SUICIDE IN CUSTODY

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 have died at the Jail since March 2018; they will be identified here by the initials HJA, AB, JC, and ER. There has not been sufficient time for the Jury to consider the two most recent deaths (JC and ER). Both of those deaths were reported in the local press, appear to have been due to natural causes, and will be forwarded to the 2019-2020 Jury to review as it sees fit. The 2018-2019 Jury reviewed the death of AB, who committed suicide in a cell in July 2018, and of HJA, who died from natural causes at a local hospital in March 2018. This Report examines the circumstances of the suicide death of AB. The death of HJA is the subject of a separate Jury report.

METHODOLOGY

Information pertaining to the suicide of AB was obtained from a number of sources. Specifically, the Jury: conducted face to face and telephone interviews with many individuals having first-hand knowledge of the events; collected written reports from senior Sheriff Department (Sheriff) senior officers, custody and patrol deputies, and other sworn staff members of the Department; interviewed and obtained reports from officers and staff employees of Wellpath, the County's current contracted Jail medical/mental health provider; interviewed AB's two brothers; interviewed the forensic pathologist who conducted the autopsy; and reviewed many other miscellaneous documents and records, including the County contract with the medical provider and policy manuals.

Of special importance, as part of its investigation the Jury viewed several hours of video which—with one important exception—captured AB's movements from the time he was arrested on July 5, 2018, through the removal of his body from the Jail later that day. These videos included officer body camera and Sheriff patrol vehicle dashboard videos taken at AB's residence and during his transport by patrol car to the Jail, and videos showing him at the Jail booking desk and entering Cell C-9, where shortly thereafter he took his own life. The Jury also viewed videos of the investigative activities which took place in the cell after he died and inspected the cell twice.

Before discussing the specific circumstances of AB's death, the Jury is compelled to comment on two procedural issues surrounding its efforts. First, throughout the investigation, the Sheriff's Office impeded the Jury's ability to obtain what we believed to be highly relevant documents and information, by ignoring requests, making delayed or partial responses, or flatly refusing to honor requests. On more than one occasion, the Jury needed to make two or more follow-up requests before the documents were produced. Moreover, a specific request for the production of important internal investigative reports pertinent to our inquiry - Risk Assessment Unit (RAU) and Criminal Investigation Division (CID) reports in particular – at first was ignored, and ultimately rejected. Although the Jury later interviewed some of the same persons who were questioned by the RAU

and CID investigators (*e.g*., Wellpath employees), the Sheriff's Office's refusal to produce not only the reports themselves, but the notes or transcripts of those interviews, or recordings of the interviews (if any), deprived the Jury of the opportunity to compare them with what we were told many months later by the same interviewees. As a result, assessing the credibility of these witnesses was made much more difficult.

The Jury chose for practical purposes not to challenge all of the refusals, although some records the Sheriff's Office originally withheld on "privilege" grounds eventually were produced in response to the Jury's persistence in seeking their disclosure. Ultimately, the Jury reluctantly concluded that pursuing production of all the withheld information through the subpoena process would be too time consuming, and the Jury proceeded without having obtained all of the information to which we continue to believe we were entitled

Nor did the Jury pursue Wellpath's refusal to produce pertinent documents without a subpoena. We believe this refusal directly violates the provider's contract with the County, which expressly declares such records to be the property of the County. Again, given the logistical and time constraints involved in the subpoena process, the Jury chose not to challenge the refusal, but a future Jury may do so.

The Jury learned during the course of its investigation that the Jail continues to carry on its medical/mental health functions without National Commission on Correctional Heath Care (NCCHC) accreditation. The original 2015 contract between the County and Wellpath's corporate predecessor, CFMG, required this accreditation to be obtained no later than April 30, 2017. While the Jury understands that the certification process can be lengthy, the lack of accreditation constitutes a continuing violation of the contract and is a matter of real concern. Especially considering that the North Branch Jail is scheduled to open later this year, this issue should be addressed promptly by the Board of Supervisors.

