DEATHS IN CUSTODY

SUMMARY

Since July 1, 2009, when the current Santa Barbara County Civil Grand Jury (Jury) took office, two inmates have died in the Santa Barbara County Main Jail (Jail) operated by the Santa Barbara County Sheriff's Department (Sheriff). The first death occurred in October 2009, and the second in November 2009. The Coroner determined both to be accidental.

The first inmate who died while in custody, J.E. was a 71-year-old male with alcohol withdrawal and mental status issues who choked to death on his sandwich in a single-person observation cell on October 17, 2009. The second inmate, L.B., was a 29-year-old male who died in his cell as the result of a heroin overdose on November 25, 2009.

While the deaths of these two individuals are tragic, the Jury's primary concern is with jail practices and procedures surrounding these deaths and to determine if anything should be done differently to minimize the possibility of future incidents of this nature. These steps would include: (1) reviewing the protocols for observing inmates like J.E. who are mentally and/or physically impaired; (2) reviewing the search protocols to try more effectively to prevent the introduction of drugs and other contraband into the Jail; (3) providing additional training to custody deputies in the use of medical equipment needed in an emergency, and (4) improving access to information which may potentially be useful in the Jury's investigation of deaths-in-custody.

INTRODUCTION

In 2007, the federal Bureau of Justice Statistics reported that 7,008 persons died while in custody in local jails in the United States during the period 2000-2006. Fifty percent of the deaths were the result of illness (including 3 percent attributable to AIDS), and 30 percent were due to suicides. Drug/alcohol intoxication accounted for another 7 percent and accidents about 3 percent. The remaining 10 percent were due to homicide or other causes. The Coroner found that the two deaths in custody, which are the topic of this investigative report, were accidental. One was due to an inmate choking on his food, the other to a drug overdose. The following sections describe the methodology used by the Jury to investigate the circumstances of the two deaths, discuss those circumstances, make specific findings of fact and offer specific recommendations intended to address the Jury's concerns.

METHODOLOGY

California Penal Code, Section 919(b), requires civil grand juries to examine the "condition and management of the public prisons" in their respective counties. Pursuant to that statutory obligation, the Santa Barbara County Civil Grand Jury (Jury) reviewed the circumstances surrounding the two Jail deaths occurring since July 1, 2009. That investigation included a wide variety of activities.

Senior custody officials were interviewed at the Main Jail (Jail) and Jury members toured parts of the facility to view both the single-person observation cell where J.E. died and the internal control room where he was monitored in his cell 24 hours per day. Members of the Jury also were shown a video recording of the last approximate 40 minutes of his life.

Many records were provided pursuant to the Jury's request and reviewed in detail. These documents included, among others, custody officer observation logs of J.E., medical and mental health progress notes for J.E. and L.B., medical records for both inmates, medical logs and equipment maintenance logs. Sheriff custody operations policies and procedures for searches, safety checks and use of observation cells also were reviewed, as was the 2006-09 contract and 2009-11 contract extension between the Sheriff and Prison Health Services, Inc. (PHS), the private contractor engaged to provide medical services at the Jail.

Several typed narratives and handwritten statements prepared by custody deputies who had personal knowledge of the events, and two Coroner Reports related to the deaths were also reviewed.

BACKGROUND AND DISCUSSION

A. Background Of The Death Of J.E.

The first of the two deaths involved J.E., a 71-year-old male characterized by medical staff as an alcoholic who had been booked in on October 11, 2009, on charges that included brandishing a weapon other than a firearm. J.E. was evaluated by medical staff; on October 14, 2009, his condition was described as "deteriorating" and he was transferred to a single person observation cell. There, the internal control room deputy could monitor him 24 hours per day via closed circuit video. An intercom system was also available in the cell for two-way communication between the internal control room and the cell. In addition, twice every one-half hour, J.E. was to be observed by custody deputies through a large window in his cell door.

