DEATHS IN CUSTODY 2019

SANTA BARBARA COUNTY

SUMMARY

Pursuant to *California Penal Code Section 919, subdivisions (a) and (b)*, "[t]he grand jury may inquire into the case of every person imprisoned in the jail of the county on a criminal charge and not indicted," and "shall inquire into the condition and management of the public prisons within the county." Under that statute, prior Santa Barbara County Grand Juries often have examined the circumstances surrounding inmate deaths at the Santa Barbara County Main Jail. Four inmates died in 2019 while in the custody of the Santa Barbara County Sheriff's Department; they will be identified here by the identifiers A1, B1, C1, and D1. The deaths of A1 and B1 were determined to be natural causes, while C1 and D1 were determined to have died by suicide.

The 2019-20 Santa Barbara County Grand Jury investigated the circumstances surrounding these deaths, studied the facts, and offers recommendations with the goal of improving local government operations.

METHODOLOGY

Information pertaining to the four deaths was obtained from the Sheriff's Office (Sheriff). These included written reports from Senior Deputies, Custody Deputies, and other sworn staff of the Department. Further, the Jury reviewed reports from the staff of Wellpath, the County current contracted medical and mental healthcare provider for the Main Jail and studied other documents, records, and policy and procedure manuals for both custody staff and Wellpath.

OBSERVATIONS

1.0 A1 Death in Custody January 10, 2019

A1 was seriously ill when he was arrested and placed in custody on February 20, 2018. He remained there or in Cottage Hospital through several continuances and the filing of additional charges on July 16, 2018, until his death in Cottage Hospital on January 10, 2019 with several family members present. The attending physician certified his death as from natural causes.

While in custody, he made several sick call requests, describing a variety of very serious medical problems. He was seen by Wellpath staff, who carried out standard measurements, and an interview followed each visit until December 16, 2018, when he was sent to Cottage Hospital. He was discharged and returned to the Main Jail on December 26, 2018. A plan was developed, including medications and diagnostic tests, but he refused both on several occasions after his return to custody.

On January 5, 2019, A1 was returned to Cottage Hospital as his condition worsened. After discussion with the medical director on January 7, 2019, his family met with him, and he asked to be transferred to comfort care, focusing on symptom control which required discussion with the District Attorney. He died on January 10, 2019.

There is no evidence of mistreatment or negligence by any member of either the custody staff or the Cottage Hospital staff. A1 had been seriously ill for some time, and he frequently refused treatment or diagnostic tests. The Jury found no indication that custody hastened his death.

2.0 B1 Death in Custody April 12, 2019

B1 was admitted to Cottage Hospital on April 3, 2019. He had a history of diabetes and heart problems. He was prescribed stent placement, cardiac catheterization, and new medications. B1 refused invasive treatment and was released from the hospital on April 4, 2019.

B1 was again admitted to Cottage Hospital on April 9, 2019. He was brought to the emergency room by ambulance directly from the street with palpitations, nausea, occasional vomiting and dizziness. His lab tests showed hypoglycemia likely due to noncompliance with Type 1 Diabetes treatment. His rapid atrial fibrillation was treated, and it was determined that admission was not warranted due to history of chronic medical noncompliance. He was discharged and referred to the county medical clinic. The Jury was told that the hospital record states, "Patient understands that he is at risk of permanent disability, worsening, death all related to his noncompliance."

B1 was booked at the Main Jail on April 10, 2019 on a parole violation. He was confined to a wheelchair at his admission and was a diabetic with a history of non-compliance with treatment protocol. B1 reported that he had been in the Intensive Care Unit for cardiac problems. The jail medical staff reported his vital signs were out of control, and no new medications were administered.

B1 had advised the arresting officer that he could not be transferred to the Rescue Mission or People Assisting the Homeless (PATH) because of his previous conduct at those facilities. Similarly, he was no longer permitted at Cottage Hospital due to his conduct.

