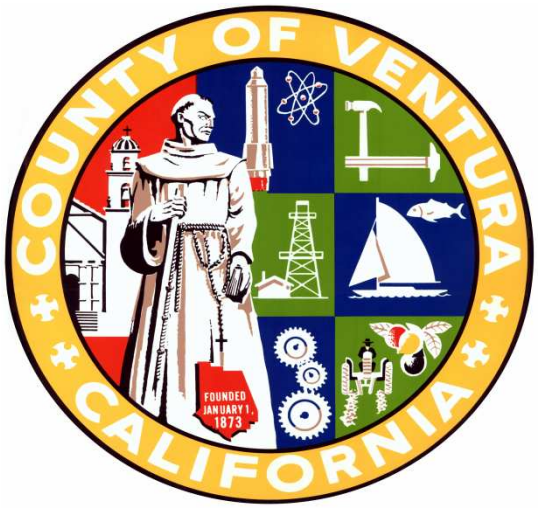
Ventura County Grand Jury
2010 - 2011



Final Report

Inmate Processing and Suicide Prevention in the Ventura County Jail

May 31, 2011

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Inmate Processing and Suicide Prevention in the Ventura County Jail

Summary

The 2010-2011 Ventura County Grand Jury (Grand Jury), pursuant to its responsibility for government oversight, elected to review the organizational response to two suicides and a death in the Ventura County (County) Jail during 2010. The purpose of this review was to understand the process of reception, screening, classification, housing, and monitoring of inmates in the County Jail by the Ventura County Sheriff's Department (VCSD). It was determined that—though VCSD had implemented many elements of a suicide prevention policy that can be considered best practice—the mortality and suicide averages increased in the years 2008 through 2010, as compared to the averages of the prior eight years. The Grand Jury recommends: that the Sheriff present the District Attorney with investigative results of all in-custody deaths; that the Sheriff include the Ventura County Behavioral Health Department (VCBHD) in the assessment of jail suicides; that the Sheriff increase organizational focus on suicide prevention; and that the Sheriff increase the availability of training in suicide issues for staff and community volunteers at the jail.

Background

Section 919 of the California Penal code states "… (a) The grand jury may inquire into the case of every person imprisoned in the jail of the county on a criminal charge and not indicted. (b) The grand jury shall inquire into the condition and management of the public prisons within the county…"

Based on the requirements of that section, the Grand Jury pursued an investigation to understand the process of inmate booking, reception, classification, housing, and monitoring. The specific approach was to study the cases of two suicides and one natural death that occurred within the County Jail during 2010. For the purpose of this review, the term County Jail includes the Main Jail (MJ) adjacent to the County Courthouse, the Todd Road Jail (TRJ) near the city of Santa Paula, and the East Valley Jail (EVJ) near the city of Thousand Oaks. All these facilities are operated by the VCSD. A particular emphasis was placed on the investigation of the suicides.

Inmates fall into three major categories: pre-trial awaiting arraignment, post-trial serving sentence in the County Jail, and post-trial awaiting transportation to state prison. They are housed in cells with the general population or separately, based on the individuals' need to be protected from themselves, to be protected from other inmates, or to protect other inmates and custody staff.

The VCSD has complete responsibility for the inmates within its care. A key issue is to identify and mitigate those factors associated with the inmate and within the facility environment which may either trigger or facilitate a suicide.

This includes screening, classifying, housing, monitoring, and responding to observed suicidal behavior of the inmates. Another responsibility is to provide a physical environment that reduces the potential for the performance of suicidal acts. Suicide itself is not a mental illness, but can be triggered by certain factors that are associated with mental illness.

Methodology

The approach to this study had two major thrusts. The first was to review the inmate processing policies, standards, and procedures within the County Jail. The second was to examine the response of the VCSD to the suicides in 2010, in order to evaluate the appropriateness of existing County Jail policies. A comparison of the VCSD policies was also made to recommendations developed by the National Commission on Correctional Health Care, statistics from the Department of Justice, Title 15 of the California Code of Regulations, and with practices identified by various state and international bodies.

The Grand Jury reviewed the VCSD internal policy and operating procedures for custody operations. This included reviewing the protocols for the observation, recording, and search of inmates; reviewing training of custody personnel in emergency response; evaluating inmate susceptibility to suicide; and reviewing the role of contracted medical services as a participant in the screening and evaluation of inmates. The Grand Jury reviewed the contract between the VCSD and the medical services contractor.

The Grand Jury interviewed key managers and senior custody officials within the VCSD; checked on adherence to operating policies through unscheduled visits to the jail to view intake and assessment procedures; and reviewed custody operations, policies and procedures for searches, safety checks, and observation cells.

The Grand Jury reviewed the details of the responses to the three deaths in 2010; interviewed the VCSD investigators and custody personnel responding to the death incidents; collected copies of reports, team reviews, and other administrative documents related to examinations conducted internally by the VCSD and the County Medical Examiner; and developed timelines for inmates from the time of booking until their deaths. The Grand Jury visited parts of the jail system and viewed the applicable control booths and the cells where the men died. In order to establish points of comparison, the Grand Jury visited jails in Los Angeles and Santa Barbara counties.

Facts

FA-01. The California Code of Regulations provides standards for detention facilities and requires that "[A] facility administrator shall develop a written program for a suicide prevention program to identify, monitor, and provide treatment to those inmates who provide a suicide risk." [Ref-01]

FA-02. The California Code of Regulations provides the necessary standards for suicide prevention, but leaves room for implementation of a site-specific suicide prevention program. There are numerous approaches for implementing suicide prevention policies that have been developed across the country and around the world. [Ref-01through Ref-04]

FA-03. Over an eleven-year period, bookings into the County Jail ranged from 20,256 to 31,930 per year. The total bookings into the County Jail in 2010 were 28,045. The rated capacities are: MJ (793), TRJ (782), and EVJ (31). During 2010, the monthly average daily population range for these facilities was: MJ (691–723), TRJ (692–736), and EVJ (9–18).

FA-04. Over an eleven-year period, suicides in the County Jail ranged from zero to two per year. In seven of the last eleven years, there was at least one suicide per year reported. There were two successful suicides in 2010 and there were thirteen known attempts.

FA-05. Inmates are classified for housing accommodations based on an evaluation as to the risk to themselves and others. According to information from the VCSD, Table 1 illustrates the percentage distribution of inmates by certain classifications housed separately in each of the County Jail facilities.