Medical health progress notes for J.E., dated October 16, 2009, commented that the inmate was urine incontinent and unable to walk without assistance. Medical progress notes prepared on October 17, 2009, the day he died, described him as too "disoriented" even to be assessed. J.E. had been incarcerated previously in September 2009, was diagnosed as "psychotic" and a physician prescribed an antipsychotic drug to treat his" schizoaffective" disorder.

The observation log for October 17, 2009, revealed that for much of that day J.E. was observed either sitting or lying down. At 1635 hours a "receiving sack" containing his evening meal (a peanut butter sandwich, milk and an orange) was left for him in the cell door food slot since the inmate appeared at that time to be asleep. At 1654 hours, a custody deputy looked into the cell through the window and observed that J.E. was in a slumped, seated position leaning against the door. The deputy then determined to shake the door to try to rouse J.E. who appeared to be sleeping. When J.E. could not be awakened, even after the door was shaken, the deputy entered the cell and determined that he was not breathing.

Medical assistance was summoned at about 1655 hours. When the responding nurse arrived, she found J.E. lying face up on the cell floor. He had no pulse, no respiration and had what appeared to be thick secretions in his mouth, including "some food." Despite efforts to restore respiration, J.E. was pronounced dead in his cell by paramedics at 1727 hours. A post-mortem examination was performed on October 20, 2009, which determined J.E. had choked on a portion of his sandwich. The official cause of death was described as, "asphyxia by aspiration of food bolus."

Discussion Of The Death Of J.E.

As part of the Jury's inquiry into the circumstances of J.E.'s death, members inspected the interior of the cell where the inmate died, as well as the internal control room where the monitors displayed images of more than 20 different locations simultaneously. Although the camera view of the cell is expansive (the camera is located in the center of the ceiling), the glass panel in front of the lens appeared upon inspection to be scuffed and/or dirty. That condition potentially could degrade the video image of the inmate and his activities within the cell. Indeed, the video image viewed by the members of the Jury appeared to be "grainy" and only J.E.'s gross motor movements could be discerned with any precision.

The internal control room, where the video monitors are located, is staffed by only one deputy at a time who is assigned to a 12-hour shift. This is a demanding task requiring the deputy to devote full attention to all of the images, all of the time. Included among the locations monitored, in addition to cells and hallways, are: (a) the receiving desk where incidents involving a need to summon assistance promptly is always a possibility; and (b) an outside sliding gate to allow vehicle access to and from the premises, which is operated remotely by the control room deputy.

Although J.E.'s death in his cell was a distressing occurrence, the Coroner found that he choked to death accidentally. Whether his death could have been avoided had closer attention been paid to this "at risk" inmate, bearing in mind his advanced age, his deteriorated physical condition and his tenuous mental status, is a question which cannot be answered without a detailed examination of the events. An in-depth inquiry of that sort would also require medical knowledge and investigative expertise that the Jury does not possess.

Jurors observed the video and could not see J.E. display signs of breathing distress so labored as to alert either the deputies periodically observing him through the cell door window, or the deputy watching the internal control room screen, to the possibility that he was in the process of choking to death. Whether a custody deputy looking through the window in J.E.'s cell door, or

watching the video monitor, could have suspected that J.E. was in respiratory distress, and not simply resting or asleep, is a conclusion which the Jury, on the limited facts at its disposal, is not able to reach with any degree of certitude.

B. Background Of The Death Of L.B.

The second death involved L.B. who died of a drug overdose while in custody. It is of special concern to the Jury due to: (a) its timing (two weeks after he was booked); (b) its cause (acute morphine [heroin] intoxication resulting from an overdose of heroin which had been smuggled into the Jail) and (c) unsuccessful efforts by custody deputies and a PHS nurse to revive him and confusion, at least, with respect to the use of oxygen equipment in those efforts.

L.B. was booked in on November 10, 2009, on drug related and other offenses and remained continuously in custody while awaiting trial until his death on November 25, 2009. He was no stranger to the Jail, having previously been incarcerated there both in September, and again in October 2009. A PHS doctor's mental health progress notes dated October 5, 2009, indicated that L.B. was taking medication for heroin dependence. When booked in on November 10, 2009, it was reported that he was under the influence of drugs.

