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Office of the Sheriff

BY: _____



SANTA BARBARA COUNTY

HEADQUARTERS

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www.sbsheriff.org

August 17, 2016

BILL BROWN

Sheriff - Coroner

BERNARD MELEKIAN

Undersheriff

STATIONS

Buellton
140 W. Highway 246
Buellton, CA 93427
Phone (805) 686-8150

Carpinteria
5775 Carpinteria Avenue
Carpinteria, CA 93013
Phone (805) 684-4561

Isla Vista
6504 Trigo Road
Isla Vista, CA 93117
Phone (805) 681-4179

Lompoc
3500 Harris Grade Road
Lompoc, CA 93436
Phone (805) 737-7737

New Cuyama
70 Newsome Street
New Cuyama, CA 93254
Phone (661) 766-2310

Santa Maria
812-A W. Foster Road
Santa Maria, CA 93455
Phone (805) 934-6150

Solvang
1745 Mission Drive
Solvang, CA 93463
Phone (805) 686-5000

Sheriff - Coroner Office
66 S. San Antonio Road
Santa Barbara, CA 93110
Phone (805) 681-4145

Main Jail
4436 Calle Real
Santa Barbara, CA 93110
Phone (805) 681-4260

COURT SERVICES CIVIL OFFICES

Santa Barbara
1105 Santa Barbara Street
P.O. Box 690
Santa Barbara, CA 93102
Phone (805) 568-2900

Santa Maria
312 E. Cook Street, "O"
P.O. Box 5049
Santa Maria, CA 93456
Phone (805) 346-7430

Ms. Maria Millsaps
2015-2016 Santa Barbara County Grand Jury
Grand Jury Chambers
Santa Barbara County Courthouse
1100 Anacapa Street
Santa Barbara, California 93101

RE: Response to the Santa Barbara County Grand Jury Report Entitled
"Santa Barbara County Jail, Intake Screening Process"

Dear Ms. Millsaps:

Enclosed please find the Santa Barbara County Sheriff's Office response to the 2015-2016 Santa Barbara County Grand Jury Report entitled "*Santa Barbara County Jail, Intake Screening Process*".

Please do not hesitate to contact me if I can provide any additional information.

Sincerely,

BILL BROWN
Sheriff - Coroner

SANTA BARBARA COUNTY SHERIFF'S OFFICE
RESPONSE TO THE SANTA BARBARA COUNTY
GRAND JURY 2015-2016 REPORT

“SANTA BARBARA COUNTY JAIL, INTAKE SCREENING PROCESS”

FINDINGS AND RECOMMENDATIONS

Finding 1: *The Santa Barbara County Sheriff is using an antiquated paper system for maintaining inmate medical records at the Santa Barbara County Main Jail.*

Response to Finding 1: **The Sheriff’s Office agrees with the finding.**

Recommendation 1: *That the Santa Barbara County Sheriff implement a computerized medical record system for maintaining inmate medical records at the Santa Barbara County Main Jail.*

Response to Recommendation 1: **The recommendation has not yet been implemented.**

The contract between the Sheriff’s Office and Corizon Correctional Healthcare will expire at the end of March, 2017. The Sheriff’s Office, in conjunction with the Santa Barbara County Probation Department and Chief Executive Officer, are in the process of developing a Request For Proposals (RFP) as part of a competitive bidding process for awarding a contract for correctional healthcare. The RFP will include a provision for providing the installation and use of an electronic medical records system.

In addition, the Sheriff’s Office has secured funding for purchasing their own electronic medical record software in case the bidding process does not result in substantial savings for Santa Barbara County.

Finding 2: *The Santa Barbara County Sheriff Staff, has not always followed procedures, policies, and protocols pertaining to the intake process of arrestees.*

Response to Finding 2: **The Sheriff’s Office agrees with the finding.**

Recommendation 2: *That the Santa Barbara County Sheriff follow the established procedures, policies, and protocols pertaining to the intake process of arrestees.*

Response to Recommendation 2: **The recommendation requires further analysis.**

In any complex process, such as the Intake Screening Process, there are numerous opportunities to deviate from standard protocol and practice. The Sheriff’s Office recognizes this and continuously strives to identify failures and shortcomings of the many tasks performed. The report

does not provide enough information concerning an alleged breach of protocol for the Sheriff's Office to investigate and fully evaluate the exact circumstances involved. The Sheriff's Office does not agree with the Grand Jury in its assumption that a single instance of failure to follow protocol indicates a systemic problem with the Intake Screening Process.

The Sheriff's Office takes great strides to ensure staff members follow *all* established procedures, policies, and protocols designed to carry out the functions of the office. The Sheriff's Office also recognizes that it is a natural process for the procedures, policies, and protocols of any organization to continually evolve to keep pace with workload, staffing levels, and a myriad other factors.

