Five Deaths in Santa Cruz

An Investigation of In-Custody Deaths

2013-2014 Santa Cruz County Grand Jury

May 2014

Summary

Between August 2012 and July 2013, five in-custody deaths occurred at the Santa Cruz County Main Jail. Many in the community were deeply concerned by this, and for some it was a very personal tragedy. Four of these deaths occurred after the private California Forensic Medical Group (CFMG) had assumed medical responsibility for the jail. People questioned whether the Sheriff's Office could conduct an impartial investigation into these deaths since they occurred at its facility and involved its personnel. In light of these issues, members of the Grand Jury conducted a thorough investigation of the five deaths. We worked with the Sheriff's Office and its Corrections Bureau, the Crisis Intervention Team (CIT) of the County Health Services Agency (HSA), and personnel from CFMG. Our goal was to determine how the environment at the Main Jail could be made safer for individuals in custody.

The Grand Jury learned that the health of inmates entering the Main Jail was often poor due to their existing medical and mental health conditions, such as chronic drug or alcohol abuse. All of the individuals who died in custody had medical problems, mental health problems, or both. In this high pressure environment, the process for classifying, monitoring, and treating high risk individuals needs to be carefully formulated and executed. People with the correct training and expertise must be active participants at each step in the process. In all of the in-custody death cases, we identified failures at critical points in the process. In some instances, individuals were incorrectly classified or not properly monitored. In others, inadequate treatments were applied.

Steps are now being taken at the Main Jail to improve inmate safety. New leadership is in place in all areas directly involved in inmate care, including the Corrections Bureau, CFMG, and CIT. New staff members have been hired, and protocols have been reviewed and upgraded. The different organizations now report a higher degree of cooperation with one another and an improved team focus. Corrections Bureau and CIT staff speak highly of the professionalism of CFMG. Yet, in spite of these improvements, we believe additional changes in protocols and procedures are needed for the protection of the mental and physical health of inmates.

Background

The last two years have been turbulent for the Santa Cruz County Jail system. Because of the massive change in the California State Prison system, mandated by the 2011 Public Safety Realignment Act (AB 109), Santa Cruz County has seen a spike in its inmate population, especially among those serving longer sentences. Cutbacks in state mental health facilities have also led to a growing number of inmates with severe mental health problems in the county jails. Many of these inmates are awaiting transfer to state facilities when beds become available. The September 2012 transfer of medical care responsibilities in the three county jails from the County to CFMG introduced additional dynamics into an already challenging environment.

Against this backdrop, an unprecedented series of five in-custody deaths occurred at the Santa Cruz County (SCC) Main Jail over the course of 11 months, from August

2012 through July 2013. The deaths were tragic for the individuals and their families and friends. They were also traumatic for the corrections and medical staff at the jail and the community at large. The deaths were covered by the local media, with at least nine articles published in the *Santa Cruz Sentinel*.[1] [2] [3] [4] [5] [6] [7] [8] [9]

Members of the community expressed serious concerns regarding these deaths. Some called for an independent investigation by an outside agency. Others noted that all but one of these deaths occurred after CFMG had assumed responsibility for medical care at the jail. Because of the reported controversies and lawsuits surrounding CFMG,[10] the County Board of Supervisors' decision to outsource medical care came into question.

An April 6, 2013 protest march, organized by the Santa Cruz activist group Sin Barras, is an example of the community reaction to these deaths.[11] Other groups, such as the Good Samaritan Mobile Medics, the Santa Cruz 11, and the Homeless United for Friends and Freedom (HUFF) also participated in the march. After marching from the Town Clock tower to the Main Jail, multiple speakers spoke out against the in-custody deaths, conditions at the jail, and the CFMG outsourcing decision.

The following table summarizes the facts reported concerning the in-custody deaths.

Santa Cruz Main Jail In-Custody Deaths 8/25/12 to 7/17/13

Name	***Age***	***Date of Death***	***Time in Custody***	***Cause of Death***
Christy Sanders	27	8/25/12	12d, 4h	Lung collapse
Richard Prichard	59	10/06/12	5h	Heart attack
Brant Monnett	47	11/20/12	20h	Narcotic overdose
Bradley Dreher	47	1/13/13	1d, 12h	Asphyxiation by hanging
Amanda Sloan	30	7/17/13	8m, 4d	Asphyxiation by hanging

To help put this information in perspective, consider the statistics on 2011 nationwide local jail deaths compiled by the U.S. Department of Justice:[12]

- A total of 885 jail deaths occurred nationally in 2011. The vast majority of jails reported zero deaths; 13% reported a single death; 6% reported two or more deaths. Santa Cruz County recorded 5 deaths during an eleven month period spanning 2012-2013.

- More than a third (39%) of deaths nationally occurred within the first week of admission to a jail facility. 60% of the Santa Cruz jail deaths occurred within the first week of custody.
- Heart disease and suicide were listed as the leading causes of jail deaths nationally during this period, accounting for more than half of all jail deaths. 60% of the Santa Cruz jail deaths were due to heart attacks or suicides.
- The estimated Main Jail in-custody death rate for the period spanned by these deaths was over four times the national average for a single year. Roughly 10,000 people were booked into the SCC Main Jail in 2012.[13] Based on an average rate compiled for a multiple year period, approximately 10% of those booked were held in custody. Thus, about 1,000 individuals were held at the Main Jail in 2012. Using this estimate for the period covered by this investigation (August 2012 - July 2013), this means that the SCC Main Jail death rate was in the range of 5 for every 1,000 inmates, contrasted with the 2011 national death rate of 1.22 for every 1,000 inmates.