Wellpath has adopted the policy of Correctional Medical Group Companies, Inc. The Santa Barbara County Adult Facilities Policy & Procedures Manual states in Section E02B, "The following medical conditions identified initially upon arrival of the arrestee will require refusal and referral to the emergency room for medical evaluation and clearance… 6) Arrestees with any type of serious injury or illness." According to a Sheriff Department source, B1 had a long history of serious illness, and he should not have been admitted to the jail but referred to the emergency room.

On April 12, 2019, at 2:30 p.m., the on-duty Registered Nurse (RN) received a phone call from the basement officer who advised her that B1 was complaining of chest pains. The officer was instructed to bring B1 into the Central Treatment Room so that she would have access to all the necessary equipment. The RN did a full assessment of his vital signs and applied oxygen. B1's sugar levels were at 534 mg/dl. An Electrocardiogram (EKG) was administered to the patient. The RN attempted to contact the on-call physician to report the high blood sugar levels and to evaluate the EKG but was unable to get an answer. She left a voice mail and administered nitroglycerine by placing it under his tongue. At 3:24 p.m., another assessment was conducted. At that time the patient was talking and joking with officers and did not appear to be in distress. B1 was cleared to return to his housing unit pending a diabetic check at 5:00 p.m. The 5:00 p.m. check yielded a blood sugar level of 587 mg/dl. The on-call physician was still unavailable.

At 5:40 p.m., a Custody Deputy (CD1) and a trainee began normal meal service in the cell block. B1 refused his meal when his name was called so the trainee asked another inmate to take the tray to him. About five minutes later, an inmate approached the desk and stated that B1 "is not

looking too good." CD1 told the trainee to call medical as he went to check on B1. CD1 could see that B1 was foaming from the mouth but was still coherent. When contacted, medical asked if B1 could be transported to the Central Treatment Room for an EKG. The custody deputy, his trainee and an inmate were able to get B1 into a wheelchair and CD1 started rolling him out to the hallway. At this point B1 started foaming from the mouth and nose, and his head and eyes were rolled back. CD1 called medical via the radio and reported a "code blue" (cardiac arrest).

CD1 and his trainee lowered B1 to the ground and started life saving steps. Custody Deputy 2 (CD2) heard the radio code blue and proceeded to the basement area. Upon arriving at the scene, he saw CD1 conducting Cardiopulmonary Resuscitation (CPR) on B1. He noticed that the medical team had yet to arrive and an Automated External Defibrillator (AED) was needed. CD2 went up the east stairwell to retrieve an AED and saw the medical team coming down the stairwell. He asked if they had an AED and they said they did not. CD2 went to the east treatment room and grabbed an AED as well as a "man down bag" (an emergency kit with instruments, equipment and medications).

When CD2 returned to the scene, he saw that more medical staff was on scene, and he assisted in setting up the oxygen tank. CD2 noted that CD1 had been doing CPR for quite a while, so he replaced CD1 and continued CPR. After about two minutes of CPR, American Medical Response (AMR) arrived and took over the lifesaving efforts. The patient was pronounced dead at 6:41 p.m.

FINDINGS AND RECOMMENDATIONS

Finding 1

B1 was accepted into the Main Jail despite his potentially life-threatening condition and inability to walk.

Recommendation 1

That the Santa Barbara County Sheriff enforce the policy regarding not admitting inmates to the Main Jail with life threatening medical conditions.

Finding 2

When the on-call physician was unable to be reached on April 12, 2019, at 2:30 p.m., the inmate was not transferred to the local hospital emergency room.

Recommendation 2

That the Santa Barbara County Sheriff require all medical staff be instructed to transfer inmates to the local hospital emergency room when there is an emergency that is a life threatening or serious injury or illness and the on-call physician does not respond.

Finding 3

When the blood sugar level was determined to be 587mg/dl at 5:00 p.m., and the on-call physician did not respond, the inmate was not sent to the emergency room.

Recommendation 3

That the Santa Barbara County Sheriff ensure that medical staff follow policy and procedures when the on-call physician does not respond.

Finding 4

When Wellpath personnel responded to a man down emergency, they did not bring an emergency kit to the scene.

Recommendation 4

That the Santa Barbara County Sheriff ensure that Wellpath personnel bring an emergency kit whenever they respond to a man down notification.