OBSERVATIONS

The following are the essential facts surrounding AB's death in custody. On the afternoon of July 5, 2018, AB was arrested by Sheriff patrol deputies outside his home. The deputies had been dispatched to the premises as the result of a 9-1-1 telephone call reporting that AB was acting aggressively toward another resident in the house. When apprehended in a neighbor's backyard, AB appeared clearly to be under the influence of alcohol. Later, toxicology test results from a bodily fluid sample drawn at the autopsy on July 9, 2018, revealed AB had a blood alcohol level above the legal limit for driving while impaired. In addition, the presence of methamphetamines was detected.

Following his arrest, AB was handcuffed and placed in the rear seat of one of four responding patrol cars. In the meantime, the deputies, two of whom were still within their probationary period, continued their investigation inside and around the house. A family member who was present told the Jury they had important information about AB's mental health history but was not interviewed by the deputies.

Left alone in the rear of the vehicle, AB became increasingly agitated. Although he began loudly to complain that he was thirsty, no one brought him water. As observed on the dashboard camera video, AB then became even more agitated and began purposely to strike his head violently against the vehicle's interior.

California Welfare and Institutions Code §5150 provides that if a peace officer determines that probable cause exists to believe that a person has a mental health disorder creating a danger to himself or others (although not necessarily imminent), or is gravely disabled, the officer may take that person into custody to be brought to a designated mental health facility for an evaluation. In Santa Barbara County, unlike all other counties in California, it is the Sheriff's Office policy that the arresting officer cannot make that preliminary judgment himself or herself and a mental health professional must first determine if the predicate exists. In this instance the deputy drove directly from AB's home to the Jail and there is no indication that he made any effort to arrange for a "5150" evaluation.

The patrol vehicle's dashboard camera video revealed that, while in transit from his home to the Jail, AB kept calling out to God for help and continued to strike his head forcefully against the vehicle's interior, causing contusions to his forehead. As a result, the deputy radioed ahead to the Jail that the arrestee was "combative." Thus, several custody deputies were posted outside the Jail sally-port to await AB's arrival and be available to help subdue him if necessary. Although the medical provider policy manual requires that a registered nurse (RN) conduct an initial evaluation to "clear" an arrestee medically and mentally, in this instance the RN initially directed a licensed vocational nurse (LVN) to meet the patrol vehicle when it arrived and to check AB's vital signs before he was escorted into the sally-port.

When the patrol car arrived, the LVN, as instructed, went out to the vehicle where she took AB's blood pressure. Then he was escorted into the sally-port where there is a separate small room expressly designed for use by the RN to privately interview an arrestee and evaluate his or her mental and medical condition. Importantly, a dedicated computer is located in that room on which prior medical/mental health records can be retrieved. Although video revealed that by then AB appeared to be compliant with directions and to pose no physical danger to the RN or others, the standard procedure for the RN to use that room was not followed. Rather, AB was escorted directly through the sally-port into the booking area, where the RN questioned him. In a "late entry" added to the computerized medical records after AB's death, the RN stated that AB had refused to answer questions about his mental state when questioned at booking. That refusal, even without his record of a "5150" hold at the time of a prior arrest, should have triggered an immediate psychiatric evaluation.

Yet, to this point, contrary to the medical provider's policy, it does not appear that anyone made any effort to review computerized or any other records of AB's mental health or arrest history or gave any consideration to whether a "5150" might be indicated. Even a quick review of available records would have revealed that AB was arrested in December 2015, at which time it was noted that AB engaged in "suicidal talk," which triggered a "5150" hold and his transport to the Cottage Hospital Emergency Department.

At this point in the booking process, according to a deputy whom the Jury interviewed, it appeared likely that AB would be treated as a "cite and release." This meant that he would not be classified for housing purposes since he would be detained at the Jail only long enough to "sleep it off." Thereafter, he would be released from custody and served with a citation to appear in court at a later date. Despite AB's prior arrest record, which included a 5150 hold, and despite his palpable agitation, his anger, his apparent state of intoxication, and his repeated self-harming behavior while seated in the patrol car, at his home, and in transit to the Jail, none of the patrol or custody deputies, or the Wellpath nursing staff, recognized that AB potentially was suicidal.

