# 2022 - 2023
# Ventura County Grand Jury


## Final Report

## Deaths in Ventura County Detention and Jail Facilities

## June 20, 2023

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# Deaths in Ventura County Detention and Jail Facilities

## SUMMARY

The 2022-2023 Ventura County Grand Jury investigated the deaths of persons in custody during the period 2016 to 2022 in two detention facilities operated by the Ventura County Sheriff's Office (VCSO): the Pre-Trial Detention Facility (PDTF) and Todd Road Jail (TRJ).

The investigation sought to determine whether current policies and practices sufficiently promote and ensure the safety of detained persons and prevent deaths. The Grand Jury considered what improvements could be made in the care of detained persons, and what institutional oversight exists and could be improved to prevent deaths in Ventura County's two jails.

The Grand Jury finds that:

- 25 deaths of detained persons occurred at PTDF and TRJ during the period 2016 to 2022, and while investigated by the VCSO and the Ventura County Medical Examiner, the public was not informed of the results of these investigations.
- current training regarding suicide prevention and response, while fully compliant with state law and Board of State and Community Corrections (BSCC) requirements, does not follow recommended best practice of consistent joint training of deputies and contracted medical personnel assigned to the jails.
- communication with families coupled with better orientation processes are key to prevention of suicide by detained persons.
- VCSO leadership is committed to implement effective suicide prevention.
- current incentives to surrender illicit substances and the body searching protocols do not result in the adequate detection and confiscation of all the increasingly dangerous drugs in the jails.
- use of detection dogs is an effective methodology to enhance detection of illicit drugs.
- historically, the medical and behavioral health delivery process in Ventura County jails has often been reactive rather than proactive.
- the intake screening process and reassessments during incarceration at Ventura County jails do not always provide a complete evaluation of current medical and behavioral health.
- involvement of the public and independent subject matter experts in the review of deaths in jail may reduce the risk of death, provide additional insight, justify additional resources and increase transparency.

Consequently, the Grand Jury recommends that the Board of Supervisors (BOS) institute a review panel comprised of community members and independent subject

matter experts to review jail deaths and support death prevention efforts by the VCSO.

Additionally, the Grand recommends that the VCSO:

- implement, along with its medical contractor, consistent in-service suicide prevention cross-training for all deputies and medical personnel.
- along with its medical contractor, improve existing communication protocols for monitoring suicidal ideation and/or increased risk factors among detained persons.
- develop and implement suicide and self-harm prevention protocols involving family input.
- include information in its Inmate Orientation explaining available resources for prevention of suicide, self-harm, and overdose.
- evaluate and report to the BOS on the technical and financial feasibility of adding drug detection dogs to each jail facility.
- implement a more robust protocol of "See Something, Say Something" reinforced by ongoing staff training and detained persons' orientation.
- report to the BOS on the implementation of training and the suicide prevention program.
- align its intake tool with the National Commission on Correctional Health Care's standard for Initial Health Assessment.
- implement a procedure to inform the public of the circumstances surrounding all jail deaths after its investigation and/or independent review are completed.

# METHODOLOGY

The Grand Jury conducted personal interviews with leadership and staff of the Ventura County Sheriff's Office (VCSO), medical service providers, other Ventura County officials and community leaders. The Grand Jury focused its analysis on deaths of detained persons caused by suicide, overdose/intoxication and other medical causes in Ventura County jails between 2016 and 2022.

During the study period, there were 25 jail deaths at the Pre-Trial Detention Facility (PDTF) and the Todd Road Jail (TRJ). The table below highlights the categories that the Ventura County Medical Examiner's (ME) determined to be the cause of death.

| Cause of Death | Number of Cases | Number of Cases Reviewed by the Grand Jury |
|---|---|---|
| Medical | 12 | 3 |
| Overdose/Intoxication | 6 | 4 |
| Suicide | 4 | 4 |
| Homicide | 2 | 1 |
| Undetermined | 1 | 1 |
| **Total** | **25** | **13** |

Table 1.

The Grand Jury reviewed all four suicide cases because expert analysis indicates that suicides are largely preventable through proven practices. (Ref-01, Ref-02, Ref-03, Ref-04)

Of the six deaths caused by overdose/intoxication, the Grand Jury reviewed the most recent four as a representative sample, considering drug overdoses reflect a larger community concern. (Ref-05)

Three of the twelve deaths due to other medical causes were reviewed as a representative sample.