While some information concerning the inmate deaths in the Main Jail was released to the press, the majority of data obtained by the Sheriff's Office during its investigation would not normally be made public. Without a careful investigation by an independent group with access to this information, the community would always question whether the public received the whole truth.

Scope

The Grand Jury conducted a comprehensive investigation of the events involved in the five in-custody deaths. In addition to sharing the community concern over the care and treatment of inmates, the Grand Jury has a legal mandate to inspect the County jails every year. Our focus was to identify ways in which the Main Jail could be a safer place for those in custody.

We sought the following information during our investigation:

1. Were there common factors contributing to the deaths?
2. Were adequate procedures, protocols, and resources in place that could have helped prevent such deaths?
3. To what extent were existing protocols and good practices followed?
4. What changes in practices and protocols have occurred since these events?
5. Are additional changes in practices and protocols needed?

For each jail death, the Grand Jury prepared a detailed timeline covering the decedent's time in custody because we believe the community deserves a thorough account of what transpired.

Investigation

Investigation: Timelines

Christy Sanders (August 2012)

(Note: This death took place prior to CFMG assuming medical responsibility in the jail.)

8/12/12: Sanders was arrested for petty theft and a probation violation. Prior to booking, she complained of pain in her left side and was sent to the Dominican Hospital Emergency Room (ER). While at the hospital, she was examined and X-rayed before being returned to the Main Jail. ER staff reported to jail personnel that the results of the X-ray were normal and recorded that result in their Elysium electronic medical record system, which is accessible by Main Jail medical staff.

8/13/12: Sanders received several medical assessments and screenings for vital signs. She refused some medications, including those for opiate detoxification and deep vein thrombosis (DVT). She saw the doctor at the Main Jail clinic that afternoon, complaining of chest pain. On the same day, the Dominican Hospital radiologist revised the original ER X-ray diagnosis and indicated in a new Elysium medical record entry that “close follow up” was warranted.

8/14/12: Sanders returned to the Main Jail clinic still complaining of chest pain.

8/17/12: Sanders displayed heroin detox symptoms and was started on a detox protocol.

*8/18/12***:** Corrections Officers (CO)s called medical staff when Sanders suffered a seizure and had difficulty breathing. After treatment by a nurse, Sanders requested to be sent back to Dominican Hospital, but her request was denied after the nurse consulted by phone with the jail doctor. She was then sent to the ‘O’ Unit for observation.

8/20/12: Sanders complained of shortness of breath and pain in her entire chest. She indicated that she did not trust the medical staff at the Main Jail or at Dominican Hospital. At the jail clinic she was assured that she was receiving appropriate treatment. From that time on, she was only seen sleeping in a cross-legged position, leaning forward with her forehead against the wall.

*8/23/12***:** Sanders again requested to go to the hospital but was refused.

8/24/12: Sanders complained of a fever. She asked for medication, and when refused, threatened to kill herself. She was then transferred to a suicide watch cell. Later, she was returned to general housing after signing a “no harm” contract, which stated her agreement not to harm herself.

*8/25/12***:** Sanders was again observed sleeping in a cross-legged sitting position with her forehead against the wall. At 8:47 a.m., an inmate noticed that Sanders was not breathing and called for help. COs responded, sounded a panic alarm (Code 3) and

began cardiopulmonary resuscitation (CPR). When paramedics arrived, she was examined and then pronounced dead at 9:08 a.m.

Coroner's Report: The Sheriff-Coroner's Office reported[14] that both of Sanders' lungs had collapsed due to a large amount of pus present in the pleural cavity between her lungs and ribs (bilateral empyema). There were also abscesses in the upper lobe of her right lung. Her bilateral empyema and pulmonary abscesses had been developing over a period of weeks. She had Hepatitis C and DVT, and damage from these and from heroin abuse had been occurring for years. A toxicology report indicated the presence of methamphetamine ("meth") and amphetamine in her blood.

Richard Prichard (October, 2012)

10/5/12: Just before midnight, an officer pulled Prichard over for erratic driving. Prichard then failed a Breathalyzer test showing a blood alcohol concentration of 0.17%, over twice the legal limit (0.08%).

*10/6/12***:** Prichard arrived at the Main Jail at 1:52 a.m. and was placed in the open seating area prior to being booked. At 2:30 a.m., he was brought into the intake area where he answered "No" to all medical questions on the intake form, indicating he was not physically impaired, not using medication, and not under a doctor's care. He was then placed in Holding Room 1 in the Booking Section. At 5:52 a.m., he was fingerprinted and placed back in the open seating area after he complained of back pain from sitting on a bench in the holding room. At about 6:30 a.m., booking officers were told by an inmate that Prichard had urinated on himself. Officers responded but were unable to wake him and called a Code 3. A nurse and a CO then performed CPR and used an Automated External Defibrillator (AED) on Prichard. When Santa Cruz Fire Department medics arrived they continued treatment, but Prichard was pronounced dead at 7:14 a.m.

Coroner's Report: A subsequent autopsy[15] determined that Prichard suffered from coronary arteriosclerosis, hypertension, and arteriosclerotic cardiovascular disease. The Sheriff-Coroner's Office listed the cause of death as an acute thrombotic occlusion (blockage) of the left anterior descending coronary artery. This condition is colloquially known as a "Widow Maker" and is normally a lethal occurrence.

