DEATH IN CUSTODY

SUMMARY

The loss of life under any circumstances is a tragedy. The 2011-12 Santa Barbara County Grand Jury (Jury) received notice from the Santa Barbara County Sheriff's Office (SBSO) about an inmate death that had taken place at the Santa Barbara County Main Jail. The Jury decided to see what, if anything, could be done to prevent this from happening again. During the investigation it was learned that the death of a 29-year-old male had been declared a suicide.

METHODOLOGY

Penal Code Section 919(b) states that: "…any death in custody has to be reported to the county grand jury." The SBSO was very cooperative in providing all reports and logs to the Jury so that a clearer picture of the circumstances was available. The Jury reviewed all reports, interviewed Custody staff and Coroner personnel. It also inspected the isolation cell and corridors where the death occurred.

OBSERVATIONS AND ANALYSIS

The Jury learned that from 2009 through 2011 there had been 14 attempted inmate suicides at the Main Jail with one death in July 2011. The decedent was discovered when a deputy handed out dinner. The inmate was lying on his bunk and did not respond or move when told his dinner was ready. He was on his mattress, but because of the decedent's position, the deputy could not see his face or head. His left foot was resting on the floor and his left arm hung free. The decedent's sleeping accommodations consisted of a mattress on a built-in metal bed frame and was partially in an alcove built into the wall on the west side of the cell. He was found lying on his back with his head toward the front of the cell. His head was hidden by the alcove wall. With further observation through the meal service slot, the deputy was able to see the decedent had a clear plastic bag over his head. After summoning assistance, he entered the cell and pulled the bag off the inmate's head, but then found a strip of torn vinyl fabric wrapped around the decedent's mouth and tied together at the back of his head. After removing the fabric, he then pulled what was later determined to be a portion of a torn terry cloth, from his mouth. It was discovered that the vinyl fabric had been torn from the cover of the inmate's mattress and another piece of the vinyl fabric had been tied to the door which caused resistance when the door was opened.

When paramedics arrived they instructed custody staff to stop any life saving measures, due to the obvious signs of the decedent's death. He was in the early stage of rigor mortis and post mortem lividity was noted on his back and other parts of his body. The inmate had been discovered several hours after death had occurred.

The decedent had been housed for over a month in the East Isolation area of the jail where there are 12 single-person cells. Records showed the custody deputies checked the East Isolation cells approximately 41 times during this day.

Inmates in adjoining cells told deputies that the decedent had been complaining about pain for the past five days. He was taken to the medical unit on the first request, but nothing appeared wrong with him. During his incarceration, he had over 26 "sick call requests" for which he was seen. Several times during his four months in the Main Jail, he also requested to be moved to other cells saying he feared for his safety. When the decedent's family was questioned by the Coroner, it was learned that they were not aware of any emotional or mental health issues, but said he was possibly paranoid and a hypochondriac. Jail Mental Health staff felt he appeared to have chronic anxiety issues, but the decedent repeatedly refused any mental health assistance. Could the decedent's frequent requests for medical visits and cell location moves been triggers for a more comprehensive mental health evaluation which could have resulted in a suicide watch?

The Jury received a copy of a SBSO memorandum dated July 24, 2008 addressed to "All Custody Deputies" with the subject "Directive: Safety Check Policy." It states that:

> ...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 in [sic] obtained... RATIONALE: As described in the **Custody Policy Manual,** The intent of safety checks is to provide for the health and welfare of inmates through regular, intermittent and prescribed direct visual observations without the aid of audio/video equipment. **Title 15, CCR** [California Corrections Regulation] further describes the intent of a safety check as: 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 Grand Jury determined that the above policy and procedures were not followed. The decedent's head was in the alcove when he was found. How long had it been since verbal contact had been made with the decedent since he had been deceased long enough for rigor mortis to set in?

The Jury was told that all custody staff attend a "comprehensive suicide prevention program" to help identify those inmates who may be suicidal. They are educated on the signs and symptoms of potential suicide risk, and are aware of and follow proper first aid, CPR, and emergency procedures. Suicidal inmates are placed in "safety cells" and

checked at 15-minute intervals. However, the decedent was assessed but not determined to be suicidal by Mental Health staff.

While the Jury reviewed all the facts, the question arose as to where the decedent obtained the plastic bag that was over his head. It was discovered that inmates' meals are delivered in plastic bags and that additional plastic bags are distributed for trash. However, there is no scheduled time for trash pickup and no accountability of who is given a trash bag and if or when it is picked up.

While inspecting the Isolation Cell and corridors, it was pointed out to the Jury that the corridors outside the cells have video cameras but at that time no recordings were made. Therefore, the Jury was unable to review videos of custody officers to see if they actually look in each cell and communicate with inmates. Consequently, only after this inmate's death were videos recorded.

The 2011-12 Santa Barbara County Grand Jury concluded that closer inspection and communication by deputies with inmates should take place. Additionally, inmates who are placed in Isolation Cells should have more frequent monitoring by Mental Health staff.

FINDINGS AND RECOMMENDATIONS

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

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.

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

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.

Finding 2
Approximately half of Isolation Cells in 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.

Recommendation 2
That in 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.

Finding 3
Plastic bags were left in Isolation Cells.

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

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

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

Recommendation 4b
That Isolation Cell corridor video recordings be retained for at least 180 days.

Finding 5
The decedent made numerous requests for medical checks and several requests for cell relocation saying he feared for his saftey.

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.

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 are the affected agencies for this report, with the mandated response period for each.

Santa Barbara County Sheriff's Department – 90 days
Findings 1a, 1b, 1c, 2, 3, 4, 5
Recommendations 1, 2, 3, 4a, 4b, 5