.1(e)(13)(B); *see also* LOP 467(VII)(N)(2) ("Whenever an appliance, is in need of repair or replacement, the patient shall utilize the CDCR 7362 Request for Health Care Services to alert health care of the need for DME repair/replacement.").
[58] HCDOM 3.6.1(13)(C).
[59] HCDOM 3.6.1(f).
[60] LOP 467(VII)(N)(3).
[61] There is a special local operating procedure regarding the repair and replacement of wheelchairs, which designates "Facility Provider Support" as being responsible for reviewing patient requests for repair or replacement of wheelchairs and routing wheelchairs in need of repair to the facility's Wheelchair Repository. It is not clear if "facility provider support" refers

Neither the HCDOM nor the local operating procedure explains who is responsible for repair or replacement of DME in urgent situations when a patient cannot wait days or weeks to be seen by a provider, such as when a person without the ability to walk has a wheelchair that no longer rolls.

Unsurprisingly, given the vague and incomplete local operating procedure, we heard from class members in surveys and interviews that it took a long time for DME to be repaired or replaced, and many class members did not have a clear understanding of how to get broken DME repaired or replaced. Staff at SATF also expressed conflicting ideas of how a class member should go about getting their DME repaired or replaced, with some believing incarcerated people had to request the repair or replacement through a 7362, others understanding they could walk into a yard clinic and get DME repaired or replaced on the spot, and yet others reporting that they had to file an 1824.

This lack of a clear process for the timely repair and replacement of DME at SATF puts strain on incarcerated people, custody staff, healthcare staff, and the RAP. Class members often request help with their broken DME from the only healthcare staff member they are likely to see each day, which is an LVN administering medication. But an LVN who is in the midst of distributing medication to dozens or even over a hundred people often is not able to stop the pill line to assist the class member with their DME request. Even if they did pause the pill line, it is not clear how the LVN would assist them, given that policy states the incarcerated person needs to file a 7362 to be seen by a provider about the broken DME. Additionally, class members frequently file 1824s requesting the repair or replacement of DME, which creates unnecessary additional workload for the ADAC and other members of the RAP. We observed this cycle play out when we toured at SATF; we saw class members asking LVNs in pill line for assistance with broken DME, and we saw the RAP reviewing 1824s requesting the repair or replacement of DME.

iv. Failure to Issue Incontinence Supplies

We learned from our surveys and interviews, as well as from reports from Plaintiffs' counsel, that the provision of incontinence supplies has been an ongoing problem at SATF. Some of the issues seem to be due to inexplicable failures in the provisioning of supplies, and others arose from unnecessary restrictions placed on the supplies.

a) Pull-Ups

The problems with the provision of incontinence supplies are illustrated by class members' inability to obtain pull-up diapers. As early as 2019, class members with both mobility disabilities and incontinence at SATF reported to plaintiffs' counsel that they had requested pull-up diapers, as opposed to diapers with adhesive tabs, to accommodate their disabilities. It

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to medical assistants or some other staff position. There is no specifically assigned staff responsible for repair of other types of DME.

appears some class members reported that the adhesive on the tabbed diapers was ineffective, and some reported that they had difficulty fastening the tabs due to their upper extremity mobility impairments. These class members reported that healthcare staff told them the institution simply did not carry pull-up diapers, with no further explanation or recourse.

We find that healthcare staff did deny pull-ups to class members, not because the class members did not require pull-ups as an accommodation, but because healthcare workers mistakenly believed they were not available at SATF. In September 2019, a class member requested pull-ups, and an RN documented that he explained to the class member, "whatever we have in stock is what we give him." In December 2019, a class member filed a 602HC requesting pull-ups. In responding to the grievance, an RN documented that she informed the class member that "our warehouse does not have pull ups, they carry diapers." Similarly, in May 2021, an elderly incarcerated person at SATF filed an 1824 requesting pull-up diapers for his incontinence, rather than the diapers with adhesive tabs that he was receiving. He explained in his request that, due to arthritis in his hands, he was unable to grip the tabs of the diapers. The RAP denied the incarcerated person's request for this accommodation, stating that the PCP had evaluated him and "noted no acute issues" and "educated [him] on the intuitions [sic] availability." Supporting documentation clarified that the provider explained "that the institutions [sic] availability is a non-pull-up diaper."

In fact, SATF did carry pull-ups. We visited the medical supply warehouse at SATF and spoke with staff there. They showed us that pull-up diapers were a standard item available for order in their medical supply catalog and kept in stock at the warehouse. According to staff in the warehouse, pull-ups had always been available at SATF. They explained that the confusion seemed to stem from one or more medical assistants ordering the wrong item (fastening diapers instead of pull-up diapers) but believing they had ordered pull-ups, receiving fastening diapers instead of pull-ups, and incorrectly assuming this meant the warehouse did not carry pull-ups. The medical assistant or assistants failed to call the warehouse to clarify the situation, and instead communicated to other healthcare staff that the item was not available at SATF.

Even if pull-up diapers had not been available as a standard formulary item kept in stock and available from the medical supply catalog at SATF, that would not have justified SATF healthcare providers denying class members pull-up diapers if they needed pull-ups to accommodate both their incontinence and upper extremity mobility disabilities. As discussed above, there is a process at SATF and at all institutions by which medical providers or their staff can order nonformulary items that an individual needs as a disability accommodation. All healthcare providers are trained in how to order nonformulary items. If an elderly class member with arthritis in his hands could not fasten the tabs of a diaper and required a pull-up diaper, the provider's responsibility was to accommodate that class member by ordering him pull-up diapers, whether through the formulary or nonformulary process. Denying a class member a needed accommodation because that item is not kept at the medical supply warehouse is never acceptable.

Troublingly, it appears SATF healthcare leadership did not make appropriate efforts to resolve this issue when they became aware of it. Plaintiffs first raised the issue of class members being denied pull-ups in a monitoring tour report following an October 2019 tour. In that report, Plaintiffs' counsel informed SATF leadership that class members had been told by SATF healthcare staff that "the institution does not carry pull-up style diapers." Plaintiffs listed several class members who had been denied pull-ups. In its response in June 2020, SATF did not deny that healthcare staff had been informing class members that pull-ups were not available, and in the case of one class member, SATF acknowledged that "the PCP ordered incontinence briefs according to supplies available in the standardized medical supply catalog." SATF healthcare leadership apparently made no effort at that time to educate healthcare staff on the availability of pull-ups at SATF or their responsibility to order appropriate accommodations regardless of whether the supplies were carried at the warehouse or not.

Plaintiffs again raised the issue of class members being denied pull-ups in a May 2021 advocacy letter. Around the same time, on May 19, 2021, a class member requested pull-ups in an 1824, stating that he had increasingly severe arthritis in his hands and could not attach the adhesive tabs on his diapers. The RAP, which included a member of healthcare leadership at SATF, denied the request and stated the class member was "educated on the institutions [sic] availability" of pull-ups. Custody staff at the RAP meeting confirmed that healthcare leadership stated pull-ups were not available. It thus appears that even SATF healthcare leadership did not understand the nonformulary ordering process or the institution's responsibility to provide individualized accommodations for people with disabilities.

After Plaintiffs' counsel raised the issue with CCHCS leadership in June 2021, the then-CEO finally investigated and intervened to clarify with staff that pull-ups were indeed available to class members who needed them. It is difficult to understand why SATF healthcare leadership resolved this issue only after Plaintiffs' counsel raised it and had engaged in advocacy about the issue for over a year. It is also troublesome that this issue could have been resolved instantly had healthcare staff taken the initiative to call the medical warehouse to clarify why they were not receiving an item they believed they were ordering.

Healthcare providers and staff at SATF who order supplies should be retrained to understand they are responsible for communicating with the medical supply warehouse if there are problems with their orders. Healthcare staff, including PCPs and RNs, and all members of the RAP should also be reminded of the responsibility to provide individualized disability accommodations, even if doing so requires ordering nonformulary items, and this incident should be used as a teaching moment when re-training healthcare staff.

b) Other Incontinence Supplies

Healthcare staff at SATF are responsible for both prescribing incontinence supplies and distributing those supplies to patients. We find that there have been significant problems with the prescription and delivery of incontinence supplies at SATF. Healthcare staff often did not

seem to take claims of incontinence as seriously as they should have, exhibited reluctance to provide additional supplies to those who requested them, or lacked a sense of urgency in responding to requests for incontinence supplies.

We spoke with one class member, Person D, who told us that he had asked for incontinence supplies and simply never received them. A review of records verified his claim. He reported incontinence in an August 2021 Form 7362 and was seen by an RN two days later. In notes of the encounter, the RN noted Person D had no previous urological symptoms in his chart but was "on multiple medications that can put him to deep sleep." Nonetheless, the RN did not refer Person D to be evaluated by the PCP for incontinence but instead advised the patient to "monitor condition and find out what factor is contributing to incontinence." This was inappropriate; the RN should have referred Person D to be evaluated by the PCP and should have immediately issued incontinence supplies as an interim accommodation. The RN's response demonstrated a lack of empathy and a lack of understanding that for those experiencing incontinence, it is urgent to receive supplies to accommodate that condition.

Person D again requested briefs for wetting accidents about a month later, but the RN denied his request and instructed Person D to talk to his PCP. However, it does not appear that the patient was referred to the PCP. Person D again requested diapers in April 2022, but it does not appear from medical records that this issue was discussed with the RN or a PCP. An incontinence diagnosis by a PCP is the first step for incarcerated people to receive regular incontinence supplies, and therefore the system relies on healthcare staff to take seriously claims of incontinence and evaluate those patients to determine if supplies are an appropriate accommodation.