3.0 C1 Death in Custody June 25, 2019

C1 was arrested and booked at the Santa Barbara County Main Jail on April 10, 2018. C1 remained in custody and unsentenced while his court date was continued 25 times. The Jury questioned why C1 was held 14 months awaiting trial. The 6th amendment of the United States Constitution guarantees a speedy trial and *California Penal Code Section 1382* dictates that unless waived a person charged with a felony be brought to trial within 60 days. The date of arrest on both the Sheriff's letter to the Jury and the Coroner's report incorrectly state 2019, giving the false impression that his incarceration was two months rather than fourteen months.

C1 had a decades-long history of prior arrests, detention, and mental health issues with suicidal ideations. C1 was evaluated by a Wellpath psychiatrist in August of 2018, diagnosed with schizophrenia, and prescribed antipsychotic medications. Within five days, C1 was noncompliant and stopped taking prescribed medications, and there was no follow-up. A January 2019 assault at the Main Jail resulted in orbital and nasal fractures.

It was reported to the custody deputies on June 25, 2019, that C1 was accused by fellow inmates of being a child molester, which he denied. On the same day at approximately 1:00 p.m., C1 was removed from his cell by a custody deputy after arguments among inmates. He was handcuffed, removed from his housing unit and displayed combative behavior toward a neighboring inmate. He was placed in the temporary cell Front Central C-14 at 1:11 p.m. The handcuffs were removed. The video provided to the Jury shows C1 began pacing in the cell.

C1 requested to be assigned to a cell alone for permanent placement. C1 was advised Wellpath mental health (MH) would be contacted to meet with him prior to rehousing. The Custody Deputy stated he contacted MH and informed the clinician of his conversation with C1. Later that day at 1:34 p.m., C1 asked a MH clinician walking by his cell for help with housing and stated he would kill himself if he did not get a cell alone. At the end of their conversation, C1 denied any suicidal or homicidal intention. The same MH clinician determined C1 was not a danger to himself. This MH clinician, the last person to speak with C1 minutes prior to his hanging, stated in an interview that they are not required to inform a supervisor or custody personnel upon hearing a patient make a suicidal statement.

Shortly thereafter, at 1:51 p.m., C1 took off his T-shirt and is shown on video experimenting by tying it at varying heights on the bars of his cell. At 1:59 p.m. C1 was standing normally in his cell, with the T-shirt tied to the bar, as a Custody Deputy walked by. At 2:01 p.m., C1 secured the T-shirt, tied at chest height, around his neck.

At 2:13 p.m., C1 was discovered hanging by a Custody Deputy. He was cut down and life-saving measures were initiated. No carotid pulse or vital signs were detected. CPR was administered and the AED indicated no shock was needed, as a pulse was detected. AMR and Fire Department personnel arrived at approximately 2:23 p.m., and C1 was removed at 2:30 p.m. on a backboard and taken to Cottage Hospital.

On June 30, 2019, C1 was removed from life-support equipment at Cottage Hospital with his family at his bedside.

In its investigation the Jury discovered that 28 of 48 interviews regarding C1's hanging in his cell omitted the date and time the witness was interviewed. Some interviews occurred in September, more than two months after the event.

FINDINGS AND RECOMMENDATIONS

Finding 1

Following an accusation of being a child molester and being assaulted by other inmates, C1 was agitated and threatened suicide unless he received a permanent cell to himself.

Recommendation 1

That the Santa Barbara County Sheriff immediately place an inmate threatening suicide in a safety cell and monitor the inmate more frequently.

Finding 2

There was a significant date inaccuracy in both the Santa Barbara County Sheriff's letter and the Coroner's Report, giving the false impression that his incarceration was two months rather than fourteen months.

Recommendation 2

That the Santa Barbara County Sheriff ensure that all reporting documents are complete and accurate.

Finding 3

Omission of the dates of interviews conducted by Sheriff's Deputies make it difficult to assess the accuracy or recall of circumstances surrounding a death in custody.

Recommendation 3

That the Santa Barbara County Sheriff ensure that the dates contained in investigative reports be stated and interviews completed as soon as possible after the event.