Finding 3: *The Santa Barbara County Sheriff does not have adequate oversight methods in place for ensuring Corizon Health staff are following their medical intake procedures at the Santa Barbara County Main Jail before the inmate is transferred to custody officers for classification.*

Response to Finding 3: **The Sheriff's Office agrees with the finding.**

Recommendation 3: *That the Santa Barbara County Sheriff update Appendices A and B and add two signature blocks, one for medical clearance staff the other for the custody officer prior to classification at the Santa Barbara County Main Jail.*

Response to Recommendation 3: **The recommendation requires further analysis.**

Appendix A is no longer used. Appendix B has replaced Appendix A. Appendix B allows for an in-depth evaluation. As noted in the Grand Jury Report "Santa Barbara County Jail, Intake Screening Process," Registered Nurses (RN's) now conduct all medical intake screenings and utilize Appendix B.

A form entitled Mental Health Housing Evaluation (Appendix C) already existed. The use of this form has been expanded to include medical and has been updated to include signature blocks. It is entitled Health Housing Evaluation (Appendix D) and will be used for all arrestees at intake. Additionally, the Sheriff's Office *Classification Plan* has been updated with the following:

The receiving deputy will make a determination as to appropriate cell assignment while inmates are held in the Inmate Reception Center's holding cells. The receiving deputy will make this determination based on the information collected during the receiving process and the deputy's actual observation of the arrestee. A final determination shall not be made prior to receiving a completed Health Housing Evaluation from the Booking Nurse.

The *Classification Plan* has been updated and was issued to staff on 08/09/2016 (see Appendix E).

Finding 4: *The Santa Barbara County Sheriff medical intake prescreening questionnaire is now being conducted by Corizon Health registered nurses; however, the Medical Process Overview Chart does not reflect this.*

Response to Finding 4: **The Sheriff's Office agrees with the finding.**

In reference to the Medical Process Overview Chart, the Grand Jury requested a copy of this flowchart prior to the change of RN's conducting medical intake screening of arrestees entering the Jail (see Appendix F). The Sheriff's Office communicated this intake change to the Grand Jury and did not receive a request for an updated flowchart. This flowchart is a Sheriff's Office generated chart and is used for informal purposes. It has been updated and can be found in Appendix G.

Recommendation 4: *That the Santa Barbara County Sheriff continue to use Corizon Health registered nurses to conduct all medical intake screening of arrestees entering the Jail and include this provision in all future contracts and in the Medical Process Overview Chart.*

Response to Recommendation 4: **The recommendation has been implemented.**

The Sheriff's Office does continue to utilize Corizon Health registered nurses to conduct all medical intake screening of arrestees entering the jail and will include this provision in all future contracts.

Finding 5: *The Santa Barbara County Sheriff's Custody Operations Policy and Procedures Manual regarding the intake process needs revision.*

Response to Finding 5: **The Sheriff's Office disagrees with the finding.**

As stated in the Grand Jury Report "Santa Barbara County Jail, Intake Screening Process," these procedures are not outlined in the Receiving Screening Process (see Appendix H). These protocols are only referenced in the Custody Operations Policy and Procedures Manual, Section 303, Use of Sobering/Observation Cell. However, Appendix H is a Corizon generated form used in the contract for informational purposes. This form is not related to Custody Operations Policy and Procedures, Section 303, Use of Sobering/Observation Cell. Therefore, a Policy and Procedures update is not required.

Recommendation 5:

That the Santa Barbara County Sheriff update the Custody Operations Policy and Procedures Manual to reflect the new changes being implemented to the intake process.

Response to Recommendation 5: The recommendation has been implemented.

As previously stated, the Classification Plan has been updated and was issued to staff on 08/09/2016 (see Appendix E).

Finding 6: *The Santa Barbara County Sheriff staff has not always confirmed arrestees were medically cleared by Corizon Health staff prior to classification and placement into the Jail population.*

Response to Finding 6: The Sheriff's Office agrees with the finding.

Recommendation 6: *That the Santa Barbara County Sheriff initiate a procedure to ensure that all medical intake procedures are properly completed prior to classification and that inmate classification not be allowed to occur without verification of the completion of medical evaluation and clearance.*

Response to Recommendation 6: The recommendation requires further analysis.

The Santa Barbara County Sheriff's staff follows the established procedures, policies, and protocols pertaining to the intake process of arrestees. When exigent circumstances occur within the jail, these processes may not be followed verbatim as written with the potential to be forgotten. The Sheriff's Office will reiterate the importance of adhering to this protocol regardless of circumstance to its Custody Deputies.