Another class member we interviewed claimed that, despite multiple requests, he was not receiving necessary incontinence supplies like disposable gloves and bags to dispose of diapers. This claim was also verified by documents in the patient's record. The class member filed a 7362 in January 2022 requesting bags and gloves. Notes from an encounter with nursing indicated that he would be referred to the PCP to discuss the request, but it appears healthcare staff failed to schedule that appointment. About a month later, the patient requested bags to dispose of incontinence supplies from another healthcare staff member. That staff person emailed their supervisor regarding the request for bags, but the supervisor instructed the nurse to direct the incarcerated person to file a 7362 to request the supplies, even though the patient had already filed a 7362 a month prior. There is no indication in the medical file that the patient ever received bags or gloves.

We also reviewed records in which incarcerated people with incontinence claimed they did not have sufficient supplies and were running out, but PCPs denied requests for additional supplies without documenting the reason for the denial. While incarcerated people should not receive more supplies than necessary to accommodate their disability, in the absence of evidence that an incarcerated patient is hoarding supplies, we do not see a basis to disbelieve an incarcerated person who claimed to have run out of supplies.

CCHCS recently issued a memorandum changing the process for distribution of incontinence supplies, such that PCPs prescribe incontinence supplies and healthcare staff distribute the prescribed supplies, but custody staff in the housing units also have incontinence supplies to provide on an as-needed basis. Thus, if an incarcerated person runs out of their allotted supplies, they can receive additional supplies from custody staff. Or if a person who has not been prescribed supplies experiences incontinence, he can get incontinence supplies from custody staff as an immediate accommodation while he is waiting to be evaluated by a provider.

While we are hopeful the availability of supplies on demand in the housing units will ensure speedy access to supplies for those who need them, healthcare staff are still required to diagnose incontinence and prescribe incontinence supplies in the first instance. Consistent with new CCHCS guidance, incarcerated people claiming to be incontinent should receive supplies as an interim accommodation until they can be evaluated by a PCP. We note that it should not have taken a directive from headquarters for SATF to take steps necessary to treat these class members with greater dignity.

v. Denial of Accommodations and Effective Communication for Deaf and Hard of Hearing Population

Deaf class members who use sign language and responded to our surveys or spoke with us in interviews had nearly uniformly positive things to say about the quality and availability of SATF staff sign language interpreters. Those using sign language at SATF also reported having access to video relay phones.

However, hard of hearing people who use hearing aids at SATF consistently reported, in surveys and in interviews, that the hearing aids they received were of poor quality and did not work well. This is a system-wide issue that representatives from CDCR, CCHCS, and Plaintiffs' counsel have been discussing in a workgroup focused on issues affecting deaf and hard of hearing incarcerated people. We understand that CCHCS is currently in the process of hiring an expert to assess the sufficiency of its hearing aid offerings.

Another issue that we learned about from several deaf and hard of hearing incarcerated people at SATF was that announcements frequently were not communicated to them. Typically, an intercom system is used for announcements in a housing unit, for example to inform incarcerated people that it is time for medication distribution. Deaf people and many hard of hearing people cannot hear an audio announcement played over the intercom. CDCR policy therefore requires custody staff to individually deliver the announcement to deaf or hard of hearing incarcerated people through other means, such as by writing on a whiteboard. But we learned from several deaf individuals that this often did not happen, and they had to rely on their cellmates to inform them via sign language or written notes of what was said on intercom announcements.

One particularly troubling and still unresolved issue at SATF is ensuring effective communication for deaf people who cannot understand sign language. While many deaf people

rely on sign language as their primary method of communication, there are others who do not understand sign language, often because they became deaf later in life and thus did not learn sign language growing up. Many deaf people who cannot hear or sign require written communication to be able to access education and programs, to communicate with their family and friends, and to otherwise participate in daily living. Unfortunately, SATF does not ensure access to written communication for these individuals.

The experience of one such individual demonstrates the severity of this problem, and also the failure of SATF staff to adequately accommodate this disability. During our interviews with incarcerated people, we spoke with Person E, who was deaf and could not sign; he lost his hearing as an adult, shortly before coming to SATF. Person E explained that over many years, he had tried to request help accessing programs at SATF and to communicate with family outside the prison, but SATF did not help him, and eventually he gave up. He described a lonely and frustrating existence at SATF due to an inability to communicate with most fellow incarcerated people, an unwillingness by custody staff to communicate with him, confusion on the part of healthcare staff regarding how to communicate with him, a lack of meaningful access to programs or education or employment, and an inability to communicate with his family outside of the prison.

Person E arrived at SATF in approximately 2011 and by that point already had significant hearing loss. In the first few years at SATF, he retained some hearing such that he could hear some words with the assistance of both hearing aids and a pocket talker. In 2015, his pocket talker stopped working, and in a RAP response to an 1824, the RAP refused to replace it, even though his hearing continued to get worse.

Person E described that many fellow incarcerated people were illiterate, so they could not read the notes he wrote. He told us that there was one sign language book in the library, which he checked out and began to study. But when he tried to practice his sign language with other signers in the building, they informed him that much of the sign language in the book was incorrect and unintelligible.

Person E said that while some staff were "good about writing" to him when he approached them, he "gets no communication" when it comes to announcements, and he wished he could get "all the same information other people get." For example, he has been told that custody officers are supposed to flash lights and give him information on a whiteboard regarding announcements,[62] but they do not do that, and he has to rely on his "bunkie" to get information. He told us that custody staff do not write down announcements for him, and instead they either do nothing to deliver him announcements, or they sometimes send another incarcerated person to sign the

[62] Indeed, the RAP response to his 2015 Form 1824 requesting replacement hearing aids and a replacement pocket talker stated that "[s]taff are ensuring effective communication regarding public address announcements and reporting instructions by utilizing personal notification, white boards, flashing the lights and with the use of ADA workers."

announcement to him by spelling the letters of the words, since he can understand the sign language alphabet.

Person E's claim that staff failed to accommodate his disability was corroborated by a follow-up interview we had with him. For our second interview, which happened via Microsoft Teams, he informed us that custody staff made an announcement over the intercom for him to report for the interview, so he only learned of the announcement when another incarcerated person alerted him. Once he arrived at the interview, custody staff put him in front of the computer but did not offer any solution, such as turning on automated captioning on Microsoft Teams, for him to be able to communicate with us. Our team was forced to conduct the interview by writing our questions with a marker on sheets of paper and holding the paper up to the computer's camera.

Regarding healthcare staff, Person E described an incredibly frustrating situation. Initially, healthcare staff did not believe that he was deaf because he spoke English normally and without issue. He said that pill call nurses would refuse to write him notes, because they believed he could hear them, since they heard him speaking. To address this issue, in 2019 he filed an 1824 requesting that staff place a sticker on his ID card that said "deaf." He explained in the 1824 that "sometimes when I go to the window [and] show staff my ID, they do not know that I am deaf and need written notes." The RAP denied the request for a sticker, explaining that "there is no policy currently in place requiring placement of a deaf sticker on the identification card of hearing impaired inmates." Despite the denial, staff from Prison Law Office advocated on behalf of the incarcerated person, and staff from the ADAC's office eventually agreed to place a "deaf" sticker on his ID card.

Once he had the deaf sticker, staff began to communicate with Person E through written notes, but then he faced a new hurdle: because his primary method of communication was listed in SOMS as written communication, healthcare staff insisted on making *him* write notes to them, despite his ability to speak without issue. This caused his healthcare encounters to be painfully slow, conducted entirely via back-and-forth note writing, when he could have spoken and voiced his concerns quickly. He tried to explain to healthcare staff that he was able to speak and only needed them to write notes to him, but to date they have insisted that he write notes to them as well.

The lack of accommodation of his disability has also led to Person E being unable to fully participate in education and programming. In late 2018 and early 2019, he took a computer class but struggled to fully participate due to his inability to hear or sign. He recalled that he or Plaintiffs' counsel had requested Computer Assisted Real Time Transcription (CART),[63] but that

[63] CART is the instant translation of spoken language into text, transcribed by a human reporter. The text is then displayed on a computer monitor or projected on a screen for the deaf or hard of hearing person to read. *See* National Disability Resource Collective Navigator, *Computer Aided Real-Time Transcription (CART)* (2022), *available at* https://nationaldisabilitynavigator.org/ndnrc-materials/disability-guide/computer-aided-real-time-transcription-cart/

the ADAC at the time denied the request because the teacher of the computer class was "sending notes" to him. Documents confirmed that Plaintiffs' counsel advocated on the man's behalf for him to receive CART. The then-ADAC responded that the teacher of the computer class had attempted to accommodate Person E by providing written handouts to him in lieu of a lecture. Therefore, the ADAC believed Person E was "receiving equal access to the program." The letter also stated that CART was not currently available at the institution. Plaintiffs' counsel responded by explaining that Person E had missed much of the information taught in the computer class due to his inability to hear the lectures, and regardless, there were other programs that the incarcerated person would not be able to participate in without CART. In response, OLA stated that the then-ADAC at SATF had inquired about obtaining CART, as he believed "real time captioning is useful and would be effective for inmates with a hearing disability who do not know sign language." The OLA response stated that a workgroup had been formed to evaluate CART.

Understanding that he could not get CART at SATF, Person E told us that he gave up attempting to participate in self-help groups or other classes. He had previously attempted to attend religious services and a group class for veterans, but he could not understand anything, and he stopped attending. He did not see a point in filing an 1824 to try to gain access to these programs, since his previous requests and the requests of Plaintiffs' counsel had been rejected.

Person E also lost touch with family members outside of the institution due to a lack of disability accommodations. He explained to us that over the years, he had tried to keep in touch with two relatives outside the prison who had phone numbers but either did not have an email address or did not consistently respond to email. The incarcerated person was unable to use the regular telephone due to his hearing impairment. The incarcerated person had heard that TTY phones were broken and eventually eliminated at SATF.[64] He therefore attempted to communicate with his relatives by asking other incarcerated people who used sign language to set up a video relay call with his family members. This required another incarcerated person to sign to him, using the letters of the alphabet, what Person E's family members were saying. The process of speaking to family through another incarcerated person and an interpreter was incredibly tedious, and Person E could not always find a fellow incarcerated person who signed and who was available or willing to help. He also sometimes felt uncomfortable discussing private family matters through fellow incarcerated people.