Narrative statements prepared by custody personnel who were present at the scene of L.B.'s overdose on November 25, 2009, revealed the following: at 0850 hours, L.B. was observed lying on his back on his cell bunk; when a deputy tried to rouse him, he found L.B. to be unresponsive; his mouth was open; his skin was pale and his eyes were closed. When no pulse was detected, a "man down" call for medical assistance was made and a PHS staff nurse (an RN) arrived to find L.B. "still warm" to the touch. She promptly directed that he be placed on the floor so that cardio-pulmonary resuscitation (CPR) could be started.

The nurse then told one of the deputies to place an oxygen mask over the inmate's mouth. However, according to the statement of another custody deputy who was present, she was unable to get the oxygen tank to work properly. Another deputy commented in his written narrative that when the nurse told someone else to "hook up the oxygen," the deputy could not do so, explaining it was a function "we are not trained in."

Another custody deputy related in his narrative statement that when the PHS nurse first arrived she declared she would, "set up the oxygen mask instead of breaths." However, when the person whom she had directed, "to assemble and operate the oxygen bottle, hoses, and mask," asked for assistance, the nurse "appeared to be unable to help [and] pulled the oxygen equipment away and instructed that we were to administer breaths."

Despite continued efforts to revive L.B., including the use of a defibrillator, no heart rhythm could be detected. He was removed from the cell and transported to the emergency room at Cottage Hospital where he was pronounced dead. At the emergency room, a small clear plastic "baggie" containing several unidentified pills was found stuffed into one of his socks. A post-mortem examination was performed on November 30, 2009, and following receipt in December of a forensic toxicology report, the Coroner concluded that L.B. died accidentally due to "acute morphine (heroin) intoxication."

DISCUSSION OF THE DEATH OF L.B.

L.B. died of a heroin overdose on November 25, 2009, while in custody at the Jail where he had been incarcerated for two weeks. His access to heroin should not have been possible. As a result, an investigation into the circumstances of his death began promptly on the day he died. The narrative statements of custody deputies who conducted that investigation disclosed that a search of the cell area was commenced late in the morning on November 25, 2009, and led to the discovery of two clear plastic bags containing various pills, pill fragments and a black substance, which appeared to be "tar heroin." In addition, marijuana was discovered in the fingertip of a latex glove. The pills and pill fragments were identified by the medical staff doctor as consisting of one 30 mg. Oxycontin (a pain reliever), 38 "pieces" of Alprazolam (an anti-anxiety drug), 34 Hydromorphone pills (a pain reliever), 12 "pieces" of Methadone and 39 additional “fragments" of Oxycontin.

Several inmates were interviewed, and a preliminary determination was made that L.B. died from an overdose of heroin likely brought into the jail by another inmate who had been booked in on November 23, 2009, on drug related charges. The primary source of this incriminating information was obtained from a cellmate of L.B. who related to the investigator that on November 24, 2009, he personally observed another inmate remove what appeared to be a large number of pills, a "chunk" of tar heroin and a syringe from his “buttocks area." He further claimed that inmate then gave L.B. "an unknown amount of heroin" which he placed on a plastic spoon, added water until it dissolved and snorted it up his nose.

When the inmate who was alleged to be the person who brought the drugs into the Jail was interviewed, at first he vehemently denied complicity in either bringing the drugs into the facility or supplying them to L.B. However, after further questioning he soon admitted that he was involved in the events, but claimed the drugs had been thrown through the bars of the cell wrapped in a newspaper by another inmate housed in an adjacent cell. That inmate, he said, had wrapped the drugs (and a syringe) in a newspaper and thrown it there since he did not want to be caught with them in his possession. Given the information developed during the above investigation, the matter was referred to the district attorney for possible criminal charges.