After AB was booked, several custody deputies escorted him from the booking desk intending to place him in a nearby cell. Initially, he was taken to Cell C-14 because it was unoccupied. However, since that cell had no toilet, and AB said that he had to use a toilet, he was taken past Cell C-14 and placed into Cell C-9, located in a short hallway further away. Neither cell is located on a main corridor.

Although a video camera is suspended in a fixed position from the ceiling at one end of the short hallway where Cell C-9 is located, and is intended to provide a complete view of both the entire cell and the hallway, the camera does not provide a full view of the interior of the cell. Specifically, the upper portion of the left corner of the cell as one faces into it from the front cannot be seen on the video monitor.

Video viewed by the Jury showed that, after AB entered Cell C-9 at 7:10 p.m., his handcuffs were removed. Since he had arrived at the Jail shirtless, clothed only in board shorts, he was directed to remove the shorts and custody personnel provided him with a white T-shirt and beltless blue pants. Approximately 15 minutes later, AB removed his T-shirt and, out of camera sight, he affixed it to the bars above a slightly elevated concrete sleeping area located in the cell's front left corner, tied the T-shirt to the upper portion of the bars, and proceeded to hang himself using the shirt as a ligature. It was not until nearly nine minutes later, at 7:35 p.m., that a custody deputy walked by and discovered AB hanging in the cell. The deputy immediately radioed for "man down" assistance, other custody deputies quickly arrived, and AB was lowered down and cut free from the ligature. Life-saving measures were begun, unfortunately to no avail, death was pronounced at 8:02 p.m. His body was later removed from the cell and an autopsy was performed on July 9, 2019. The forensic pathologist who conducted the autopsy attributed AB's death to asphyxiation.

Based upon the Jury's viewing of the video of the scene at Cell C-9 from the time life-saving measures were initiated to the time AB's death was pronounced, approximately sixteen people responded to the "man down" announcement. Although some clearly were engaged in resuscitation procedures, others in and around the cell did not appear to be doing anything but watching. No one appeared to take control of the scene and dismiss unnecessary personnel, despite a medical provider policy requiring that a licensed professional take charge in that situation.

The video also appeared to show a deputy removing a piece of evidence from the cell. The deputy told the Jury that the item was a towel; however, the Jury believes the item shown in the video was the T-shirt ligature, a potentially important piece of evidence. The T-shirt later reappeared inside a paper bag at the autopsy, as shown by autopsy photographs. However, the Sheriff's Department told the Jury the T-shirt was then "thrown away" and not preserved as evidence.

In viewing the video, the Jury also noted that Jail personnel did not appear to use emergency resuscitation equipment, such as suction apparatus to clear an airway. In investigating further, the Jury learned that, when AB was first discovered hanging in his cell, emergency resuscitation equipment could not be located, and when located, did not function properly. The Sheriff's Department told the Jury that the malfunctioning resuscitation equipment had not been retained as evidence, and more importantly, that there was no log or other documentation showing that required inspections of the Jail's life-saving equipment had occurred.

CONCLUSION

The purpose of this report is not to speculate whether AB's death could have been avoided had employees of the Sheriff's Office and Wellpath done a better job. The Jury's role in this case is to investigate the circumstances of the death, determine the facts, and make recommendations with the goal of improving local government operations. **The Jury regrets that, for the most part, the Sheriff's Office seemed more interested in obstructing than working cooperatively with the Jury toward that goal.** Dealing with persons who are under the influence of drugs, alcohol, and/or mental illness is no easy task. Nevertheless, the Sheriff is responsible for the physical safety of every person taken into custody.

As a result of the RAU and CID investigation reports that were withheld from us, the Sheriff may already have identified and addressed the deficiencies we report here. The Sheriff's statutorily required response to the findings and recommendations below will show whether that has occurred, or whether more action is required by the Sheriff, the Board of Supervisors, or the 2019-2020 Grand Jury.

