VENTURA COUNTY SHERIFF'S OFFICE

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August 12, 2011

RECEIVED

AUG 17 2011

VENTURA COUNTY
GRAND JURY

The Honorable Vincent O'Neill, Jr.
Presiding Judge of the Superior Court
County of Ventura
800 S. Victoria Avenue
Ventura, CA 93009

SUBJECT: Grand Jury Report "Inmate Processing and Suicide Prevention in the Ventura County Jail."

Dear Judge O'Neill:

This letter is in response to the Grand Jury's Findings and Recommendations pertaining to the Sheriff's Office procedures related to Inmate Processing and Suicide Prevention in Detention Services Division.

FINDINGS

Finding 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 take an institutional focus on this kind of issue 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 not one individual formally responsible for suicide prevention in the County Jail (FA-01 through FA-04)

Response:

We concur with this finding.

Finding FI-02

The majority of those booked into County Jail return to private life in the community and some are sent to 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, 04 and FA-06 through FA-11)

Response:

We concur with this finding.

Finding 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 the processes are considered to be best practices. (e.g. 72 hour reception housing and 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)

Response:

We concur with this finding. We thank the Jury for acknowledging our efforts to reduce the potential of suicide through our best practices and modification to the physical plant.

Finding FI-04

Institutionally, dealing with potentially suicidal inmates is a challenging problem. Collecting information from those inmates about suicidal factor 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)

Response:

We concur with this finding. All staff members assigned to the jail receive training in life safety protocols in conjunction with maintaining facility security. As the deputies conduct hourly safety checks, oftentimes they are alerted to and respond to suicidal ideation and attempts, thus saving lives.

We believe our strongest effort in support of the inmate population is that deputies interact with all inmates on a regular basis. Most of these contacts occur when the deputies conduct hourly cell checks. These incidents of contact provide an opportunity for deputies to note any change in behavior, or possibly obtain intelligence on potential security and safety issues in the housing section.

Finding FI-05

When compared with nationwide data collected form 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).

Response:

We only concur with the final sentence of this finding. Statistical comparisons alone do not provide a basis for assessing the quality of our efforts. It is not realistic to cite the experience of 2010 with an eight year experience of other jails to draw a credible conclusion. Oftentimes a comparison is made between the jail population and the communities we serve. It is more reasonable to use the community's experience of suicides in comparison with those that have occurred in the jail.

In 2010, there were 80 suicides within Ventura County and 2 suicides in the jail. Comparing the number of suicide events to the population, .007% of the jail population (jail incidents as compared to the jail population) and .02% (community incidents as compared to the total county population) of the community is significantly less than the information cited.

Using the information cited within the report, six percent of jails experienced 2 or more deaths per year in an eight year period (2000-2007). Suicide was not clearly delineated as being the reason for all of the listed deaths. In the same eight years within the Ventura County Jail, the average death percentage for natural deaths was .006% and .004% for suicides with the jail population.

Finding 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)

Response:

We concur with this finding. As stated, there is not a "single plan" related to suicide prevention, but rather a philosophy woven into each element of our operation. This is evidenced in our mission of providing safe, secure and humane detention.

Once again, we believe our use of the interactive inmate management philosophy is effective. It is not the panacea; however it does provide more opportunities for dialog between the inmates and deputies, which may lead to recognizing suicidal ideation. If the inmate is more confident in disclosing information to the staff, we are able to respond immediately. When an inmate does not share their thoughts with others, internally or externally, it is nearly impossible to determine their thoughts or interrupt potential actions.

Finding 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)

Response:

We disagree with this finding. In each area of our operations, we have proven to be thorough and transparent. The Sheriff's protocol does not differ from any other law enforcement agency as it relates to investigations of major incidents.

The role of the Sheriff's Major Crimes bureau is to provide an intensive inquiry of all inmate deaths. The specialized resources, skills and experience provided by Major Crimes investigators are essential when making a determination of whether the event was a criminal act or not. Their involvement adds yet another layer of analysis to the investigation.

In addition to Major Crimes, the Ventura County Medical Examiner conducts an independent death investigation.

Finding 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).

Response:

We concur with this finding. We believe our alliance with our internal and external partners strengthens our abilities to operate a safe, secure and humane jail.

Finding 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)

Response:

We concur with this finding. The Sheriff is dedicated to providing a high level of training to all of the staff members within the Jail system. Each member of our staff, whether sworn, professional or volunteer, is a part of the Sheriff's team. Our deputies save lives every day through the use of the Interactive Inmate Management Philosophy, and the gathering of intelligence gained from the hourly cell checks.

Finding 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)

Response:

We disagree with this finding. While there is not an actual form completed related to "psychological autopsies", it is an element of our investigation to determine if the inmate relayed his/her intentions to others.

Inquiries are made of the family and friends during the investigation. Recent calls to family or friends are also reviewed. There is some value in researching information on identifying categories of individuals who may be prone to suicide.

Finding 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)

Response:

We disagree with this finding. One of the areas within law enforcement that often receives the most criticism is the appearance that our employees lack emotion and/or compassion. The responsibilities of a deputy sheriff and sheriff service technicians are difficult within the jail. Oftentimes it is necessary to create an emotional barrier as a means to cope with the rigors of the job.