TABLE 1

HOUSING ACCOMMODATIONS BY CLASSIFICATION

Housing Classification	MJ by %	TRJ by %	EVJ by %
Administrative Segregation	12	3	0
Psychiatric	5	0	0
Protective Custody	2	16	0
Other Categories	17	9	0
General Population	64	72	100

FA-06. For the eight-year period between 2000 and 2007, 83% of all jails surveyed by the Bureau of Statistics of the United States Department of Justice reported no deaths for any cause. For the same period, 12% of jails, nationwide, reported a single death and 5% reported two or more deaths. The smallest jails in the United States had an average annual *suicide* rate of 167 per 100,000, while the 50 largest jails (average daily inmate population of 1,000 or more) had an average annual *suicide* rate of 27 per 100,000 inmates. Table 2 illustrates the mortality and suicide rates for certain large California county jails. [Ref-05]

TABLE 2
MORTALITY AND SUICIDE RATES FOR LARGE JAILS IN CALIFORNIA
2000-2007

California County	Average Annual Mortality Rate Per 100,000 Jail Inmates (2000-2007)	Average Annual Suicide Rate Per 100,000 Jail Inmates (2000-2007)	County Population (2007)
Los Angeles	167	26	9,862,049
Orange	80	13	3,010,759
San Bernardino	129	28	2,015,355
San Diego	195	46	3,001,072
Santa Clara	122	44	1,764,499
Sacramento	170	65	1,394,154
Alameda	215	41	1,474,368
Fresno	152	34	909,153
Riverside	145	44	2,100,516
Kern	128	30	800,458
Ventura	138	48	797,740

FA-07. Between 2000 and 2007, suicide was the single leading cause of death in local jails (29%), followed by deaths associated with heart disease (22%), intoxication (7%), AIDS-related causes (5%), and numerous other causes (37%). The overall mortality rate of inmates ages 45 and older (475 per 100,000) was nearly five times that of younger inmates (98 per 100,000). [Ref-05]

FA-08. Across the United States, 24% of inmate deaths occurred within the first two days of incarceration, 38% of deaths took place within the first seven days, and 56% of deaths occurred within the first 30 days. [Ref-05]

FA-09. Suicide rates for all inmate age groups were at least three times higher among local jail inmates than the civilian population. [Ref-05]

FA-10. White inmates are six times more likely to commit suicide than Black inmates and three times more likely than Hispanic inmates. Violent offenders commit suicide at nearly triple the rate of nonviolent offenders. [Ref-06]

FA-11. Of all offender groups, public order offenders (weapons, parole violation, obstruction of justice, etc.) spent the shortest time in custody prior to committing suicide; half of their suicides took place in the first three days of custody. Property and drug offenders each had a median time in custody of about a week prior to suicide. Half of the violent offender suicides took place after spending three weeks in custody. [Ref-06]

FA-12. At least 80% of suicides in custody occurred in the inmate's cell; time of day was not a factor. [Ref-06]

FA-13. A definitive cause-effect relationship between risk factors and suicidal death cannot be established. Some inmates attempt suicide with no intention of ever completing the act, while others persist, using more lethal methods until successful. [Ref-07]

FA-14. The VCSD systematic process for receiving, housing, and monitoring inmates is as follows:

A Transporting Officer introduces the inmate to the facility. The booking process begins with completion of the initial Intake Health Screening Form. (Att-01)

The inmate is then classified as to type of housing. Based on the results of this initial screening form, an immediate medical review may be undertaken; otherwise, the screening form is reviewed later in the booking process by medical staff.

The classified inmate is then placed in a 72-hour Reception Housing Area for incoming inmates. The inmate is closely monitored prior to assignment to long-term housing. Before leaving Reception Housing and being assigned to long-term housing, the inmate is interviewed by medical staff and a Reception Housing Clearance, Reception Housing Bypass Form is completed. (Att-02)

After being assigned to a cell and monitored hourly, any anomalies in the inmate's situation may cause reassignment to a cell which is more intensively monitored.

Depending on the type of cell to which the inmate is assigned, the inmate is monitored every 15 minutes (Safety/Suicide Watch cells and Sobering cells), every 30 minutes (Medical Housing and Suicide Precaution cells), or every hour (all other cells). Logs of monitoring activities are recorded electronically for every cell monitored hourly. Logs are recorded manually for the Safety, Sobering, and Medical housing cells.

If an inmate emergency occurs, a critical response protocol is executed. Deputies secure the area and implement emergency procedures. Jail medical personnel respond with a higher level of care. When necessary, Emergency Medical Technicians assume medical responsibility and transport the inmate to the hospital.

If a death ensues, the Medical Examiner performs an examination and issues a report. The VCSD Major Crimes unit investigates and issues an investigative report. If it is determined to be a suicide, these reports are reviewed by the Legal Sergeant on the staff of the head of detentions. Based on this review, the Legal Sergeant, in conjunction with other detention staff members, may recommend changes to detention policy, training, or facilities. [Ref-08]

FA-15. Two parts of the screening process are conducted prior to the assignment of an inmate to long-term housing.

The first screening is completed prior to the 72-hour Reception Housing process. This is done by booking deputies with support, as required, from the California Forensic Medical Group (CFMG) medical personnel. The completion of the first form may trigger an immediate interview with CFMG medical personnel. Otherwise, the form is reviewed by CFMG prior to the inmate leaving the booking floor. (Att-01)

The second screening is completed and documented by CFMG after the 72-hour Reception Housing interval. These two forms capture the mental and physical health state of the inmate. While the Ventura County Justice Information System (VCJIS) is able to easily keep track of institutional data on inmates who have had multiple bookings, these two paper forms used in the screening process are not maintained electronically. (Att-02)

A briefing paper developed by the California Corrections Standards Authority includes a screening form with data elements that are not included in the Ventura County forms. [Ref-09] (Att-03)

FA-16. The sources of information about inmates are the inmates themselves, transportation officers, intake personnel, custodial personnel, fellow inmates, and medical staff. If the inmate is a client of the Ventura County Behavioral Health Department (VCBHD), VCBHD medication records are available. If the inmate was previously incarcerated, criminal history data is also available in VCJIS.

FA-17. Besides uniformed VCSD personnel, there are other categories of people who can have direct access to inmates. They include ministers, teachers, adult literacy volunteers, and civilian supervisors of the kitchen and print shop, etc.

FA-18. Inmate communications with family, friends, and the outside world are mail, telephone calls, and personal visits. Visitors enter a lobby area where there are posted regulations.