Finding 4

When walking by C1's cell, a Custody Deputy failed to observe the T-shirt tied to the bars.

Recommendation 4

That the Santa Barbara County Sheriff ensure that Jail Custody staff are alert to items hanging from bars and take appropriate action.

Finding 5

An inmate suicide threat was not reported to a supervisor.

Recommendation 5

That the Santa Barbara County Sheriff ensure that all detention facility personnel inform their supervisor of any threats of suicide.

Finding 6

C1's mental illness was not reevaluated for the ten months prior to his suicide.

Recommendation 6

That Santa Barbara County Board of Supervisors provide psychiatric services to better serve mentally ill inmates in detention.

4.0 D1 Death in Custody October 31, 2019

D1 was arrested on October 19, 2019 by the Lompoc Police Department on a violation of felony probation charge. On October 20, 2019 D1 was booked into the Main Jail and the medical intake screening was completed. D1 claimed to be suffering from mood disorders, anxiety and Post Traumatic Stress Disorder (PTSD), but claimed no drug or alcohol use. The records provided to the Jury did not show whether his previous booking records were reviewed. A thorough review of prior booking assessments would have revealed a history of drug use and suicidal ideations. An initial mental health assessment was attempted, but D1 refused services and no referral to a psychiatrist was made.

D1 complained of withdrawal symptoms to the custody staff on October 23, 2019. The Jury learned custody staff later referred him to the medical staff where he was assessed and placed on a Benzodiazepine protocol. Later, he refused monitoring and appropriate medications.

On October 23, 2019, D1 attempted to exit the facility by attempting multiple times to walk past Custody Deputies as they were serving meals. He was medically evaluated and cleared. He was then rehoused to cell IRC100-113 which contained a wall phone that had a long cord to the receiver. D1 was referred to Mental Health for evaluation because of demonstrated bizarre behavior. He was not seen that day and placed on "welfare check" for the next day by Mental Health.

On October 31, 2019 at approximately 11:15 a.m., D1 committed suicide in his cell by wrapping a phone cord around his neck and dropping his feet out from under his body. When D1 was discovered, a custody deputy placed the pads from an AED device on D1's chest. An RN arrived and checked for breathing and pulse and found none. CPR was then administered by several deputies, pausing only to allow the AED to check the patient. The deputies reported that the AED never gave the order to administer a shock. At 11:28 a.m., medics from the Santa Barbara County Fire Department arrived and took over CPR. At 11:50 a.m., D1 was pronounced dead.

The required Responder Defibrillator Report was not found in the files provided to the Jury. In addition, during the incident one of the medical staff heard a Code 33 on the radio, thus knowing that this was an emergency but not knowing what type of emergency.

FINDINGS AND RECOMMENDATIONS

Finding 1

A thorough review of D1's prior booking assessments would have revealed a history of drug use and suicidal ideations.

Recommendation 1

That the Santa Barbara County Sheriff direct staff to review all prior bookings and assessments at intake.

Finding 2

D1 was not started on treatment at the first mention of his statement of experiencing withdrawal symptoms.

Recommendation 2

That the Santa Barbara County Sheriff ensure that Wellpath conduct remedial training of medical staff regarding withdrawal statements or recognizing symptoms.

Finding 3

After D1 refused medications, no follow-up assessment was scheduled.

Recommendation 3

That the Santa Barbara County Sheriff require Wellpath conduct remedial training of medical staff regarding individuals who refuse medication.

Finding 4

The inmate was housed in a cell that was not intended for mental health or medical observation.

Recommendation 4

That the Santa Barbara County Sheriff Custody Staff house inmates displaying symptoms of mental illness in cells intended for mental health or medical observation.

Finding 5

D1 was housed in a cell with a long-corded wall-mounted telephone.

Recommendation 5

That the Santa Barbara County Sheriff ensure that the Custody Staff not house inmates in cells with corded telephones.

Finding 6

An initial mental health assessment was attempted, but D1 refused services and no referral to a psychiatrist was made.

Recommendation 6

That the Santa Barbara County Sheriff ensure that Wellpath conduct remedial training of staff regarding medical and mental referrals at intake.