[64] TTY, also known as TDD, are devices that allow people with hearing loss to place phone calls using the assistance of a relay operator. The person with hearing loss connects to their caller using a relay operator, who types what the caller is saying so the person with hearing loss can read the conversation. The "Inmate Orientation Handbook" for SATF does state that TDD phones "are available on each facility for hearing impaired inmates." It is not clear whether TDD was operational in the buildings where Person E lived, but if it was, he was not aware of how to request a TDD call. In fact, custody staff in the building that housed Person E also did not know if TDD calls were available in his building. In addition, the Court previously found that another incarcerated person at SATF had been denied access for several months to a TDD phone. Dkt. No. 3217 at 10.

Person E had heard that tablets were coming to SATF, and he was excited that they might provide speech-to-text technology. He also hoped that the tablets would provide captioning of video calls, so he could speak directly with his family members. Tablets did arrive at SATF but provided neither speech-to-text nor captioning of video calls. Thus, while everyone around him could use tablets for family video calls, he could not.

Finally, Person E reported that despite many requests, he did not receive a job for many years at SATF. He stated that he asked his counselors every year to put him on a waitlist for a job, and he was told he was on a waitlist, but he did not receive a job. Records corroborated this claim. It appeared that he was not placed on any waitlists for jobs for the first approximately four years he spent at SATF, for reasons that are unknown. In 2015, he received a job as a porter, which he enjoyed doing and performed for about two years. However, in 2017 he was moved to a new yard and lost his job. Person E filed an 1824 asking to be moved back to his previous yard so he could get his job back, but the 1824 was denied. It appears he was placed on a waitlist to be an ADA worker in 2018, but he did not receive that or any other job until 2022. At that time, a new captain took over the yard and noticed that Person E seemed withdrawn and depressed. Believing a job would help him, the captain pushed for him to receive the next opening available as an ADA worker. The captain obtained a small whiteboard and gave it to Person E so he could communicate with others to perform the ADA worker job. Person E reported that the job had helped him a great deal, and having access to the whiteboard had also helped him communicate with other incarcerated people in his building.

To recap Person E's experience over the last decade at SATF: he has not consistently received announcements; he has been largely unable to communicate with other incarcerated people due to a lack of opportunity to learn sign language; he has largely been unable to communicate with his family due to a lack of technology or education about the technology available at SATF; he struggled to communicate with healthcare staff due to staff initially disbelieving his disability and later misunderstanding his communication needs; he could not meaningfully access programs due to a lack of CART or similar system; and he did not have a job for approximately eight of eleven years he has spent at SATF.

The institution should take immediate steps to address the needs of people who are deaf or hard of hearing and cannot sign. First, the institution should provide CART or another reasonable accommodation that would allow deaf people who cannot sign to meaningfully participate in hearings, education, and programs, including religious services, substance abuse treatment programs, and self-help groups.

To be fair to SATF leadership, it is not within the control of the institution to enter into a contract for CART services. It is the responsibility of CDCR to propose a system-wide solution to providing CART or another reasonable accommodation for class members who are deaf but cannot sign, and so far, CDCR has failed to do so. However, it does appear within the control of the institution to immediately provide, whenever possible, automated captioning via Microsoft

Teams in settings when staff are utilizing a computer and interacting with deaf people who cannot sign.

Thus, the Court Expert recommends two simultaneous actions: First, SATF should immediately provide automated captioning via Microsoft Teams whenever possible. Second, CDCR must propose a solution, whether CART or an alternative, to accommodate people who are deaf but cannot sign so they can participate in the full spectrum of prison life, like their hearing peers. This must include accommodations in due process events such as hearings, but also in education and other programming, including religious services, substance abuse treatment classes, and self-help groups.

It is not in the control of the institution to determine what technology is available to incarcerated people via tablets. We understand that Plaintiffs have advocated, both before the rollout of tablets and after, for the tablets to be equipped with captioning or relay services that would ensure tablet calling was accessible to people who are deaf or hard of hearing and cannot sign, but the tablets do not currently include that technology.

However, it is in the immediate control of the institution to ensure that deaf and hard of hearing people who cannot sign are able to communicate via telephone. SATF must ensure that deaf people who cannot sign have access to TTY/TDD phone calls and are educated on how to request those calls and use the service.

Finally, we believe that custody staff at SATF are not complying with the requirement to ensure deaf and hard of hearing people receive announcements. It is not clear if this is because staff do not understand their obligation in this regard or are simply not doing what is required. SATF leadership cannot continue to respond to complaints by deaf and hard of hearing people about not receiving announcements by stating that staff will ensure they receive announcements. SATF leadership should audit staff compliance with the requirement to make individualized announcements to people who cannot hear the intercom. Custody staff who do not comply with this requirement should receive training followed by progressive discipline.

vi. Denial of Other Assistive Devices

SATF's local operating procedure also includes unclear processes and responsibilities for ensuring incarcerated people at the prison receive non-medical assistive devices necessary to accommodate their disabilities.[65] The local operating procedure does not clearly delineate between devices that are medically prescribed and ordered by healthcare staff and those that incarcerated people should be able to obtain without the involvement of healthcare staff.[66] The local operating procedure also requires incarcerated people to purchase their own non-medical assistive devices,

[65] *See* LOP 403(VI)(C)(4).
[66] LOP 403(VI)(C)(4)(a)(1)-(2).

with the approval of the ADAC, and does not explain how an incarcerated person who is indigent can obtain necessary non-medical assistive devices.[67]

The confusing guidance has led to the denial of accommodations for some incarcerated people at SATF. We provide as an example the lengthy advocacy of one individual who has been trying to obtain an assistive device to help him write in his cell for nearly three years.

Person F has a documented history of an upper extremity mobility disability that affects his hands and makes it difficult for him to hold a pen or write legibly. In January 2020, he filed an 1824 requesting the assistance of ADA workers to help him write or type. He noted that some forms he submitted, including a staff complaint, were rejected due to his handwriting being illegible, and he therefore needed writing assistance. In February 2020, the RAP denied his request, stating that he could ask staff for help writing. The RAP's response thus assumed that Person F would ask staff for help every time he needed to write or fill out a form, including to fill out a 602 complaint for staff misconduct. It is hard to imagine any incarcerated person feeling comfortable asking staff for help in filling out a staff misconduct complaint.

Person F appealed the RAP's response in a 602, and in response in April 2020, the then-Warden of SATF granted his appeal in part, stating that he could receive the assistance of ADA workers to write, but that "class members have priority use as you do not have a verified disability."

Person F appealed, noting that he had a well-documented medical condition that affected his ability to write, and thus he was disabled.[68] The Office of Appeals denied his appeal in May 2020 with little explanation, stating that the RAP had provided "an appropriate and substantive response" to his request for an accommodation, even though the Warden had actually overturned the RAP's determination.

Person F filed another 1824 in September 2020 requesting a typewriter, or in the alternative, an Ergo Writer, which is a device that assists people with holding a pen. He noted in his 1824 that staff had denied him help in writing or in obtaining the help of ADA workers to write because they believed he was "not ADA." He reiterated his request to receive help transcribing from ADA workers. In reviewing his request, the RAP acknowledged that Person F had a condition that could "impact your ability to grasp or write" yet denied his request for accommodation with little explanation. The RAP stated Person F could "go to the library to get paperwork scribed" or could "receive assistance from an ADA worker," despite Person F having stated in the 1824 that he continued to be denied the help of ADA workers due to his disability not being recognized.

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[67] LOP 403(VI)(C)(4)(a)(4)-(5).

[68] *See* 28 C.F.R. § 35.108(a)(1)(i) (defining disability as "[a] physical or mental impairment that substantially limits one or more of the major life activities of such individual."); 28 C.F.R. § 35.108(c)(1) (defining major life activities to include writing).

In October 2020, Plaintiffs' counsel sent an advocacy letter regarding the RAP's continued denial of accommodation to Person F. At that time, a new Assistant Warden became the ADAC at SATF. In November 2020, the new ADAC added a chrono to Person F's file noting that he did have a disability that affected his ability to grasp and write, and he was permitted to receive the assistance of ADA workers. The chrono also indicated he should be allowed to purchase a typewriter and Ergo Writer.

Shortly after he received the chrono acknowledging his disability and approving his purchase of a typewriter or Ergo Writer, Person F filed an 1824 in December 2020 requesting a catalog and a special-order form so that he could try to order the items. The RAP provided a special-order form and catalog and recommended two typewriters that could be purchased "through an approved vendor."

In January 2021, Plaintiffs' counsel sent a second advocacy letter noting that while it was a positive step that SATF was recognizing Person F's disability and documenting his access to ADA workers, the response still required Person F to purchase the items he needed to accommodate his disability. The letter stated that Person F was indigent, and CDCR should therefore provide the necessary accommodation. At the same time that Plaintiff's counsel sent the advocacy letter, Person F submitted a "Special Purchase Order Form" requesting three different assistive devices designed to make it easier to hold a pen or pencil. Person F noted on the form that he was indigent. The ADAC rejected the form, stating that Person F could select one of the three assistive devices, and that he had to purchase the device himself.

As a result, in April 2021, Plaintiffs' counsel sent its third advocacy letter. The letter explained several reasons Person F required an assistive device, such as for writing documents related to his ongoing court case that discussed the nature of his conviction, and for writing letters to family and friends that were private in nature. The letter again requested that CDCR provide the typewriter and Ergo Writer, and noted that Plaintiffs' counsel, institution staff, and OLA had "spent and billed many hours discussing whether to provide an indigent, disabled man with a reasonable accommodation that costs less than $15."