The Jury's concerns, of course, involve the following circumstances of L.B.'s death: (1) the clandestine introduction of drugs into the Jail; and (2) the apparent inability of custody staff to properly and/or timely use available oxygen equipment due to their lack of training in the use of that equipment. The versions of exactly how the particular drugs in L.B.'s case found their way into the cell where he was housed, who brought them there, who else may have handled them and who else may have observed the illicit activity are legitimate subjects for further investigation for possible criminal charges by the district attorney. They are not the concern of the Jury whose primary focus in deaths-in-custody incidents is civil in nature under Section 919(b) of the *Penal Code.*

Regarding the first concern, the Jury has an obligation to address the introduction into the Jail of contraband and/or drug paraphernalia and, if possible, recommend steps that can be taken to interdict that activity and thereby potentially save the life of inmates such as L.B. One such step would be to attempt to improve the present protocols regarding inmate "strip" and "body cavity"

searches, a subject addressed in the *Sheriff's Policy and Procedures Manual for Custody Operations, Chapter Three.* A stated purpose of this policy is to, "ensure the security of the jail facilities by reducing contraband."

While privacy rights of inmates are entitled to be recognized, and compliance with applicable state and federal guidelines is required, so, too, is the need to ensure staff, visitor and inmate safety. In this respect, the Sheriff's policy provides that "strip" searches may be conducted only where "reasonable suspicion/justification" exists to do so. This, in turn, requires consideration of various criteria, such as the nature and degree of the inmate's alleged offense, the inmate's appearance, his or her conduct or behavior and any prior arrest record. To conduct a more intrusive "body cavity" search, the policy requires much more - the circumstances must legally justify the issuance of a search warrant, the search must be performed under prescribed conditions of utmost privacy and only a member of the medical staff can conduct it.

Given the circumstances under which L.B. allegedly obtained and used the heroin that killed him, it did not appear to custody staff under the present language of the policy that a valid reason existed to undertake a strip search, no less a body cavity search. While an unexpected search of his cell and bunk area on November 24-25, 2009, might have turned up the controlled dangerous substances that were present, that would have been serendipitous.

Assuming the information obtained during the Sheriff's investigation is credible, drugs were brought illegally into the Jail by an arrestee and provided to L.B. with fatal consequences. The possible filing of criminal charges stemming from this activity is not this Jury's concern. However, the Jury believes that an effort should be made by the Sheriff, in consultation with legal counsel, to review the existing search policy and, to the maximum extent possible consistent with current law, consider changes so that the number of events like this one are greatly reduced, if not eliminated altogether.

The other major area of Jury concern regarding L.B.'s death is the lack of coordination between custody and medical staffs regarding training in the use of oxygen equipment. During the Jury's visit to the Jail, it was pointed out that under the contract with PHS all medical equipment remains the property of PHS, not the Sheriff. While the training of Sheriff personnel specifically is referred to in Exhibit B, Section D.1.4 of the contract, no particular reference is made to training in the use of oxygen equipment, *per se.*

Although PHS represents in the contract that it is prepared to offer in-service training in cardio-pulmonary activity, this does not include training in the use of oxygen equipment. The lack of coordination between medical and custodial staffs pertaining to this training surfaced when the PHS registered nurse, who was called to the scene to treat L.B., was unable to obtain help to use the oxygen equipment because the custody deputies are not trained in the use of this equipment.

Custody staff mentioned that the nurse's prior experience had been in a hospital setting where many skilled persons (doctors, nurses, EMT personnel, etc.) are available and familiar with the use of oxygen equipment. They pointed out that, by contrast, in a correctional facility, a readily available pool of such experienced persons would be atypical. The more important point is that it in the interest of public health and safety, a need does exist to upgrade life saving training at

the Jail, and to the extent this requires greater coordination between medical and custody staffs, it is imperative this be done.

A specific section in the contract regarding training (Exhibit B, Section D.1.4), requires PHS and the Sheriff to work together in partnership to identify specific training needs and to plan on-site training programs accordingly. The Jury expects that appropriate steps will be taken to implement this mandate including, in particular, training custody personnel. The proper use of oxygen equipment could spell the difference between life or death, not only for inmates, but also for staff members and visitors as well.