As previously stated, the Health Housing Evaluation form (CO-1039, Appendix D) has been updated with the signature blocks and is used to communicate medical/mental health-related concerns for re-housings within the jail. This form will now be used for all arrestees at intake.

APPENDIX A

SBSO SANTA BARBARA SHERIFF MEDICAL PRE-SCREENING

Inmate:

PLACEMENT REC:

Officer:

DATE:

ALLERGIES:

- SB
- SM
- COURT

HEALTH INS

- YES

PRIVATE

OTHER

- NO

WORKER'S COMP.

- YES
- NO

OFFICER VISUAL OBSERVATIONS:

1. WAS THE INMATE BROUGHT VIA THE HOSPITAL? IF YES, WHAT HOSPITAL?

- YES
- NO

2. DID THE INMATE ENTER THE JAIL UNDER HIS/HER OWN POWER? IF NO, HOW?

- YES
- NO

3. IS THE INMATE UNCONSCIOUS OR SHOWING SIGNS OF ILLNESS, INJURY, BLEEDING, PAIN, OR OTHER SYMPTOMS SUGGESTING THE NEED FOR IMMEDIATE EMERGENCY MEDICAL REFERRAL? IF YES, WHAT?

- YES
- NO

4. IS THE INMATE'S MOBILITY RESTRICTED IN ANY WAY? IF YES, HOW?

- YES
- NO

5. ARE THERE ANY VISIBLE SIGNS OF FEVER, JAUNDICE, SKIN LESIONS, RASH OR INFECTIONS, CUTS, BRUISES, MINOR INJURIES, NEEDLE MARKS OR BODY VERMIN? IF YES, WHAT?

- YES
- NO

6. DOES THE INMATE APPEAR TO BE UNDER THE INFLUENCE OF, OR WITHDRAWING FROM, DRUGS OR ALCOHOL? IF YES, WHAT?

- YES
- NO

7. DOES THE INMATE HAVE A PROSTHESIS (CRUTCHES, EYEGLASSES, WHEELCHAIR, DENTURES, ARTIFICIAL LIMB, HEARING AID, ETC.)? IF YES, WHAT?

- YES
- NO

8. DOES THE INMATE EXHIBIT ANY SIGNS THAT SUGGEST THE RISK OF SUICIDE, ASSAULT OR ABNORMAL BEHAVIOR? IF YES, WHAT?

- YES
- NO

9. DID THE INMATE GO DIRECTLY TO THE SAFETY CELL? (CONTACT MEDICAL)

- YES
- NO

INMATE QUESTIONNAIRE:

10. ARE YOU TAKING ANY MEDICATIONS PRESCRIBED BY A PHYSICIAN OR PSYCHIATRIST NOW? IF YES, NAME MEDICATION AND LAST TIME TAKEN

- YES
- NO

11. DID YOU COME INTO CUSTODY WITH PRESCRIBED MEDICATIONS?

IF YES, WHAT?

- YES
- NO

12. HAVE YOU BEEN TREATED FOR (CHECK AS APPROPRIATE)

- ASTHMA
- DIABETES
- ALCOHOL SEIZURES

APPENDIX A

SBSO SANTA BARBARA SHERIFF MEDICAL PRE-SCREENING

Inmate:
Officer:

PLACEMENT REC:
DATE:

- DELIRIUM TREMENS (DT'S)
- EPILEPSY
- HEART CONDITION
- HIGH BLOOD PRESSURE
- MENTAL HEALTH PROBLEMS
- ULCER

ANY OTHER MEDICAL CONDITION? IF YES, WHAT?

- YES
- NO

13. DO YOU NOW HAVE A CONTAGIOUS OR COMMUNICABLE DISEASE OR BEEN EXPOSED TO ANYONE WITH ONE? (I.E., AIDS, HEPATITIS, TUBERCULOSIS OR SEXUAL TRANSMITTED DISEASE) IF YES, WHAT?

- YES
- NO

14. DO YOU SUFFER FROM SHORTNESS OF BREATH , COUGH FOR 3 OR MORE WEEKS, BLOODY SPUTUM, NIGHT SWEATS OR FATIGUE? IF YES, WHAT?

- YES
- NO

15. HAVE YOU NOTICED A DECREASE OR INCREASE IN WEIGHT RECENTLY? IF YES, HOW MANY POUNDS?

- YES
- NO

16. HAVE YOU BEEN HOSPITALIZED BY A PHYSICIAN OR PSYCHIATRIST IN THE PAST YEAR? WHEN? WHERE?

- YES
- NO

17. HAVE YOU FAINTED OR HAD A HEAD INJURY WITHIN THE PAST 72 HOURS? IF YES,

- YES
- NO

18. HAVE YOU EVER CONSIDERED OR ATTEMPTED SUICIDE? IF YES, WHEN?

- YES
- NO

19. ARE YOU SUICIDAL NOW?

- YES
- NO

20. DO YOU USE DRUGS?

- YES
- NO

WHAT KIND?