Two of the deaths reviewed were not reflected in the Grand Jury findings or recommendations. One was categorized as a homicide, and one was an undetermined cause of death.

The Grand Jury reviewed research materials detailed in the reference section of this report and the following documents in formulating its findings and recommendations:

1. The Board of State and Community Corrections (BSCC) Title 15 Minimum Standards for Local Detention Facilities (1/1/19 and 1/1/23)
2. BSCC Biennial Inspection Reports for PTDF and TRJ

3. February 3, 2022, Audit Report of the San Diego County's Sheriff's Department by the Auditor for the State of California
4. VCSO and Ventura County Sheriff's Detention Services Division policies and procedures
5. Individual case files for 13 of 25 total deaths at PTDF and TRJ during the period 2016 to 2022
6. National Commission on Correctional Health Care (NCCHC) standards and resource guides
7. Ventura County Board of Supervisors public meetings
8. California Forensic Medical Group - Medical Services Contract #8705
9. California Penal Code and California Health and Safety Code
10. Suicide and Self-Harm in Prisons and Jails (second edition), by Christine Tartaro
11. Numerous whitepapers and online articles from expert sources

# BACKGROUND

Pursuant to its statutory duty under California Penal Code Section 919(b) (Ref-06) the 2022-2023 Ventura County Grand Jury made inquiry into the conditions and management of all the public prisons (jails) and places of detention within Ventura County.

Separately, because of the August 2022 death of a detained person at the Todd Road Jail (TRJ) (Ref-07), the Grand Jury initiated a further investigation into the protocols and procedures used by the Ventura County Sheriff's Office (VCSO) for prevention and handling of deaths in custody.

The Grand Jury's investigation focused on the 25 deaths in custody at TRJ (capacity 796) and the Pre-Trial Detention Facility (PTDF) (capacity 890) during the period 2016 to 2022, as shown in Attachment-01.

This report does not discuss pending criminal and/or civil litigation beyond indicating that an event occurred and what information was released publicly by VCSO.

### Investigation of deaths

Several Ventura County agencies investigate deaths of detained persons in the PDTF and TRJ, including the Ventura County Sheriff's Major Crimes Unit (MCU), the Ventura County Medical Examiner (ME) and Wellpath, the contracted medical provider. Each MCU investigative report includes the independent ME's report. In the case of suicide, Wellpath also conducts a "psychological autopsy". (Ref-08) Every case is also examined in a mortality review by a multidisciplinary team of Ventura County Sheriff's Detention Services Department (DSD) leadership. (Ref-08, Ref-09, Ref-10, Ref-11, Ref-12)

Information discovered in these investigations is utilized by DSD to determine any necessary modifications to existing processes, focusing on preventing future deaths in custody, establishing responsibility, providing information to the public and next of kin, and promoting the security of other detainees. (Ref-08, Ref-12, Ref-13, Ref-14)

Disseminating information to the public regarding the results of these investigations indicating cause, manner and mechanism of death, assures the public of the County authorities' commitment to fulfilling their ethical and legal obligations. (Ref-13; Ref-15, Ref-16)

### Suicide

Numerous studies conclude suicides occurring in jail are largely preventable. (Ref-01; Ref-02; Ref-03) However, preventing suicides in jail remains challenging because compared to the public in general, a detained person is at higher risk of suicide. Furthermore, jail culture reduces the likelihood of "help-seeking" behavior. (Ref-17)

Actions of self-harm are further complicated by the fact that positive coping skills cannot be developed if the primary treatment is removal of the detained person from social contact/interaction through confinement for extended periods in safety cells. (Ref-17)

Due to the complex and evolving nature of the factors involved in self-harm and suicide attempts in detention situations, The American Psychiatric Association recommends "cross training" between the security, clinical and medical staffs. (Ref-17) The National Commission on Correctional Health Care (NCCHC) recommends a similar approach. (Ref-18)

The collateral effects of death by suicide can extend to others including detained persons who witness the event or knew the person involved, the security staff and the medical staff. All can be emotionally and psychologically affected by the suicide event in a significant way. (Ref-17, Ref-19)