When the Jury asked for copies of all reports, team reviews and/or other administrative documents related to any examination of the events conducted internally by the Sheriff, PHS and others on-site stemming from the two deaths-in-custody, it was advised that some of those materials previously had been sent to PHS and no copies were kept. Retention of pertinent data by the Sheriff is essential since, according to Section D.1.6 of the contract with PHS, the very purpose of the internal review process related to deaths-in-custody is to evaluate health care services and to "identify opportunities for improvement." That task is precisely in the interest of the Jury as well.

Retention of copies of these data by the Sheriff is essential since, according to Exhibit B, Section D.1.6 of the contract with PHS, the very purpose of the internal review process related to deaths-in-custody is to evaluate health care services and to "identify opportunities for improvement." That task is precisely in the interest of the Jury as well.

The contract with PHS specifically requires cooperation among the County Coroner, Probation/Sheriff Executive, Probation/Sheriff Management, PHS, the facility administrator, the responsible physician and other health care and supervisory staff relevant to in-custody deaths. This presumably would include facilitating the Jury's statutory obligation to investigate those events and the Jury is unaware of any valid reason for the Sheriff not to retain copies of all team reviews, mortality reviews, reports or the like, however and by whomever generated, involving deaths-in-custody.

It is recommended that the Sheriff adopt a policy to retain copies of all pertinent reports, administrative reviews and analyses and similar information for the Jury's possible use in its consideration of deaths-in-custody matters, by whoever prepared. In addition, regularly maintaining a central deaths-in-custody file where such copies of relevant reports, reviews and the like can be kept in one readily accessible place should be implemented so that the time it might take to retrieve the data from different locations or from other sources can be eliminated and the process expedited.

The Jury cannot be expected to know, or somehow be aware intuitively, of every particular document it should ask for pertinent to a deaths-in-custody inquiry. All of these data should be made available immediately as a matter of course. If the Sheriff determines not to provide certain information to the Jury, because of a claim of privilege for example, the reason for the refusal should be stated specifically so that the Jury may pursue a further course of action to obtain them in timely fashion if it believes it necessary and appropriate to do so.

FINDINGS AND RECOMMENDATIONS AS TO J.E.

Finding 1a
J.E., a 71-year-old male characterized by Prison Health Services medical staff as an alcoholic, was booked in at the Santa Barbara County Main Jail on October 11, 2009, on a charge of brandishing a weapon. He previously had been incarcerated there in September and earlier in October 2009 as well. On all these occasions, J.E. displayed signs and symptoms of alcohol withdrawal and schizoaffective disorder and medications were prescribed for both conditions.

Finding 1b
On October 14, 2009, Prison Health Services medical staff determined that J.E.'s physical and mental status was "deteriorating" and transferred him to a single-person holding cell where he could be observed twice every half hour, 24 hours per day, by custody deputies through a large window in his cell door.

Finding 1c
In addition to personal observations, J.E. was viewed by a custody deputy on a video monitor located in an internal control room.

Finding 1d
The internal control room contains over 20 monitors with views of cells, hallways, a receiving area and an outdoor sliding gate for vehicular ingress and egress, which the deputy operates remotely. The room is staffed by only one deputy who works a 12-hour shift. There is also two-way communication via intercom between the internal control room and the cells.

Finding 1e
The video camera used to view the interior of J.E.'s cell is recessed in the center of the ceiling behind a glass panel which, when inspected by members of the Jury, was dirty and/or scuffed.

Finding 1f
Image quality of the video of J.E. viewed by Jury members was insufficient to provide a clearly detailed display of the inmate's movements.

Finding 1g
On October 17, 2009, at about 1640 hours, a meal, which included a peanut butter sandwich, an orange and milk, was left for J.E. in the food slot in his cell door.

Finding 1h
The video image of J.E.'s movements, beginning at approximately 1625 hours on October 17, 2009, at first show him moving around in his cell, then later eating the sandwich but apparently throwing a portion of it onto the floor. He then moved to a position next to the cell door where he sat down with his right side against the door and his back against an adjacent wall.

Finding 1i
Custody officers in the hallway outside J.E.'s cell periodically observed him through the window in the cell door and noted in their October 17, 2009, log sheet that he often appeared to be sitting or asleep.