Brant Monnett (November 2012)

11/19/12: Monnett was arrested that evening for possession of a controlled substance, resisting arrest, and a probation violation. He advised the Main Jail staff that he would be detoxing from methadone and heroin. At 10:45 p.m. he was booked and held in Holding Room 1.

11/20/12: At around 6:00 a.m., nurses checked on him during his opiate/methadone withdrawal watch. COs observed that his speech was both slurred and confused and that his gait was unsteady. At 9:30 a.m. Monnett was placed on the CFMG opiate detoxification protocol. Between 1:45 p.m. and 4:00 p.m. officers noted that Monnett still appeared unsteady, shuffled his feet and had half-closed eyes. At 6:10 p.m., nurses

found Monnett unresponsive in his bunk. Officers called a Code 3, but life-saving attempts failed. Monnett was pronounced dead at 6:42 p.m.

Coroner's Report: The Sheriff-Coroner's office reported[16] the cause of death as an unintentional overdose of both prescribed and illegal narcotics. The report listed the cause of death as cerebral and pulmonary edema due to cardiac arrhythmia and opiate and methamphetamine intoxication, noting the presence of THC, amphetamines, methadone, and their derivatives. Methadone had the highest concentration, with a reported half-life of between 15 and 55 hours.

Bradley Dreher (January, 2013)

1/11/13: Dreher was arrested on a felony charge of making criminal threats. The charges stemmed from a failed attempt to obtain prescription drugs from a Doctors on Duty medical clinic. Dreher, who was visiting from New York, was attempting to obtain prescriptions for Valium and Xanax. After evaluation by a nurse at the Main Jail, he was denied intake and sent to Dominican Hospital for further evaluation. Upon being returned to the Main Jail, he was given a Crisis Intervention Team (CIT) referral and kept in Holding Room 1. He was put in a locked single cell under Administrative Segregation because of statements he made about his inability to get along with other inmates.

1/13/13: At 5:13 a.m., during medication rounds, Dreher complained to the nurse that he was missing a couple of his normal medications. Additionally, he refused to take one of the medications, saying it would interfere with another he was taking. At 11:15 a.m., a CO saw Dreher in a sitting position by his bunk. Upon entering the cell, the officer found Dreher unconscious with a noose (fabricated from the bed sheet) around his neck and tied to his bed frame. Officers called a Code 3 and staff performed CPR. Dreher was pronounced dead at 11:40 a.m.

Coroner's Report: The Sheriff-Coroner's Office[17] determined the cause of death to be intentional asphyxiation due to hanging. It classified the death as a suicide. The toxicology report revealed the presence of multiple antidepressants and a Valium derivative in his blood.

Amanda Sloan (December 2012 - July 2013)

12/13/12: Sloan was booked into the Main Jail on multiple charges, including assault with a firearm on a peace officer, shooting at an inhabited dwelling, discharging a firearm from a vehicle, and reckless driving while evading a peace officer.

7/14/13: During a visit by a friend, Sloan learned that she was losing custody of her children, became very upset and stormed out of the jail visiting area.

7/16/13: COs noted that Sloan was "very agitated and uptight."

7/17/13: At 4:15 a.m., Sloan did not come down for her meds and soon after was found hanging in her cell. A Code 3 was called when she was found, but life-saving efforts failed and Sloan was pronounced dead at 4:25 a.m. Officers observed a large hole in

the cell wall, exposing an interior pipe, to which she had tied a handmade noose. The hole had been hidden by a poster. She had also hidden a meth pipe and a razor blade behind other posters.

Coroner's Report: The Sheriff-Coroner's Office[18] determined the cause of death to be intentional asphyxiation due to hanging and classified the death a suicide.

Investigation: Analysis

The following concerns and additional facts emerged during this investigation:

Concern A: Whether the Main Jail medical staff responded correctly to complications resulting from opiate detoxification.

There were two opiate detox cases, Sanders and Monnett. County protocols were used in the Sanders case, while CFMG protocols were applied to Monnett.

Sanders

The official County protocols included the medications clonidine, Vistaril (hydroxyzine), and Imodium (loperamide). Sanders originally refused detox medications, but agreed to take them on 8/17/12.

Due to her refusal to take blood thinners, Sanders was at elevated risk for a pulmonary embolism, which is a known risk for intravenous opiate abusers. Basic standards of treatment indicated that she should have been closely monitored.[19]

Sanders also showed other danger signs that were witnessed by COs and inmates: a bluish tinge to her lips, escalating complaints of severe chest pain, and difficulty breathing, along with the seizure mentioned in the timeline.

California Correctional Health Care Services (CCHCS) is an organization mandated by the federal government to provide medical care within California prisons in response to a federal class action lawsuit.[20] It created a set of policies and procedures that "are designed to meet ***the minimum level of care necessary to provide constitutionally adequate medical care*** to patient-inmates in the State of California." (emphasis added) While these protocols do not officially apply to county jails, they are indicative of basic standards of care. The Registered Nurse protocol for chest pain includes the following:

> *"4. <u>Pleuritic chest pain</u> accompanied by fever, chills, cough, dyspnea on exertion, tachycardia, diminished breath sounds, crackles, wheezes.*
>
> > *a. Notify physician **STAT**.*
> > *b. Administer O_2 at 2-6 L/minute via nasal cannula to maintain oxygen saturation ≥ 90%.*
> > *c. Place patient in position of comfort.*
> > *d. Start IV with large bore needle (16-18 gauge) and infuse normal saline at TKO.*
> > *e. **Monitor and record vital signs and oxygen saturation every***

15 minutes. (emphasis added)
f. Prepare to transfer patient to outside facility or admit to a facility capable of providing a higher level of care if indicated.
g. Fax a copy of the relevant progress notes, physician orders, and emergency care flow sheet to the receiving facility.