FA-19. Staff supporting the County Jail for medical and psychiatric services is contracted through CFMG. This group has been under contract with Ventura County since 1987. [Ref-10]

FA-20. A subsidiary of the California Medical Association, The Institute for Medical Quality (IMQ), has awarded the Ventura County Adult Correctional Facilities accreditation for demonstrating 100% compliance with the IMQ applicable Essential Standards. The accreditation period is September 2010 to September 2012. [Ref-11]

FA-21. The suicide monitoring and response process is implicit in many aspects of County Jail operation, including management, Legal

Sergeant, custody staff, investigators, medical staff, and intake screening staff.

FA-22. The County has a process improvement approach for organizational evaluation and review of its departments. The Sheriff has embraced this approach to organizational change. A part of this management approach is to identify and emulate best practices from any source. The Sheriff has reduced overhead in his administration. For example, Detention Services and Major Crimes now report to the same Assistant Sheriff.

FA-23. In 2010, one inmate died of natural causes; two inmates, A and B, were suicides. Inmates A and B had prior incarcerations. Inmate B had been incarcerated on a frequent basis during the prior six years. The ages of the three were between 48 and 52. In the case of the suicides of inmates A and B, custody personnel responded quickly. Deputies and attending nurses performed emergency procedures until Emergency Medical Technicians arrived in a timely manner and transported the inmates to the hospital.

FA-24. Inmate A left reception housing and was interviewed by a nurse three days after booking. Inmate A was transferred from the MJ to the TRJ eight days after booking. Inmate A was found hanged in his cell 104 days after booking.

An after-death investigation identified that former cellmates stated they had observed two prior suicide attempts. The first attempt was reportedly one day after booking; the second was 96 days after booking. Both attempts were unknown to the custody staff prior to the suicide investigation. The first cellmate claimed to have had contact with an unsworn employee at the MJ about this incident. This contact was not substantiated. The second attempt at the TRJ was not communicated to VCSD personnel by the cellmate before the successful suicide.

FA-25. Inmate B was interviewed by a nurse at the end of reception housing. He was transferred from the MJ to the TRJ four days after booking. Inmate B was found hanged in his cell eleven days after booking. Subsequent investigation indicated that some family members were aware that the inmate had a bipolar disorder, was under psychiatric care, and had exhibited suicidal behavior. This information was not communicated to custody personnel.

FA-26. Based on the analysis of prior suicides, various modifications to cells were initiated to mitigate suicide. These included rounding of bunk railings to prevent attachment of a rope or sheet and installing clothing hooks that would not support the weight of an inmate without giving way. These modifications were observed in the MJ but, based on review of the Investigative Reports and Grand Jury visits, the bunk alterations were not yet completed in the cells of inmates A or B at the TRJ.

FA-27. The VCSD investigates all deaths in the County Jail. The Medical Examiner determines the cause of death and notifies the family of the decedent. If a death is determined to be a homicide, the District Attorney is presented with the investigative results. Similarly, the District Attorney is presented with the results of all investigations of officer involved shootings. In the case of suicides, the District Attorney is not presented with investigative results.

FA-28. The VCBHD currently participates with the Sheriff in a number of ways:

A VCBHD employee works in the County Jail to facilitate discharge planning of inmates and works jointly with custody personnel in support of the Jail Workgroup of the Ventura County Mental Health Board (VCMHB).

The VCBHD screens inmate lists in order to identify those inmates who are already being served by the VCBHD. Some medication record formats have been standardized between the County Jail and the VCBHD to allow smooth access to medication records.

The VCBHD does not participate in the evaluation of suicides and attempted suicides within the County Jail. The VCBHD supports the quarterly Quality Assurance Reviews of the CFMG.

FA-29. Dealing directly with suicides is stressful and challenging. Employees of the VCSD have the Employee Assistance Program (EAP) that provides stress counseling to members of the custody staff. Supervisors can encourage employees to avail themselves of this service. Custody personnel have acknowledged the stressful impact of suicide incidents and have, in some cases, declined suggested counseling.

Chaplains and CFMG medical personnel provide a similar counseling role for inmates when requested. In the particular case of the suicide of inmate B, CFMG provided an unrequested psychiatric intervention to a cellmate who demonstrated a severe emotional reaction.

FA-30. The uniformed personnel in the County Jail are composed of Sheriff Deputies and Sheriff Service Technicians (SSTs). Deputies undergo a six-month VCSD Academy training program. County Jail SSTs undergo a 176-hour training program developed by the California Corrections Standards Authority. Both deputies and SSTs also attend an 80-hour Standards and Training for Corrections Course (STC). All uniformed custody personnel are trained and annually tested in twenty-four knowledge domains associated with specific custody situations.

FA-31. Of the 80 hours of STC training, one hour is devoted to "Indicators of Suicide (In a Jail Setting)." [Ref-12]

FA-32. Counseling by chaplains is a key component in any suicide prevention program. Chaplains in the County Jail undergo specialized training developed by the International Conference of Police Chaplains (ICPC). Suicide prevention is part of the training. Two chaplains and a Catholic Services Representative coordinate the efforts of clerical volunteers from over 50 churches to provide religious support to the inmates. All three of these coordinators have had suicide prevention training.

FA-33. There are approximately 350 volunteers and non-uniformed staff who provide a number of services to the inmates. These activities include vocational, adult literacy, religious, educational, family, and discharge planning services.

FA-34. The National Institute of Corrections Library identifies a thirty-two hour instructional program on suicide prevention. [Ref-13]

FA-35. In some organizations experiencing multiple suicides, the process of reviewing suicide deaths has involved the use of a procedure designated as a "Psychological Autopsy." For example, Psychological Autopsy is considered by the Department of the Army as a key element in the assessment of suicides in its Suicide Prevention Program. [Ref-15] (Att-03)

FA-36. Using the metrics developed by the U.S. Department of Justice and the average daily population and mortality data from the VCSD for the County Jail, over the eleven-year period from 2000 through 2010, the average annual suicide rate was 59 per 100,000 inmates and the average annual mortality rate was 170 per 100,000 inmates.

When calculated over the eight-year period from 2000 through 2007, the annual suicide rate was 48 per 100,000 and the average annual mortality rate was 138 per 100,000.

Over the three-year period 2008 through 2010, the suicide rate was 83 per 100,000 and the average annual mortality rate was 209 per 100,000.