Finding 1j
At about 1654 hours a custody officer, believing J.E. to be asleep, shook the cell door to try to rouse him, but without success. As a result, the deputy immediately entered the cell where he found the inmate not breathing.

Finding 1k
Additional deputies and Prison Health Services medical staffs were summoned and efforts were made to resuscitate J.E. These efforts were not successful; J.E. was pronounced dead at 1727 hours and his body was removed to the Coroner's Bureau.

Finding 1l
A post-mortem examination conducted by the Coroner on October 20, 2009, determined J.E. had died as the result of "asphyxiation by aspiration of food bolus." His death was characterized in the Coroner's Report as "accidental."

Recommendation 1 (Findings 1a, 1b, 1c, 1d, 1h, 1i, 1j, 1l)
The Sheriff, in cooperation with Prison Health Services medical staff, review for possible modifications the adequacy of the current protocols for custody deputies to follow when observing inmates, like J.E., who have a known history of serious physical and/or mental disorders.

Recommendation 2 (Findings 1c, 1d, 1e)
Modify duty assignments to the internal control room so that the length of the shifts (presently 12 hours) are reduced, thereby limiting the possibility of inattention to the monitors due to deputy fatigue.

Recommendation 3 (Findings 1e, 1f)
Cameras and their covers mounted in ceilings or elsewhere for viewing cells, hallways or other areas in the Santa Barbara County Main Jail regularly be inspected, cleaned and/or replaced and updated at stated intervals to assure clarity of the image on the monitors located in the internal control room.

FINDINGS AND RECOMMENDATIONS AS TO L.B.

Finding 2a
L.B., a 29-year-old male, was booked on November 10, 2009, on a variety of charges, including possession of controlled dangerous substances. When booked in, he was described as being under the influence of drugs.

Finding 2b
Previously, in both September and October 2009, L.B. had been incarcerated at the Santa Barbara County Main Jail on drug charges and treated for depression and heroin addiction.

Finding 2c
On November 25, 2009, at about 0850 hours, when L.B. could not be roused from his bunk, a custody deputy immediately entered the cell and found the inmate to be unresponsive. He was lying on his back on his bunk, with his mouth open, his eyes closed, not breathing and with no identifiable pulse.

Finding 2d
A Prison Health Services registered nurse came to the cell where she determined that L.B.'s abdomen was still warm to the touch. The nurse directed that he be placed on the floor and she asked a custody deputy to place a mask over his mouth so that oxygen could be administered.

Finding 2e
The nurse could not get the oxygen equipment to work after asking one deputy to "hook up" the mask, and another to "assemble and operate" the equipment. She then was told that custody deputies were "not trained" in the use of the oxygen equipment.

Finding 2f
Despite efforts to resuscitate L.B. with CPR and a defibrillator, no pulse could be detected. Emergency medical technicians, who also were called to the scene, attempted without success to resuscitate L.B. His body then was removed from the cell and transported to the emergency room at Cottage Hospital where he was pronounced dead.

Finding 2g
At the emergency room, a small plastic "baggie" containing a number of unidentified pills was discovered stuffed into one of L.B.'s socks.

Finding 2h
Given the nature and circumstances of L.B.'s death in his cell on November 25, 2009, a drug overdose was suspected, which later was confirmed. The Sheriff promptly initiated an investigation, and a search of the cell area late in the morning on that day quickly resulted in the discovery of two plastic bags containing various pills, pill fragments, and a substance believed to be "tar heroin." Marijuana also was found in the fingertip of a latex glove.

Finding 2i
The Sheriff’s investigation concluded that drugs likely were brought into the Santa Barbara County Main Jail on November 23, 2009, by a cellmate of L.B., who allegedly told another inmate he had secreted them between his buttocks when booked that day.

Finding 2j
Regardless of how the drugs actually came into the Santa Barbara County Main Jail, or into that cellmate's possession, a third inmate said he saw the drugs given to L.B., including a substance he believed to be heroin. He then observed L.B. place the substance into a plastic spoon, mix it with water to dissolve it and "snort" it up his nostrils.