In general, a public health framework for suicide prevention should include intervention at three levels: primary, secondary, and tertiary. Primary interventions are actions that make an individual less likely to start an emotional downward spiral, lowering the likelihood of someone becoming suicidal. Secondary interventions are actions to manage the environment and prevent suicides from occurring (e.g., screening of who is suicidal; elimination of objects or circumstances enabling a person to act on suicide ideation). Tertiary interventions are actions taken to prevent death during a suicide attempt. (Ref-17)

The benefits of implementing the above best practices for suicide prevention may be reflected in safe outcomes. (Ref-17) Achieving NCCHC accreditation based on these standards is further evidence of commitment to keep detained persons safe from harm. (Ref-14, Ref-17, Ref-18)

**Overdose/Intoxication**

Correctional facilities establish and implement withdrawal protocols for people entering the facility intoxicated and/or addicted. (Ref-08, Ref-09, Ref-10, Ref-20) However, individuals are known to continue consuming illicit drugs while detained, creating a demand for these drugs in jails. (Ref-08, Ref-10)

Different standard operating procedures, methods, technologies, and incentives can be deployed to prevent drugs from entering jails. These include reducing methods of entry of illicit drugs and paraphernalia, improving inspections of the external and internal facilities, and inspecting anyone or anything that enters the jail. (Ref-21)

Trained security staff and body scanners may be limited in their capacity to find small or concealed illicit substances. Passive-alert drug detection dogs have demonstrated an increased effectiveness in discovering contraband. Drug detection dogs and their handlers can conduct unannounced and random searches of premises, mail and other dispatched items as well as conducting effective inspections of detainees, visitors and employees. (Ref-21, Ref-22, Ref-23, Ref-24)

A January 2023 audit by the California Office of the Inspector General found the California Department of Corrections and Rehabilitation has not taken full advantage of drug detection dogs and has underutilized its canine program despite research studies finding them to be effective. (Ref-25) Drug detection dog teams are currently utilized in Santa Barbara, Los Angeles, and Riverside County jails. (Ref-26, Ref-27, Ref-28)

**Correctional Health Care – Medical**

Provision of health care to detained persons in the jail setting is guaranteed under the Eighth Amendment to the United States Constitution. (Ref-29, Ref-30, Ref-31) It can be provided directly by government personnel or by a private provider on a contractual basis. (Ref-32)

Effective July 1, 2022, the County of Ventura entered into a five-year contract for medical, dental, and psychiatric services with Wellpath. (Ref-33) The new contract includes detailed service standards with a key objective of achieving NCCHC accreditation at PTDF and TRJ by 2024. NCCHC accreditation is considered a commitment to high-quality correctional health care services that are constitutionally appropriate and based on nationally recognized standards (best practices) for elements of policy such as suicide prevention and patient intake evaluation. (Ref-08, Ref-14, Ref-18, Ref-34, Ref-35)

Even assuming an adequate level of funding and staffing, health care in the correctional setting presents specific challenges. During incarceration, multiple factors and situations can lead to a personal crisis at any time after the initial screening. Effective communication, including with the families of the detained person, and timely follow-up become key for preventing tragic outcomes. (Ref-16, Ref-17)

> Historically, the incarcerated have a high burden of medical and mental health problems and comparatively limited access to and use of routine preventive and primary care services in their communities before and after incarceration. A major challenge for correctional settings, particularly during the initial days and weeks after arrest, is to match the individual need for care properly with the appropriate level of medical, mental health, and specialist care. (Ref-36)

Behavioral health issues of detained persons may be more difficult to detect and address during the jail intake process because of fear and inability or unwillingness to share information. These issues, among others, can mask physical or emotional pain and significantly affect a person’s ability to seek emotional or medical support. (Ref-18, Ref-37)

## Oversight

Jails are by definition closed facilities, and their operations are not generally visible to the public. "Because jails and prisons exert total authority over individuals' bodies and liberty, transparency and accountability are necessary to ensure that facilities uphold their duty of care to respect the dignity of people who are imprisoned and ensure that prisons are safe and secure." (Ref-38)