5. <u>Chest wall pain</u>: For patients with chest wall tenderness whose symptoms can be entirely reproduced by applying pressure directly to the chest wall, ***who are not dyspneic*** (emphasis added)*, and have normal vital signs:*

a. Ibuprofen 200 mg 3 tabs P.O. QID PRN X 7 days.
b. Naprosyn 500 mg P.O. BID PRN X 7 days.
c. Alternating ice or heat to chest wall for 15 minutes QID PRN.
d. No heavy lifting.
e. Follow-up with a physician in one week or sooner if symptoms persist."[21]

In the Sanders case, protocol #4 should have been adopted because of her seizure, complaints of feeling feverish, and on-going difficulties with breathing (dyspnea), especially since the presence of dyspnea is a key symptom in the diagnosis of pleuritic chest pain. The jail doctor did give Sanders pain relievers, a remedy appropriate for the less severe diagnosis of chest wall tenderness (#5).

Monnett

The CFMG protocol for opiate withdrawal includes the medications clonidine, Benadryl (diphenhydramine), Lomotil (diphenoxylate/atropine), Phenergan (promethazine), and multivitamins. This protocol can be modified based on the patient's vital signs. Monnett was treated according to this protocol.

Monnett was not placed in the sobering cell for monitoring during intake, even though he advised COs that he would be detoxing from heroin and methadone. Nor was he housed in the 'O' Unit for treatment in spite of the fact that methadone is a drug whose peak respiratory depressant effects are known to occur much later than those of heroin.

According to the document "Emergency Department Management of Methadone Overdose" by the Center for Addiction and Mental Health:

*"**Clinical features:** Methadone acts for at least 24 hours, much longer than other opioids. Symptoms begin up to 10 hours after the overdose. Early symptoms include nodding off, drowsiness, slurred speech and emotional lability.* ***Respiratory depression occurs later****.* (emphasis added) ***Monitoring:*** *Check frequently for vital signs, respiratory rate and O2 sat, and hold a brief conversation to assess alertness. ECG and cardiac monitoring are recommended ..."*[22]

From New York State Office of Alcoholism and Substance Abuse Services comes this

discussion:

> ***"Methadone's peak respiratory depressant effects typically occur later, and persist longer than its peak analgesic effects.*** *With repeated dosing, methadone may be retained in the liver and then slowly released, prolonging the duration of action despite low plasma concentrations. Steady state plasma levels are not usually attained until 3 to 5 days of dosing. Signs of methadone overdose include trouble breathing or shallow breathing; extreme tiredness or sleepiness; blurred vision; inability to think, talk or walk normally; and feeling faint, dizzy or confused.* ***Patients require immediate medical attention If these signs occur."***[23]
> (Emphasis added)

At 6:00 a.m., roughly 7 hours after his arrest, Monnett had an unsteady gait and confused slurred speech, which are clinical features of early symptoms of methadone overdose. At this point, according to these standard protocols, he should have been either hospitalized or transferred to 'O' Unit for much closer monitoring.

Concern B: Whether the Corrections Bureau had appropriate protocols for utilizing Main Jail medical staff in evaluating intoxicated individuals and deciding when to use the sobering cell.

Prichard

The August 14, 2012 CFMG contract with the County, Section L, titled "Detoxification Treatment," mandates the following procedures:

> *"Inmates booked into the Santa Cruz County Correctional Facilities who are intoxicated will be placed in sobering cells and monitored by medical and custody staff in accordance with established written policies and procedures approved by the medical director and facility commander and in accordance with Title 15 and IMQ/CMA Standards. Inmates will be evaluated on an individual basis by medical staff to determine the need for medically supported detoxification during incarceration. Health services staff will assess inmates placed in sobering cells within one hour of placement and every four hours thereafter..."*[24]

According to Corrections Bureau protocols, decisions about calling medical staff to intake and using the sobering cell for inebriated individuals are left to the judgment of COs. In the case of Prichard, officers, based on their assessment of his level of inebriation, chose not to call a nurse. Prichard was in the holding area for over 4 hours with no monitoring of his heart rate or blood pressure, even though CFMG protocols maintain that medical staff should always participate in the evaluation of inebriated subjects. Current officer training materials, provided by CFMG, emphasize the necessity of calling a nurse to intake for any intoxicated individual.

COs also decided not to place Prichard in the sobering cell, a special padded room which requires frequent checks by COs. When this room is occupied, a timer goes off

every 15 minutes at the booking desk to notify officers that it is time to check the room. The Grand Jury was told that on an extremely busy night these checks can disrupt officer routines. The potential disruption may influence their choice of holding rooms assignment. Since a nurse's participation in the assessment process was optional, nurses were often relieved that their late night medication preparation and distribution rounds were not interrupted by calls to the intake area or sobering cell. The discretionary nature of this process creates the possibility that staff judgments about inmate monitoring may not always give proper attention to inmates' health and safety.