Finding 2k
A forensic examination of urine and blood samples taken from L.B. revealed a "toxic level of morphine" present in his body. As a result, the Coroner determined his death to be accidental due to "acute morphine (heroin) intoxication."

Finding 2l
The Sheriff's Policy and Procedures Manual for Custody Operations, Chapter Three, Section IV(2)(A)and IV(B)(3) provide guidelines for "strip" searches and "body cavity" searches. A "strip" search may be conducted only where "reasonable suspicion/justification" is determined to exist, and where the inmate also meets certain criteria, such as the individual's appearance and conduct, an arrest for a crime, felony or misdemeanor offense involving a controlled dangerous substance and the existence of a previous drug arrest record. A "body cavity" search on the other hand requires the issuance of a valid search warrant and it must be conducted in private by a medical staff member.

Finding 2m
Some information requested by the Jury to aid in its investigation was not made available because it had been transmitted to other agencies and the Jury was informed that no copies were retained by the Sheriff. Other information was prepared by Prison Health Services; the Jury was informed that it no longer was within county control and no copies were retained.

Recommendation 4 (Finding 2m)
The Sheriff adopt a policy to retain copies of all documents generated as the result of, in relation to or in any way connected to death-in-custody incidents, by whomever and whenever prepared, and maintain these records in a central file located at the Santa Barbara County Main Jail.

Recommendation 5 (Findings 2a, 2b, 2c, 2d, 2e, 2f, 2g, 2h, 2i, 2j, 2k, 2l)
The Sheriff, in consultation with legal counsel, thoroughly review the present search policy and to the maximum extent possible consistent with state and federal law, make such improvements as may be necessary to more effectively prevent the introduction of drugs and other contraband into the Santa Barbara County Main Jail.

Recommendation 6 (Findings 2d, 2e, 2f)
Custody staff be trained by Prison Health Services medical staff in the use of oxygen equipment kept on site at the Santa Barbara County Main Jail, which may have to be employed in life saving activity. In addition, require periodic refresher training of custody staff to insure they maintain its proficiency in the use of this equipment.

Recommendation 7 (Findings 2d, 2e, 2f)

The Sheriff and Prison Health Services staffs, as required by their existing contract, work in partnership to identify the need for and implement training in all areas of joint concern where such training will assist both in "identifying opportunities for improvement" in carrying out their vital health, safety and general welfare obligations.

REQUEST FOR RESPONSE

In accordance with *California Penal Code Section 933.05* each agency and government body affected by or named in this report is requested to respond in writing to the findings and recommendations in a timely manner. The following is the affected agency for this report, with the mandated response period set forth.

SANTA BARBARA COUNTY SHERIFF'S DEPARTMENT - 60 DAYS

Findings 1a through 1l
Recommendations 1, 2, 3

Findings 2a through 2m
Recommendations 4, 5, 6, 7

COMMENDATION

On two occasions since July 1, 2009, custody deputies were instrumental in saving the lives of inmates who had attempted suicide. On August 9, 2009, a deputy, responding to the shout of a "man down," found an inmate lying on a mattress in a dayroom with two deep, self-inflicted wounds. The deputy quickly summoned a medical staff member who applied life saving measures. The inmate was transported to a hospital for treatment and it was determined that he had narrowly missed cutting his jugular vein.

The second incident took place on October 23, 2009, when a deputy observed an inmate in a holding cell who had fashioned a noose from his shirt, tied it around his neck and was attempting to hang himself. The deputy promptly summoned help from three other deputies and all participated in removing the noose and lowering the inmate to the floor. Since the inmate had no detectable pulse, and was not breathing, CPR was begun. After a nurse arrived, she continued CPR and the inmate then began to breathe on his own. The quick action taken in this situation saved the inmate's life and he made a full recovery from his suicide attempt.

The Jury believes that the actions taken by custody staff in these two instances warrant recognition and the deputies who participated in these life saving efforts deserve commendation.