Finding 7

The radio call of Code 33 did not identify the nature of the emergency.

Recommendation 7

That the Santa Barbara County Sheriff direct all radio calls for medical emergencies be in plain language, including details of the symptoms encountered such as suicide by hanging, bleeding wounds, suspected overdose, etc.

Finding 8

The required Responder Defibrillator (AED) Report was not found in the files provided to the Jury.

Recommendation 8

That the Santa Barbara County Sheriff ensure that Wellpath test all AEDs monthly and after each use and keep logs of the dates of these checks.

CONCLUSION

During 2019, four inmates in custody at the Santa Barbara County Main Jail died. Dealing with persons who have severe medical conditions and/or mental illness is no easy task. The 2019-20 Santa Barbara County Grand Jury's role in these cases is to investigate the circumstances of the death, determine the facts, and make recommendations with the goal of improving local government operations.

The death of A1 was ruled by the Coroner's Office to be the result of natural causes. The Jury has concluded from its inquiry into the circumstances of A1's death in custody that all pertinent health rules, regulations and policies were followed by the Sheriff's Department and that no further action is required. Accordingly, pursuant to *California Penial Code Section 933.05*, the report in this death requires no response.

The death of B1 was also ruled to be due to natural causes. The Jury concluded that the inmate was booked into the Jail with critical health issues, which was against Santa Barbara County Sheriff and Wellpath policies. In addition, errors occurred in the response and treatment of the inmate during his seizure.

The death of C1 was ruled by the Coroner's office to be the result of suicide by hanging. C1's threats of suicide were inadequately addressed despite the fact he had previously been seriously assaulted at the jail. All threats of suicide must be taken seriously. C1 was jailed and unsentenced for 14 months, while his court date was continued 25 times. Many of the official interview documents surrounding C1's death did not include a date when each interview took place. Documents from the Sheriff and Coroner included the incorrect year of his arrest. Once C1 was discovered hanging in his cell, deputies and medical staff immediately came to his aid and provided life-saving measures. C1 was taken off life support at the hospital five days following his suicide attempt at the jail.

The death of D1 was ruled by the Coroner to be the result of suicide by hanging. The Jury concluded that many of the pertinent health rules, regulations and policies were not followed by the Sheriff's Department and its medical provider, Wellpath. D1 was not referred to a

psychiatrist at intake, was not started on treatment at first mention of withdrawal, was not scheduled for assessment when medications were refused, and was housed in a cell that was not intended for mental health or medical observation.

The 2019-20 Santa Barbara County Grand Jury concludes that the Santa Barbara County Sheriff's Department needs to upgrade training and review policies and procedures with staff and Wellpath to avoid serious errors. The Sheriff needs to insist on more adequate psychiatric responses from Wellpath.

REQUEST FOR RESPONSE

Pursuant to *California Penal Code Section 933 and 933.05*, the Santa Barbara County Grand Jury requests each entity or individual named below to respond to the enumerated Findings and Recommendations within the specified statutory time limit:

Responses to Findings shall be either:

- Agree
- Disagree wholly
- Disagree partially with an explanation

Responses to Recommendations shall be one of the following:

- Has been implemented, with brief summary of implementation actions taken
- Will be implemented, with an implementation schedule
- Requires further analysis, with a completion date of no more than six months after the issuance of this report
- Will not be implemented, with an explanation of why

2.0 B1 Death in Custody April 12, 2019

Santa Barbara County Sheriff-Coroner - 60 days

Findings: 1, 2, 3, 4

Recommendations: 1, 2, 3, 4

3.0 C1 Death in Custody June 25, 2019

Santa Barbara County Sheriff-Coroner - 60 days

Findings: 1, 2, 3, 4, 5, 6

Recommendations: 1, 2, 3, 4, 5, 6

4.0 D1 Death in Custody October 31, 2019

Santa Barbara County Sheriff-Coroner - 60 days

Findings: 1, 2, 3, 4, 5, 6, 7, 8

Recommendations: 1, 2, 3, 4, 5, 6, 7, 8