In May 2021, OLA responded to Plaintiffs' counsel's advocacy letters. The response stated that Person F could use the typewriter in the library and that because he had successfully submitted many 7362s, 602s, and 1824s, in OLA's view he "does not seem to have issues impeding him from completing documents and correspondence." This response did not recognize that Person F frequently had had to rely on other incarcerated people to help him fill out those forms, and it did not explain why Person F was not entitled to an accommodation to assist him in writing while in his cell, like any other incarcerated person. The response again noted that Person F could purchase an Ergo Writer and typewriter but did not address Plaintiffs' counsel's position regarding CDCR's obligation to purchase assistive devices for indigent incarcerated people with disabilities.

In July 2021, Person F submitted a 7362 requesting the Ergo Writer. It does not appear he received a response or was seen by the provider as a result of the 7362. Later that month, he submitted another 1824 stating he had submitted a special-order form for an assistive device and needed it approved. He said the purchase catalog SATF provided did not have an Ergo Writer, but he did order a typewriter. The RAP denied the request because the typewriter he had ordered had screws. The RAP response did not explain how Person F could get the Ergo Writer or a typewriter without screws.

In November, Person F then filed another 1824 requesting an Ergo Writer. As a result of this 1824, he was evaluated by a provider who confirmed the medical diagnosis causing difficulty writing. The RAP then approved the request for the Ergo Writer, and the provider noted in the medical records that a nonformulary order for one would be placed.

Despite the records noting healthcare staff would order the Ergo Writer, Person F did not receive one; he again requested an Ergo Writer via 7362s in January and February of 2022. He also filed a 602HC regarding not having received the Ergo Writer. In response, in April 2022, the then-CEO of SATF wrote that access to Ergo Writers were "not healthcare services issues" and that he should consult the appropriate custody channels, even though it was a provider who had supposedly submitted an order for the Ergo Writer.

In April 2022, the incarcerated person spoke with the RN about the missing Ergo Writer. The RN stated they would follow up with a medical assistant. However, our understanding is that to this day, the incarcerated person has not received the Ergo Writer. Thus, after nearly three years of advocating for himself, several advocacy letters from Plaintiffs' counsel, a response from OLA, a rejection from the Office of Appeals, numerous 7362s, several 1824s and RAP responses, several 602s, and an order from a provider, Person F still had not received the assistive device to help him hold a pen.

As this example illustrates, the lack of clear policies at SATF for when staff must provide an assistive device, who must provide it, and how, is causing significant confusion and the delay of necessary accommodations. We recommend that SATF amend the LOP to create a clear process for incarcerated people to receive non-medical assistive devices to accommodate their disabilities.

We also observed during our tours of SATF that low vision assistive devices, such as Merlins and Optelecs, were broken in multiple libraries at SATF. It was not clear that the devices had been reported as broken or when they would be repaired. One librarian noted that class members who requested to use the broken devices could be taken to a program office to use an alternative, working device, a solution that does not provide them with equal access to the library. We also heard from staff that there was not high demand for using the devices, but we note it is possible class members would not keep asking to use devices that are broken. SATF must ensure broken assistive devices are promptly repaired and ADA staff should regularly audit whether low vision assistive devices in the libraries are operable.

B. Safety of Class Members

i. Murders of Class Members and Institutional Response

Between September 2019 and May 2021, five *Armstrong* class members were murdered by other incarcerated people at SATF during four separate incidents. Following the murder of two class members who were convicted of sex offenses, healthcare staff at SATF made social media comments celebrating the murder. On an Instagram post, SATF employees commented that the murder was "epic," and another employee referred to the alleged killer as a "hero."

The Court ordered the Court Expert to investigate "[w]hat investigation has been done to determine if the deaths of class members at SATF were in any way connected to a lack of concern by SATF staff members for *Armstrong* class members" as well as "[w]hat, if any, disciplinary action has been taken against any staff member in relation to the deaths of class members beyond placing on leave nurses who posted offensive comments."

We reviewed the investigation files regarding these murders and did not find evidence that the deaths were caused by a lack of staff concern specifically for *Armstrong* class members. One murder was investigated by the Investigative Services Unit, it was determined to be gang-related, and no allegations of staff misconduct surfaced. Three of the murders resulted in a referral to the Office of Internal Affairs (OIA) to investigate allegations of staff misconduct, including whether staff disregarded the safety of incarcerated people. These investigations did not uncover evidence of staff exhibiting a lack of concern specifically for class members. In one case, a correctional officer was ultimately terminated for falling asleep on shift, leaving incarcerated people to yell "man down" and scream for help for over an hour after an incarcerated class member was murdered by his cellmate. While it certainly exhibits a lack of concern for the safety of incarcerated people to fall asleep on the job, there is no evidence that animus towards incarcerated people with disabilities contributed to his conduct. Similarly, there is evidence that custody staff may have disregarded the safety of incarcerated people when they designated for dorm housing an incarcerated person who warned that he would harm fellow incarcerated people if he did not live in a single cell. But that disregard for safety was not specifically directed at class members; it threatened to harm all incarcerated people in that dorm.

As for healthcare staff making disrespectful comments on social media about the murder of class members, after Plaintiffs' counsel informed SATF of the comments, the Warden referred the matter to OIA for investigation. Beginning in late May 2021, OIA conducted an investigation and interviewed the three healthcare employees and one custody employee who made inappropriate comments. The investigation resulted in formal discipline and a pay reduction for an SRN, RN, and an LVN at SATF. The correctional officer received training on CDCR's social media policy, as well as a Letter of Instruction from the Warden admonishing him for his comment, which implied solidarity with the negative comments made by SATF healthcare staff.

ii. Disability Causing Safety Concerns

An issue that we heard about repeatedly from class members and observed being discussed in the RAP concerns the appropriate housing of class members with severe incontinence or other disabilities that create safety issues for class members. For example, those with severe incontinence may have difficulty safely residing in shared living situations, such as double cells or dormitories, because their incontinence disturbs incarcerated people with whom they share a living space.

Custody staff, rather than healthcare staff, determine where an incarcerated person will be housed based on a number of factors, including sentence length, history of being the victim of or perpetrator of assault, and "[v]ulnerability . . . due to medical, mental health, and disabilities."[69] In a memorandum issued in 2016, CDCR clarified that "[e]xamples of inmates who should be considered for single-cell status" on the basis of vulnerability due to their disability included "[a]n inmate who is incontinent, and has 'uncontrolled mishaps' that require him to clean himself at all hours of the day and night."[70] The memo noted that those "who are incontinent, or use diapers or colostomy supplies . . . may have an increase in their vulnerability to attack, threats, or extortion by a cell partner."[71] The memorandum instructed custodial staff that "[i]f there is a question whether a medical, mental health [sic] condition is present and consultation with medical or mental health staff is required, custodial staff shall submit a request for review and recommendations related to single-cell consideration."[72] Custody staff should then consider the recommendation of medical staff "given the vulnerability that maybe created [sic] by their medical or mental health condition(s)."[73]

A 2021 memorandum again emphasized that custody staff should consider "other available information that would indicate or present an immediate risk or safety concern for the inmate" including "Medical issues or Physical Capabilities and/or Limitations (Review for status in the Disability Placement Program (DPP)."[74] As an example of a situation in which custody staff should consider a person's disability when determining appropriate housing, the memorandum offered this example:

> Inmate A returns from the hospital after a medical procedure and now has a colostomy bag. Staff should take this change in case factor into consideration and evaluate if inmate A's new medical condition causes them to be in a vulnerable position with their cellmate. If the cellmate is not sympathetic to the new

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[69] DOM 54046.4.
[70] *Inmate Housing Assignment Considerations During the Screening and Housing Process*, January 19, 2016.
[71] *Id.*
[72] *Id.*
[73] *Id.*
[74] *Expectations for Screening Inmates for Cellmate Compatibility*, June 15, 2021.

> limitations, a move may be necessary and/or assigning inmate A single cell status via committee action.[75]

Despite the guidance offered in the memos, we believe additional guidance is required to clarify who between custody and healthcare staff is responsible for raising concerns about a person's safety due to their disability, to whom they direct those concerns, who is responsible for obtaining the opinion of medical when necessary, what level of present or potential future safety risk is required to warrant a move to single-cell status, and who is responsible for ensuring a review of a person's housing takes place when the incarcerated person or staff raise concerns about their disability posing a safety concern.

For example, we observed the RAP discussing an 1824 from an incarcerated person with incontinence who claimed that his incontinence was causing "problems" with other incarcerated people in his shared housing, and that he wanted to be "moved to a safe environment." The discussion at the RAP showed that some staff believed a person must have a specific enemy concern to justify single-cell status. This appears to be unsupported by CDCR's memoranda discussed above.

We have also observed a lack of clarity among healthcare and custody staff as to what to do when an incarcerated person requests single-cell housing based on their disability. We have reviewed cases in which a person suffering severe incontinence asks their PCP to help them get single-cell status, only for the healthcare provider to tell the incarcerated patient to ask custody for help. The incarcerated person then asks custody staff for help, only to be told to get an opinion from medical.

Healthcare staff need clear guidance on what their obligations are and to which custody staff they should report when an incarcerated person requests single-cell status based on their disability, or when the healthcare provider independently has concerns that an incarcerated person is in an unsafe housing situation due to their disability. Likewise, custody staff need clear guidance on what their responsibilities are when an incarcerated person asks to be single-cell housed due to their disability, and they should be trained to understand that a specific enemy concern is not a requirement to warrant that they be considered for single-cell status. If custody staff feel they need the opinion of medical to determine appropriate housing, the onus should be on custody staff to obtain that opinion, not on the incarcerated person.

We recommend that the parties form a workgroup, including representatives from CDCR, CCHCS, and Plaintiffs' counsel to address these issues and the process for housing class members whose disabilities pose safety concerns for them.

