2017 AUDIT RECOMMENDATIONS PROJECT

The Inspections Unit is charged with managing the Sheriff's Office response to both internal and external audits. The Inspector will ensure recommendation tasks from audits are assigned and completed in a timely manner. The Sheriff will sign off each completed task after the Inspector reviews the relevant solution document. The overall objective of this project is to ensure transparency and accountability in addressing recommendations put forth in recent audits by Disability Rights Oregon, the National Institute of Corrections and the 2016 Corrections Grand Jury.

CATEGORY	REFERENCING DOCUMENT	PROJECT ID	RECOMMENDATION DETAIL	PARTNERS	ASSIGNED LEAD	TARGET DATE	BEGIN DATE	COMPLETED DATE	WORKING FILES	SOLUTION DOCUMENT	INSPECTIONS REVIEW	SHERIFF SIGNOFF
Operations	*Disability Rights Oregon*	DR-01	Conduct medical/behavioral health triage to divert indviduals with mental health needs in jail to treatment									
Operations	*Disability Rights Oregon*	DR-02	Jail should post an RN as the first point of contact in booking to divert anyone with an urgent healthcare need to the hospital or crisis resource									
Partnership	*Disability Rights Oregon*	DR-03	PPB, MCSO, City//County leadership, criminal defense bar and DA to implement pre-booking diversion options, rather than jail									
Partnership	*Disability Rights Oregon*	DR-04	Implement the recommendations of the 2015 Mental Health Jail Diversion Feasibilty Study									
Partnership	*Disability Rights Oregon*	DR-05	Continue and expand the Law Enforcement Assisted Diversion (LEAD) Program									
Partnership	*Disability Rights Oregon*	DR-06	Look at the Sequential Intercept Model seek assistance from SAMHSA's GAINS Center									
System Accountability	*Disability Rights Oregon*	DR-07	Reevaluate recognizance screening Screening and bail to review whether "stability" considerations lead to disproportionate incarceration									
Partnership	*Disability Rights Oregon*	DR-08	The DA should not pursue charges if not a public safety risk and conduct was disability-driven and competency is potential trial issue									
Partnership	*Disability Rights Oregon*	DR-09	Hospitals should not arrest patients or call LE, based on disability-related behavior that does not present an imminent safety risk									
Partnership	*Disability Rights Oregon*	DR-10	The County, City, and service providers should better match individuals' mental health care needs with services:									
Partnership	*Disability Rights Oregon*	DR-11	Collaborate to create dual diagnosis treatment resources, expand mental health crisis services									
Partnership	*Disability Rights Oregon*	DR-12	Create medical respite care options to provide healthcare for people that may not meet hold criteria for a civil commitment/hospital									
Partnership	*Disability Rights Oregon*	DR-13	Hospitals should invest financially in these services									
Operations	*Disability Rights Oregon*	DR-14	Never House Individuals with Serious Mental Illness in Solitary Confinement									
Operations	*Disability Rights Oregon*	DR-15	House detainees with mental health concerns in areas of the jail where they can access programming									
Operations	*Disability Rights Oregon*	DR-16	Detainees cannot be denied programming, education, drug and alcohol treatment or early release opportunities because of their disabilities									
Partnership	*Disability Rights Oregon*	DR-17	Open the jail to outside service providers and community partners, tailored to address any identified needs or barriers									
Partnership	*Disability Rights Oregon*	DR-18	Detainees should be offered a more thorough evaluation. Interventions and conditions of confinement should address needs/barriers									
Partnership	*Disability Rights Oregon*	DR-19	Detainees with mental health concerns should receive appropriate mental health care/therapy. May require hiring additional clinical staff									
Operations	*Disability Rights Oregon*	DR-20	Currently, detainees are required to pay $10 to make a request for healthcare. This should be free, except for repetitive/frivolous requests									
Policy	*Disability Rights Oregon*	DR-21	Detainees should not be charged financially for treatment of their injuries, especially those that occurred as a result of staff violence									
Partnership	*Disability Rights Oregon*	DR-22	Discharge planning should include initiating the eligibility process for government benefits									
Policy	*Disability Rights Oregon*	DR-23	Create new protocol for responding to mental health related behavior in jail									
Policy	*Disability Rights Oregon*	DR-24	Discipline: One incident should be punished by no more than one infraction									
Policy	*Disability Rights Oregon*	DR-25	Discipline: Lessen the restrictiveness of disciplinary sanctions, shorten timeframes									
Policy	*Disability Rights Oregon*	DR-26	Discipline: Detainees should not be disciplined for behavior related to their disabilities									
Policy	*Disability Rights Oregon*	DR-27	Discipline: Solitary Confinement should not be imposed against for longer than 2 consecutive weeks or more than 3 weeks in a 60 days									
System Accountability	*Disability Rights Oregon*	DR-28	Discipline: The jail should track infractions by staff to prevent excessive or abusive use of the disciplinary process									
Operations	*Disability Rights Oregon*	DR-29	Restraints: Should only be used when ordered by a licensed clinician (or on an emergency basis pending arrival of clinical staff to the scene)									
