Summary:

Section 919 of the California Penal Code requires each Grand Jury to inspect all correctional facilities within the county. In this capacity, the Monterey County Civil Grand Jury (MCCGJ) visited the Monterey County Jail, located in Salinas, in partial fulfillment of that requirement. Site visits, interviews with staff and written documentation were used in the evaluation.

The MCCGJ also agreed to a preliminary investigation into the proposed County Jail addition and new Juvenile Hall. The purpose was to determine:

- The necessity for additions to the County Jail and Juvenile Hall
- The nature of the cost analysis to build the addition
• Enhancements to be incorporated in the addition

• The feasibility of simply remodeling the existing facilities

In this report, the term “prison” refers to the California state institutions of incarceration. The Monterey County Jail is referred to as the “jail”.

**Background:**

As part of the investigation, the jury examined two class actions. The first was a federal case, *Coleman v. Wilson*, decided in 1995. In the latest enforcement of the 1995 case, now *Coleman v. Brown*, U.S. District Judge Karlton in 2013 determined:

“Systemic failures persist in the form of inadequate suicide prevention measures, excessive administrative segregation of the mentally ill, lack of timely access to adequate care, insufficient treatment space and access to bed, and unmet staffing needs.”

The second case, filed in 2013, was *Jesse Hernandez*, et al v. Monterey County, Monterey County Sheriff’s Office (MCSO) and California Forensic Medical Group (CFMG). *Hernandez* was a class action lawsuit brought by inmates and former inmates of Monterey County Jail. The plaintiffs claimed:

• The conditions in the Monterey County Jail violated federal and state laws.

• The County failed to protect inmates from violence.

• The County and CFMG failed to provide the inmates with adequate medical and mental health care.

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3 Case Number CV 13 2354 PSG. *Hernandez v Monterey County*. The case alleged “failure to provide adequate mental health care to inmates” and “failure to provide reasonable accommodations to inmates with disabilities”.

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• The County did not provide reasonable accommodations for inmates with disabilities.

A settlement agreement was reached on May 7, 2015. The defendants denied every allegation brought against them in the case, but agreed to institute the changes in procedures and staffing, as required in the settlement agreement, and to pay $4.8 million in attorney’s fees to the plaintiffs.

**Investigative Methodology:**

The MCCGJ conducted interviews with members of the MCSO, and re-interviewed those when necessary. The MCCGJ toured the County Jail, requested and received data from numerous divisions of the MCSO and performed additional research on the Internet to clarify the requirements of the Hernandez Settlement and other pertinent court cases.

The focus of this study is on the improvements taken to meet the requirements in the Hernandez Settlement and the impact on staffing. One of the unintended consequences of complying with the Hernandez Settlement has been that numerous deputies were transferred from patrol to the jail. This resulted in a shortage of deputies on patrol, which is addressed in a separate report titled: “Insufficient Number of Sheriff Deputies: Car 54 Where are You?”

On November 9, 2016, the MCCGJ toured the County Jail and both juvenile detention facilities. After completing its tour, it was the jury’s consensus that these facilities have a critical lack of mental health services available for inmates and detainees. On average, more than 100 women and 900 men are housed at the Monterey County Jail. It was estimated in 2015 that the percentage of detainees with mental health issues in California prisons and jails was approximately 45%.

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1 When did prisons become acceptable mental healthcare facilities? Stanford Law School Three Strikes Project, Feb 19, 2015
Facts:

1. In May 2013 recently released inmates filed *Hernandez v. Monterey County*. The lawsuit cited problems involving the medical and mental health care provided as well as dangerous conditions and practices. The suit also alleged:

   - There were serious structural and systematic problems with the jail, and conditions inside the facility did not meet constitutional and ADA standards.
   - Failures to provide inmates with adequate medical care left them vulnerable to injury, unnecessary suffering and even death.
   - Staffing shortages were found to be so severe that numerous duties were not performed consistently or were performed poorly, including evaluation of health requests, chronic illness care, evaluations in sobering and isolation cells, management of patients in the Outpatient Housing Units and intake assessments.

2. Based on MCSO’s incident reports, there were more than 150 separate acts of violence between inmates from January 2011 through early-September 2012, and in more than 100 of these incidents at least one prisoner required medical treatment. Violent incidents were reported in 26 of the jail’s 29 housing units.

3. According to the *Hernandez* case:

   - Many prisoners with disabilities did not have access to important services, programs, activities and accommodations in the jail.
   - The jail failed to provide interpreters to prisoners who required sign language to communicate.
   - None of the areas of the jail complied with federal and state regulations regarding accessible housing for people in wheelchairs.
• Prisoners, who were physically challenged, did not have access to the outdoors, exercise areas and to religious services. Those programs could only be accessed by walking up long flight of stairs.

• Overwhelming systemic problems with the jail’s mental health system placed prisoners with mental illness at greater risk of deterioration in their mental health and greater risk of suicide.

• Among the most shocking practices was the use of “rubber rooms”, which were filthy windowless cells in which they placed suicidal prisoners for multiple days. These cells lacked toilets, beds and sinks. Prisoners were stripped naked and forced to sit, lie and sleep on the same floor in which a grate served as a toilet.

4. Following *Hernandez* Settlement agreement in 2015, improved inmate care and safety procedures were implemented. For example:

• Previously, a deputy conducted a medical questionnaire for incoming detainees. A registered nurse is now present 24-hours a day to evaluate them upon intake.

• The jail’s visiting area has also been upgraded to be compliant with the Americans with Disabilities Act.

• Nearly 300 new cameras have been added to the facility, replacing many cameras installed in the mid-90s. These additional cameras were installed to adequately monitor inmates, reduce the number of blind spots, improve staff safety, and help prevent suicides.