Pursuant to California Penal Code section 6031.1 (Ref-39) and California Welfare and Institutions Code sections 209 and 885, the Board of State and Community Corrections (BSCC) is responsible for conducting biennial inspections of local adult and juvenile detention facilities and providing a report. The BSCC report is filed with the institution and posted on the BSCC website for public access. The report consists of a checklist and comments related to compliance with policy, policy review, health and safety issues and reporting requirements. (Ref-20, Ref-40, Ref-41, Ref-42)

Pursuant to California Health and Safety Code §101045, the county health officer investigates health and sanitary conditions in any of the jails and detention facilities. These investigations are aimed at verifying that the food, clothing, and bedding are meeting minimum standards. (Ref-20, Ref-43)

The Grand Jury is required pursuant to California Penal Code section 919(b) to "inquire into the condition and management of the public prisons within the county." In practice, this consists of annual inspections limited in scope. (Ref-06, Ref-10, Ref-44, Ref-45)

Government Code section 25303.7 authorizes the creation, either by board of supervisors' action or vote of county residents, of a sheriff oversight board and/or an inspector general. (Ref-46)

# DISCUSSION (Statements of Fact)

**SF-01.** Between 2016 and 2022, Ventura County jails experienced 25 deaths of detained persons. Of these, the Grand Jury reviewed 13 case files as a representative sample, as shown in Table 1. (Ref-10, Att-01)

### Investigation of deaths

**SF-02.** The Ventura County Sheriff's MCU investigated all 25 deaths, including the 13 reviewed by the Grand Jury. (Ref-08, Ref-09, Ref-10)

**SF-03.** The independent ME's office also investigated all 25 deaths, including the 13 reviewed by the Grand Jury. Their investigation included autopsy and toxicology to officially determine cause, manner and mechanism of death. In each case, a report was provided to the MCU for inclusion in its investigation report. (Ref-08, Ref-10)

**SF-04.** For the 13 deaths reviewed by the Grand Jury, the VCSO issued press releases and online notifications shortly after each death. Only for the one homicide case reviewed was an additional notification issued after the MCU investigation concluded. (Ref-10, Ref-47)

### Suicide

**SF-05.** Deputies, Sheriff's Security Technicians (SSTs) and Wellpath medical personnel assigned to PTDF and TRJ are not consistently trained together on suicide prevention and response measures recommended by NCCHC. Current practices are compliant with state law and Board of State and Community Corrections (BSCC) (Ref-08, Ref-14, Ref-18)

**SF-06.** The four instances of suicide deaths investigated by the Grand Jury presented multiple factors that research proves to be predictors for suicide, compounded by confinement:

- Defendants waiting for trial
- Defendants with suspicion of sex offenses
- Previous suicide attempts or self-harm (as a detained person or in the community)
- Documented history of mental illness and/or past trauma
- Periods of improvement before suicide (gaining energy and clarity to act)
- Imminent court dates
- Initial incarceration days
- Transfer (from other facility, section or cell), especially if punitive in nature
- Negative legal, disciplinary or family news
- Confined alone, or temporarily alone
- Substance abuse problems

In summary, two case files exhibited eight of these eleven factors. The other two case files exhibited seven of these eleven factors. (Ref-10, Ref-14)

**SF-07.** For two out of four suicides reviewed by the Grand Jury, lack of proactive measures was a factor in the death of the detained persons. (Ref-08, Ref-09, Ref-10, Ref-14, Ref-20, Att-02)

**SF-08.** At the PTDF and TRJ, DSD has implemented screening procedures to identify people at risk for suicide at intake and during incarceration, providing secondary level intervention where necessary. (Ref-08, Ref-14, Ref-15, Ref-17)

**SF-09.** Safety cells have historically been used at PTDF and TRJ to deny opportunity for self-harm, however they may have also aggravated the emotional distress of detained persons. (Ref-08, Ref-09, Ref-14, Ref-20)

**SF-10.** Actions of self-harm, including manipulation to obtain changes in living conditions, have proven to be difficult to distinguish from suicidal intent, and can be dangerous or fatal. (Ref-08, Ref-14)

**SF-11**. Current Orientation and Rules documents provided to detained persons do not contain specific and detailed information regarding suicide prevention resources and support. (Ref-10)