HOW OFTEN?

LAST TIME?

HOW MUCH?

21. DO YOU USE ALCOHOL?

- YES
- NO

WHAT KIND?

HOW OFTEN?

LAST TIME?

HOW MUCH?

FEMALES

22. WHEN WAS YOUR LAST PERIOD?

23. ARE YOU TAKING BIRTH CONTROL PILLS?

- YES
- NO

24. ARE YOU PREGNANT, RECENTLY DELIVERED OR MISCARRIED, OR EXPERIENCING ABDOMINAL PAIN OR DISCHARGE? IF YES, WHAT, AND NOTIFY MEDICAL

- YES
- NO
- PREGNANT
- RECENTLY DELIVERED

APPENDIX A

SBSO SANTA BARBARA SHERIFF MEDICAL PRE-SCREENING

Inmate:

PLACEMENT REC:

Officer:

DATE:

- MISCARRIED**
- EXPERIENCING ABDOMINAL PAIN OR DISCHARGE**

I have answered all questions. I have been told and shown how to obtain medical services and advised on how to obtain medication upon release. I hereby give my consent for professional services to be provided to me through Corizon Health, Inc

Inmate's Signature: _____ Date: _____ Officer's Signature: _____ Date: _____

APPENDIX B



Intake and Receiving Screening

| | | | | | | |
|---|--|------------------------------------|---|---------------|--|-------------------------------|
| Last Name: | | First: | | MI: | ID: | |
| Date: | Time: | <input type="checkbox"/> AM | <input type="checkbox"/> PM | DOB: | Age: | |
| Sex: | <input type="checkbox"/> Male <input type="checkbox"/> Female | Alias: | | | | |
| Most recent incarceration: | <input type="checkbox"/> None | When: | Where: | | | |
| Have you ever been incarcerated here: | <input type="checkbox"/> No <input type="checkbox"/> Yes | When: | | | | |
| Intake refused: | <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Interpreter used: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Name: | Service: | | | |
| Inmate transfer: | <input type="checkbox"/> Yes <input type="checkbox"/> No | Records received: | | | | |
| Private insurance: | <input type="checkbox"/> No <input type="checkbox"/> Yes (Name): | | | | | |
| VITAL SIGNS <input type="checkbox"/> One or more refused | | | | | | |
| Height | Weight | Temperature | Pulse <input type="checkbox"/> A <input type="checkbox"/> P | Respirations | Blood Pressure <small>*Recheck if Indicated</small> | Pulse Ox (optional) |
| _____ | _____ | _____ | _____ Initial | _____ Initial | _____ Initial | _____ Initial |
| <input type="checkbox"/> Act <input type="checkbox"/> Rptd | <input type="checkbox"/> Act | <input type="checkbox"/> Not taken | *Recheck | *Recheck | *Recheck | *Recheck |
| Body Mass Index (BMI) (Weight x 703) / (height in inches x height in inches): | | | | | | If >25 do random fingerstick: |
| Physical Build/Characteristics: | | | | | | |
| <input type="checkbox"/> Average <input type="checkbox"/> Thin <input type="checkbox"/> Slender <input type="checkbox"/> Small in stature <input type="checkbox"/> Muscular <input type="checkbox"/> Large in stature <input type="checkbox"/> Overweight <input type="checkbox"/> Obese | | | | | | |
| CRITICAL OBSERVATIONS | | | | | | |
| Urgent/Emergent Medical Referral <input type="checkbox"/> None identified <input type="checkbox"/> Yes, check all that apply | | | | | | |
| <input type="checkbox"/> Severe injury <input type="checkbox"/> Life threatening illness <input type="checkbox"/> Uncontrolled bleeding <input type="checkbox"/> Severe pain <input type="checkbox"/> Head trauma with mental status changes <input type="checkbox"/> Other: _____ | | | | | | |
| Urgent/Emergent Mental Health Referral <input type="checkbox"/> No <input type="checkbox"/> Yes, check all that apply | | | | | | |
| <input type="checkbox"/> Active hallucinations <input type="checkbox"/> Active delusions <input type="checkbox"/> Actively suicidal <input type="checkbox"/> Other: _____ | | | | | | |
| Responsiveness (choose one) | | | | | | |
| <input type="checkbox"/> Alert <input type="checkbox"/> Lethargic <input type="checkbox"/> Verbal stimulus <input type="checkbox"/> Painful stimulus <input type="checkbox"/> Unresponsive (Call 911) Describe: _____ | | | | | | |
| Oriented to Person, Place, and Time <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| Skin Observations <input type="checkbox"/> None identified <input type="checkbox"/> Yes, check all that apply | | | | | | |
| <input type="checkbox"/> Tattoos <input type="checkbox"/> Varicella (chicken pox) <input type="checkbox"/> Herpes Zoster (shingles) <input type="checkbox"/> Lice/Pediculosis <input type="checkbox"/> Jaundice <input type="checkbox"/> Needle marks <input type="checkbox"/> Surgical scars <input type="checkbox"/> Open lesions <input type="checkbox"/> Pallor <input type="checkbox"/> Sores <input type="checkbox"/> Lacerations <input type="checkbox"/> Tracks Other: _____ Describe: _____ | | | | | | |
| Mobility Restrictions/Physical Disabilities/Impairments <input type="checkbox"/> No <input type="checkbox"/> Yes, check all that apply | | | | | | |
| <input type="checkbox"/> Deformity <input type="checkbox"/> Cast <input type="checkbox"/> Paraplegic <input type="checkbox"/> Wheel chair <input type="checkbox"/> CPAP <input type="checkbox"/> Brace <input type="checkbox"/> Blind <input type="checkbox"/> Deaf <input type="checkbox"/> Amputation <input type="checkbox"/> Splint <input type="checkbox"/> Quadriplegic <input type="checkbox"/> Crutches/Cane <input type="checkbox"/> Other: _____ Comments: _____ | | | | | | |
| HISTORY | | | | | | |
| Major surgery or medical hospitalization within past year <input type="checkbox"/> No <input type="checkbox"/> Yes, check all that apply and include date | | | | | | |
| <input type="checkbox"/> Brain surgery _____ <input type="checkbox"/> Heart surgery _____ <input type="checkbox"/> Abdominal surgery _____ <input type="checkbox"/> Stroke _____ <input type="checkbox"/> MI _____ <input type="checkbox"/> Transplant _____ <input type="checkbox"/> Due to traumatic injury _____ <input type="checkbox"/> Other: _____ | | | | | | |

