SHERIFF'S DEPARTMENT RESPONSE
SANTA BARBARA COUNTY GRAND JURY'S 2009-2010 REPORT
"Deaths in Custody"

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."

Response to Finding 1a: The Sheriff's Department agrees with the finding.

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."

Response to Finding 1b: The Sheriff's Department agrees with this finding.

The "single-person holding cell" allows for direct visual observations that are performed at least twice every half hour by Custody Deputies as required by Title 15 of the California Code of Regulations:

"Direct visual observation" means direct personal view of the inmate in the context of his/her surroundings without the aid of audio/video equipment. Audio/video monitoring may supplement but not substitute for direct visual observation.

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."

Response to Finding 1c: The Sheriff's Department agrees with this finding.

As referenced in Response to Finding 1b, J.E. was periodically monitored by a Custody Deputy by way of a camera in his cell.

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

Response to Finding 1d: The Sheriff's Department agrees with this finding.

The deputy assigned to Inmate Reception Center (IRC) Control Room also has the responsibility of monitoring individuals who request to enter and exit from this area, not just vehicular egress and ingress.

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".

Response to Finding 1e: The Sheriff's Department agrees with this finding.

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."

Response to Finding 1f: The Sheriff's Department partially agrees with this finding.

The video quality was sufficient to provide adequate display of gross motor movements of J.E. It was not of a quality to determine subtle movements such as breathing while someone is sitting or laying down.

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."

Response to Finding 1g: The Sheriff's Department agrees with this finding.

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 the adjacent wall."

Response to Finding 1h: The Sheriff's Department agrees with this finding.

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."*

Response to Finding 1i: The Sheriff's Department agrees with this finding.

A key component to logging that someone is merely sleeping and not in distress is the actual observation of the person to be breathing normally. When breathing cannot be observed through the window, deputies routinely knock on, or shake the door in an effort to rouse the inmate and confirm that they are not in distress. Title 15 of the California Code of Regulations requires that the personal observation be at least twice every 30 minutes.

Finding 1j: "At about 1645 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."

Response to Finding 1j: The Sheriff agrees with this finding.

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."

Response to Finding 1k: The Sheriff's Department agrees with this finding.

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 and 'accidental.'"

Response to Finding 1l: The Sheriff's Department agrees with this finding.

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."

Response to Recommendation 1(Findings 1a, 1b, 1c, 1d, 1h, 1i, 1j, 1l):

Protocols for monitoring inmates placed in the observation cells, where J.E. was placed, are reviewed by Custody Operations personnel annually, in collaboration with Prison Health Services (PHS). This review is to ensure compliance with the Corrections Standard Authority (CSA), a division of the California Department of Corrections and Rehabilitation. The CSA inspects our facilities bi-annually. In March 2010 the CSA conducted their bi-annual inspection of our policies and procedures, including those related to safety and observation cells. The CSA determined that the Santa Barbara County Jail met or exceeded all CSA standards.

Article 11 of Title 15, of the California Code of Regulations, Medical and Mental Health Services section requires health care staff work closely with jail staff. The Jail Classification Unit works closely with PHS on a daily basis to review inmate cases with serious physical or mental health disorders. This communication process allows our staff to provide appropriate cell placement within the facility. Currently, when PHS is concerned about a specific inmate, they will contact the Classification Unit and request a cell that best meets the inmate's needs. When determined necessary, inmates are placed in observation cells. These observation cells are in areas of increased foot traffic by deputies and medical staff thereby increasing the ability for enhanced observation of the inmate. These cells provide the most effective method for closely observing and monitoring inmates. Inmates placed in these cells are put on special logs to make certain a visual check is made by officers and medical staff at least two times every 30 minutes as required by Title 15 of the California Code of Regulations. Additionally, deputies and medical staff look into these cells as they pass by, increasing the number of physical checks. Each observation is recorded on a log outside the cell.

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."

Response to Recommendation 2:

There is no direct connection in the death of J.E. to fatigue of the officer within the Control Room . As stated in Finding 1b:

The "direct visual observation" required by Title 15 of the California Code of Regulations, means direct personal view of the inmate in the context of his/her surroundings without the aid of audio/video equipment. Audio/video monitoring *may supplement but not substitute* for direct visual observation. Video monitoring is most useful in determining if inmates are attempting to physically hurt themselves or are displaying other violent or bizarre behavior. In such cases the deputy viewing the monitor will request a direct personal observation of the inmate by a deputy to determine what is occurring. Video monitoring is not intended to scrutinize the inmate to the level of determining breathing. The determination of breathing and consciousness is the main reason for the requirement of direct personal observation, which in this case was how the deputy realized J.E. was not breathing. Title 15 of the California Code of Regulations and the Corrections Standard Authority (CSA) has determined that the direct personal view of inmates two times every 30 minutes is the appropriate standard for these situations. In the case of J.E. these standards were met.

Deputies assigned to control rooms are provided periodic breaks during their shift to ensure fatigue is not a factor. They are also able to request a break if needed.

The Sheriff's Department is currently in the process of upgrading this control room. The upgrade will be designed to reduce the number of cameras the officer is responsible for monitoring, thus allowing for increased efficiency.

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 rooms."

Response to Recommendation 3:

Staff is required to check the condition of all equipment at the beginning of each shift. Inmates often throw items at the cameras in an effort to obscure the image. In the case of a camera lens being obscured, the deputy would make an attempt to clean it, if practical. In most cases, the request would be submitted to General Services for repair and cleaning of the camera and lens. The Sheriff's Department acknowledges that cameras within areas of the jail facility require constant checking to ensure good working order. As stated above, we are in the process of

replacing and upgrading our current control rooms with higher quality monitors to aid in closer observation of inmates. Our goal has been, and will continue, to provide for the safety and security of staff and inmates.