Concern C: Whether contraband/drug interception and screening protocols for individuals entering the Main Jail were successful.

Preventing the influx of drugs and other contraband into jails has always been a serious challenge. This problem was made worse countywide by the prohibition of strip searches as a result of a lawsuit against the County. The prohibition was in force during most of the period covered by our investigation of in-custody deaths. Since the summer of 2013, strip searches have resumed subject to new guidelines.

Inmates entering the Main Jail from Drug Court pose a special risk. Often they are ordered by inmates already in the jail to bring drugs back with them or face serious reprisals. We were also told that there are no consistently enforced rules for screening visitors and attorneys entering the Main Jail.

Sanders, Monnett, and Sloan

Small amounts of methamphetamine were found in the post-mortem toxicology screenings for both Sanders and Monnett.[14] [16] Given its short elimination half-life, the meth was probably acquired in the jail. A meth pipe was found hidden in Sloan's cell after her death, though no evidence of recent meth use was found in her post-mortem toxicology screening.[18] The methadone found in Monnett's blood was likely ingested prior to his arrest.

Concern D: Whether Corrections Bureau regulations regarding cell inspection and permitted materials in cells were effectively followed and enforced.

Sloan

The Sheriff's Office has protocols, which are summarized here, concerning cell inspections and regulations for items permitted in cells:

1. Safety checks should be conducted at least once an hour. Officers should observe the inmate through the cell window, making sure they see visible skin, and verify that the inmate is breathing. They should document their check using the Pipe Log.
2. Inmates are not allowed to place anything on the doors, windows, or walls of their cells. No items are to be thrown on the floor of the cell. No food may be stored.

The facts uncovered for the Sloan case showed that neither of these protocols was followed.

The signed Pipe Log for the CO assigned to Sloan's area for the night of 7/16/13 - 7/17/13 reported the officer as viewing Sloan at 22:21, 22:58, 00:14, 02:28, and 03:26. However, the video record for her unit shows that only the 22:21 safety check occurred. Contrary to the second protocol, Sloan had covered the window to her cell, except for a one-inch slot, with a poster. She also used a poster to hide a hole dug in the cell wall that exposed a pipe she used in her suicide. In addition, the cell's light switch cover had been removed and replaced with a poster.

California's Board of State and Community Corrections (BSCC) inspected the Main Jail on 3/12/13 - 3/13/13 and found the inmate safety check documentation to be out of compliance. On 8/2/13, the County sent a Corrective Action Response to BSCC. The documentation subsequently passed the re-inspection. Corrections Bureau management instituted new requirements for supervisors to review their officers' Pipe Logs on a daily basis and to accompany officers on some of their safety checks to improve performance.

During the Grand Jury inspection of the Main Jail on 1/27/14, jurors observed multiple instances of towels covering cell windows, posters on cell walls, and various items haphazardly spread around the cells and on the floor, including fruit, all in violation of Corrections Bureau regulations. Jurors did not notice inmate regulations posted anywhere in the housing unit.

The Grand Jury heard that staffing limitations and Main Jail configurations impact the ability of officers to conduct effective cell inspections. When the Grand Jury asked COs about enforcement issues, jurors were told that enforcement is often left to officers' discretion because they need to "pick their battles" to maintain good relations with inmates. Jurors also heard that there are no consistently applied disciplinary standards for rule violations, and that officers on different shifts sometimes have different approaches to inmate discipline.

According to the Sheriff's Office, steps are under way to create a uniform policy of enforcement, and to foster an atmosphere of greater accountability. Since the recent appointment of a Compliance Officer, the Grand Jury believes disciplinary practices at the Main Jail are improving. Disciplinary reports classify inmate infractions according to degree of severity and document what privileges are lost. Within the last six months, the number of these reports has almost doubled, possibly due to a higher degree of enforcement vigilance. During the calendar year 2013, the Main Jail staff, because of effective safety checks, successfully intervened in eight attempted suicides.

Concern E: Whether procedures and resources for mental health screening, monitoring, and suicide prevention were effective.

Santa Cruz County Mental Health, a department under HSA, is responsible for the mental health of inmates in the jails. The CFMG contract (Section Z, Item 16) describes their suicide prevention responsibilities as follows:

> *"The Santa Cruz County Mental Health representative will work collaboratively with the CFMG program manager and the facility manager*

> *to develop and implement a suicide prevention program. This plan will include the following elements: identification, training, assessment, monitoring, housing, referral, communication, intervention, notification, reporting, and review."*[24]

In the two suicide cases, there is no evidence that either individual showed suicidal behavior in the period immediately preceding their deaths. Medical staff described both individuals as stable.

Sloan

While medical staff reported that Sloan appeared happy and unusually calm, COs noted that she was agitated on the day before her death. Sloan was known to be highly volatile and it was not unusual for her to be happy with one person and angry with another. Given this volatility, some in CIT believed that she would someday hurt herself. Although Sloan had been kept in the 'O' Unit for mental health observation during some of her confinement, she was returned to the general population six weeks before her suicide. Medical and CIT staff emphasized they did not have the authority to keep her indefinitely locked down against her will in the 'O' Unit. She had the right to be returned to the general population once she indicated that she was feeling better and showed an improved attitude.

The question of her rehousing was presented at the morning review sessions between CFMG, CIT, and Corrections Bureau staffs. The group regularly meets Monday through Friday at 8:15 a.m. to discuss all inmates housed in the 'O' Unit and all other inmates considered at risk. Sloan had been a frequent topic of discussion at these meetings. The consensus was that she was doing better. The decision to move her from the 'O' Unit back into the general population occurred during one of these meetings.