Policy	*Disability Rights Oregon*	DR-30	Restraints: Should never be considered "voluntary." All uses of restraints should be subject to the same reporting and review requirements									
Partnership	*Disability Rights Oregon*	DR-31	Restraints: Seek technical assistance from National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint (NCTIS)									
System Accountability	*Disability Rights Oregon*	DR-32	Restraints: Track demographics									
Partnership	*Disability Rights Oregon*	DR-33	Suicide Precautions: Suicide risk/observation should be addressed by staff with basic mental health training, rather than deputies									
Operations	*Disability Rights Oregon*	DR-34	Suicide Precautions: Property/privileges related to mitigating suicide risk should be determined on a case-by-case basis by clinical staff									
Technology	*Disability Rights Oregon*	DR-35	Suicide Precautions: Consider new technology that allows vital signs to be monitored remotely, allowing a detainee to engage in normal activities									
System Accountability	*Disability Rights Oregon*	DR-36	Suicide Precautions: Track demographics									
Training	*Disability Rights Oregon*	DR-37	Suicide Precuautions: Train Staff to Appropriately Handle Mental Health Crises, Prevent Violence									
Training	*Disability Rights Oregon*	DR-38	Suicide Precautions: Require Crisis Intervention Training, basic mental health, and cultural competency training for all jail staff									
Training	*Disability Rights Oregon*	DR-39	Suicide Precautions: Require an enhanced level of training for staff in designated mental health units									
Operations	*Disability Rights Oregon*	DR-40	Preventing Staff Violence: Staff should be assigned to mental health units at the Facility Commander's discretion, rather than by seniority bidding									
Technology	*Disability Rights Oregon*	DR-41	Preventing Staff Violence: Install video cameras at MCDC with recording capacity; store footage for 180 days, including all areas of the jail									
Policy	*Disability Rights Oregon*	DR-42	Preventing Staff Violence: Require handheld video of any anticipated use of force									
System Accountability	*Disability Rights Oregon*	DR-43	Preventing Staff Violence: Uses of force should be subject to substantive review, including interviews of the detainee.witnesses, review video									
Partnership	*Disability Rights Oregon*	DR-44	Preventing Staff Violence: MCSO should consider contracting with an outside agency to conduct review of any significant use of force									
Policy	*Disability Rights Oregon*	DR-45	Preventing Staff Violence: Prohibit use of prone restraint									
System Accountability	*Disability Rights Oregon*	DR-46	Preventing Staff Violence: Identify, monitor, and where appropriate, discipline staff who abuse detainees. Terminate employee if serious misuse of force									
Policy	*NIC Use of Force Audit*	NIC-01	Review and revise UOF policies									
Policy	*NIC Use of Force Audit*	NIC-02	Provide clarity and authority of UOF Inspector role									
Policy	*NIC Use of Force Audit*	NIC-03	Response to Resistance (RTR) in policy language									

Policy	*NIC Use of Force Audit*	NIC-04	Recommend that we consider identifying levels of UOF to ensure appropriate reporting and investigative response										
Policy	*NIC Use of Force Audit*	NIC-05	Determine whether staff should view videos prior to writing reports										
Training	*NIC Use of Force Audit*	NIC-06	Improve Training in de-escalation										
Training	*NIC Use of Force Audit*	NIC-07	Improve Training in understanding of basic UOF principles										
Training	*NIC Use of Force Audit*	NIC-08	Improve Training in relevant case Law										
Training	*NIC Use of Force Audit*	NIC-09	Improve Training by using actual use of force videos										
Training	*NIC Use of Force Audit*	NIC-10	Improve Training in cultural sensitivity										
Training	*NIC Use of Force Audit*	NIC-11	Improve Training in supervisorial training										
Training	*NIC Use of Force Audit*	NIC-12	Improve Training in FTEP trainer training										
Training	*NIC Use of Force Audit*	NIC-13	Improve Training in Crisis Intervention Training (CIT)										
System Accountability	*NIC Use of Force Audit*	NIC-14	Establish a committee to design ongoing UOF data collection and reporting										
System Accountability	*NIC Use of Force Audit*	NIC-15	Determine UOF reduction goals										
System Accountability	*NIC Use of Force Audit*	NIC-16	Create professional expectations video for staff										
System Accountability	*NIC Use of Force Audit*	NIC-17	Improve data collecting and develop auditing processes for UOF										
System Accountability	*NIC Use of Force Audit*	NIC-18	Prepare for follow-up UOF analysis to be done										
System Accountability	*NIC Use of Force Audit*	NIC-19	Recommended specific data collection requirements for UOF										
System Accountability	*NIC Use of Force Audit*	NIC-20	Develop ongoing HIR/IAU reporting from the data collection										
System Accountability	*NIC Use of Force Audit*	NIC-21	Periodic random review of UOF videos by Command Staff to ensure accountability										
Operations	*NIC Use of Force Audit*	NIC-22	Log escort holds										
Policy	*NIC Use of Force Audit*	NIC-23	Revisions to and more clarity with the Inmate Manual										
System Accountability	*NIC Use of Force Audit*	NIC-24	Examine inmate disciplinary process and usage (high number of misconducts, why?)										
