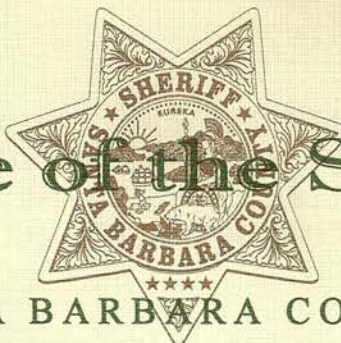


Office of the Sheriff



SANTA BARBARA COUNTY

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July 17, 2012

BILL BROWN

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JIM PETERSON

Undersheriff

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P.O. Box 5049
Santa Maria, CA 93456
Phone (805) 346-7430

Mr. Ted Sten
Santa Barbara County Grand Jury
1100 Anacapa Street
Santa Barbara, California 93101

RE: Response to 2011-12 Grand Jury Report Entitled "*Death In Custody*"

Dear Mr. Sten:

Enclosed please find the Santa Barbara County Sheriff's Office response to the 2011-2012 Santa Barbara County Civil Grand Jury Report entitled "*Death In Custody*".

Should you have additional questions, please feel free to contact me at 681-4290 or Chief Deputy Don Patterson at 681-4245.

Sincerely,

A handwritten signature in blue ink, appearing to read "Bill Brown".

BILL BROWN
Sheriff - Coroner

Enclosure

RECEIVED
JUL 3 4 2012
BY _____

SANTA BARBARA COUNTY SHERIFF'S OFFICE
RESPONSE TO THE SANTA BARBARA COUNTY
GRAND JURY 2011-2012 REPORT
"DEATH IN CUSTODY"

FINDINGS AND RECOMMENDATIONS

Finding 1a: *Custody Deputies conducted Isolation Cell Safety checks at least once every hour as required by policy and procedures...*

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

It should be noted that the number of safety checks conducted in the Isolation Cells, where the incident evaluated by the Grand Jury took place, were above and beyond what is required by policy, and State standards. Policy requires that safety checks be completed at least once every hour. The Custody Deputies working that housing unit logged approximately 41 checks in a 9 ½ hour period.

Finding 1b: *The policy requiring staff to insure that each inmate's head/face is visible and they are alive and not experiencing any trauma was not followed.*

Response to Finding 1b: **The Sheriff's Office disagrees wholly with the finding.**

The "policy" mentioned in this finding is actually a Directive that states:

"Deputies conducting safety checks shall instruct each inmate housed in single person cells to keep their head/face free from obstruction. If an inmate fails to comply with this instruction, the object they are using to obstruct view (blanket, towel, sheet, etc.) shall be removed until compliance is obtained."

This Directive was written to address the occasions when an inmate "cocooned" in his/her blanket, making it very difficult to determine their status. Standing in front of their cell and carefully watching for movement (breathing) is the only way to properly determine if a sleeping inmate is alive. However, even if breathing is observed, it is still often impossible to tell if the inmate has signs of observable stress or trauma. Therefore, a Directive was issued to inform staff that inmates would not be allowed to cover their entire bodies in blankets, and that if that behavior continued, the blankets could be removed from the cells.

In this instance, the inmate was not wrapped from head-to-toe in his blanket. Although his head was obstructed from full view by the design of the cell, it was not obstructed by a blanket, towel or sheet, which was the intent of, and reason for, the directive prohibiting the covering of inmate's head.

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BY:

The Safety Check policy states:

"Custody Operations will conduct and document safety checks in all inmate housing, holding, and recreation areas. This shall be accomplished by directly and visually accounting for the presence of the inmate, identifying if anything appears out of order and looking for obvious signs of distress or trauma. Safety checks will be conducted at least once every hour."

These checks were conducted beyond that required by internal policy and the State standards. The Custody Deputies did not see anything that appeared out of order or any obvious signs of distress or trauma. The language for the safety checks corresponds with the language in California Code of Regulations Title 15 - Minimum Standards for Local Adult Detention Facilities. In Title 15, safety checks is defined as: "*Safety checks*" means regular, intermittent and prescribed direct, visual observation to provide for the health and welfare of inmates."