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."

Response to Finding 2a: The Sheriff's Department agrees with this finding.

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

Response to Finding 2b: The Sheriff's Department agrees with this finding.

L.B. had been in and out of custody since 1998: once in 2000, once in 2005, twice in 2007, twice in 2008, and twice in 2009. He was booked into custody on November 10, 2009 on new charges and had been in custody and housed for 15 days prior to his death.

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."

Response to Finding 2c: The Sheriff's Department agrees with this finding.

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 deputy to place a mask over his mouth so that oxygen could be administered."

Response to Finding 2d: The Sheriff's Department agrees with this finding.

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 oxygen equipment."

Response to Finding 2e: The Sheriff's Department disagrees with this finding.

The PHS RN responded with a man-down bag, assessed, and found no pulse or respirations. She instructed deputies to pull L.B. to the floor and begin CPR. As deputies began CPR, the RN opened the AED and placed pads on L.B. She then pulled a small oxygen bottle out of the man-down bag and attempted to open the valve, but the valve was tightened beyond her ability to

open. There was a deputy standing by and the RN asked him if he could open the bottle. The valve was too tight for him to open. The nurse did not ask deputies to "assemble and operate" the equipment. The nurse only asked for help in opening the valve on the oxygen bottle and placing the mask over L.B.'s face. The placement of a mask on a subject is covered in basic CPR training. Deputies are trained in first aid and CPR, which they performed. Since CPR was already in progress, the oxygen was actually not required. There was adequate medical staff on-scene to administer oxygen had it been needed. The opening of a valve on the oxygen bottle does not require specialized training.

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."

Response to Finding 2f: The Sheriff's Department agrees with this finding.

In addition to emergency medical technicians, the jail physician was also present at the site.

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."

Response to Finding 2g: The Sheriff's Department agrees with this finding.

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."

Response to Finding 2h: The Sheriff's Department agrees with this finding.

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."

Response to Finding 2i: The Sheriff's Department agrees with this finding.

While the investigation did reveal the most likely source of the drugs and how they entered the jail, the evidence was not strong enough to pursue criminal charges.

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."

Response to Finding 2j: The Sheriff's Department agrees with this finding.

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

Response to Finding 2k: The Sheriff's Department agrees with this finding.

Finding 2l: *"The Sheriff's Policy and Procedures Manual for Custody Operations, Chapter Three, Section IV(A)(2)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 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."*

Response to Finding 2l: The Sheriff's Department agrees with this finding.

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."*

Response to Finding 2m: The Sheriff's Department disagrees with this finding.

It is unclear what specific information the Grand Jury is referring to, specifically the information that was transmitted "to other agencies." All documents, reports, etc, are collected and maintained for Administrative Investigations. All documents and information are available for review by the Grand Jury.

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."*

Response to Recommendation 4 (Finding 2m):

It is unclear what specific reports the Grand Jury is referring to in Finding 2m; however, the Sheriff's Department Lexipol Policy 375, Administrative Investigation Team, clearly dictates the procedure for documents relating to in-custody deaths. It is the responsibility of this team to gather all evidence and documents regarding the incident under investigation. These documents are available for review by the Grand Jury.

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.*

Response to Recommendation 5 (Findings 2a, 2b, 2c, 2d, 2e, 2f, 2g, 2h, 2i, 2j, 2k, 2l):

The Sheriff's Department continually reviews our search policy, with assistance from legal counsel, in order to ensure that our procedures comply with current state laws and regulations. For example, in February 2010, the 9th Circuit Court of Appeals upheld San Francisco's strip search policy (*Bull v. City and County of San Francisco*). This decision broadens the scope of strip searches allowed in jails. However, the practical impact of that decision on jail operations has not been determined. We are waiting to learn if the decision will be appealed to the US Supreme Court before we make alterations to our current policy on strip searches or our physical environment to allow more strip searches while maintaining the required privacy associated with them.

Dealing with contraband in a jail environment is very challenging. The Sheriff's Department's jail staff conducts hundreds of inmate searches daily and conducts random cell searches as often as possible. In an effort to combat the presence of contraband in the jail, a Search Strike Team was established on July 14, 2010, to conduct additional searches above and beyond those done on a routine basis. This Team will be used periodically to reduce the introduction of contraband within our facility.

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."*

Response to Recommendation 6 (Findings 2d, 2e, 2f):

While Sheriff's Department staff could be trained in the emergency use of oxygen, this task is not one typically assigned to custody staff, and the legal duty of custody deputies in such situations is to summon medical staff. There is adequate medical staff on-site to deploy and administer oxygen when needed. As stated, deputies are required to be trained in CPR, including refresher training and recertification in CPR every two years. CPR training includes the use of masks. Masks used for CPR and oxygen are deployed in a similar manner. The actual flow of the oxygen is something that a trained EMT or nurse normally controls. In this case oxygen was not called for since CPR was being delivered. If CPR had been successful and L.B had begun breathing on his own, then the use of oxygen would have been appropriate. PHS's review of this incident has identified specific locations where Oxygen needed for emergency use is kept. The review has also confirmed the requirement that oxygen bottles be checked on a regular schedule to ensure proper function when needed.

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 obligations."*

Response to Recommendation 7 (Findings2d, 2e, 2f):

The Sheriff's Department agrees that a good partnership is essential to maintain safety and security within our facility. The Sheriff's Department and Prison Health Services staff have several regularly scheduled meetings to discuss operational and training issues within the jail. These meetings discuss policy issues, operational concerns, security and safety issues, and training. The Sheriff Department and Prison Health Services will continue to work together to identify training topics and opportunities to increase the overall safety and security of both the inmates and staff within the jail.