FA-37. A recent report from the National Institute of Corrections has indicated the following: a) Inmate suicide is no longer centralized in the first 24 hours of confinement and can occur at any time within the inmate's confinement; b) All correctional, medical, and health personnel, as well as any staff who have regular contact with the inmates, should receive eight hours of initial suicide-prevention training and two hours of refresher training each year; c) The majority of inmates who committed suicide attended (or were scheduled to attend) a court hearing within two days of when they committed suicide; d) Every completed suicide as well as attempts that require hospitalization should be examined through a morbidity-mortality review process, ideally, coordinated by an outside agency.

A psychological autopsy is recommended as part of this process. [Ref-16]

Findings

FI-01. The Sheriff is mandated to establish institutional processes that meet legal standards. Attempting to avoid a statistically rare event, like a suicide, is a unique management challenge. It takes an institutional focus on this kind of issue to insure that despite the conflicting demands and budget priorities of day-to-day events, this issue is always part of the management process. Other than the Sheriff, there is no one individual formally responsible for suicide prevention in the County Jail. (FA-01 through FA-04)

FI-02. The majority of those booked into County Jail return to private life in the community and some are sent to a state prison. Some individuals are booked into the County Jail and released on a regular basis. A statistically small number die in County Jail custody. Of the 28,045 bookings in 2010, three inmates have died. (FA-03 and FA-04, FA-06 through FA-11)

FI-03. The Sheriff has instituted a set of processes to screen, monitor, respond, and evaluate inmate suicides. After review of the literature, the Grand Jury has determined that some of these processes are considered to be best practices (e.g., the 72-hour reception housing and the multi-stage screening). These processes involve not just the detention staff, but also the Major Crimes staff and contracted medical staff. The Sheriff has instituted a project to modify the County Jail based on lessons learned from past suicides. (FA-05, FA-14 through FA-16)

FI-04. Institutionally, dealing with potentially suicidal inmates is a challenging problem. Collecting information from those inmates about suicidal factors is sometimes difficult. Some inmates withhold information from custody staff even when it is in their best interest to provide that information. Some inmates withhold information when it is not in the best interest of their cellmate. Sometimes families are not forthcoming with pertinent information until after the event. Some inmates make non-serious attempts at suicide, therefore compounding the suicide prevention problem. Some aspects of suicidal tendencies are associated with mental illness. (FA-13, FA-24 and FA-25)

FI-05. When compared with nationwide data collected from the Justice Department, the County Jail ranks in the top 12 percent in experiencing inmate deaths for seven of the last eleven years. Its eleven-year suicide rate is less than the smallest jails nationally and greater than most of the largest jails in California. Both suicide and mortality rates in the County Jail have risen over the three-year period 2008 through 2010. There are many factors correlated with

suicides in a jail environment. When addressing a specific institution, the analysis of the two suicide events in 2010 does not provide enough data to make a credible evaluation of patterns, but does lead to an understanding of special factors, e.g., cell configuration. (FA-04, FA-06 through FA-12, and FA-36)

FI-06. The VCSD Policies and Procedures track all of the elements of a suicide prevention program identified by the National Commission on Correctional Health Care. There is not a single "Plan" for the VCSD, but a program does exist. The suicide prevention program is not represented in a single document, but it meets Title 15 criteria. What is significant is that all of the written policies and procedures exist in a coherent framework and contain standard practices that are not only followed to the letter, but are followed with commitment as well. For example, the immediate institutional responses to the suicides of inmates A and B were timely and appropriate. The teamwork that was demonstrated in the institutional responses to these two suicides indicates the dedication that exists within the detention staff. (FA-14 through FA-19, FA-22 through FA-26, FA-28, and FA-30 through FA-34)

FI-07. Despite the thoroughness and dedication of the VCSD Major Crimes investigators, the fact that the VCSD is investigating deaths in its own jail can be perceived as a lack of transparency. This can lead to a false perception as to the integrity of the investigative process and findings. (FA-23 and FA-28)

FI-08. The participation of the VCSD, the Jail Work Group of the Ventura County Mental Health Board, and the VCBHD with regard to inmate release, has demonstrated an openness that allows for effective communications across the community. This kind of relationship can be considered a best practice. (FA-29)

FI-09. There is a spectrum of personnel available to observe the potential suicidal inclinations of inmates. These include individual deputies, chaplains, and psychiatrists from the CFMG, religious volunteers, teachers, work supervisors, and maintenance personnel. The amount of training regarding suicidal issues in this spectrum is varied. (FA-30, FA-33, and FA-37)

FI-10. Psychological Autopsies have not been an explicit element in the VCSD suicide assessment process. There are two institutional resources available to the VCSD with the technical capability to support custody staff in performing Psychological Autopsies: the CFMG and the VCBHD. The CFMG is a contractor to the VCSD with a clinical perspective; the VCBHD is an independent organization within the County with a community-based perspective. (FA-35) (Att-04)

FI-11. The stoic culture of custody staff and inmates is an inhibiting factor in their requesting counseling services. This can preclude staff and

inmates from requesting counseling services even if those services could be beneficial. (FA-29)

Recommendations

R-01. The District Attorney should review VCSD suicide investigations, as is done in officer-involved shootings, with results of this review to be posted on the District Attorney website. (FI-07)

R-02. The Sheriff should designate a "Suicide Prevention Officer" with the responsibility to focus on the elements described by the National Commission on Correctional Health Care. (FI-01 and FI-06)

R-03. The Sheriff should solicit the Ventura County Health Care Agency for VCBHD's participation with the VCSD legal unit in the analysis of suicides in order to provide an independent perspective. (FI-06, FI-08, and FI-10)

R-04. The Sheriff should establish a team composed of members of custody staff, the VCBHD, and the CFMG, which would review suicides over the past eight years in order to identify potential patterns. (FI-02 and FI-05)

R-05. The Sheriff should develop a brochure that would be available to the inmates' visitors. The brochure would solicit information from friends and relatives about the pre-incarceration mental or physical behavior of inmates that may be indicative of suicide risk. A telephone number should be provided in order to communicate this information to a nurse in the County Jail medical unit. (FI-01 and FI-04)

R-06. The Sheriff should post signs in all three jail lobbies with the contact telephone number for a nurse who can receive comments from friends and relatives on inmates' mental and physical health. (FI-04)

R-07. The Sheriff should consider developing a supplemental Critical Incident Stress Debriefing protocol for staff and inmates who are involved with suicides. (FI-06 and FI-29)