The intent of a safety check is described in the Title 15 - Guidelines is to have a supplementary document that is provided to help define the intent of the Title 15 - Regulations. In these guidelines the intent of the safety check is described as:

"The intent of the safety check is to account for the presence of the inmate, identify if anything appears out of order and look for signs of observable distress or trauma. This includes looking for indications that the inmate may be ill, injured, involved in an altercation, have attempted suicide or otherwise be in need of assistance."

"Safety checks are intended to provide for the health and welfare of inmates (**Section 1006, Definitions**). This means that staff must be able to see each inmate without the aid of audiovisual equipment to assure that he/she is alive and not experiencing any trauma in order to consider that the intent of the regulation is met."

The Custody Deputies working that housing were able to observe, throughout the day, that this inmate changed position several times. There were no obvious signs of distress or trauma. It appeared to them as though he was sleeping.

The Custody Deputies working that day were not in violation of either the Policy for safety checks or the Directive.

Finding 1c: *Isolation Cell inmates were not awakened when a deputy could not determine if they were breathing.*

Response to Finding 1c: The Sheriff's Office disagrees wholly with the finding.

The assumption of this finding is that Custody Deputies are always required to determine if an inmate is breathing when conducting safety checks in isolation cells. It is most often impossible for a deputy to appropriately ascertain whether or not someone is breathing when viewing them

from a distance of approximately 4 to 6 feet. It is not a requirement to stand in front of each inmate and attempt to determine if they are breathing. The purpose of the policy and directive are to look for obvious signs of trauma or distress.

The Custody Deputies working that housing were able to observe, throughout the day, that this inmate changed position several times. There were no obvious signs of distress or trauma. It appeared to them as though he was sleeping.

Recommendation 1: *That the Jail policy and procedure be amended to require Isolation Cell inmates to be awakened if the deputy has no other method of determining that the inmate is breathing.*

Response to Recommendation 1: The recommendation will not be implemented because it is not reasonable.

Inmates are placed in isolation cells for a variety of reasons stemming from classification issues. An inmate who exhibits signs that they may harm themselves, or are in emotional or psychological distress, are evaluated for potential self-harm. If they exhibit behavior which indicates self-harm, or state they are motivated to harm themselves, they are moved to an observation cell, where they are checked twice every 30 minutes. In these cases, the inmate is awakened if the Custody Deputy cannot determine if the inmate is breathing since they are considered "at-risk."

In fact during this incident, when the Custody Deputy became concerned that the inmate was not responding to his call for the evening meal, the Custody Deputy took immediate action to ascertain the status of this inmate. Prior to the call for the evening meal, there were no obvious indications of stress or trauma.

It is impossible for a Custody Deputy to always ascertain whether or not an inmate is breathing when viewing them from outside an isolation cell, at a distance of approximately 4 to 6 feet. To mandate confirmation that an inmate is breathing would often require the Custody Deputies to awaken each inmate that is sleeping during the security checks. Such a practice would impact the inmate's ability to get a proper amount of sleep and would most likely result in the inmate becoming agitated and confrontational. Sleep deprivation may be considered cruel and unusual punishment, especially for inmates who have no current indications they are suicidal.

Finding 2: *Approximately half of the Isolation Cells in the East, numbered 11 to 22 contain an alcove at the end of the bed nearest the cell door that allows an inmate's head to be hidden from view.*

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

The type of Isolation or Single Person cells in the Main Jail, East and West Modules, like the one involved in this incident, were designed and built under the 1963 standards for construction of jail facilities. The East Isolation cells were constructed to provide a specific amount of cell and

bunk space, as required by regulations at the time of construction. The design of these cells in which there is a lower-bunk does create an alcove at the corner of the bed where the table and chair are located.

Recommendation 2: *That the Isolation Cells containing an alcove at the end of the bed, the alcove be filled in at a 45-degree angle to prevent an inmate's head being hidden from view.*

Response to Recommendation 2: This recommendation will not be implemented because it is not reasonable.

The type of Isolation or Single Person cells in the Main Jail, East and West Modules, like the one involved in this incident, were designed and built under the 1963 standards for construction of jail facilities. The East Isolation cells were constructed to provide a specific amount of cell and bunk space, as required by regulations at the time of construction. The design of these cells in which there is a lower-bunk does create an alcove at the corner of the bed where the table and chair are located. Altering them and filling-in the alcove would place the facility out of compliance with the State regulations for cell space and bunk space.

