TEXAS COMMISSION ON JAIL STANDARDS
SPECIAL INSPECTION REPORT

Facility Name: El Paso County Jail **Date:** October 30, 2017

Item	Section	Paragraph	Comments
1	273	.2(7)	Provide procedures for the distribution of prescriptions in accordance with written instructions from a physician by an appropriate person designated by the sheriff/operator. **After reviewing video and medical protocols regarding the distribution of medications, it was determined that medical staff failed to administer medications in accordance with protocols. Per protocols, medical staff is required to observe the inmates taking medication(s). After reviewing video, it was determined that the medical staff did not observe the inmate taking his/her medications. During an investigation of the in-custody death of I/M Robert Gallegos, it was noted in the report that the investigator also found the medications, that were to supposed to have been taken by the inmate, sitting on the table in his cell.**
2	273	.3	All medical instructions of designated physicians shall be followed. **After reviewing the medication administration records for I/M Brooks Plecas-Perrin and a timeline provided by the medical staff, it was determined that he did not receive all of his medications per the doctor's orders.**
3	273	.4(b)	Separate health records shall reflect all subsequent findings, diagnoses, treatment, disposition, special housing assignments, medical isolation, distribution of medications, and the name of any institution to which the inmate's health record has been released. **After reviewing documentation received from the El Paso County medical staff, it was determined that there was not a Medical Administration Record (MAR) maintained of all medications dispensed to I/M Plecas-Perrin. There was a missing MAR that could not be located to verify that the inmate received his medications per the doctor's orders.**
4	275	.1	Observation shall be performed at least every 30 minutes in areas where inmates known to be assaultive, potentially suicidal, mentally ill, or who have demonstrated bizarre behavior are confined. **After reviewing documentation and video, it was determined that jailers failed to conduct visual face to face observation of inmates in separation cells in accordance with minimum jail standards. In regards to the death in custody of I/M Robert Gallegos, it was confirmed and verified that inmates housed in POD 1400 Cellblock 10 are to be observed at least every 30 minute observations. Video and logs revealed that jail staff exceeded the required 30 minute observations by as few as 2 minutes and by as many as 11 hours and 7 minutes.**

Jackie Benningfield

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