Each person responds to traumatic incidents in different ways and their needs vary. Discussing the use of mental health services is a personal obstacle not easily accomplished. The problem is not isolated to law enforcement, but rather extends to the community as well.

Our employees have a variety of different counseling resources available to them through the department, County EAP, and their own medical provider. Supervisors and managers strongly encourage and support the choice to access psychological services internally and /or externally, even many months after a critical incident.

RECOMMENDATIONS

Recommendation 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)

Response:

We disagree with this recommendation. We do not believe it is the role of the District Attorney Office to investigate suicides. Currently, the Medical Examiner (M.E.) investigates all deaths within the county. We believe the involvement of the M.E. is most appropriate to add an external investigative perspective.

Recommendation 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)

Response:

This recommendation is already in place, although not in the form of one person. We believe it is the responsibility of every staff member to be "suicide prevention officers". We value the information provided in this report as a tool to assist us to provide for the safe, secure and humane detention of those persons legally conveyed into our facilities.

Recommendation 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)

Response:

In essence, this recommendation is already in place. Members of the VCBH are invited to the quarterly CFMG Quality Assurance/Quality Control (QA/QC) meeting. Our partnership with VCBH is strong and affords us the ability to request assistance whenever we may need assistance in understanding mental health issues.

Recommendation 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)

Response:

We disagree with this recommendation. Each incident related to the death of an inmate is reviewed, internally and externally, taking all factors of each incident into consideration. If patterns are identified, all options to prevent the incident from occurring again are evaluated and put into practice, wherever practical.

Recommendation 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)

Response:

We agree in part with this recommendation. We have partnered with the National Alliance for the Mentally Ill (NAMI) to provide brochures for family members upon visiting the PTDF. Within this brochure is the number to our medical staff member and the Jail's Watch Commander. We are in the process of developing a poster for display in the public lobbies or our jails.

We do not agree that that contact should be the Jail nurse. We advocate the call being sent to the Jail Watch Commander as they would be best suited to respond operationally, in partnership with our medical staff, to respond to any suicidal threat.

Recommendation 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)

Response:

This is answered in Recommendation #5.

Recommendation 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)

Response:

We believe this recommendation is in place. All staff members responding to any inmate death are offered access to and highly encouraged to participate in a Critical Incident Debriefing. All inmates in the immediate area are also offered access to the CFMG psychiatric staff.

Recommendation 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)

Response:

We agree that interviewing inmates at the completion of the reception center process appears to be valuable. One of the obstacles in this recommendation is that the current interview is a mental health screening of the inmate being interviewed, not about another person. Once the assessment is completed, the form becomes part of their confidential medical record.

The recommendation has merit. We will evaluate our options.

Recommendation 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)

Response:

The Sheriff has implemented additional training in the form of a CIT Academy. In discussing this topic with mental health professionals we are in the process of developing an additional knowledge domain as recommended for annual training all our detention staff members.

Recommendation 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)

Response:

We believe our investigations into these deaths were thorough and covered the areas outlined in a "Psychological Autopsy." As previously stated, we will continue to foster strong partnerships with VCBH.

Recommendation R-11

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

Response:

We believe this recommendation currently occurs. The department representatives have several meetings with the family as a means of offering condolences, as well as possibly identifying additional information. Each contact with the family is an element in the further investigation.

Recommendation 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)

Response:

We believe the existing Intake Health Screening Form is the best available. During the last Accreditation Review from the Institute of Medical Quality (IMQ) our procedures were identified as being "best practices." Several of our forms were requested to be shared with other jails as being "model" forms.

Recommendation 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 restriction. (FI-02 and FI-03)

Response:

Privacy laws prohibit dissemination of this information as recommended. All intake health screening forms are retained the inmate's medical file, which is confidential.

Thank you for the opportunity to respond to this Grand Jury report. If additional explanation is needed, please feel free to contact my office at 654-2381.

Sincerely,

Geoff Dean
Ventura County Sheriff

C: Foreman, Ventura County Grand Jury
Brown Mail # L-3751
Frank Chow, CEO Analyst

Response to Grand Jury Report Form

Report Title: ~~Inmate Processing and Suicide Prevention in~~ VC Jail

Report Date: May 31, 2011

Response by: August 15, 2011 Title: Sheriff G. Dean

FINDINGS

- I (we) agree with the findings numbered: 1,2,3,4,6,8,9
- I (we) disagree wholly or partially with the findings numbered: 5,7,10,11
  (Attach a statement specifying any portions of the findings that are disputed; include an explanation of the reasons therefor.)

RECOMMENDATIONS

- Recommendations numbered 2,3,7,9,11 have been implemented.
  (Attach a summary describing the implemented actions.)
- Recommendations numbered 5,6, have not yet been implemented, but will be implemented in the future.
  (Attach a timeframe for the implementation.)
- Recommendations numbered 8, require further analysis.
  (Attach an explanation and the scope and parameters of an analysis or study, and a timeframe for the matter to be prepared for discussion by the officer or director of the agency or department being investigated or reviewed, including the governing body of the public agency when applicable. This timeframe shall not exceed six months from the date of publication of the grand jury report.)
- Recommendations numbered 1,4,10,12,13 will not be implemented because they are not warranted or are not reasonable.
  (Attach an explanation.)

Date: _____ Signed: _____

Number of pages attached ____