R-08. The Sheriff should institute a policy that, during the interview of an inmate at the end of the reception housing period, an inmate is requested to provide information about possible suicidal ideation and behavior of a cellmate. That information could be used in the transitional interview of the fellow cellmate. (FI-03)

R-09. The Sheriff should develop a course and implement recurring training for the recognition of suicidal tendencies in a custodial setting by non-medical personnel. This could be used as a supplement to the STC training. It is further recommended that the VCBHD, the CFMG, and members of the chaplain's office participate in the development of this course. This course should be used to establish an additional knowledge domain required for review by

custody staff. The VCSD should provide wallet-sized help cards, based on this course, to staff and volunteers. (FI-09)

R-10. The Sheriff should consider requesting the VCBHD and the CFMG to support the performance of Psychological Autopsies on inmates A and B. (FI-03 and FI-10)

R-11. The Sheriff should insure departmental contact with the family members of inmate suicides, not only to express condolences, but to gain understanding of the individual's pre-incarceration behavior. (FI-04 and FI-05)

R-12. The Sheriff should task CFMG to assess the use of information from the Draft Mental Health Assessment Form (Attachment 3) for applicability to the VCSD screening process. (FI-04 and FI-05)

R-13. The Sheriff should establish a database of inmate screening forms to be kept for future reference, to the extent that it does not violate legal privacy restrictions. (FI-02 and FI-03)

Responses

Responses Required From:

Sheriff, County of Ventura (FI-01through FI-11) (R-01 through R-13)
District Attorney, County of Ventura (R-01)

Responses Requested From:

Health Care Agency, County of Ventura (FI-08, FI-10) (R-03, R-06, R-09, and R-10)

Commendations

The Sheriff is commended for accelerating the process of altering the Todd Road Jail in order to reduce the risk of suicide.

The leadership team within the County Jail is commended for initiating processes considered best practice in dealing with suicide and mental illness.

The custody and investigative rank and file of the VCSD are commended in their demonstration of an admirable balance of wariness of, and responsibility for, the well-being of the inmates in the Ventura County Jail system.

References

Ref-01. California Code of Regulations, Title 15, Crime Prevention and Corrections, Division 1, Chapter 1, Subchapter 4, *Minimum Standards for Local Detention Facilities.*

Ref-02. U.S. Department of Justice, *Suicide/Mental Health Update* (A Joint Project of the National Center on Institutions and Alternatives and the National Institute of Corrections, U.S. Department of Justice) Winter 2004, Volume 13, Number 3.

Ref-03. World Health Organization, Department of Mental Health and Substance Abuse, *Preventing Suicide in Jails and Prisons*, 2007, ISBN 978 92 4 159550 6.

Ref-04. International Centre for Criminal Law Reform and Criminal Justice Policy, *Mental Health and Substance Use Services in Correctional Settings A Review of Minimum Standards and Best Practices*, March 2009.

Ref-05. U.S Department of Justice, Bureau of Justice Statistics, *Special Report- Mortality in Local Jails 2000-2007* July 2010 NCJ 222988.

Ref-06. U.S. Department of Justice, Bureau of Justice Statistics *Special Report- Suicide and Homicide in State Prisons and Local Jails*, Aug 2005 NCJ 210036.

Ref-07. *Preventing Suicide in Prison*: A collaborative Responsibility of Administrative, Custodial, and Clinical Staff – The Journal of the American Academy of Psychiatry and the Law 34:165-175, 2006.

Ref-08. Selected VCSD Pretrial Detention Facility (PTDF) Policies and Procedures, and Detention Services Divisional Policies and Procedures (DSDP), for intake, screening, monitoring, and emergency response in County Jails:

Section 4, Chapter 1, PTDF, Reception Booking Procedures

Section 4, Chapter 2, PTDF, Booking Identification Procedure

Section 4, Chapter 3, PTDF, Special Handling Inmates

Section 4, Chapter 6, PTDF, Booking, Job Responsibilities

Section 6, Chapter 2, PTDF, Inmate Classification and Placement

Section 6, Chapter 3, PTDF, Classification Unit Intelligence Responsibilities

Section 6, Chapter 4, PTDF, Reception Housing Center

Section 6, Chapter 5, PTDF, Classification Job Responsibilities

Section 7, Chapter 6, PTDF, Medical Lines, Medical Treatments and Pill Call

Section 7, Chapter 7, PTDF, Interaction with Medical Staff

Section 7, Chapter 10, PTDF, Handling of VA/VC Inmates

Section 7, Chapter 11, PTDF, Suicide Attempts

Section 7, Chapter 12, PTDF, Inmate Monitoring Logs

Section 8, Chapter 2, PTDF, Sobering Cells

Section 9, Chapter 1, PTDF, Inmate Rights

Section 13, Chapter 14, PTDF, Death and Critical Incident

Article 2, DSDP, Documentation of Injury or Illness to an Inmate

Article 37, DSDP, Inmate Death and Critical Incidents

Article 38, DSDP, Use of Safety Cells, Inmate Monitoring Log-Safety Cell, Sobering Cell

Article 43, DSDP, Cell Scan Policy

Ref-09. California Corrections Standards Authority, *Jails and Mentally Ill: Issues and Analysis, A briefing paper developed by The California Corrections Standards Authority (CSA) at the request of The California Department of Corrections and Rehabilitation (CDCR) Council on Mentally Ill Offenders (COMIO)*, September 17, 2009, Appendix 1 Draft Mental Health Assessment Instrument.

Ref-10. Contract No. 5210 between the County of Ventura and California Forensic Medical Group to provide medical, dental and psychiatric outpatient services for inmates in custody facilities operated by the Sheriff as well as medical and dental services for minors in custody facilities operated by the Probation Agency, July 11, 2006.

Ref-11. "*Accreditation Report to the Corrections and Detentions Committee, Ventura-Adult, June 30-July 1, 2010,"* Institute for Medical Quality, California Medical Association.

Ref-12. Ventura County Sheriff's Department, Standards for Training and Corrections (STC) Program, Course record Step 10 of 10, *Mental Illness and Developmentally Disabled (MIDD)*.

Ref-13. National Institute of Corrections Library, Vermont Department of Corrections, *Suicide Prevention: Instructors Manual* (32 hour Training Program).

Ref-14. *Custody Suicide: A compendium of Suicide Prevention Standards and Resources, for the Suicide Task Force*, American Association of Suicidology.