APPENDIX B

Last Name: _____

First: _____

MI _____

ID: _____

Female History

Date of LMP: _____ Unknown N/A

Are you currently pregnant: Yes No Maybe / Don't know

Pregnancy test: Yes No Scheduled Refused Test result: (+) (-) Fingertstick result (if pregnant)

MEDICATION REPORTED None Unknown See below See attached form

| Name / Dose | Frequency / Last Taken | Prescribed by or Provided by: | Verification Through |
|-------------|----------------------------|-------------------------------|---|
| | Freq: _____ Last: _____ | | <input type="radio"/> Practitioner <input type="radio"/> Pharmacy <input type="radio"/> Unable to verify |
| | Freq: _____ Last: _____ | | <input type="radio"/> Practitioner <input type="radio"/> Pharmacy <input type="radio"/> Unable to verify |
| | Freq: _____ Last: _____ | | <input type="radio"/> Practitioner <input type="radio"/> Pharmacy <input type="radio"/> Unable to verify |
| | Freq: _____ Last: _____ | | <input type="radio"/> Practitioner <input type="radio"/> Pharmacy <input type="radio"/> Unable to verify |

ALLERGIES: Do you have any allergies (food, medication, environmental)? No Yes See attached

| Allergy | Reaction Type (Hives, rash, SOB, anaphylaxis shock) | Allergy | Reaction Type (Hives, rash, SOB, anaphylaxis shock) |
|---------|---|---------|---|
| | | | |
| | | | |
| | | | |

SUBSTANCE USE / ABUSE

Ever been hospitalized for substance abuse: No Yes Detoxification or outpatient treatment: No Yes

Alcohol Use: Do you drink alcohol: No Yes Type: _____ Last use: _____

How much: _____ How often: _____

If 2 or more Ever had alcohol withdrawals, tremors, seizures or DTs when you stopped drinking? No Yes (CIWA)when: _____

“Yes” answers Have you ever felt you should cut down on your drinking? No Yes

complete Have people annoyed you by criticizing your drinking? No Yes

CIWA and Have you ever felt bad or guilty about your drinking? No Yes

mental health referral Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? No Yes

Substance/Drug Use/Rx: Do you use drugs Yes No

Do you use injectable drugs: No Yes Last injectable use: _____

| Rx or Street | How often? | How much? | Last use? |
|----------------|------------|-----------|---|
| Heroin | | | <input type="checkbox"/> Hx of withdrawal |
| Narcotics | | | <input type="checkbox"/> Hx of withdrawal |
| Benzodiazepine | | | <input type="checkbox"/> Hx of withdrawal |

Methamphetamines Cocaine Other:

