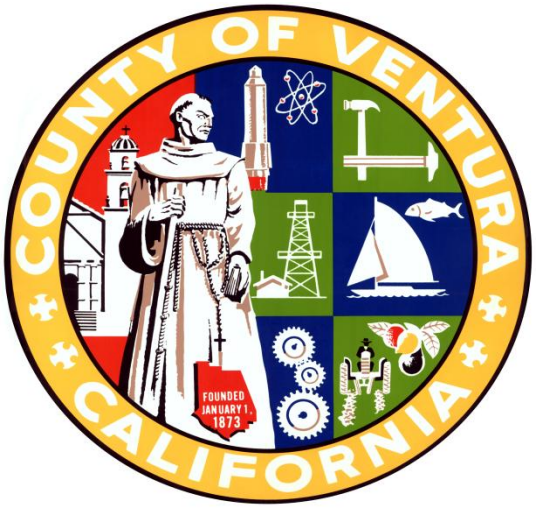
Ventura County Grand Jury
2012 – 2013



In Custody Death

Final Report

June 27, 2013

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In Custody Death

Summary

On the night of August 4, 2012, a female inmate died in the Medical/Special Housing Unit of the Ventura County Main Jail (Pre-Trial Detention Center) (VCMJ). Pursuant to its responsibility for government oversight, the 2012–2013 Ventura County Grand Jury (Grand Jury) elected to investigate the events leading up to this death. The basis of the investigation was a newspaper article reporting the death.

The Grand Jury found that during the course of her 24 hours in custody at Medical/Special Housing, the inmate/decedent's health declined rapidly. She became so debilitated that she and others asked for medical care, on more than one occasion, on her behalf. The inmate/decedent's request was noted in her medical records. Other requests for care were reflected in the Simi Valley Police Department's (SVPD) and Ventura County Sheriff's Department's (VCSD) records. There were no responses to these requests.

The Grand Jury reviewed documents from the time of arrest to pronouncement of death. They found that certain jail and medical procedures and/or protocols fell short, especially for those inmates assigned to the Medical/Special Housing Unit. The Ventura County Medical Examiner's Office ruled the death was due to natural causes.

The Grand Jury recommends that the Ventura County Health Care Agency (VCHCA) and the VCSD conduct a search for competitive medical groups to ensure standards of care are met and carried out. The mission of the Ventura County's incarceration policies should reflect the mission of the VCSD.

Background

The Ventura County Sheriff's Department's mission is "to safeguard the lives and property of residents of the County and respond to public concerns in a manner which promotes neighborhoods free from the fear of crime. The strategy for accomplishing this mission is to preserve the peace, prevent crime, apprehend offenders, facilitate problem solving community partnerships, enforce laws, provide secure and humane detention for persons lawfully entrusted to our care and display empathy and respect for the dignity of all individuals." [Ref-01]

The VCMJ, opened in 1980 and located in the Government Center Complex, accepts arrestees from every law enforcement agency in Ventura County. It is a secure correctional facility holding pre-trial detainees, both male and female sentenced inmates, and violent/assaultive offenders, psychiatric inmates, and inmates in need of medical services.

The Medical/Special Housing Unit of the jail consists of eighteen cells with two inmates in each cell. Each cell has a combination sink and toilet. There are thirty-six inmate/patients in the Unit. There are one nurse and one deputy on duty. Inside the Unit is a second nurse referred to as the facility nurse who is charged with responding to medical issues in the rest of the jail. There is an intercom system between each cell and the nursing station so that inmates can make their needs known. An interior switch to the light over each exterior cell door is another way for inmates to communicate with the deputies and nurses.

The inmate/decedent, a resident of Simi Valley, was arrested by the SVPD on August 3, for an outstanding warrant and then transported from her residence to the VCMJ. She was booked into a shared cell in the Medical/Special Housing Unit of the VCMJ.