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Attachments

Att-01. Intake Health Screening Form

Att-02. Reception Housing Clearance, Reception Housing Bypass Form

Att-03. Draft Mental Health Assessment

Att-04. Psychological Autopsy

Appendices

App-01. Suicide Discussion

App-02. Elements of Suicide Prevention

App-03. Suicide Helpcard

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Glossary

TERM	DEFINITION
Administrative Segregation	Inmates segregated for their own protection or the protection of others
Best Practices	Best practices are generally accepted standardized techniques, methods, or processes that have proven themselves over time to accomplish given tasks
CFMG	California Forensics Medical Group
County Jail	Main Jail (MJ), Todd Road Jail (TRJ), and East Valley Jail (EVJ)
DSDP	Detention Services Divisional Policies and Procedures
EAP	Employee Assistance Program
EMT	Emergency Medical Technician
General Population	Pre-trial and post-trial inmates, otherwise not classified
ICPC	International Conference of Police Chaplains
Process Management	An approach which ignores internal organizational boundaries and focuses on linking suppliers to customers
Protective Custody	Inmates segregated for their own safety
Psychiatric	Inmate displaying a continual pattern of bizarre behavior or mental disorder
PTDF	Pretrial Detention Facility-alternative name of Main Jail (MJ)
Public Order Offenses	Weapons, obstruction of justice, traffic, driving while intoxicated, drunkenness, parole or probation violation
SST	Sheriff Service Technicians
STC	Standards and Training for Corrections Program
VA/VC	Violently Assaultive/Violently Charged Inmates
VCBHD	Ventura County Behavioral Health Department
VCJIS	Ventura County Justice Information System
VCSD	Ventura County Sheriff's Department

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Attachment 01

Intake Health Screening Form

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VENTURA COUNTY SHERIFF'S DEPARTMENT * CUSTODY DIVISION

INTAKE HEALTH SCREENING

Inmate Name _____ DOB _____ Booking Number _____ ☐ MALE ☐ FEMALE

OBSERVATIONS *(Check Box)* — YES / NO

1. Are there visible signs of trauma, wounds, illness, tremors and/or sweating? ₸ ☐ ☐
   If yes, describe: _____
2. Does the inmate appear under the influence of drugs or alcohol? ☐ ☐
3. Are there visible signs of : ☐ Jaundice ₸ ☐ Needle Marks ☐ Lice/Crabs/Scabies ₸ ☐ Bruising ☐
4. Does behavior suggest danger to self or others? ₸ ☐ ☐
5. Level of orientation: ☐ Alert ☐ Oriented to time, place, person ☐ Confused ₸
6. Does inmate appear to have any developmental disabilities, i.e.:
   ☐ Hearing ☐ Sight ☐ Mental Retardation ☐ Other: _____ ☐
7. Does inmate have mobility restrictions or body deformities? ☐ ☐

QUESTIONS

1. Have you had a serious illness or injury within the past 24 hours? ₸ ☐ ☐
2. Have you been seen by a private doctor or in an emergency room in the past 24 hours? ₸ ☐ ☐
   Where & Why: _____
3. Have you refused medical treatment from anyone within the past 24 hours? ☐ ☐
4. Are you now under a doctor's care for a medical or psychiatric reason? ☐ ☐
5. Are you taking any medications? If yes, what: _____ ☐ ☐
6. Are you a military veteran? If yes, did you serve in a combat zone: _____ ☐ ☐
7. Have you had a cough for 3 weeks or more? ₸ ☐ ☐
8. Have you been coughing up blood? ₸ ☐ ☐
9. Have you had unexpected weight loss, night sweats and/or fatigue? ₸ ☐ ☐
10. Do you now have or have you ever had any of the following *(check box)*: ☐ ☐
    ☐ Diabetes ₸ ☐ Seizures ☐ Tuberculosis ₸ ☐ Venereal Disease
    ☐ Heart Disease ☐ High Blood Pressure ₸ ☐ Hepatitis ☐ Asthma
    ☐ Emphysema ☐ Cancer ☐ AIDS ☐ Psychiatric Problems
11. Do you have a drug or alcohol habit which could cause withdrawal problems? ☐ ☐
12. Have you ever thought of ending your life? ☐ ☐
    Do you feel that way now? ₸ ☐ ☐
13. Are you allergic to any food or medication? ☐ ☐
    If "yes", what? _____
14. Are you pregnant or have you had an abortion or delivered a baby within the last year? ☐ ☐
    If "yes", refer to TITLE 15, Section 1207.5.
15. Are you on birth control pills? ☐ ☐
16. Do you have any other medical problems? ☐ ☐
17. Do you have medical insurance? If yes, what _____ ☐ ☐

"₸" – ***Need to notify medical ASAP*** Sick Call procedures explained *(Deputy's initial/ID)* _____

_____ _____
Interpreter's Name *Interpreter's Signature*

_____ _____
Inmate's Signature *Screening Deputy's Signature & ID / Date / Time*

DISPOSITION *(check box)* ☐ Refer to VCMC ER for clearance ☐ House per Classification ☐ Sobering Cell *(Notify Medical ASAP)* ☐ Safety Cell *(Notify Medical ASAP)*

Medical Staff notified? ☐ Yes ☐ No Date _____ Time _____ Deputy's initials/ID _____

Medical Staff / Deputy's Comments _____

_____

Medical Staff's Signature / Date & Time

SO 32 (Rev. 6/10)

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Attachment 02

Reception Housing Clearance, Reception Housing Bypass Form

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VENTURA COUNTY
SHERIFF'S DEPARTMENT

☐ **Reception Housing Clearance**
☐ **Reception Housing Bypass**

Name:_____ **Booking:** _____ **Class:**_____

What are your **current** mental health problems: _____

What are your **past** mental health problems: _____

Date(s) when you tried to hurt yourself: _____

How did you try to hurt yourself: _____

Do you have any problems that need immediate attention that you have not made us aware of: _____

Inmate's Signature Date/Time

Do not write below this line; for official use only

Reception Housing Bypass *Medical Staff will check appropriate box. Must have all four signatures.*

☐ House in Reception Housing - Psych F/U ☐ House in Special Housing ☐ Cleared to Bypass Reception Housing

1. Screening Deputy's Signature/ID# Date/Time
3. Classification Deputy's Signature/ID# Date/Time
2. Medical Staff's Signature/ID# Date/Time
4. Watch Commander's Signature/ID# Date/Time