COMMUNICABLE DISEASES

HIV/AIDS Do you have HIV infection or AIDS: No Yes Are you taking medications: No Yes

TB Symptoms Do you have any of the following: Weight Loss: Yes No Night sweats: Yes No

Appetite loss: Yes No Fever: Yes No Persistent cough 2+ weeks: Yes No

Coughing blood: Yes No Weak/tired: Yes No None

TB Skin Test Prior +PPD: Yes No Plant PPD now: Yes No

Location of PPD: LFA RFA

Date planted: _____ Planter's initials: _____

APPENDIX B

Last Name: _____

First Name: _____

MI: _____

ID: _____

MEDICAL PROBLEMS

Do you have any current or ongoing medical problems we should know about Yes, complete applicable No, proceed to BH section
 Do you have any dietary needs: No Yes

Asthma How long: _____ Last asthma attack: _____ ER visit in last 90 days: Yes No
 If yes, when: _____ Hospitalization in the last year: No Yes, when: _____
 Have you ever had a tube put down your throat so that a machine breathes for you No Yes, when: _____
 Currently on steroids: Yes No Peak flow: Yes No, why: _____
 Peak flow #1: _____ Peak flow #2: _____ Peak flow #3: _____

Cardiovascular/ Cerebrovascular Angina Yes No Atrial fibrillation Yes No Stents Yes No
 Pacemaker Yes No Heart attack Yes No Internal defibrillator Yes No
Ask each question Bypass surgery Yes No Endocarditis Yes No CHF Yes No
 Blood clot in lungs or legs: Yes No Last CVA: _____ Last TIA: _____
 Are you taking Warfarin, Coumadin or Jantoven: Yes No Are you taking another blood thinner Yes No
 Date of onset: _____ Last episode: _____
 Comments: _____

Hypertension How long: _____
 Are you currently taking three or more anti-hypertensives: Yes No

Diabetes How long: _____ Fingertick: _____ Not done, reason: _____
 Are you currently taking medication(s): Yes No Are you taking insulin: Yes No
 If fingertick > 300, ask the following: Nausea: Yes No Vomiting: Yes No
 Excessive thirst: Yes No Urine ketones (if taken): Yes No Not taken, reason: _____
 Have you ever been hospitalized for your diabetes: No Yes, dates: _____
 Comments: _____

Epilepsy/Seizure Last Seizure: _____
 More than one seizure a month: Yes No Two or more anticonvulsants: Yes No

Gastrointestinal GERD: Yes No Hiatal hernia: Yes No
 Have you ever vomited blood: No Yes Frequency _____ Last: _____
 Comments: _____
 Ever had dark, black stools from bleeding: No Yes Frequency: _____ Last: _____
 Comments: _____

Cancer Do you currently have cancer: No Yes Are you currently being treated for cancer: No Yes
 Type: _____ Comments: _____

Dialysis Type: Hemodialysis Peritoneal Number of times per week: _____
 Last dialyzed: _____

COPD/Emphysema O₂ dependent: Yes No Peak flow: _____ Not taken

HCV Yes No

Other: _____

BEHAVIORAL HEALTH

Do you have any current mental health complaints? Yes No Do you feel vulnerable because you are incarcerated? Yes No
 Have you ever been diagnosed with a mental illness: No Yes, check which illness: Schizophrenia Bipolar Other
 History of outpatient treatment No Yes Within the last year: Yes No History of psychotropic medications Yes No
 History of psych hospitalization: Yes No Within the last year: Yes No
 History of hearing things: Yes No History of seeing things: Yes No

APPENDIX C

SHERIFF'S DEPARTMENT
SANTA BARBARA COUNTY

MENTAL HEALTH
INMATE HOUSING EVALUATION

To: Classification _____

Date: _____

Inmate: _____

Time: _____

CID# _____

Booking: _____

In response to your request, the inmate listed above appears to be appropriate for the following suggested housing at this time.

- SAFETY CELL
- CAMERA CELL ONLY (C-7, C-8, SI-21, H-1, H-2, H-9)

Reason: _____

- SINGLE PERSON CELL, CAMERA NOT NECESSARY

Reason: _____

- NO MSF
- FOR NORMAL CLASSIFICATION PROCEDURE
- OTHER _____

Reason: _____

Mental Health Staff

Signature: _____

CO-1039 (11/2009)(M/H)

APPENDIX D

SHERIFF'S DEPARTMENT
SANTA BARBARA COUNTY

HEALTH HOUSING EVALUATION

To: Classification

Date:

Inmate: _____ Time: _____
CID# _____ Booking: _____

In response to your request, the inmate listed above appears to be appropriate for the following suggested housing at this time.