The Grand Jury found that the CIT staff is in the process of reviewing, modifying, and documenting its treatment protocols and record keeping requirements. In the past, record keeping requirements were lax and many procedures went undocumented. The CIT staff members said they were unable to provide information about their interactions with Sloan and Dreher because of inadequate record keeping. New staff members had to ask more experienced members for guidance in performing basic procedures. As part of its review process, CIT implemented a procedure for transitioning an inmate isolated for treatment in 'O' Unit back into the general population. The procedure is based upon an inmate's behavior and medication compliance over several weeks. The inmate is first moved into a locked mental health transitioning unit ('K' Unit) and then ultimately back into the general population.

Dreher

Dreher had indicated at intake that he suffered from mental health issues and was given a CIT referral, but no CIT clinicians were on duty at the time of his intake. Dreher was then housed in a single cell because he indicated he was violent. He was not placed in a monitoring cell in the 'O' Unit or an isolation cell in the 'K' Unit, even though he was off his normal medication and threatened violence. CIT staff could not clarify for the Grand

Jury whether it had knowledge of the severity of his alleged crime or of his other psychiatric conditions. According to the CIT staff, both of these factors should have been taken into account when determining an inmate's housing classification. Had CIT clinicians been available sooner to assess his condition, he might have been placed under tighter monitoring. CIT said that even though the Emeline complex HSA psychiatric staff is on call during the night shift, it is often unacquainted with the patients at the Main Jail, and not completely familiar with CIT and jail protocols.

Concern F: Whether the Main Jail medical staff had access to necessary diagnostic information and facilities for proper identification and treatment of inmates with severe illnesses.

Sanders

In the Sanders case, County nurses, physicians, and physician assistants did not have all of the necessary information for correct diagnosis and treatment. The Dominican Hospital ER had cleared Sanders for return to the Main Jail. In spite of several visits by Sanders to the Main Jail medical clinic, and multiple stays in 'O' Unit, County nurses and physician assistants had relatively limited contact with Sanders, and physicians had even less contact. Only one CO is stationed in the 'O' Unit, which has 16 cells to monitor. Nurses make only limited visits to 'O' Unit during rounds. In addition, the cells in the 'O' Unit are not equipped for the proper treatment and monitoring of inmates under a medical watch. These cells do not contain hospital beds or medical monitoring equipment.

Medical personnel felt that they were providing Sanders appropriate medical care and told her so. They discounted the severity of her complaints, possibly because they had all been exposed in the past to inmates engaging in fraudulent, drug-seeking behaviors. This exposure created a dangerous presumption of inmate deceit that was hard to overcome in the Sanders case, given the initial inaccurate Dominican Hospital report. They told Sanders to "practice positioning for comfort" to help her cope with her painful breathing, and they refused all her requests to be sent to Dominican Hospital.

Because nurses and physicians had incomplete diagnostic information, there was also disagreement between medical and corrections staff about the severity of Sander's illness. Corrections staff described Sanders as "bouncing" back and forth between the 'O' Unit and general population. County medical staff told corrections staff that Sanders was a "medical management problem."

The Grand Jury found no indication that County physicians or physician assistants reviewed Sanders' Dominican Hospital medical records on the Elysium system during her visits to the Main Jail medical clinic. They were apparently unaware of the radiologist's subsequent report in Elysium which raised the severity of the original diagnosis and advised constant monitoring. Nor did the Grand Jury find any evidence that anyone from Dominican Hospital attempted to contact doctors at the Main Jail directly to correct their original report.

CFMG management described to jurors their procedure for coordinating with Dominican

Hospital. If an inmate is seen at the Dominican Hospital ER, that inmate is scheduled for a doctor's visit at the Main Jail clinic the following day. During this visit, the doctor is required to review the latest Elysium records. This last step is very important. The Dominican Hospital ER typically calls the Main Jail when an inmate is released back to the jail and summarizes the result of the examination over the phone. Because of the widespread belief that if the inmate "is cleared by the hospital, that's good enough for us," medical staff might not be inclined to recheck the inmate's medical records.

While this procedure is an improvement over a more informal approach, it does not go far enough. Sometimes an inmate's diagnosis at Dominican Hospital may be updated by Dominican Hospital staff and posted in the Elysium records even after the jail clinic visit. In this situation CFMG staff in the Main Jail has no way of knowing that the Elysium records have been updated.

Investigation Summary: The Need for Collaboration

The flow of accurate and timely information between the different organizations (the Corrections Bureau, CIT, the medical staff, now CFMG, and Dominican Hospital) providing care to the inmates at the Main Jail is of critical importance. Any breakdown in communication or lack of consultation among them endangers high risk individuals. Decisions about inmate monitoring and care need to be made by those with the right expertise and information. If there is a common factor involved in all these in-custody deaths, it is that poor decisions were made due to lack of expertise or inadequate information.

Much better relations now exist between the Corrections Bureau, CFMG, and CIT staffs. Members of these organizations speak highly of the quality and dedication of the other groups. They report a high degree of cooperation and teamwork. Cases of high risk individuals continue to be reviewed every weekday among the departments. A quarterly Quality Assurance Review Meeting looks at problem areas and investigates potential solutions.