During a routine cell check at 10:21 P.M. on August 4, there was no response from the inmate/decedent. A deputy called for a second deputy and a nurse to render assistance. Once inside the cell, they attempted to rouse the inmate/decedent without success. They then called for fire and ambulance assistance to respond to a Code-3 (a call for emergency medical services), and cardiopulmonary resuscitation was performed by deputies and medical staff until fire personnel took over. The doctor on call pronounced the inmate expired with the time of death at 10:43 P.M.

Methodology

The Grand Jury interviewed senior staff of the VCSD, SVPD and personnel at the VCMJ. In addition, the VCSD provided the Grand Jury with narratives and log sheets documenting the events of the inmate/decedent's incarceration. The policies and procedures governing the VCSD and California Forensic Medical Group (CFMG) were also provided. The Grand Jury reviewed real-time camera videos of the hallways in the hours of the inmate/decedent's incarceration at the Medical/Special Housing Unit. An on-site visit provided a clear picture of the area in which the inmate/decedent was housed. The Grand Jury listened to the audio interview of witnesses by the VCSD.

Facts

Facts are presented in reverse chronology, from the time of death to the time of arrest.

FA-01. The inmate/decedent succumbed on August 4, 2012 at 10:43 P.M., 24 hours after her arrest. The Medical Examiner's Office declared that the death was due to natural causes (probable bacterial sepsis). The VCSD conducted a debriefing documented by a memorandum dated May 16,

2013, as is required by the policies and procedures of the VCSD. The Sheriff's Department failed to produce the document. [Ref-02, 03]

FA-02. During a psychiatric evaluation, the inmate/decedent asked to go to the hospital. There was no response noted in the medical record sheet for this transfer request. [Ref-04]

FA-03. In her cell, the inmate/decedent experienced diarrhea and other symptoms of withdrawal from alcohol. The inmate/decedent summoned help for breathing difficulties, pain and instability on her feet. No help arrived after several requests. [Ref-05]

FA-04. A suicide watch was in place for the inmate/decedent. [Ref-06]

FA-05. It was determined during intake that the inmate/decedent needed monitoring for alcohol withdrawal symptoms and to receive medication for same. [Ref-06]

FA-06. The Medical/Special Housing Unit requires a check every thirty minutes by a deputy who should note an inmate's status on a log sheet outside the cell door. This is a visual check from the hallway through the cell window. [Ref-07]

FA-07. After a routine booking process (approximately two plus hours) into the VCMJ, the inmate/decedent was placed in a cell around midnight in the Medical/Special Housing Unit. [Ref-08]

FA-08. At the time of arrest, the inmate/decedent appeared to be intoxicated and the SVPD was informed that she was taking prescription medications. The SVPD indicated the family was concerned about her being incarcerated due to these medical conditions and the possibility of alcohol withdrawal symptoms while in custody. [Ref-09]

FA-09. The subject was arrested by the SVPD at 8:30 P.M. on August 3, 2012, in her home after she made attempts to evade arrest. [Ref-10]

FA-10. The VCSD inmate monitoring logs and the CFMG medical records do not match. [Ref-10]

FA-11. Out of forty-eight entries made in the VCSD inmate monitoring logs for the inmate/decedent, there was not one entry of any symptoms of alcohol withdrawal, no mention of illness, and no record of requests for assistance made by the inmate/decedent and others. [Ref-5, 11]

Findings

FI-01. The request by the inmate/decedent to be transferred to the hospital was written in the psychiatric evaluation conducted at 9:30 A.M. on August 4, and repeated in the nurses' progress notes at 5:00 P.M. (FA-05-07, 11)

FI-02. The Sheriff's inmate monitoring log, the psychiatric evaluation and the nurses' progress notes do not match. The psychiatric evaluation and the nurses' progress notes each record the inmate/decedent's request to

transfer to the hospital. The Sheriff's log did not contain this request. There were discrepancies in the nurses' progress notes and the psychiatric evaluation. The main discrepancy showed time differences, hours apart, documenting the request for hospital transfer. (FA-03, 05-07, 10)