- SAFETY CELL
- CAMERA CELL ONLY (C-7, C-8, SI-21, H-1, H-2, H-9)

Reason: _____

- SINGLE PERSON CELL, CAMERA NOT NECESSARY

Reason: _____

- NO MSF
- FOR NORMAL CLASSIFICATION PROCEDURE
- OTHER _____

Reason: _____

Medical/Mental Health Staff Classification Deputy
Signatures: _____ / _____

CO-1038 (06/2016)(M/H)

APPENDIX E

II Classification Procedures:

A. Classification at Receiving

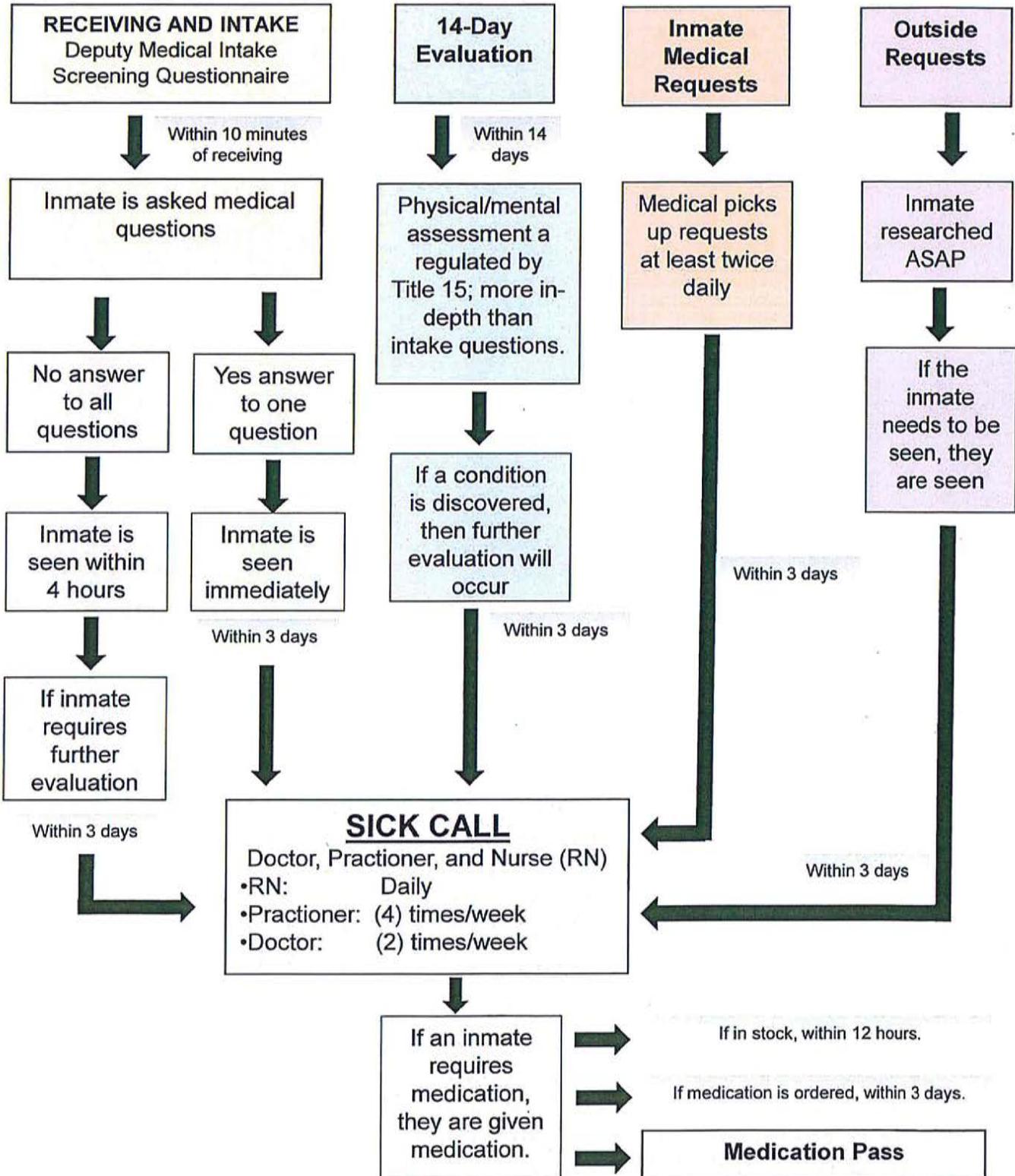
The receiving deputy plays an integral role in the inmate classification process. They are the first member of the correctional staff to come in contact with the arrestee. Many times the receiving deputy may determine that an individual is intoxicated, under the influence of drugs and/or mentally disoriented. The receiving deputy will make a determination as to appropriate cell assignment while inmates are held in the inmate reception centers holding cells. The receiving deputy will make this determination based on the information collected during the receiving process and the deputy's actual observation of the arrestee. A final determination shall not be made prior to receiving a completed Health Housing Evaluation from the Booking Nurse.