With CFMG now responsible for medical services at the Main Jail, Corrections and CIT staff members report a high degree of confidence in the quality of inmate medical care. The Grand Jury determined that CFMG has extensive, detailed protocols as well as training programs for both medical and corrections personnel. Some CFMG nurses, who are former County employees, expressed their appreciation of the thoroughness of CFMG's treatment protocols. CFMG regularly commissions external audits of staff compliance with these protocols.

The following table summarizes the impact of the six areas of concern about the five Jail deaths. It shows the extent to which these cases share common factors. A "**?**" indicates that the concern is relevant to the particular case but did not have a clearly negative impact. An "**X**" indicates that this concern increased the probability of a poor outcome.

Areas of Concern in the In-Custody Deaths

	Detox Care	***Alcohol Sobering***	***Drugs in Jail***	***Cell Inspection***	***Mental Health***	***Diagnostic Information***
Sanders	**X**		**?**			**X**
Prichard		**X**				
Monnett	**X**		**?**			
Dreher					**X**	
Sloan			**?**	**X**	**X**	

Findings

F1. County medical staff in 2012 at the Main Jail did not follow accepted standards of care in treating an inmate with complications arising from intravenous opiate abuse.

F2. There was inadequate communication between Dominican Hospital and the Main Jail medical staff regarding a critical change in diagnostic information.

F3. CFMG's current procedures may fail to detect diagnostic updates by Dominican Hospital under certain situations.

F4. CFMG staff failed to identify and treat symptoms of methadone overdose.

F5. CFMG staff at the Main Jail has insufficient oversight and treatment facilities for inmates confined in 'O' Unit.

F6. Corrections Bureau and CFMG policies differ over when to call CFMG staff for intake screening of inebriated individuals at the Main Jail.

F7. Corrections Bureau staff at the Main Jail made incorrect judgements regarding the use of monitored housing for inebriated or impaired individuals.

F8. The availability of CIT staff is not adequate for the proper determination of an inmate's needs for immediate mental health medication and monitoring during intake at the Main Jail.

F9. During the period covered by our investigations, CIT had inadequately documented procedures and lax medical record keeping for the mental health care of inmates at the Main Jail.

F10. Corrections Bureau regulations for the frequency of cell inspections and the enforcement of rules governing items permitted in cells have not been consistently

followed by Corrections Bureau staff at the Main Jail.

F11. During the period covered by our investigations, Corrections Bureau protocols and screening practices for individuals entering the Main Jail were insufficient for the interception of illegal drugs.

F12. CFMG has an extensive catalog of best practices based on decades of experience that are detailed in CFMG protocol manuals and maintained through regular training, review, and audits.

F13. The addition of a Compliance Officer to the Corrections Bureau staff, and a new regime of accountability, should result in an improvement in regulation compliance and enforcement at the Main Jail.

F14. CIT record keeping procedures and treatment protocols are undergoing a much needed process of review and improvement.

F15. CIT has established an improved protocol for gradually transitioning inmates under mental health watch in 'O' Unit back into the general population.

Recommendations

R1. CFMG and Dominican Hospital should create a formal protocol by which a CFMG contact person at the Main Jail is directly notified of any changes to an inmate's medical record at Dominican Hospital. (F2, F3)

R2. CFMG should modify its detoxification protocols and training procedures to enable its staff to recognize and treat cases of methadone overdose. (F4)

R3. CFMG should maintain a higher level of monitoring in the Main Jail's 'O' Unit, which should contain at least one hospital bed with monitoring equipment and video/audio surveillance accessible by medical staff. (F5)

R4. Corrections Bureau policy should align with CFMG policy calling for CFMG staff to examine all inmates brought into the Main Jail who are inebriated or detoxing to any degree. (F6, F7)

R5. The Corrections Bureau should have regulations regarding inmate behavior posted in all Main Jail housing units and ensure that these regulations are consistently enforced by every CO. (F10)

R6. The Corrections Bureau should apply Main Jail screening protocols equally to all visitors. (F11)

R7. CIT staff at the Main Jail should be involved in the final determination of monitoring and housing requirements for inmates with mental health conditions. (F7)

R8. CIT staff should be available, in person or by phone, 24 hours a day at the Main Jail to participate in mental health screening, inmate classification decisions, and inmate treatment. (F7, F8)

R9. CIT should complete a comprehensive procedural manual of CIT protocols and practices to enable new staff members to perform their jobs without the need for excessive guidance. (F9)

Commendations

C1. We commend the CFMG staff and management for its high degree of dedication and professionalism. (F12)

C2. We commend the Corrections Bureau for its addition of a new Compliance Officer. (F13)

C3. We commend CIT management and staff for its efforts to improve and fully document its reporting and procedural protocols. (F14, F15)

Responses Required

Respondent	***Findings***	***Recommendations***	***Respond Within/ Respond By***
Santa Cruz County Sheriff-Coroner	F1-F7, F10, F11, F13	R1- R7	60 Days July 21, 2014
County of Santa Cruz Health Services Agency, Crisis Intervention Team	F7-F9	R7-R9	90 Days August 21, 2014

Responses Requested

Respondent	***Findings***	***Recommendations***	***Respond Within/ Respond By***
California Forensic Medical Group	F2-F5	R1-R4	90 Days August 21, 2014
Dignity Health Dominican Hospital	F2, F3	R1	90 Days August 21, 2014

Definitions

Correctional terms

- *AB 109*: A law enacted in 2011 in response to the U.S. Supreme Court's order to reduce the number of inmates in state prisons to 137.5% of the original design capacity by sending new low-level offenders to county jails.
- *Administrative Segregation*: When inmates are segregated from the general

population due to an assessed risk of violent or disruptive behavior, either by them or directed against them.

