Ventura County
SHERIFF'S OFFICE

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VENTURA COUNTY SUPERIOR COURT
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OFFICE OF THE
PRESIDING JUDGE

August 18, 2023

Honorable Kevin G. DeNoce
Presiding Judge of the Superior Court
Ventura County Hall of Justice
800 S. Victoria Avenue
Ventura, California 93009

Re: Response to the 2022-2023 Ventura County Grand Jury Report entitled *Deaths in Ventura County Detention and Jail Facilities*

Dear Judge DeNoce:

As required by California Penal Code § 933.05, this letter is a response to the findings and recommendations of the 2022-2023 Ventura County Grand Jury's Final Report "Deaths in Ventura County Detention and Jail Facilities" dated June 20, 2023 (the "Report").

The Grand Jury's role of acting as the eyes and ears of Ventura County residents is an important factor in building public trust. The Ventura County Sheriff's Office ("Sheriff's Office") values the importance of the annual Grand Jury inspection of its detention facilities and welcomes objective criticism from the Grand Jury as an important tool for transparency, mission accomplishment, and positive change. We know that the Grand Jury's efforts were in good faith and the Report was an honest attempt to evaluate this issue.

The Report, however, included certain inaccuracies and mischaracterizations that justify clarification to avoid future confusion or misinterpretation. The methodology used in the recent Grand Jury Report shows a bias which should lead the reviewer of this Report to question the veracity of its conclusions. Reports generated by the Grand Jury should not simply be a good-faith effort to get facts, when a more comprehensive investigation will reveal more accurate facts. The accuracy of the Report is critical to appropriately consider the recommendations that the Grand Jury makes.

When an incarcerated person dies in a detention or jail facility, there are multiple layers of review, both internally by the Sheriff's Office and externally by other independent agencies, including the Grand Jury. A comprehensive death investigation is conducted by the Sheriff's Major Crimes Bureau, along with an independent inquiry carried out by the Ventura County Medical Examiner,

and an internal review is conducted to determine what if any lessons can be learned. In addition, the District Attorney's Office and the Grand Jury have access to both the reports and the findings from each investigative body.

Unfortunately, a majority of the people who commit suicide in custody have suicidal ideations or suicide attempts prior to being incarcerated. Understandably, suicide history while out of custody is not usually self-reported by the incarcerated person and not known by medical, mental health, or correctional staff. Incarcerated people in our detention facilities are evaluated by mental health professionals any time an indicator of previous or current suicidality is presented. The medical and mental health services provided in the detention facility mirror and exceed those available in the community. In some cases, our success rate in deterring suicides is greater than that found in the community because the incarcerated persons are more compliant with consistent, supervised treatment.

There are points in the Report that we agree on. Namely, that communication and transparency are key to improving the conditions in the jail and preventing suicides and deaths. The Report is accurate when it says the Sheriff's Office is committed to implementing effective suicide prevention and it is also accurate when it says the Sheriff's Office is fully compliant with state law and the Board of Community Corrections (BSCC).

The Sheriff's Office is committed, and has been committed, to the safety and wellbeing of those incarcerated in our jails. This decades long journey has been a continual effort by a long list of elected Sheriffs. The Sheriff's Office has always looked to be the leader in corrections policies, practices, and outcomes. The Sheriff's Office recently opened the 64-bed Health and Programming Unit; expanded its Jail Based Competency Treatment (JBCT) program from 8 beds to 10 beds; expanded Medication Assisted Treatment (MAT) including partnering with New York University and Community Memorial Health on a multi-year Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP) grant; and sharing the framework and successes of our Therapeutic Inmate Management Unit (TIMU) at several national conferences. In addition, the Sheriff's Office is never satisfied and is always looking for new and innovative ways to improve care and results for all persons entrusted to the care of our detention facilities.

From 2016, the first year of the Grand Jury's evaluation, through 2022, the Sheriff's Office has implemented multiple programs, policies, and practices to reduce the possibility of jail deaths, provide better medical evaluations and care, and help those struggling with addictions or mental health issues. During the seven years of the evaluation period, the Sheriff's Office has implemented our Jail Based Competency Program, the Early Access to Stabilization Services Program, the Therapeutic Inmate Management Program, and the Medicated Assisted Treatment Program. We have also brought in the National Commission on Correctional Health Care (NCCHC) to evaluate our medical and mental health services to provide an independent review and ensure we are meeting or exceeding national standards in these areas. We have also renegotiated our medical contract and expanded our services significantly, with Board of Supervisors approval, because we all recognize how important these services are for incarcerated persons.

The following list highlights the changes and program implementations the Sheriff's Office has undertaken during the Grand Jury review timeframe. The list is not exhaustive but reflects the effort the Sheriff's Office has put into aligning our correctional health care and mental health care to community standards.

- August 2017 – Moral Reconation Therapy and incarcerated person socialization groups added
- 2018 –California Forensic Medical Group (CFMG) becomes affiliated with Wellpath
    - Staffing and procedures change
    - Increased mental health staffing
    - Increased mental health follow up for inmates removed from safety precautions
- December 2018 – Health Intake screening done by a Registered Nurse instead of Custody Staff to incorporate a more in-depth medical and mental health screening
- 2019 – Collaboration with Ventura County Behavioral Health (VCBH) to get inmates admitted on temporary mental health hold while in custody to treat acute suicidal behaviors
- June 2019 - Creation of TIMU
- April 2020 – At-Risk Inmates-Psych/Suicidal & Aggressive Indicator Trackers produced weekly by Crime Analysis
- 2020 – Update Safety Cell/Safety Precautions policy to allow more flexibility in placing incarcerated persons on less restrictive monitoring based on objective factors
- December 2020 – 8 bed JBCT Program established
- October 2021 - Plexiglass covers installed over window frames to reduce ligature attachment points
- February 2022 – Implementation of Animal-Assisted Therapy Program into the TIMU
- July 2022 – After year-long nationwide Request For Proposal, new contract with CFMG approved; increased staffing for medical and mental health staff
- July 2022 – Added medical Captain position to oversee medical and mental health services, TIMU, JBCT, and the Health and Programming Unit
- August 2022 – Implemented the Early Access and Stabilization Services (EASS) program in collaboration with the Department of State Hospitals (DSH) and Wellpath affiliates CFMG and California Health and Recovery Solutions (CHRS) to begin treating IST incarcerated persons waiting to enter JBCT
- October 2022 - Increased JBCT by 10 beds