In the event that the inmate states or the receiving deputy observes a medical condition requiring immediate action, the receiving deputy will contact the medical department for an evaluation. In the event that the arrestee relays, or the receiving officer observes behavior that is indicative to suicide potential, the receiving deputy will immediately contact the Shift Commander, Jail Medical (Corizon) and the Mental Health unit for evaluation.

APPENDIX F

MEDICAL PROCESS OVERVIEW

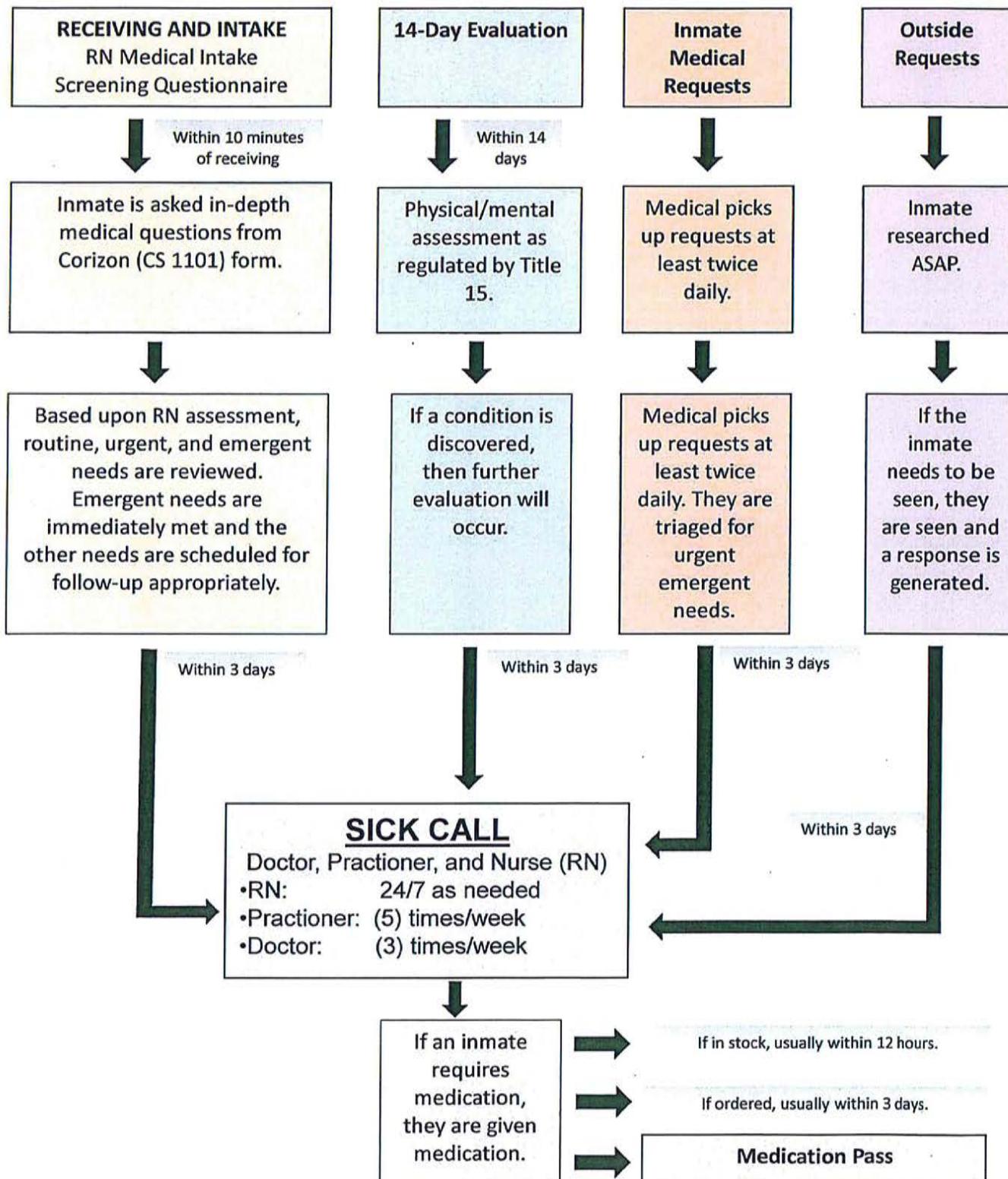
Medical Referral Sources



APPENDIX G

MEDICAL PROCESS OVERVIEW

Medical Referral Sources



APPENDIX H

Receiving Screening Process