Finding 3: *Plastic bags were left in isolation cells.*

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

Commissary items as well as inmate breakfast and lunch meals are provided in clear plastic bags. Plastic bags are also used to collect trash.

Recommendation 3: *That Jail policy and procedure include accountability of all plastic bags to ensure they are not left in cells.*

Response to Recommendation 3: The recommendation will not be implemented because it is not reasonable.

Commissary items are delivered in clear perforated bags to allow the staff to easily view the bag contents and to impede the ability of an inmate to hide prohibited items. Plastic bags are also utilized for breakfast and lunch to protect the food from contamination. Such protection is not possible with paper bags. It is impractical to expect Custody Deputies to wait outside each cell until the inmates fill the trash bags, or eat their meals since most inmates do not eat their meals immediately upon receiving them.

We are in the process of changing the meal service bags to perforated clear bags similar to the commissary. Perforated bags would reduce the potential for using the bags for suffocation.

Inmates are provided plastic trash bags on a 1 for 1 exchange. Custody Deputies collect trash from the Ad-Seg and ISO Cells by exchanging trash bags as they conduct their rounds.

Finding 4: *There was no video camera recording of deputies inspecting corridors to allow verification that the Jail policy and procedures were being followed.*

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

Although a camera exists in this area, its purpose is for security; it is not intended to be used to verify that policy is being followed. The Electronic Verification System (known as the "Pipe") is the tool used to provide documentation and verification of safety checks.

Recommendation 4a: *That the Jail policy and procedure be initiated requiring 24/7 video recording of all Isolation Cell Corridors.*

Response to Recommendation 4a: This recommendation has been partially implemented.

There are several Isolation Cell corridors where cameras do not exist.

In August 2011, the Sheriff's Office installed video recording capabilities of all cameras in the Northwest, IRC and Main Jail. It is anticipated that by August 2012, the cameras in the Medium Security Facility security system will be upgraded to include video recording of all cameras. There are dead-end corridors with isolation cells on the west side of the jail. These corridors do not have cameras. However, each corridor has an electronic verification check point at the dead end. These checkpoints verify the Custody Deputy is performing the required checks of isolation cells as mentioned above.

Recommendation 4b: *The Isolation Cell corridor video recordings be retained for at least 180-days.*

Response to Recommendation 4b: The recommendation has already been implemented.

The video recording system for all cameras is designed to store recordings for at least 1 year, as required by state law.

Finding 5: *The decedent made numerous requests for medical checks and several requests for relocation saying he feared for his life.*

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

During the time of his incarceration, the inmate submitted over 26 medical request slips for which he was seen by medical staff.

Also during his incarceration, he made several requests to the Classification Unit for re-housing. Upon his initial incarceration, he was housed in a "General Population" housing unit. He claimed to have problems with several inmates in the unit and was moved to another General Population housing unit. He received not less than eight housing changes, either at his request or at the request of others, based upon his inability to get along with others. He was exhibiting

behavior that indicated he was having some mental health issues. He was subsequently seen and treated by Mental Health staff. On June 25, 2011, he was housed in East ISO 14, a single person cell. On July 5, 2011, an attempt was made to house him in a two-person cell. He refused and remained in East ISO 14.

Recommendation 5: *That the Jail Mental Health staff monitor Isolation Cell inmates previous and ongoing requests (e.g. for medical checks and cell relocation) as possible triggers for evaluation for a potential suicide watch requirement.*

Response to Recommendation 5: This recommendation has already been implemented.

Jail Mental Health receive and respond to requests from inmates, staff, the courts and family members to evaluate and treat inmates for mental health illness.

Although this inmate denied any current or previous mental health problems, he was, at the request of jail staff, evaluated on at least two occasions by the Mental Health Staff. The Mental Health Staff evaluated him and concluded he had chronic anxiety issues. However, he repeatedly refused mental health assistance. As an adult, he had the right to refuse mental health assistance and/or medications.

Had this inmate displayed any suicidal behavior or stated any suicidal intentions, he would have been placed in a Safety Cell for closer observation as discussed above.