**SF-12.** For the four suicides reviewed by the Grand Jury, only one case file shows supportive family involvement. (Ref-10)

**SF-13.** VCSO leadership and staff are committed to implementing more effective suicide prevention by continually improving standards. (Ref-08, Ref-14)

**SF-14.** The VCSO has taken reactive measures to adapt facilities for suicide prevention such as retrofitting cell features and adding new space for support programs. (Ref-08, Ref-09, Ref-10)

**SF-15.** The VCSO has implemented proactive programs for suicide prevention such as Therapeutic Inmate Management Unit and Jail Based Competency Treatment. (Ref-08, Ref-09, Ref-10)

**SF-16.** The VCSO is currently planning or implementing:

- Revision of DSD Standard Operating Procedures
- Revision of Orientation and Rules documents
- Updated BSCC - Title 15 requirements for suicide prevention program
- NCCHC standards based on the contract with Wellpath. (Ref-08, Ref-09, Ref-12, Ref-14, Ref-18, Ref-20, Ref-33)

### Overdose/Intoxication

**SF-17.** Despite search and screening efforts, some detained persons are still able to access illicit drugs. Moreover, potentially lethal drugs (e.g., Fentanyl) are being used more frequently by detained persons in Ventura County's jails, following a similar pattern in the general public. (Ref-08, Ref-10, Ref-48)

**SF-18.** Of the four overdose/intoxication deaths of detained persons reviewed by the Grand Jury, two cases occurred while unsafely transporting or concealing drugs; two cases occurred after taking the drug for personal use. (Ref-10)

**SF-19.** In the four overdose/intoxication deaths reviewed by the Grand Jury, the drugs most commonly identified in the toxicology reports were:

- Fentanyl
- Heroin
- Methamphetamine
- Morphine

In three of the four cases, combinations of these drugs were reported. (Ref-10)

**SF-20.** Passive-alert drug detection dogs have proven their effectiveness in identifying illicit drugs such as fentanyl, methamphetamine, and heroin/morphine. (Ref-22, Ref-23, Ref-24, Ref-25, Ref-26)

**SF-21** Drug detection dogs are not currently embedded at PDTF or TRJ but are brought in and used in a limited capacity. (Ref-08)

**SF-22.** Since 2020, DSD has used body scans of all detained persons to detect illicit drugs during the booking process. (Ref-08, Ref-09)

**SF-23.** Since 2022, DSD has placed amnesty boxes at different points during the booking process encouraging detained persons to surrender illicit drugs. (Ref-08, Ref-09)

**SF-24.** Since 2022, DSD has placed Narcan dispensers throughout the jails, so that both staff and detained persons have access for rapid overdose intervention. (Ref-08, Ref-49)

### Correctional Health Care – Medical

**SF-25.** The three deaths for medical reasons of detained persons reviewed by the Grand Jury presented these factors:

- Diagnosed or potential psychiatric problems
- Documented history of mental illness and/or past trauma
- Persons with previous or current history of drug abuse

- Confined alone, or temporarily alone
- Manifestation of pre-existing medical conditions that were not addressed
- Comorbidities

Two of three detained persons also verbalized pain or needed medical attention for other reasons. (Ref-10, Ref-48, Ref-50, Ref-51, Ref-52)

**SF-26.** Of the three deaths for medical reasons reviewed by the Grand Jury, issues identified at intake and throughout the incarceration period went unaddressed or were under-addressed by medical staff, including:

- History of substance abuse
- Suicidal or self-injurious behaviors, suicidal ideation, suicidal plan
- Vomiting, or blood in stool or urine
- Reports of pain or other issues to medical staff
- Recent substantial weight loss
- Blood culture positive for bacteria (Ref-10, Ref-50, Ref-53)

A "See Something, Say Something" protocol is recommended by the medical community to help prevent such occurrences of death. (Ref-51, Ref-52)

**SF-27.** The information from the medical intake form is based on the answers provided by the detained person who is often in distress, intoxicated, uncooperative, and/or had previous negative experiences in health care encounters. (Ref-08, Ref-10, Ref-35)

**SF-28.** During the intake evaluation of detained persons, historical medical information may be used to support current medical decisions and may not identify new medical or behavioral health issues. Failure to provide a comprehensive assessment based on current information is not consistent with NCCHC best practices. (Ref-08, Ref-10, Ref-18, Ref-35)