Reception Housing Clearance *Check appropriate box.*

☐ Cleared to house out of Reception Housing ☐ Referred to Medical Staff for Clearance

Screening Deputy's Signature/ID# Date/Time

☐ Retain in Reception Housing - Psych F/U ☐ House in Special Housing ☐ Cleared to house out of Reception Housing

Medical Staff's Signature/ID# Date/Time

Rev 03/04 Distribution: White – Inmate File Canary – Medical File

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Attachment 03

Draft Mental Health Assessment Form

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Draft J a i l M e n t a l He a l t h A s s e s s m e n t

Inmate's Name: _____ Assessment Date: _____
Gender: _____ Arrest Date: _____
Screener: _____ Ethnicity: _____
Age: _____

Suicide Risk
A. Are you feeling like killing yourself? □ Yes □ No
a. Plan
_____
_____
b. Means
_____
_____
c. Lethality Assessment: High □ Moderate □ Low □
d. Do you have a history of suicide attempts? If so, how, when, where?
_____
_____
_____
_____
_____
_____
_____
_____
B. Have you attempted to kill yourself in custody? □ Yes □ No
If so, how, when?
_____
_____
C. Has a family member or close friend committed suicide? □ Yes □ No
D. Do you know anyone who has committed suicide? □ Yes □ No
E. Did the patient express feelings of hopelessness? □ Yes □ No
F. Are there signs and symptoms of depression? □ Yes □ No
G. Is the inmate currently
a. Intoxicated? □ Yes □ No
b.Withdrawing? □ Yes □ No

Violence Risk
A. Are you feeling like you want to hurt someone? □ Yes □ No
Assess for:
a. Observable behaviors
b. History of violence
a. Method, means

b. Intended victims
c. Is a Tarasoff notification required? □ Yes □ No

B. Does the inmate have a history of violent behaviors in custody? □ Yes □ No

If so, when?

_____

a.Towards inmates? □ Yes □ No
b.Toward staff? □ Yes □ No

C. Is the inmate currently
a. Intoxicated? □ Yes □ No
b.Withdrawing? □ Yes □ No

Grave Disability Assessment

A. Is the inmate's safety compromised (unable to follow jail routine, basic directions, etc.)?

For example:
Inadequate nutritional intake even though food and drink is provided.
Drinking from the toilet or eating out of the garbage.
Unable to attend to daily ADL's. □ Yes □ No

B. Do you have a HX of receiving any involuntary TX due to grave disability? □ Yes □ No

Current Mental Status and Behavior (circle all that apply)

Affect: Restricted, Blunted, Broad, Flat, Labile, Irritable, Tearful, Expansive, Appropriate

Appearance: Unkempt, Disheveled, Careless, Neat and Clean, Dirty, Malodorous, Meticulous,
Inappropriate, WNL

Behavior: Aggressive, Sleep Disturbances, Appetite Disturbance, Agitated, Hyperactive, Isolative,
Assaultive, Self-Mutilation, Bizarre, Impulsive, Hypervigilant, Not Remarkable

Cognition: Poor Concentration, Confused, Memory Impairment, WNL

Intelligence: Likely below average, Likely within average range, Likely above average, Needs
investigation

Mood: Anxious, Irritable, Sad, Dystymic, Depressed, Elevated, Euphoric, Euthymic, Other

Thought Content: Obsessive, Delusional, Paranoid Ideation, Phobia, Hallucinations, Thoughts of Suicide

Thought Process: Tangential, Circumstantial, Concrete, Loose Associations, Flight of Ideas, Racing
Thoughts, Thought Blocking, Disorganized, Preservative, Incoherence, WNL

Speech: Rapid, Slurred, Soft, Unintelligible, Loud, Mute, Pressured, Normal

Orientation: Person, Place, Time, Situation

Additional Mental Status Comments:

_____
_____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Psychiatric History

A. Do you have a HX of receiving mental health treatment? □ Yes □ No
If so, when and where?

_____
_____
_____
_____

B. Do you currently have a mental health provider or case manager? □ Yes □ No
Place _____
Phone # _____
C. Have you ever been hospitalized against your will? □ Yes □ No
D. Do you receive SSI? □ Yes □ No
E. Are you conserved? □ Yes □ No
F. Do you have any family members with mental illness? □ Yes □ No
G. Residence/living situation

_____

H. Highest level of education □ GED □ HS □ Some College □ College Degree

Psychiatric Medication History

A. Have you ever been asked to take psychiatric medications? □ Yes □ No
B. Are you currently taking psychiatric medications? □ Yes □ No
Medication

_____
_____

Last Dose

_____
_____

Dose Frequency

_____
_____

Prescriber

_____
_____

Verified

_____
_____

Medication Compliance
_____

Substance Use
A. What substances do you use?
ETOH How much: _____How often: _____How long: _____Last used: _____
Methamphetamines How much: _____How often: _____How long: _____Last used: _____
Cocaine/ Crack How much: _____How often: _____How long: _____Last used: _____
Opioid How much: _____How often: _____How long: _____Last used: _____
Cannabis How much: _____How often: _____How long: _____Last used: _____
Inhalants How much: _____How often: _____How long: _____Last used: _____
Hallucinogens How much: _____How often: _____How long: _____Last used: _____
Rx/OTC How much: _____How often: _____How long: _____Last used: _____
Ecstasy/Club drugs How much: _____How often: _____How long: _____Last used: _____
Tobacco How much: _____How often: _____How long: _____Last used: _____
B. Have you ever experienced any problems detoxing from any substances?
□ Yes □ No
If yes, what substance and what difficulties did you have?
_____
_____
_____
_____
_____
C. Substance Abuse TX History
a. Peer lead (AA/NA) □ Yes □ No
b.Outpatient □ Yes □ No
c.Residential □ Yes □ No
D. Is there a family history of substance abuse? □ Yes □ No

Developmental Disabilities
A. Does the inmate appear to have a developmental disability? □ Yes □ No
B. Are you a client of the Regional Center? □ Yes □ No
If yes, has the Regional Center been contacted? □ Yes □ No
a. Who: _____
b. When: _____

DSM IV Diagnosis
>>>

Attachment 04

Psychological Autopsy

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Psychological Autopsy

The following is from the Encyclopedia on Death and Dying:

"The psychological autopsy is a procedure for investigating a person's death by reconstructing what the person thought, felt, and did preceding his or her death. This reconstruction is based upon information gathered from personal documents, police reports, medical and coroner's records, and face-to-face interviews with families, friends, and others who had contact with the person before the death.