FINDINGS AND RECOMMENDATIONS

Finding 1
One witness who was at the scene of AB's arrest disclosed to the Jury information about AB that the Jury believes might have helped avoid AB's death if Sheriff's deputies or medical personnel had obtained it; however, Sheriff's deputies did not interview this witness.

Recommendation 1
That the Sheriff review and improve training for patrol deputies in responding to calls involving persons who appear to be under the influence of drugs or alcohol, or exhibiting symptoms of mental illness, including questioning persons at the scene who may have relevant information about the subject's condition.

Finding 2
The transporting deputy radioed ahead to the Jail that AB was "combative," without disclosing that AB had engaged in self-harming behavior in the patrol vehicle, which the Jury believes was relevant information for Jail personnel to have in determining whether to arrange an immediate psychiatric evaluation.

Recommendation 2
That the Sheriff review and improve training for all deputies in recognizing and accurately communicating to Jail staff any self-harming behavior by detainees.

Finding 3
The Wellpath RN failed to follow established procedure requiring that a medical/mental health evaluation be conducted in a private interview room where the arrestee's computerized records are available for immediate reference.

Recommendation 3
That the Sheriff require the current contract health care provider, Wellpath, to assure that its staff adhere to all policies, procedures, and contractual obligations regarding the assessment of the medical/mental health status of arrestees upon their arrival at the Jail.

Finding 4
Custody deputies at booking failed to closely examine AB's prior arrest records, which contained information that might have helped avoid AB's death.

Recommendation 4
That the Sheriff require custody staff to adhere to its booking policies and procedures, specifically informing themselves as to an arrestee's prior arrest records at booking.

Finding 5
AB was placed in an observation cell monitored by a video camera that failed to show the portion of the cell where AB committed suicide.

Recommendation 5
That the Sheriff either discontinue using Cell C-9 or improve the video equipment there to allow a complete view of the cell.

Finding 6
Sheriff's custody staff and Wellpath staff failed to follow "man down" procedures regarding management and control of responding personnel.

Recommendation 6
That the Sheriff require custody staff to receive continued training regarding policies and procedures to be followed in a "man down" situation, particularly to assure proper management and control of the scene and to release personnel no longer needed there.

Finding 7
Custody staff failed to properly handle and retain evidence for possible need in the event of further investigation and potential litigation.

Recommendation 7
That the Sheriff require custody staff to properly handle and preserve evidence connected to incidents occurring at the Jail which later may be needed.

Finding 8
Wellpath medical staff and Sheriff custody staff responding to the "man down" announcement was unaware of the location of life-saving resuscitation equipment and that it was not functional.

Recommendation 8
That the Sheriff require Wellpath to inspect, repair and replace emergency life-saving equipment on a regular schedule; maintain a service log; and train custody staff regarding the location of life-saving equipment.

Finding 9
The Jail is operating without National Commission on Correctional Heath Care (NCCHC) accreditation, contrary to the contract requirement.

Recommendation 9
That the Board of Supervisors closely examine the provisions of the existing medical provider contract and enforce all of the current provider's obligations, especially with regard to the continuing failure to obtain National Commission on Correctional Heath Care (NCCHC) accreditation for the Jail.

REQUEST FOR RESPONSE

Pursuant to California Penal Code §§ 933 and 933.05, the Grand Jury requests each entity 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 with an explanation
- Disagree Partially with an explanation

Responses to Recommendations shall be one of the following:

- Has been implemented, with a brief summary of the implemented actions
- Will be implemented, with an implementation schedule
- Requires Further Analysis, with an explanation of the scope and parameters of an analysis or study and a completion date of less than six (6) months after the issuance of this report
- Will not be implemented because it is not warranted or reasonable, with an explanation of why

SHERIFF–CORONER - 60 DAYS
Findings 1, 2, 3, 4, 5, 6, 7, 8
Recommendations 1, 2, 3, 4, 5, 6, 7, 8

BOARD OF SUPERVISORS – 90 DAYS
Finding 9
Recommendation 9