[75] *Id.*

C. RVRs

i. RVRs Issued by Healthcare Staff

After a tour of SATF in the *Plata* case in August 2021, Plaintiffs' counsel requested and received a list of RVRs authored by healthcare staff at SATF between January 1, 2021 and August 17, 2021. The list included 61 RVRs that were authored by healthcare staff during this period. All 61 RVRs were authored by nursing staff, and the majority were authored by LVNs, who are responsible for administering medication, among other duties. Four LVNs were responsible for 47 of the 61 RVRs. Many of the RVRs were for minor administrative rules violations or violations of local operating procedure, such as for not bringing a water cup to the pill line.

Healthcare leadership at SATF, including the CNE and CEO, were unaware that their staff were authoring these RVRs.[76] There was no process to ensure that a healthcare supervisor, such as a supervising nurse, or healthcare leadership, such as the CNE or CEO, reviewed RVRs authored by healthcare staff, or even were notified when healthcare staff had authored RVRs. This lack of oversight by healthcare leadership meant that healthcare staff issued RVRs, including for trivial administrative infractions, without check or correction until Plaintiffs' counsel identified the issue.[77]

It appears healthcare staff at SATF received little to no training about whether or when to author an RVR. In 2016, CDCR transitioned the process of initiating and recording discipline of incarcerated people from documenting alleged misconduct on paper forms to doing so electronically in SOMS. At the time of this systemic transition, the then-director of the Division of Adult Institutions issued a memorandum that explained the new process of initiating discipline through SOMS. The memo instructed healthcare leadership at each institution, and in particular the healthcare CEO, to determine which healthcare workers would have access to the RVR system in SOMS and therefore required training in the issuance of RVRs:

> The CEO at each institution will identify which healthcare staff are to receive the SOMS Disciplinary Module training. Working in consultation with the Chief of Mental Health, Chief Medical Executive, Chief Nurse Executive, Health Program Manager III and Chief Support Executive, the CEO will identify those Health Care staff within the institution who should be trained, based on the current mission and operational requirements.

[76] In fact, when the Court Expert began investigating this issue, the then-CEO stated that healthcare staff did not author RVRs at all, but instead wrote "variance reports" that were submitted to custody staff who decided whether to create RVRs. This was incorrect.
[77] We note that receiving an RVR, even for minor infractions, can have negative consequences for incarcerated people, particularly those being considered for parole.

The previous SATF healthcare CEOs did not follow through with the directive to provide this training to healthcare staff. Therefore, at the time the nursing staff authored the 61 RVRs, they did so without the benefit of training on when and how to issue RVRs.

In November 2021, in response to the concerns raised by Plaintiffs about the 61 RVRs, custody staff conducted training for healthcare staff regarding the RVR and discipline process generally. However, this training did not clearly address when healthcare staff were responsible for authoring RVRs and when they should simply report conduct to custody staff. Healthcare staff were instructed to "consult with a custody supervisor to ensure the correct charge is selected and the RVR is appropriate." The training did not tell healthcare staff not to author RVRs, or only to author them in instances of serious criminal violations.

In December 2021, the CNE and CEO issued a memo in an effort to clarify healthcare staff's role in authoring RVRs. The memo stated that healthcare staff should not author RVRs when they observed violations of Title 15, but instead should report those violations to custody officers. The memo added that healthcare staff may be asked to document their observations in a memorandum, which "shall be shared" with the staff's healthcare supervisor and custody supervisor. The December memo did not explain whether the documenting nurse or custody staff were responsible for sharing the memo with healthcare supervisors.

The December memo also emphasized "the distinction between alleged rules violations and health care processes/policies that are not followed by patients." It clarified that "[t]hings like being late for appointments or not bringing a cup to pill line should be addressed within the normal construct of healthcare processes; but not within the RVR process" and encouraged staff to discuss with their supervisor if they were unsure of "which process they should use" to document "situations they observe."

Despite this memo, we spoke with healthcare staff in May 2022 who had widely divergent answers as to whether nursing staff could author RVRs, with some telling us they could never author RVRs and others saying they had full authority to do so. And as recently as July 2022, nursing staff continued to author RVRs, including for violations such as appearing at pill line with a scratched ID card or showing general disrespect.

We believe that nursing staff's issuance of RVRs has damaged relationships with incarcerated people. As discussed below, class members reported feeling disrespected by nursing staff. The excessive issuance of RVRs by nursing staff has surely contributed to this atmosphere. When nurses are given the power to recommend punishment for their patients, even for minor rules violations, they are no longer just care providers; they are imposers of discipline. That creates a fundamental shift in the relationship, one that likely affects both the nurse and the patient.

Recognizing this problem, CCHCS recently conducted additional training to clarify that healthcare staff are not permitted to write RVRs. Instead, healthcare staff should report administrative violations to custody staff either verbally (in the case of administrative violations)

or in a CDC-837 Crime/Incident Report (in the case of serious violations such as crimes). Custody staff will determine whether the behavior merits an RVR. CCHCS is also exploring whether healthcare staff access to the RVR system in SOMS can be removed, since healthcare staff should not be authoring RVRs. We recommend that healthcare staff not have access to the RVR system in SOMS.

ii. Discriminatory and Retaliatory RVRs

In their submission to the Court Expert, Plaintiffs identified several instances of allegedly discriminatory or retaliatory RVRs at SATF. It is beyond the scope of the Court's order to investigate whether individual RVRs were issued because of a class member's disability or in retaliation for a class member filing a staff complaint. We note that there is a workgroup including Plaintiffs' and Defense counsel discussing the issue of how to prevent and identify discriminatory and retaliatory RVRs system wide.

D. Culture and Leadership Issues at SATF

i. SATF Custody Staff

Based on what we heard from custody staff and others, it appears that many custody staff believe it is the responsibility of SATF's ADA Office, and not individual custody staff members, to ensure compliance with the ADA. Some staff at SATF also appear to believe that class members are only entitled to accommodations when they advocate for those accommodations and when existing policy requires SATF to provide the particular accommodation the incarcerated person requests. These attitudes do not serve incarcerated people well, and they do not serve SATF well in reaching sustainable compliance with the ADA and ARP. Sustainable compliance will require a fundamental mindset shift, so that all custody staff understand that each of them, and not just those in the ADA Office, is responsible for ensuring class members have the accommodations they need to access prison programs.

As an example, we previously discussed Person E, who is deaf but cannot sign. In more than a decade at SATF, he encountered countless custody officers, correctional counselors, housing building officers, sergeants, lieutenants, and captains, all of whom must have observed that he was unable to effectively communicate or access programs because of his disability. No staff member proactively worked to ensure Person E understood how to access TDD phones so he could communicate with his family, and no staff member seemed to appreciate that this person was not going to be able to meaningfully participate in education or other programming, given that his disability was not being accommodated.

Person E's story also illustrates the different results when staff are focused on providing the bare minimum that policy requires, versus when staff are focused on what is possible to provide. For example, when Person E requested the simple accommodation that the word "deaf" be placed on a sticker on his ID card so that healthcare staff understood he could not hear, the RAP denied the

request because there was no policy requiring them to provide such a sticker. But in 2021, when a new captain took over the yard, he noted the depressed demeanor of Person E, advocated for him to get a job as an ADA worker, and provided him with a small whiteboard so he could communicate. There was no written policy requiring a whiteboard; the captain simply realized it would help Person E participate in prison life and made it happen.

As discussed below, the addition of FTS sergeants at SATF has helped class members to have a defined custody staff member responsible for assisting with accommodations, but the FTS sergeants have also helped to train other custody staff regarding ADA compliance issues. FTS sergeants are also tasked with proactively approaching class members periodically to ask if they have the DME they need and other accommodations. We also understand that the Warden and other leadership are emphasizing that ADA compliance is everyone's responsibility through walking tour inspections, in which they speak with staff on every yard during every shift about the importance of ADA compliance. These are all steps in the right direction in a shift towards custody staff acting affirmatively to ensure class members have necessary accommodations.

ii. SATF Healthcare Staff

We repeatedly heard from class members, both in surveys and in interviews, that healthcare staff, particularly LVNs, frequently treated them in a manner that was rude and dismissive. They described certain members of the healthcare staff responding to requests for assistance with suspicion that the incarcerated person was faking their condition or need. In general, we found class member accounts of certain staff members acting in an unprofessional manner to be credible. And the instances discussed above, in which class members had to go to extraordinary lengths to receive basic and necessary accommodations, are consistent with the reports of class members.

We note that we also spoke with class members who had no negative comments about healthcare staff. Of those who did have negative experiences, very few held a blanket view that all healthcare staff were unprofessional. Class members distinguished between healthcare workers who were helpful, patient, and respectful and those who were short-tempered, cross, and rushed. Many class members told us that they learned to avoid certain healthcare workers, while others were "lifelines" or "life savers" on their yard. In one case, the difference was simple: one healthcare professional made a practice of asking the patient at the end of every encounter, "is there anything else you need?" Just asking that question can make the difference between a patient feeling his needs are being addressed and one who feels he must advocate aggressively to receive medical attention.

We did not investigate any individual healthcare staff member. Rather, we sought to understand systemic factors that may be contributing to the breakdown in relations between some staff and the population they serve. Healthcare staff at SATF have an enormously stressful job under the best of circumstances, and COVID placed them under acute pressures. As previously noted, at one point during the height of the pandemic, nearly half the incarcerated population at SATF had

COVID, and many healthcare staff at SATF were sick or quarantined, placing immense strain on staff who made it to work.

In addition, the 2020 rollout of the Integrated Substance Use Disorder Treatment program (ISUDT) created tension between the patient population and staff who administer medication at SATF. The ISUDT program offers medication-assisted treatment (MAT) to incarcerated people with opioid use disorder. As part of the program, nurses and other healthcare professionals administer medications, taken in the form of a sublingual film, designed to treat opioid use disorder. To ensure safe delivery of medication and avoid diversion, nurses are required to observe patients while the medication is absorbed. Custody staff are also required to monitor the distribution of the medication, though as discussed below, custody staff at SATF are not currently doing so on a consistent basis.