**SF-29.** For the three deaths for medical reasons reviewed by the Grand Jury, the medical and security staff of PTDF and TRJ failed to provide timely medical care to prevent death. (Ref-10, Ref-51, Ref-52, Ref-54, Att-02)

**Oversight**

**SF-30.** The VCSO does not have any external partnerships or mechanisms for independent local oversight of their operations, including deaths in the jails, as provided by California Government Code. (Ref-08, Ref-46)

**SF-31.** The Ventura County Sheriff's mission statement, in particular Pillars Two and Six, articulates a commitment to strengthen community partnership and make our jails a model for other California Sheriff agencies. (Ref-55, Ref-56)

# FINDINGS

**F-01.** The Grand Jury finds that of the 13 deaths of detained persons reviewed, most were avoidable. (SF-01, SF-07, SF-12, SF-18, SF-29)

**F-02.** The Grand Jury finds that in general, the public is not informed of the final results of the MCU and ME's investigations of deaths of detained persons in the Ventura County jails. (SF-02, SF-03, SF-04)

**F-03.** The Grand Jury finds that the current training regarding suicide prevention and response does not follow recommended best practices for consistent cross-training of deputies, SSTs, and Wellpath medical personnel. We did find that current practices are compliant with state law and BSCC requirements. (SF-05)

**F-04.** The Grand Jury finds that between 2016 and 2022, the VCSO committed to implementing or strengthening primary, secondary and tertiary suicide prevention measures consistent with BSCC and NCCHC standards. Despite these efforts, detained persons committed suicide. (SF-06, SF-08, SF-09, SF-10, SF-14, SF-15, SF-16, SF-24)

**F-05.** The Grand Jury finds that during incarceration, multiple factors can lead to a personal crisis after the initial screening. Communication and follow-up become key for suicide prevention. (SF-06, SF-10, SF-13)

**F-06.** The Grand Jury finds that primary level intervention measures, including improvement of the orientation process and involvement of families, aid in the prevention of suicide. (SF-06, SF-11, SF-12, SF-13, SF-16)

**F-07.** The Grand Jury finds that current incentives to surrender illicit substances and body searching protocols do not result in adequate detection and confiscation of increasingly dangerous drugs at PDTF and TRJ. (SF-17, SF-18, SF-19, SF-22, SF-23)

**F-08.** The Grand Jury finds that use of passive-alert drug detection dogs to discover illicit drugs is an effective methodology not fully utilized at the PTDF and TRJ facilities. (SF-19, SF-20, SF-21)

**F-09.** The Grand Jury finds that historically, medical and behavioral health treatment in Ventura County's jails often has been reactive rather than proactive, and has not included a robust "See Something, Say Something" protocol. (SF-06, SF-07, SF-25, SF-26, SF-29)

**F-10.** The Grand Jury finds that the intake screening process and reassessments during incarceration do not always provide a complete evaluation of current medical and behavioral health, as outlined in the NCCHC Initial Health Assessment standard. (SF-26, SF-27, SF-28)

**F-11.** The Grand Jury finds that involvement of the public and independent subject matter experts in the review of deaths in jail may reduce the risk of death, provide additional insight, justify additional resources and increase transparency. (SF-30, SF-31)

## RECOMMENDATIONS

**R-01.** The Grand Jury recommends that within six months, the Board of Supervisors (BOS) institute a review panel comprised of community members and independent subject matter experts to review jail deaths and support death prevention efforts by the VCSO. (F-01, F-02, F-09, F-11)

**R-02.** The Grand Jury recommends that within six months, the VCSO with Wellpath develop and implement a consistent in-service suicide prevention cross-training for all deputies, SSTs and Wellpath medical personnel. (F-03, F-04, F-09)

**R-03.** The Grand Jury recommends that within six months, the VCSO with Wellpath improve existing communication protocols for monitoring suicidal ideation and/or increased risk factors among detained persons. (F-03, F-04, F-05, F-09)

**R-04.** The Grand Jury recommends that within six months, the VCSO develop and implement suicide and self-harm prevention protocols involving family input, including:

- Placing Suicide Prevention Hotline Posters in visiting areas encouraging family members to contact a 24/7 number to report concerns about suicide or self-harm of a detained person.
- An automated recording with the same hotline information at the beginning of each phone call to a detained person.