FI-03. Neither the Sheriff's monitoring log nor the nurses' progress notes record the psychiatric evaluation that occurred at 9:30 A.M., August 4, 2012. (FA-02-03, 05-07, 11)

FI-04. The SVPD followed procedures and policies during the arrest and transportation of inmate/decedent to the main jail. (FA-08-09)

FI-05. The inmate/decedent was determined, during the intake process, to be okay to book and be placed in the Medical/Special Housing Unit. (FA-02, 05-07, 11)

FI-06. At the time she died, on August 4, 2012, a contributing factor in the inmate/decedent's death was a lack of timely medical attention while in custody. (FA-02, 05-07, 11)

FI-07. Lack of documentation and its discrepancies led to the inability of staff to adequately assess her condition. The inmate/decedent's medical chart was incomplete. (FA-02, 06, 07, 11)

FI-08. There was a debriefing by the VCSD after the death, but no formal document was written or recorded into the inmate/decedent's record. (FA-01)

Recommendations

R-01. The Board of Supervisors (BOS) authorize the VCSD to embark on a competitive bidding process that should include an in-depth search to select the best medical care provider for all inmates in Ventura County. (FI-01-03, 06-07)

R-02. In the interim, the CFMG should review and revise their policies and procedures in conformance with this Grand Jury report. (FI-01-03, 06-07)

R-03. The VCSD should have significant oversight requirements of any contracted services to the jails; i.e. supervising their strategic plan, policy and procedures to ensure they meet the mission of the VCSD. (FI-01-03, 06-07)

R-04. The VCSD and CFMG should issue a formal de-briefing (Review Team Report) document after an inmate's death. (FI-08)

Responses Required From:

County of Ventura, Board of Supervisors

(FI-07-08) (R-01, R-02, R-03, R-04)

Ventura County Sheriff

(FI-01, FI-02, FI-03, FI-05, FI-06, FI-07, FI-08) (R-01, 03-04)

Responses Requested From:

California Forensic Medical Group

(FI-01, FI-02, FI-03, FI-05, FI-06, FI-07, FI-08) (R-02, R-04)

Ventura County Health Care Agency

(FI-01, FI-02, FI-03, FI-06-07) (R-01)

References

Ref-01. Ventura County Sheriff's Department website: http://www.vcsd.org/mission.php (accessed April 7, 2013)

Ref-02. Autopsy Report, Ventura County Medical Examiner-Coroner's Office, Case No. 00859-12, Nov. 26, 2012

Ref-03. VCSD Detention Services Division Policy, Article 37, "Inmate Death and Critical Incidents," Dec. 18, 2012, p. 2, No. 3.

Ref-04. CFMG, Psychiatric Intake Report, August 4, 2012, 9:30 A.M.

Ref-05. VCSD narrative and audio CD, August 4, 2012

Ref-06. VCSD Intake Health Screening, August 3, 2012

Ref-07. VCSD Detention Services, Division Policy, Feb. 6, 2012, Article 39, "Use of Safety Cells," p. 4

Ref-08. VCSD Detention Services Division Inmate Monitoring Log, August 3, 2012, 11:25 P.M.

Ref-09. Transcript of SVPD interview, March 20, 2013

Ref-10. Arrest Report by SVPD, August 4, 2012

Ref-11. VCSD Detention Services Division Inmate Monitoring Logs and CFMG Medical Record Notes, August 3-4, 2012.

Glossary

TERM	DEFINITION
BOS	Board of Supervisors County of Ventura
CFMG	California Forensic Medical Group
SVPD	Simi Valley Police Department
VCHCA	Ventura County Health Care Agency
VCMJ	Ventura County Main Jail
VCSD	Ventura County Sheriff's Department