As of 2021, SATF had the largest population of patients in the ISUDT program of any institution. This has created a significant workload for healthcare staff. We spoke with staff who described how difficult it was to administer medication to long lines of patients while simultaneously monitoring individual patients who take MAT medication. We also spoke with nurses who believed that, because they were responsible for monitoring the administration of MAT medications, they were also responsible for enforcing rules and holding people accountable for misuse of MAT. This contributed to an adversarial relationship.

As discussed above, CCHCS recently trained all healthcare staff to clarify that it is the role of custody, and not healthcare, to discipline incarcerated people, including for diversion of medication. However, many nurses reported that custody staff on certain yards do not monitor the medication line consistently, and we observed at least one pill line where custody staff were not observing the distribution of medication.[78] Removing nurses from the role of monitoring for medication diversion requires custody staff to do their part. We recommend that custody staff be retrained in the importance of supporting their healthcare colleagues by monitoring pill lines as required. Custody supervisors should regularly observe pill lines on their yards to ensure custody staff are monitoring pill lines as required.

Even without the challenges of COVID or the rollout of a new program, healthcare staff work in an inherently tense setting where they must serve a significant number of patients daily and efficiently. And just as not all healthcare staff act professionally towards patients, not all patients treat healthcare staff with respect. Yet healthcare workers are required to serve patients with care and dignity, even under the difficult conditions presented in a prison.

There could be many reasons a healthcare professional might show a lack of empathy and respect towards a patient. But for many who work in direct services, anger and cynicism or a

[78] We note that there were ample custody staff in the general area of the pill line, so it did not appear to be due to a lack of staff availability that the pill line was not monitored by custody staff.

lack of empathy can be one of the first signs of professional burnout or trauma-exposure response (also known as secondary trauma or vicarious trauma).[79]

Professional burnout is caused by "chronic workplace stress that has not been successfully managed" and that results from "an imbalance between job demands and resources."[80] Thus, the first step in preventing professional burnout in healthcare professionals is to ensure that they are adequately supported in their work. This includes ensuring staffing is adequate so that demands on healthcare workers are reasonable, looking for opportunities to reduce administrative burdens including by optimizing electronic health records systems, and giving a voice to healthcare workers to identify what resources would make their job easier.[81]

Healthcare leadership at SATF has already taken some positive steps in this regard, including by holding quarterly town halls in 2021 where healthcare workers were able to submit questions and comments to leadership. Listening to healthcare workers is essential to understanding how to best support them. We understand that the new CEO at SATF plans to resume town halls in 2023, and we support that decision. In addition to using town halls as an opportunity to listen directly to healthcare staff for their ideas as to how they can be better supported, we recommend that, when possible, leadership should report back to healthcare workers in subsequent town halls on what action they took as a result of the requests and feedback they received.

Additionally, a new CNE began working at SATF in 2021, and she viewed as a key part of her job ensuring the well-being of nurses. The CNE quickly identified that a shortage of LVNs was causing tremendous pressure on staff, particularly nurses administering medication, and she advocated for additional staffing to support nurses running pill lines.[82] At the time we interviewed the CNE, she was working on securing an additional RN for the busiest yard at SATF, in large part due to her fear that the RN on that yard was going to burn out without additional support.[83] The CNE was also a vocal supporter of staff taking mental health days

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[79] *See* Laura van Dernoot Lipsky, *Trauma Stewardship: An Everyday Guide to Caring for Self While Caring for Others*, (2009), at 101-109 (noting anger, cynicism, and inability to empathize as signs of trauma exposure response in workers in direct services professions); Office of the Surgeon General, *Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce*, (2022), at 7 (noting depersonalization or cynicism as key characteristic of professional burnout).

[80] World Health Organization, *Burn-out an "occupational phenomenon": International Classification of Diseases*, (2019), *available at* https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases; Office of the Surgeon General, *Addressing Health Worker Burnout: The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce*, (2022), at 60.

[81] *Id.* at 30.

[82] The CNE did not receive as many additional positions as requested, but she received authorization for four additional LVN positions.

[83] It appears that the CEO and CME of SATF also advocated for additional support in the form of another Chief Physician and Surgeon for SATF. This request was denied in September 2021.

when necessary. At the same time, the CNE began talking to incarcerated people on the Inmate Advisory Council to get their views on the professionalism of nurses on each yard. The CNE seemed to understand her role to be as an advocate for the well-being of nursing staff, while also holding staff to a high standard of professionalism.

Addressing the root cause of burnout requires keeping a close eye on the demands placed on healthcare workers, which is a systemic issue beyond the scope of this report. We know that CCHCS is working to reduce administrative burden on healthcare staff, including by making the electronic health record system more efficient. We also believe that by addressing some of the issues identified in this report, such as by streamlining the process for repair of DME and ensuring custody staff monitor pill lines, healthcare leadership can reduce stressors on LVNs, particularly during medication distribution.

Although not a solution to the root causes of burnout or secondary trauma, one immediate recommendation we have is to provide healthcare staff at SATF with training and support regarding how to prevent, identify, and treat professional burnout and secondary trauma. Healthcare staff told us that they had not received such training and expressed an openness to receiving it.

Healthcare leadership should also continue to work to identify healthcare staff who are unable or unwilling to treat patients with respect and empathy, whether through dialogue with the incarcerated population or careful observation by supervisors. Healthcare staff who are identified as being unable or unwilling to provide compassionate care must receive professional intervention.

iii. SATF Leadership

a) Leadership's Response to Concerns in 2021

In early 2021, SATF leadership were understandably focused on controlling the spread of COVID, and the prison was not operating under normal procedures. Some staff missed out on block training, for example, and others were teleworking or otherwise not able to collaborate in ways they had prior to the pandemic. This may have contributed to some of the issues we identify in our report.

When Plaintiffs' counsel raised concerns regarding treatment of class members at SATF in May 2021, institution leadership did take steps in response. For example, the ADAC and Warden created a corrective action plan that assigned responsibility to particular staff to address problems identified by Plaintiffs' counsel in their May 2021 tour. This corrective active plan included a walking tour inspection, in which prison leadership visited every housing building during every shift, checking for compliance with ADA requirements and housing staff's knowledge of those requirements. Leadership also asked whether sergeants ensured that non-

regular staff were familiar with ADA requirements and the population in their building with disabilities.

Leadership's walking inspection tours seem to have yielded positive results. During our visits to SATF, we visited several different housing units, sometimes on short notice, and found that staff were readily familiar with the class population in their buildings, including who used wheelchairs, had incontinence, or were deaf or blind. Staff also exhibited familiarity with the procedure they would follow if a class member asked them for a shower due to incontinence.

CDCR also sent retired prison leaders to SATF in order to address problems identified by Plaintiffs' counsel. In July 2021, a retired Warden was stationed at SATF to provide advice and guidance to the ADAC, and a retired Assistant Warden with experience managing healthcare was stationed at SATF to provide guidance to the CEO. Both retired annuitants told us that they identified a disconnect and a communication breakdown between healthcare and custody, particularly at the leadership level. The retired annuitants had slightly different perspectives on the cause of the breakdown. One believed that both custody and healthcare were working too autonomously and not communicating about issues that affected them both. The other felt the former CEO appeared adversarial and image-focused, rather than focused on working collaboratively with custody leadership to solve problems. One of the retired annuitants also thought that the Assistant Warden for healthcare should have had a larger role in managing the relationship between custody and healthcare, as well as in overseeing the 1824 process, since so many requests for accommodations required the involvement of healthcare. The retired annuitants were not asked to provide a written report to CDCR regarding their observations, and it is not clear that any action was taken based on their findings.

Also around July 2021, SATF received additional custody and administrative staffing to assist with its DPP program. The ADA Office received a Staff Services Analyst to help prepare for the RAP and respond to the numerous 1824s that the RAP reviewed each week. In addition, approximately twenty FTS sergeants began working at SATF in July 2021, in accordance with the Court's Five Prisons Order.[84] The FTS sergeants were given a host of responsibilities related to ADA compliance on their assigned yards, including ensuring that building staff understand accommodation requirements, seeing that auxiliary aids are available, and checking in with newly arrived class members. Currently, all the FTS sergeants are supervised by a single lieutenant, who is only present at the prison for two of the three shifts per day, meaning one shift of FTS sergeants has no direct supervisor during their working hours. We recommend that CDCR consider adding an additional lieutenant to ensure all FTS sergeants are supervised.

We heard from many class members that the addition of the ADA-focused FTS sergeants has been helpful. However, some noted that it was often healthcare staff who stood between them and the accommodations they needed, such as being prescribed DME, and there was little the FTS sergeants could do to assist in that regard.

[84] *See* Dkt. No. 3218.

Also in the summer of 2021, and again as a result of the Court's Five Prisons Order, body-worn cameras rolled out at SATF. We heard positive feedback from class members and custody staff regarding the body worn cameras. Many people reported that the cameras improved the overall dynamic between custody staff and incarcerated people.

b) Leadership's Failure to Self-Identify Systemic Problems

Although they took steps to address problems brought to their attention, SATF leadership did not self-identify problems raised by Plaintiffs' counsel or uncovered by our investigation, despite opportunities to do so. Leadership's ability to self-diagnose and address problems is critical to sustainable compliance with the ARP and ADA. We discuss below missed opportunities, some potential reasons for those failures, and suggestions for a cultural shift towards autonomous identification of and accountability for failures to provide disability accommodations.

1) Healthcare Leadership

First, healthcare leadership had ample opportunity to realize that the system for issuing, replacing, and repairing DME at SATF was in disarray. The CME, and sometimes the then-CEO, were present at the RAPs when incarcerated people were repeatedly asking for the issuance, repair, or replacement of DME, and thus they were on notice that there were problems and confusion with the process. We observed a RAP at which *nearly half* of the 1824s reviewed involved the provision or repair of DME. Those 1824s were emblematic of the wider systemic problems with DME at SATF, involving DME that were lost in transfer, DME denied because providers stated they were simply not offered at the institution, DME not received despite multiple 7362s, and repeated requests to repair DME. And if the sheer number of 1824s regarding DME was not an indicator that the system was dysfunctional, another tip-off should have been that members of the RAP themselves, including representatives from the ADA Office and Nursing, were confused about the process for obtaining and repairing DME.