(F-05, F-06)

**R-05.** The Grand Jury recommends that within six months, the VCSO's Inmate Orientation include information explaining available resources for prevention of suicide, self-harm and overdose. (F-05, F-06, F-07, F-08)

**R-06.** The Grand Jury recommends that within ninety days, the VCSO evaluate and report to the BOS the technical and financial feasibility of adding passive-alert drug detection dogs to each jail facility. (F-07, F-08)

**R-07.** The Grand Jury recommends that within six months, the VCSO implement a more robust protocol of "See Something, Say Something" that is reinforced by ongoing staff training and detained persons' orientation. (F-09)

**R-08.** The Grand Jury recommends within six months, and annually thereafter, the VCSO report to the BOS on the key performance metrics, the implementation of training and the suicide prevention program, per the terms and conditions of the Wellpath contract. (F-03, F-04, F-09, F-10)

**R-09.** The Grand Jury recommends that within six months, the VCSO align its intake tool with NCCHC's Initial Health Assessment standard. (F-10)

**R-10.** The Grand Jury recommends that within ninety days, the VCSO implement a procedure to inform the public of the circumstances surrounding all jail deaths after the MCU investigation and/or independent review are completed. (F-02, F-11)

## RESPONSES

Responses required from:

**The following elected officer within 60 days:**
Ventura County Sheriff's Office (F-01, F-02, F-03. F-04, F-05, F-06, F-07, F-08, F-09, F-10, F-11, R-01, R-02, R-03, R-04, R-05, R-06, R-07, R-08, R-09, R-10)

**The following governing body within 90 days:**
Ventura County Board of Supervisors (F-11, R-01, R-06, R-08)

# REFERENCES

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**Ref-07.** *Inmate death from Ventura County Sheriff's Office*. Nixle. (n.d.). https://local.nixle.com/alert/9600254/, Accessed 06/05/2023

**Ref-08**. Grand Jury interviews

**Ref-09.** County of Ventura Sheriff's Office. (n.d.-d). https://s29762.pcdn.co/wp-content/uploads/2022/09/PUBLIC-Information-Plan-0722.pdf (pp. 153-156; 179-186; 325-339; 540-545; 604-612; 656-660; 690-698; 699-712) https://s29762.pcdn.co/wp-content/uploads/2022/09/Divisional-Policy-Public-Redacted-090722.pdf, Accessed 06/05/2023

**Ref-10**. Ventura County Sheriff's Office confidential files and related documents reviewed by the Grand Jury

**Ref-11.** *San Diego County Sheriff's department*. Report 2021-109. (n.d.-a). Figure 2. https://www.auditor.ca.gov/reports/2021-109/index.html#section3, Accessed 06/05/2023

**Ref-12.** *Procedure in the event of an inmate death*. National Commission on Correctional Health Care. (2022, May 16). https://www.ncchc.org/spotlight-on-the-standards/procedure-in-the-event-of-an-inmate-death/, Accessed 06/05/2023