• There were six inmate suicides between 2009 and 2015 with three in 2015 alone, several of which involved hanging. As a solution, the number of potential “tie-off” points were reduced. Ductwork and ventilation covers in cells have been replaced with ones that have smaller holes, making it more difficult for inmates to weave sheets through them.

• Chain link fencing and bars have been installed along the stairs and second floor platforms in pods to reduce the possibility of inmates jumping off.

• Other required changes include:
1. Classification reviews for inmates placed in segregation occur after one week and every two weeks thereafter.

2. Inmates placed in segregation are now allowed to be out of their cells two hours each day as opposed to the previous allowance of one hour.
   • Inmates going through alcohol or drug withdrawal must now see a medical professional within one hour of being placed in a “sobering cell”. They will be monitored twice every 30 minutes, and these welfare cases must be documented.

5. The **Hernandez** case requires inmates housed in certain identified areas to attend two hours of programming each week. Programs now offered include:

   - Addiction Recovery
   - Anger Management
   - Women affected by Trauma
   - Stress Management
   - Life Skills
   - Reentering the Workforce
   - High School Equivalency Classes

6. In the past, programming was only offered to sentenced inmates, not for those awaiting trial. Programming is now available to almost all detainees or inmates.

7. Additional challenges for the jail stem from statewide prison reform initiatives such as Assembly Bill 109, popularly known as realignment. **AB 109** requires certain inmates to serve their sentence at county jails instead of state prisons.

8. Historically, jails didn’t house inmates much longer than a period of months. Now, about 12% of the Monterey County Jail population are **AB 109** inmates serving multiple year sentences, including some sentenced to life.

9. **AB 109** also resulted in an increase in services for inmates. For example, dental care had been provided to inmates at the jail before, but it was primarily acute care. Now, the emphasis is on extended preventative care.
10. The consensus of opinion is that the number of detainees suffering from mental health issues continues to rise.

**Findings:**

F 1. The jail, with approximately 45% of its 900 inmates dealing with mental illness is, by default, serving as a de facto mental health facility.

F 2. Although health and safety standards in the jail are now being addressed to comply with the *Hernandez* Settlement, the MCCGJ is concerned that the mental health issues are still not adequately addressed.

F 3. The failure of the responsible county agencies, prior to the *Hernandez* Settlement, to properly address serious problems at the jail, ultimately cost the county $4.8 million: one-half paid by the county and one-half paid by CFMG. This money could have been better spent elsewhere.

F 4. There are no publicly funded mental health facilities in Monterey County except for Natividad Medical Center.

F 5. Natividad Medical Center, with only 22 beds dedicated to mental health, is the only facility in the county that has lock-down capability. This number is woefully short of what is needed to provide barely adequate care for the mentally ill in Monterey County.

F 6. An $80 million addition has been approved for the Monterey County Jail. With the new 586 bed annex, approximately 400 spaces, or 22,610 square feet, will be now vacant at the old jail.

F 7. The planning process for this new construction began over ten years ago. At that time, the emphasis was on overcrowding and not on mental health issues. The MCCGJ has not seen or found revised plans to reflect this change in priorities.
F 8. It would appear that Monterey County’s Behavioral Health Agency’s expertise would benefit those needing mental health care in the jail.

F 9. A significant number of state hospitals were closed under the Reagan administration. This severely restricted the access of our county’s inmates to the remaining state mental health facilities. The Monterey County Jail became the de facto mental health facility. Inmates, suffering from mental illness, did and can wait months and even longer before being transferred to a state hospital and receive treatment. This is cruel and inhumane.

F 10. Historically, the responsibility of the jail was the detention of inmates, not to attempt to provide mental health care.

F 11. There is a great need for a stand-alone mental health facility in our county.

F 12. The County, without plans to address this mental health crisis in our jails, should be prepared for additional class actions cases and significant fines. To quote Supervisor Parker, when asking for a visitation option in the new jail addition: “We need to deal with this now, before it becomes a major community, logistical and budgetary problem.” The same comment is true for the County’s need for mental health services.

Recommendations:

R 1. The Board of Supervisors should fund the building of a new mental health care facility or study the use of available properties in the county that could be repurposed for mental health facilities. For example:

• The soon to be vacant portion of the current jail

• The soon to be vacant Youth Center

 Supervisor Parker, Coast Weekly, April 20, 2017, reference “Phoning it in”
• The Stockade on the former Ft. Ord and other vacant or underutilized local buildings

R 2. The Board of Supervisors should study the other existing models of integrated mental health facilities within the jail. Examples are: Los Angeles and Santa Clara counties.

R 3. The Board of Supervisors should continue to provide funding for county agencies to participate in statewide initiatives, which deal with incarcerated patients with mental health issues. Examples are: “Jail Based Restoration of Competency”® or the “Stepping Up Initiative”.7

R 4. The Monterey County Behavioral Health Agency’s services should be integrated with the jail, rather than contracting out those duties to CFMG.

Request for Response:

Pursuant to Penal Code section 933.05, the Monterey County Civil Grand Jury requests the following to respond to the Findings and Recommendations as follows:

F 1. – F 12. Monterey County Board of Supervisors

R 1. – R 4. Monterey County Board of Supervisors

R 1. – R 4. Monterey County Sheriff

Invited Response

R 1. – R 4. California Forensic Medical Group (CFMG)

6 https://www.leg.state.nv.us/
7 https://stepuptogether.org/
APPENDIX:
CURRENT JAIL
CONCEPTUAL PLANS FOR NEW JAIL ADDITIONS