For example, in two separate incidents on the day we observed the RAP, the CME approved providers' denial of DME not based on a lack of medical necessity, but instead on the grounds that the DME was simply not issued at SATF. This was a missed opportunity to recognize that providers apparently did not understand the nonformulary process or their responsibility to utilize it to accommodate the individual needs of people with disabilities.

Also during the RAP that we observed, there were several 1824s asking for repair or replacement of DME, and it was obvious that healthcare staff, custody staff, and the CME himself did not understand the process to repair DME. For example, one incarcerated person requested that his walker be repaired or replaced due to its broken brakes. Following the filing of this 1824, an FTS sergeant escorted the incarcerated person to the medical clinic, where an LVN observed that the walker was indeed broken, "made a request" to see if parts were available to repair or replace it, but then sent the incarcerated person back to their housing unit with the broken walker, rather

than replacing it with a temporary loaner. Members of the RAP identified that staff should have provided a loaner as soon as they observed that the walker was broken, but they also expressed confusion about whether the incarcerated person should have sought repair by filing a 7362 or by bringing the walker to the clinic. The CME's view was that broken DME can be replaced in the clinic without an appointment, but the LOP in fact says the opposite.[85] Members of the ADA Office suggested training for healthcare staff on exchanging broken DME, since this was a recurring problem. But the CME declined that request, asserting that most healthcare staff knew how to replace broken DME.

Thus, the CME had an opportunity to correct the DME provision and repair process at SATF but failed to do so. The then-CEO also sometimes observed the RAP, and he also reviewed healthcare grievances that allowed him to identify and correct this issue, but he too failed to do so.

Similarly, as discussed above, a member of healthcare leadership was on the RAP that denied a request for pull-up diapers on the incorrect grounds that pull-ups were not available at SATF. It took over a year of advocacy by Plaintiffs' counsel and the intervention of CCHCS leadership for SATF to correct a problem that the institution's own leadership was directly aware of and should have corrected themselves.

The CME also had the chance to observe how failure to respond to 7362s was causing unnecessary 1824s. We have reviewed many 1824s that were filed because previous 7362s were ignored. In one example from a day that we observed the RAP, a class member requested a rubber tip for his cane, since without the rubber tip he was having difficulty pulling himself out of his wheelchair. The incarcerated person explained in his 1824 that he was using the RAP process because "I always put a medical request but the medical department will NEVER respond? I have file [sic] the 1824 multiple attempts for the simple fact the medical department never responds to my request?" In response, an FTS sergeant quickly helped the incarcerated person obtain a rubber tip—something that should have been done without an 1824.

Similarly, it was Plaintiffs' counsel, and not healthcare supervisors, who identified that 7362s were regularly being entered in the system days after SATF received them. With an effective self-auditing system, SATF healthcare supervisors would have detected this issue.

In sum, SATF healthcare leadership missed many opportunities to identify system-wide problems that were interfering with *Armstrong* class members' ability to receive disability accommodations. To be clear, SATF healthcare leadership obviously work very hard, and they have an enormously complex job. We recognize that compliance with the ARP and ADA is only a part of their numerous responsibilities, albeit an important part. But it is the responsibility of

[85] *See* LOP 467(VII)(N)(2) ("Whenever an appliance, is in need of repair or replacement, the patient shall utilize the CDCR 7362 Request for Health Care Services to alert health care of the need for DME repair/replacement.").

leadership to self-assess whether the institution is meeting the needs of the *Armstrong* class and to correct problems proactively. They currently are not doing so.

It is beyond the scope of this report to recommend systems for self-auditing ADA compliance in a health department as large as that of SATF, but we do note that, as discussed above, participation on the RAP already provides leadership with an opportunity to observe repeat problems and intervene to correct system failures. We also understand that CCHCS is currently working closely with SATF leadership to devise strategies to correct existing systemic problems and self-identify issues in the future. We recognize that a new CEO began working at SATF recently, and he brings a wealth of experience in managing large healthcare systems that we hope will aid in this effort.

2) Custody Leadership

As discussed above, custody leadership must continue to lead a shift in the mindset of custody staff to understand that compliance with the ADA is the responsibility of everyone at SATF, and not just a particular person or office. In addition, SATF leadership is responsible for identifying its own problems with ADA compliance and correcting those issues without outside intervention. SATF leadership must institute self-auditing procedures to check whether SATF is meeting the needs of incarcerated people with disabilities. We understand this is easier said than done, particularly when SATF is already subject to numerous forms of auditing by Plaintiffs in *Armstrong, Plata, Coleman*, and *Clark*, by CCHCS, by the Ombudsman, by OIG, by county health and fire inspectors, and now by the Court Expert.

But there are opportunities for custody leadership to identify its own problems with disability accommodations. Between observing accommodation requests as a member of the RAP, meeting quarterly with the Inmate Advisory Council, supervising the FTS sergeants, and managing the noncompliance log, the ADAC has an opportunity to observe trending issues with disability accommodations. Likewise, the FTS sergeants and their supervisor are on the ground with class members and have an opportunity to identify repeated issues. The Warden must ensure that she is kept informed of trending problems with ADA compliance, and that a plan is in place to correct those problems.

In addition, if the ADAC had additional staff support, they would be able to focus on self-auditing compliance with the ADA and ARP. Currently, the ADAC is the equivalent of a fire marshal of a large city being asked to manage an entire fire department while personally responding to every 911 call. For example, the ADAC is responsible for managing the RAP and responding to 1824s (often more than 50 per week, each requiring investigation and preparation), managing the response to ADA noncompliance entries, managing tours of the institution by Plaintiffs' counsel and other outside auditors, training and managing the FTS sergeants and several other staff members of the ADA Office, responding to advocacy letters by Plaintiffs' counsel, responding to certain staff complaints, and meeting with the Warden and attending inspection tours. With that amount of responsibility, it is difficult for the ADAC to spend time

critically thinking about trends, looking for systematic issues, or working at self-auditing or envisioning ways to prevent issues, rather than just responding to them.

Another sign that the ADAC position needs additional support is the high level of turnover in the position, which hurts the overall ADA program. Probably unsurprisingly, given the enormous number of duties the position entails, several recent ADACs have served for just one to two years in the position—SATF has seen four ADACs in the last five years.

Given the number of 1824s that are filed at SATF, as well as the complex and large population the prison serves, a single leader in the ADA Office shoulders a disproportionate load as compared to smaller institutions that also have one ADAC. We note that the former ADAC requested the addition of a captain position within the ADA Office to assist in responding to 1824s and advocacies, in order to allow the ADAC more time to monitor trends and self-audit. We recommend that CDCR consider staffing this position at SATF.

In addition, the Warden and the healthcare CEO must communicate more directly about ADA compliance. When systematic failures come to the attention of the Warden, such as the failure to devise a clear policy for how to issue and repair DME, the Warden must coordinate with the CEO and press for healthcare leadership to fix those problems. If class members at SATF are not receiving disability accommodations because of a problem with healthcare delivery or any other reason, that is ultimately the responsibility of the Warden.

IV. Recommendations

Legal Mail

1) All SATF mail room staff should be retrained in the procedures and requirements for handling legal mail under Cal. Code Regs. tit. 15 § 3141-43. When new staff are assigned to the mail room, supervisors must ensure they receive training in handling legal mail.

Transfer

2) SATF leadership must amend the LOP to clarify requirements for custody and healthcare staff when they discover during the transfer process that an incarcerated person is missing DME.

    a. The LOP should indicate under what circumstances custody staff must obtain a loaner DME before transporting the incarcerated person to the receiving yard. The LOP should also indicate under what circumstances custody staff must report the missing DME, and whether they report the missing DME to the R&R nurse or the healthcare staff on the receiving yard.

b. The LOP should clearly outline the R&R or TTA RN's responsibility for either replacing the missing DME or ordering replacement DME. If the LOP tasks the receiving yard (rather than the R&R or TTA RN) with replacing missing DME, the LOP must clearly state the R&R or TTA RN's responsibility for reporting missing DME to the receiving yard's healthcare staff.

c. If the LOP tasks the receiving yard with replacing missing DME, the LOP must specify which healthcare staff on the receiving yard (for example, a PCP, MA, SRN, or LVN) is responsible for ensuring the timely replacement of missing DME, the procedure for how they do so, and by when.

3) CCHCS should consider amending the HCDOM to clearly outline the R&R or TTA RN's responsibility for documenting or reporting missing DME, as well as the responsibility, procedure, and deadlines for the receiving yard healthcare staff to replace missing DME.

4) All R&R custody staff must be retrained on how to fill out the Intra-facility Health Care Appliance Inventory Chrono, as well as on the amended LOP.

5) All R&R healthcare staff must be retrained on the amended LOP and their responsibilities when they discover missing DME during transfer.

6) All TTA staff must be retrained on the amended LOP and their responsibilities when receiving new arrivals.

7) CCHCS should consider changing the reconciliation process such that a person's active DME, medications, appointments, and conditions automatically continue as active when they transfer. The reconciliation process should require a physician to take affirmative action to remove a DME, prescription, appointment, or condition, rather than requiring them to take affirmative action to maintain those DME, prescriptions, appointments, or conditions.

8) CCHCS should investigate whether the electronic health records system can alert providers when they have failed to reconcile a new patient's orders.

9) Healthcare leadership at SATF should conduct its own audits regarding incarcerated people who transfer into SATF. Healthcare leadership should review a sample of newly received incarcerated people and determine whether their DME, medication, nutritional supplements, and conditions continued without interruption upon arrival at SATF. Healthcare leadership should determine the cause of failures and device strategies to correct them.