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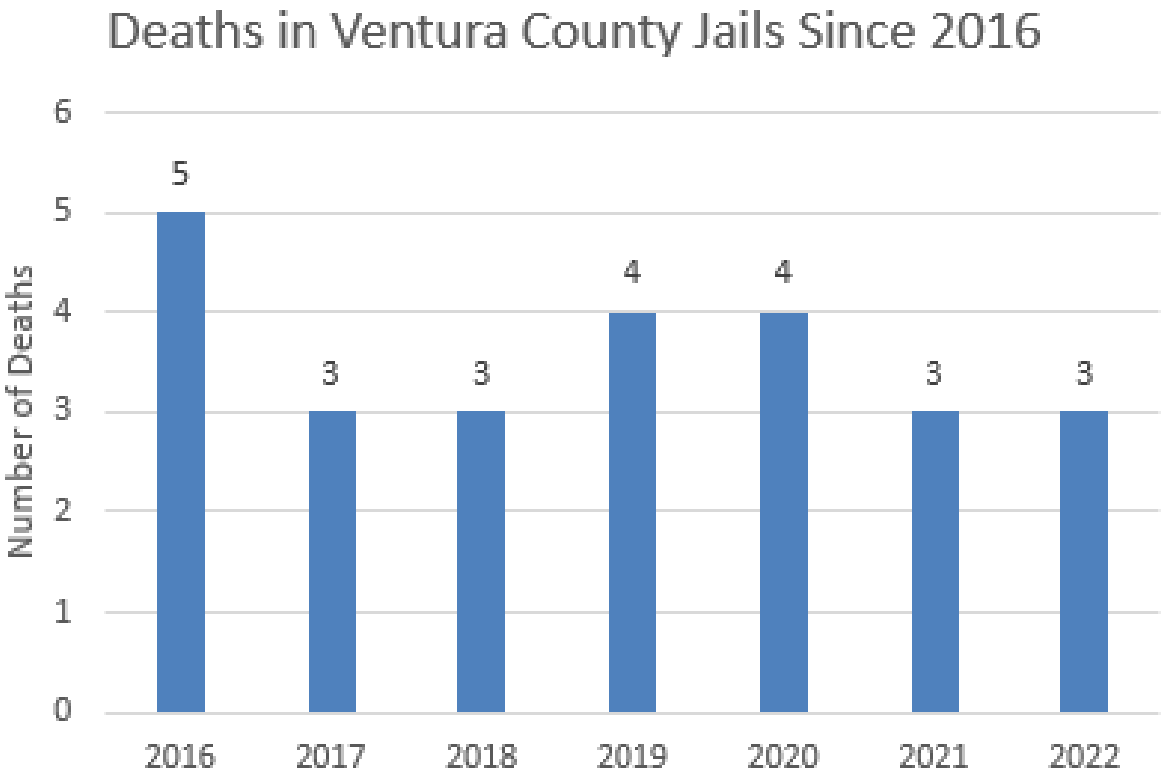
# GLOSSARY

| TERM | DEFINITION |
|---|---|
| BOS | Ventura County Board of Supervisors |
| BSCC | Board of State and Community Corrections |
| DSD | Detention Services Division |
| MCU | Major Crimes Unit |
| ME | Medical Examiner |
| NCCHC | National Commission on Correctional Healthcare |
| PTDF | Pre-Trial Detention Facility |
| SST | Sheriff's Service Technicians |
| TRJ | Todd Road Jail |
| VCSO | Ventura County Sheriff's Office |

# ATTACHMENTS

**Att-01.** Deaths in Ventura County jails since 2016
**Att-02.** Case studies

**Attachment-01**




Source: Ref-10

**Attachment-02**

# CASE STUDIES

**Suicide:**

Case Study 1 – One attempted suicide involved a cell wall fixture that was not properly attached that provided the opportunity for hanging.

Case Study 2 – One suicide involved a person with suicidal ideation of jumping to death being housed on second level with exposed railing.

**Overdose/Intoxication:**

Case Study 3 – Person was arrested for an outstanding warrant and no license plate after stopping at a convenience store. The person asked to go to the bathroom at the convenience store. After spending 14 minutes in the bathroom, the person was asked to come out of the bathroom by convenience store personnel. Paraphernalia found were found in the person's belongings. A body scan at booking was done incorrectly. Specifically, the person's hands were in a position behind his back which obscured any view of contraband hidden in the body cavity. The body scan was not redone. The detained person was found deceased 27.5 hours later. The cause of death, determined by the ME, was drug overdose.

**Medical:**

Case Study 4 – Person was booked symptomatic with signs and symptom of withdrawal, requiring intervention. Regular cell checks were not done according to VCSO's Standard Operating Procedures. Person exhibited multiple incidents of vomiting & defecation over three days but refused fluids. No indication in case file that person was given emergency treatment in hospital setting.

Case Study 5 – Person was booked under the influence. Screening process did not detect underlying medical condition (hypertensive cardiac disease, manifested by elevated blood pressure readings). There were gaps in verifying the person's physical and mental health statements; 4.5 hours between last time seen alert and responsive in cell and time seen unresponsive in cell. Paramedics did not arrive to the jail until approximately thirty minutes had past when notified.

Source: Ref-10