- *Booking Area*: The location where the booking process occurs. Typically, this is where individuals are searched for contraband, photographed, and fingerprinted, and have their information and charges entered into a computer. They are then classified and are either assigned housing or released for later processing.
- *CO*: Corrections Officer.
- *Code 3*: The code called when a medical emergency occurs in the jail.
- *Drug Court*: An interagency program that provides drug offenders access to a host of outpatient services and treatment.
- *General Population*: The dormitory-style housing area containing bunk beds and open areas.
- *Half-life*: The time it takes for a substance to reach half of its original concentration in the bloodstream.
- *Holding Rooms*: Rooms where individuals are held prior to being put into jail housing units or evaluated for release following booking.
- *Holding Room 1*: The main holding room, with a capacity of 10 - 15 individuals. It has a television, a restroom, and telephones.
- *Intake Area*: The location where arrestees are first processed and questioned before being brought into the jail for booking. The individuals are also screened for any medical conditions that might require immediate treatment by filling out a medical questionnaire.
- *'K' Unit*: A unit with locked down cells that is now being used as a mental health transitioning facility, typically for inmates being transitioned from 'O' Unit back into the general population.
- *'O' Unit*: A unit with 16 locked down cells, most of which are under constant video surveillance by a central control room CO. These cells are used for treatment and monitoring of inmates with medical and mental health concerns.
- *Pipe Log*: The electronic management report of the times at which COs document their presence at each station on their rounds by swiping an electronic reader. The Main Jail uses the Guard I Plus computer-based security system.
- *Pronouncement of Death*: The legal pronouncement by a qualified person, usually a doctor, that further medical care is not appropriate and that the patient should be considered dead under the law. Paramedics must get a remote pronouncement by a doctor if no doctor is present.
- *Racked Cell*: Another term for a cell whose door is locked the majority of the time.
- *Sobering Cell*: A holding room that has 15 minute monitoring requirements and is padded to prevent inmate injury.
- *Title 15*: The California Code of Regulations governing crime prevention and corrections.

Organizations

- *CFMG*: California Forensic Medical Group, a privately owned company that provides contracted health care services to 65 facilities statewide in 27

counties.[25]
- *CIT*: Crisis Intervention Team, a division of HSA assigned to the Santa Cruz County Main Jail. Typically, on-site staff includes a supervisor, two clinicians, and a discharge planner, as well as several interns and scheduled visits from a nurse practitioner and psychiatrist.
- *Emeline Complex*: The main campus for HSA.
- *HSA*: The County of Santa Cruz Health Services Agency, which provides a variety of health services to the community, including psychiatric care.[26]

Medical terms

- *Acute thrombotic occlusion*: A condition in which a blood clot forms in a vessel, impeding blood flow.
- *AED*: Automated External Defibrillator, a portable device that checks heart rhythm and applies electric shocks if necessary to restore normal rhythm.
- *Arteriosclerotic cardiovascular disease*: A condition in which the artery walls in the heart thicken, resulting in less blood flow to the heart muscle.
- *Benadryl (diphenhydramine)*: An antihistamine drug for treating allergic reactions.
- *Bilateral empyema*: Inflammatory fluid and debris in the pleural cavity around both lungs.
- *Cardiac arrhythmia*: A problem with the rate or rhythm of the heart.
- *Cerebral edema*: An excess accumulation of fluid in the spaces around the brain.
- *Clonidine*: A drug used to treat high blood pressure as well as anxiety and panic disorders.
- *Coronary arteriosclerosis*: Hardening of arteries of the heart.
- *CPR*: Cardiopulmonary resuscitation.
- *Detox protocol*: A set of treatments that enable patients to remove toxic substances from their systems safely.
- *DVT*: Deep vein thrombosis, a condition in which blood clots form in the deep veins, usually in the legs.
- *Dyspnea*: Difficulty in breathing.
- *Elysium EMR*: An electronic medical record (EMR) system used by Dominican Hospital, HSA CIT, and County medical staff at the jail, but not used by CFMG.
- *Hepatitis C*: An infectious disease affecting primarily the liver.
- *Hypertension*: High blood pressure.
- *Imodium (loperamide)*: A drug used to treat diarrhea.
- *IV*: Intravenous.
- *Left anterior descending coronary artery*: The artery that supplies blood to the left ventricle of the heart.
- *Lomotil (diphenoxylate/atropine)*: An opioid agonist used for the treatment of diarrhea.
- *Methadone*: A synthetic opioid often used to treat narcotic addiction.
- *Phenergan (promethazine)*: An antihistamine drug used to treat nausea and vomiting.
- *Pleural cavity*: The space within the ribcage.
- *Pulmonary abscess*: A pocket of pus within the lungs, usually caused by bacteria.

- *Pulmonary edema*: An accumulation of fluid within the lungs.
- *Respiratory depression*: When the rate of breathing falls below safe levels and fails to provide full ventilation of the lungs.
- *THC*: Tetrahydrocannabinol, the principal psychoactive ingredient of marijuana.
- *Vistaril (hydroxyzine)*: An antihistamine drug used to treat nausea and vomiting.

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Site Visits

Santa Cruz County Main Jail on 1/27/14