7362s

10) SATF healthcare leadership must ensure that any housing unit on lockdown or restricted program has nurses making rounds to each cell to collect 7362s, in compliance with HCDOM 3.1.5(c)(3)(D)(3). SATF leadership must track compliance with this requirement and must report their compliance quarterly to CCHCS personnel. SATF leadership must hold accountable nurses and their supervisors who are found in the auditing process to fail to comply with this HCDOM requirement.

11) SATF healthcare leadership must immediately end the practice of delaying entry of 7362s. SATF healthcare leadership should retrain staff responsible for triage and entry of 7362s and must audit their staff's compliance with entering 7362s in compliance with the requirements of the HCDOM. SATF healthcare leadership should report the results of this audit quarterly to designated CCHCS personnel. SATF leadership must hold accountable healthcare staff who are found in the auditing process to continue to delay entry of 7362s.

12) CCHCS should explore ways to inform patients—via tablet, physical letter, or otherwise—that their 7362 has been received and when they are scheduled to be seen by a provider on the yard.

DME

13) Providers must be retrained on the availability and process for ordering nonformulary DME and SATF's obligation to provide accommodations based on the individualized needs of incarcerated people. Providers should be trained that there is never a situation in which they can deny a request for DME because the DME is "not available."

14) SATF healthcare leadership must revise the LOP to implement a clear procedure for the repair and replacement of DME. This procedure must outline the process, deadlines, and accountabilities for replacing and repairing DME in both emergency and nonemergency situations:

    a. The LOP must clearly outline the process for replacing or repairing DME in emergency situations, such as when a class member who uses a wheelchair has a wheelchair that no longer rolls. The LOP must specify 1) to whom class members should report their issue; 2) who is responsible (whether a specific custody staff member on each yard or a specific healthcare staff member on each yard) for obtaining a "loaner" DME; 3) the deadline by which the responsible staff must obtain the loaner DME; and 4) the responsibility of the

staff member to begin the process for the permanent repair or replacement of the DME.

b. The LOP must clearly outline the process for replacing or repairing DME in non-emergency situations, such as when a person's wheelchair safely rolls but has armrests that are worn out. The LOP must specify 1) to whom and how class members should report their issue, whether by submitting a 7362, reporting the issue at a weekly "DME line," or some other avenue determined by healthcare leadership; 2) the specific healthcare staff member at each yard (whether a PCP, MA, LVN, SRN, or RN) who is responsible for arranging the repair or replacement of the DME; and 3) the deadlines by which the staff must obtain the replacement or repair of DME.

15) CCHCS should consider establishing a healthcare staff position specifically responsible for the delivery, repair, and replacement of DME on each yard.

16) Members of the RAP must be retrained to emphasize they have an independent duty to provide DME where it is a reasonable accommodation, regardless of whether providers believe the DME is "medically necessary."

Other Assistive Devices

17) CDCR and CCHCS must clarify through policy or memorandum the process and staff accountable for ordering and obtaining appliances or devices (such as typewriters or other assistive writing devices) that are not considered medical DME.

18) SATF must ensure inoperable low vision assistive devices, such as Merlins and Optelecs, in its libraries are repaired or replaced. SATF ADA staff should regularly audit, via walking tours or another means, whether low vision assistive devices are functional.

Supplies

19) Healthcare providers and staff at SATF who order supplies should be retrained that they are responsible for communicating with the medical supply warehouse if there are problems with their orders. Healthcare staff and all members of the RAP should also be reminded of the responsibility to provide individualized disability accommodations, even if doing so requires ordering nonformulary items.

20) Training regarding the ordering of supplies should include as a teachable moment the example of pull-ups discussed in this report.

21) Custody and healthcare staff should be trained to provide incontinence supplies as an interim accommodation for an incarcerated person who runs out of allotted supplies or who experiences incontinence while they are awaiting evaluation by a provider.

Deaf and Hard of Hearing Accommodations

22) SATF leadership must devise a system for auditing staff communication of announcements to deaf people at SATF.

23) Staff should include adequate information in SOMS or healthcare records to note when deaf people can speak but require healthcare staff to write notes to them. Healthcare staff should be trained that some deaf people can speak but cannot sign and how to correctly accommodate those class members.

24) SATF must ensure that deaf people who cannot sign have access to TTY/TDD phone calls, or an alternative accommodation such as captioned video calls, and are educated on how to request those calls and use the service.

25) As an immediate accommodation, SATF should, whenever possible, utilize automated transcription through Microsoft Teams in settings when staff are using a computer to interact with deaf people who cannot sign.

26) CDCR must implement CART or an alternative reasonable accommodation for deaf people who cannot sign to access programming and education at SATF. CDCR must provide a specific proposal for how SATF will implement CART or an alternative reasonable accommodation.

Housing for People Whose Disabilities Create Safety Concerns

27) CDCR and CCHCS must clarify through memorandum or policy who is responsible for raising concerns about a person's safety due to disability, to whom they direct those concerns, who is responsible for obtaining the opinion of medical when necessary, what level of present or potential future safety risk is required to warrant a move to single-cell status, and who is responsible for ensuring a review of a person's housing takes place when the incarcerated person or staff raise concerns about their disability posing a safety concern.

28) SATF custody staff should be trained that a specific enemy concern is not required to evaluate whether a class member's current housing situation is unsafe due to their disability.

29) SATF healthcare staff should be trained regarding to whom they should report concerns that a person is unsafely housed due to their disability.

30) The parties should form a workgroup to address the process for housing class members whose disabilities pose safety concerns for them.

Healthcare RVRs

31) Healthcare staff should not have access to the RVR system in SOMS.

Staffing

32) CDCR should consider the addition of an upper-level management position, such as a captain, in the ADA Office of SATF.

33) CDCR should consider offering special incentives for ADACs who remain in the position longer than three years.

34) CDCR should consider the addition of a second lieutenant position to supervise FTS sergeants at SATF.

Culture and Leadership

35) Custody staff should be retrained on the requirement to monitor pill lines. Custody supervisors should regularly supervise pill lines on their yards to assess whether custody staff are complying with this requirement.

36) Healthcare leadership should resume the practice of town halls to solicit feedback from healthcare staff regarding how their jobs could be streamlined or better supported. When possible, leadership should report back to healthcare workers in subsequent town halls on what action they took as a result of the requests and feedback of healthcare staff.

37) SATF healthcare leadership should train healthcare staff on strategies for preventing burnout and secondary trauma, as well as identifying the signs of burnout and secondary trauma.

38) Custody and healthcare leadership's job performance should be assessed based on their success in self-auditing their institution and identifying and correcting system failures.

39) In light of the problems outlined in this report, CDCR should consider changing the makeup of the population at SATF to enable it to better serve the population it houses.

Appendix A

Glossary of Terms

1824: a form that incarcerated people may use to request disability accommodations
602: a form that incarcerated people may use to allege staff misconduct
7362: a form that incarcerated people may use to request medical treatment
ADA: Americans with Disabilities Act
ADAC: ADA Coordinator
ARP: *Armstrong* Remedial Plan
CEO: Chief Executive Officer
CME: Chief Medical Executive
CNE: Chief Nursing Executive
CTC: Correctional Treatment Center
DDP: Developmental Disability Program
DME: Durable Medical Equipment
DPP: Disability Placement Program
EOP: Enhanced Outpatient Program
FTS: Field Training Sergeants
HCDOM: Health Care Department Operations Manual
ISUDT: Integrated Substance Use Disorder Treatment
LVN: Licensed Vocational Nurse
MAT: Medication-Assisted Treatment
OIA: Office of Internal Affairs
OIG: Office of the Inspector General
OLA: Office of Legal Affairs
PCP: Primary Care Provider
R&R: Receiving and Release
RAP: Reasonable Accommodation Panel
RFS: Request For Service
RN: Registered Nurse
RVR: Rules Violation Reports
SATF: Substance Abuse Treatment Facility and State Prison – Corcoran
TTA: Triage and Treatment Area

Appendix B

Attachment H

State of California — Department of Corrections and Rehabilitation

On this date, Inmate _____ CDC# _____, was moved from Facility _____ to ☐ Facility ____ ☐ R&R at the California Substance Abuse Treatment Facility and State Prison at Corcoran. After verification through SOMS and an inventory of the Health Care Appliance(s) in the inmate's possession, the following Health Care Appliances were transferred with the inmate to receiving facility.

☐ Brace	☐ Cane __Wooden __ Blind	☐ Contact Lenses/Supplies
☐ Cotton Bedding	☐ Crutches	☐ DPH Vest
☐ DPV Vest	☐ Dialysis Peritoneal	☐ Dressing/Catheter/Colostomy Supplies
☐ Extra Mattress	☐ Hearing Aid	☐ Limb Prosthesis/Orthotics
☐ Eyeglasses	☐ Shoes	☐ Special Garment
☐ Walker	☐ Wheelchair	☐ Ted hose
☐ Egg crate Mattress	☐ Wheelchair gloves	☐ C-pap machine & supplies
☐ Tens Unit (electrodes/batteries)	☐ Wheelchair cushion	☐ Batteries for hearing aids
☐ Wedge pillow	___Roho ___gel ___egg crate	Size _____ Quantity _____
☐ NO APPLIANCES	☐ Other -- specify _____	

Discrepancies/Comments _____

☐ Interim Accommodation provided prior to transfer? Yes/No

Yes – List appliance loaned: _____

No – Reason appliance denied (example, appliance not available): _____

_____

_____ _____
SENDING FACILITY PRINT/SIGN DATE

_____ _____
RECEIVING FACILITY PRINT/SIGN DATE

I ACKNOWLEDGE THAT THE ABOVE INFORMATION IS ACCURATE.

_____ _____
INMATE NAME AND CDCR# PRINT/SIGN DATE

Distribution: ADA Coordinator (FAX 7297)
ERMS

128B INTRA-FACILITY TRANSFER HEALTH CARE APPLIANCE INVENTORY CHRONO