Operations	*NIC Use of Force Audit*	NIC-25	Medical screening of inmates prior to booking										
Operations	*NIC Use of Force Audit*	NIC-26	Consider metal detectors or “amnesty” box for inmates during booking										
Operations	*NIC Use of Force Audit*	NIC-27	Classification staff to interview inmates subsequent to fights										
Partnership	*NIC Use of Force Audit*	NIC-28	Increase participation with LPSCC (especially as it relates to response to the recommendations)										
System Accountability	*NIC Use of Force Audit*	NIC-29	Develop standard media messaging context for UOF										
Operations	*NIC Use of Force Audit*	NIC-30	Increase site security issues for - inmate worker closets found unlocked										
Operations	*NIC Use of Force Audit*	NIC-31	Increase site security issues for - medical clinic drawers found unlocked										
Operations	*NIC Use of Force Audit*	NIC-32	Increase site security issues for - reassessing inmate intake form										
Operations	*NIC Use of Force Audit*	NIC-33	Increase site security issues for - having inmates in booking face staff										
Operations	*NIC Use of Force Audit*	NIC-34	Increase site security issues for - Reviewing key control at MCIJ										
Technology	*NIC Use of Force Audit*	NIC-35	Provide portable cameras/video										
Technology	*NIC Use of Force Audit*	NIC-36	Improve video collection capability										
System Accountability	*2016 Corrections Grand Jury Report*	GJ-01	Expand partnerships with community services that support mental health e.g. collaborations with the Unity Center and implementing the LEAD program										
Operations	*2016 Corrections Grand Jury Report*	GJ-02	Grand Jury supports setting up mental health dorm at Inverness Jail										
System Accountability	*2016 Corrections Grand Jury Report*	GJ-03	Conduct a new Post Factor Study to determine the number of staff appropriate for the current size and responsibilities and needs of corrections staff										
Operations	*2016 Corrections Grand Jury Report*	GJ-04	When reviewing staffing needs, consider the desirability of supporting in person visiting hours with friends and family and the staff that it would require										
Training	*2016 Corrections Grand Jury Report*	GJ-05	County should assure that deputies receive the mandatory 80 hours of training every two years, training priorities include Crisis Intervention Training										
Partnership	*2016 Corrections Grand Jury Report*	GJ-06	Partner with Community resources to aid in transition of inmates upon release										
Operations	*2016 Corrections Grand Jury Report*	GJ-07	Multnomah County should reinstate the restitution center for successful transition of inmates from the jail to the community										
Operations	*2016 Corrections Grand Jury Report*	GJ-08	MCSO should maintain a list of one-time only expenditures which could be executed quickly when projected expenditures indicate a likely budget surplus										
Operations	*2016 Corrections Grand Jury Report*	GJ-09	Review of medical clinic hours due to deputy availability. Open hours should be expanded and more inmates served										
Operations	*2016 Corrections Grand Jury Report*	GJ-10	Review of use of Medical Request Form by Inmates. Concern inmates may not request care due to 10 co-pay cost										
Partnership	*2016 Corrections Grand Jury Report*	GJ-11	Expand Partnerships with community services that support mental health, such as collaboration with the Unity Center										
Partnership	*2016 Corrections Grand Jury Report*	GJ-12	MCSO should implement the LEAD program where mentally ill people, if appropriate,can be re-directed to social services as opposed to jail										
Operations	*2016 Corrections Grand Jury Report*	GJ-13	More Deputy Staff is needed to help with court call delays										
Partnership	*2016 Corrections Grand Jury Report*	GJ-14	Work with city to remove the newspaper boxes in front of the courthouse due to contraband issues										
Operations	*2016 Corrections Grand Jury Report*	GJ-15	Instead of GED, inmates should be encouraged to prepare for obtaining their high school diploma										
Technology	*2016 Corrections Grand Jury Report*	GJ-16	Recommends sustainable repairs to detention electronics and surveillance										
System Accountability	*2016 Corrections Grand Jury Report*	GJ-17	MCSO should examine the immediate and long term consequences of deputies working extended shifts on a number of consecutive days										
Policy	*2016 Corrections Grand Jury Report*	GJ-18	Each facility is encouraged to evaluate and update polices relative to emergency preparedness										
Training	*2016 Corrections Grand Jury Report*	GJ-19	Continue to prioritize a minimum of 40 hours of training for each Deputy annually										