"The first psychological autopsy study was most likely Gregory Zilboorg's investigation of ninety-three consecutive suicides by police officers in New York City between 1934 and 1940. In 1958 the chief medical examiner of the Los Angeles Coroner's Office asked a team of professionals from the Los Angeles Suicide Prevention Center to help in his investigations of equivocal cases where a cause of death was not immediately clear. From these investigations, the psychiatrist Edwin Shneidman coined the phrase "psychological autopsy" to describe the procedure he and his team of researchers developed during those investigations. The method involved talking in a tactful and systematic manner to key persons—a spouse, lover, parent, grown child, friend, colleague, physician, supervisor, and coworker—who knew the deceased. Their practice of investigating equivocal deaths in Los Angeles continued for almost thirty years and allowed for more accurate classification of equivocal deaths as well as contributing to experts' understanding of suicide.

"In the 1970s and 1980s, researchers using the psychological autopsy method investigated risk factors for suicide. Psychological autopsies have confirmed that the vast majority of suicide victims could be diagnosed as having had a mental disorder, usually depression, manic depression, or alcohol or drug problems. Other studies focused upon the availability of firearms in the home of suicide completers, traumatic events in person's lives, and other psychological and social factors.

"There are two major trends in the use of psychological autopsies: research investigation and clinical and legal use. Research investigations generally involve many people who died by suicide and comparing the results with another group, for example, accident victims, in order to see if some factors are important in discriminating between suicides and other deaths. Clinical and legal use of psychological autopsies involves investigations of a single death in order to clarify why or how a person died. These often involve descriptive interpretations of the death and may include information to help family and friends better understand why a tragic death occurred. They also may lead to suggesting means of preventing suicides, for example by suggesting improvements in hospital treatment or suicide prevention in jails."

http://www.deathreference.com/A-Bi/Autopsy-Psychological.html

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Appendix 01

Suicide Discussion

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Suicide Discussion

Suicide, per se, is not necessarily a sign of mental illness. No discussion on suicide could be found in the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Rev. IV). The following are working definitions for the purpose of this study derived from the Penguin Dictionary of Psychology, Fourth Edition 2009:

"**Suicide 1** A person who intentionally kills himself or herself. **2** The act of taking one's life. Emile Durkheim, the first to study suicide systematically, distinguished three different types, depending on what motivates the act of self-destruction: *altruistic, anomic* and *egoistic*."

"**Suicide, altruistic** Durkheim's term for suicide based on sacrificing oneself for the good of others. The soldier who hurls himself on a grenade to save others, and ritual suicide, such as hara-kiri, intended to save one's family from shame, are classic examples."

"**Suicide, anomic** Suicide that results, in Durkheim's analysis, from the sense that life no longer has meaning, from a sense of anomie, loneliness, isolation and loss of contact with the norms and values of society."

"**Suicide, egoistic** In Durkheim's classification system, suicide resulting from a sense of deep personal failure, a feeling that one is personally responsible for not living up to societal and personal expectations."

"**Suicidal ideation** Recurrent thoughts about suicide. They may be simple and unelaborated or complex and involved detailed plans about how to take one's life. Such thoughts are common in cases of depression, post-traumatic stress disorder and bipolar disorder and while they typically do not lead to actual suicide, they are signals that mental health workers cannot ignore."

"**Suicide clusters** Multiple suicides occurring close together in time in a limited geographical area. They most commonly involve disturbed adolescents and are suspected of having an element of contagion…"

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Appendix 02

Elements of Suicide Prevention

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Elements of Suicide Prevention

The following key components of a suicide prevention program are summarized from the National Commission on Correctional Health Care, *J-51 Suicide Prevention*, Jail Suicide/Mental Health Update, Winter 2004, Vol. 13, Number 3:

1. **Training**. All staff that work with inmates should be trained to recognize verbal and behavioral cues to watch for signs of vulnerability that indicate potential suicide, and how to respond appropriately. The plan should include initial and subsequent training.
2. **Identification**. The receiving screening form should include observation and interview items related to each inmate's potential suicide risk.
3. **Monitoring**. The plan should specify the facility's procedures for monitoring an inmate who has been identified as potentially suicidal. Regular, documented supervision should be maintained
4. **Referral**. The plan should specify the procedures for referring potentially suicidal inmates and attempted suicides to mental health care providers or facilities.
5. **Assessment**. This should be conducted by a qualified mental health professional, who designates the inmate's level of suicide risk.
6. **Housing**. A suicidal inmate should not be housed or left alone. An appropriate level of observation must be maintained. If a sufficiently large staff for continuous monitoring is not available then the inmate should not be isolated. The inmate should be housed with another inmate or in a dormitory and checked every 10-15 minutes. An inmate assessed as being a high suicide risk always should be observed on a continuing, uninterrupted basis or transferred to an appropriate health care facility. The room should be as suicide resistant as possible (i.e., without protrusions of any kind that would enable the inmate to hang him/herself).
7. **Communication**. Procedures should exist for communication between health care and correctional personnel regarding the status of the inmate.
8. **Intervention**. The plan should address how to handle a suicide attempt in progress including appropriate first-aid measures.
9. **Notification**. Procedures should be in place for notifying administrators, outside authorities, and family members of potential, attempted, or completed suicides.
10. **Reporting**. Procedures for documenting the identification and monitoring of potential or attempted suicides should be detailed, as should procedures for reporting a completed suicide.
11. **Review**. The plan should specify a medical and administrative review process if a suicide or serious attempt (as defined by the suicide plan) does occur.

12. **Critical incident stress debriefing**. (CSID) Responding to and/or observing a suicide can be extremely stressful to staff and inmates. The plan should specify procedures for offering CSID to all affected personnel and inmates.

Appendix 03

Suicide Helpcard

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Suicide Helpcard

(From National Institute of Corrections Library - Suicide Prevention: Instructors Manual)

If someone you know:

- threatens suicide
- talks about wanting to die
- shows changes in behavior, appearance, mood
- abuses drugs, alcohol
- deliberately injures themselves
- appears depressed, sad withdrawn...

You can help:

- stay calm and listen
- let them talk about their feelings
- be accepting; do not judge
- ask if they have suicidal thoughts
- take threats seriously
- don't swear secrecy tell someone

Get help: You can't do it alone.

Contact: Family, friends, relatives,
Clergy, teachers, counselors, doctors,
Crisis lines, mental health services or
Hospital emergency departments