The Sheriff's Office has taken several proactive steps to reduce the influx of illegal narcotics into the jail that continue to plague our communities. All non-pregnant detainees booked into custody are placed into a body scanner which detects anomalies inside the body. If a detainee is found to have an anomaly, the booking is refused, and the arresting officer must obtain a medical clearance for that detainee. The number of overdose deaths in Ventura County has almost doubled in the past six years. During the same period the overdose deaths in custody have not. As an additional incentive to deter drugs being brought into custody, we have placed amnesty boxes throughout

the booking area and admonish every inmate that they can surrender illegal drugs with no threat of arrest. There are also video monitors in the booking area which illustrate the availability and instructions on how to use Narcan, a drug used to treat life-threatening opioid overdoses. In addition to all staff members carrying Narcan, there are fixed locations in every housing section that have Narcan available for inmates to use without delay.

Lastly, References 01, 03, and 04 cited were reports from various advocacy groups. None of these reports had any content connected to any local detention facilities or incarcerated population.

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)

Response: The Sheriff's Office disagrees wholly with this finding.

This finding is anecdotal in its foundation. The philosophy of the Sheriff's Office is that correctional healthcare is community healthcare. Mortality in the community is largely unavoidable and thus the same standard should be applied when evaluating mortality in a correctional setting. The Sheriff's Office ensures its standards and training go above and beyond state law and state standards to prevent as many adverse outcomes as possible.

Furthermore, any conclusion regarding the four cases of suicide being preventable according to "expert analysis" is hollow. Suicides, especially jail suicides, are complex and individualized and not all suicides, jail or otherwise, are preventable. Reputable mental health professionals in the field of corrections have affirmed that jail suicides are complex and individualized.

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)

Response: The Sheriff's Office partially disagrees with this finding.

Prior to January 1, 2023, there was no requirement to inform the public about the final results of an incarcerated person's death. On January 1, 2023, California Assembly Bill 2761 took effect which requires certain information be released to the public and updated after investigations are complete. The Sheriff's Office has complied fully with the new law. Additionally, the Sheriff's Office recognizes that legal obligations related to the privacy of Protected Health Information do not terminate upon the death of an incarcerated person. The Sheriff's Office considers these privacy rights when releasing information to the public.

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)

Response: The Sheriff's Office partially disagrees with this finding.

The Sheriff's Office agrees that its current practices are compliant with state law and BSCC requirements. Regarding the issue of consistent training on suicide prevention and response measures recommended by the NCCHC, the Sheriff's Office has met, and exceeded, the NCCHC standard. The NCCHC standard requires annual health emergency "man-down" drills. Since May 2021, the Sheriff's Office has conducted joint custody-medical "man down" drills quarterly on each shift at each jail facility.

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)

Response: The Sheriff's Office agrees with this finding.

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)

Response: The Sheriff's Office agrees with this finding.

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)

Response: The Sheriff's Office agrees with this finding.

Should a family member have an immediate concern about the health, and/or well-being of an inmate, they can complete an Inmate Emergency Medical Notification Form located at www.venturasheriff.org. This notification form is immediately routed to the jail Watch Commander and medical personnel. There is a drop-down box specifically for suicide concerns. Family members can also contact public reception either in person or via phone.

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)

Response: The Sheriff's Office disagrees wholly with this finding.

The Sheriff's Office goes to great lengths to detect and confiscate illegal substances from entering any of our jail facilities. Arrestees are searched at least twice by arresting officers prior to booking. Detention Services deputies then conduct a third, and sometimes fourth physical search in booking. When reasonable suspicion arises, and approved by the Watch Commander, a visual strip search of the arrestee is conducted and documented. A fifth search using a whole person body scanner is then conducted for every incarcerated person who is not pregnant.

In addition, we use our patrol K-9s to conduct random drug searches in the jail on a regular basis. And lastly, we offer immunity from criminal charges to arrestees coming into the jail if they will voluntarily surrender illegal substances into our amnesty boxes.

Since the installation of the amnesty boxes at all jail facilities in March 2022, there have been 181 amnesty surrenders through July 23, 2023. This equates to an estimated half-pound of potentially deadly drugs that this incentive has prevented from entering our jails.

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)

Response: The Sheriff's Office disagrees wholly with this finding.

The Ventura County Sheriff's Office currently has seven dogs in our Patrol Services Division. All seven of these dogs are trained in narcotics detection, which includes the ability to locate fentanyl using Scent Logix as the training aid. Our office has only been using Scent Logix (fentanyl) in training for the past year. Previous to that, our dogs were not trained in the detection of fentanyl. Our dogs do not train with the street drug fentanyl directly, as it is extremely dangerous for the dog, and the handler.

Our Detention Services Division does frequently utilize our patrol detection dogs for searches in our housing units. Our handlers are available, and on-call (if not already on duty), on a 24-hour basis, so using contracted resources in this capacity is unnecessary.

Although it would make sense to assume that drug detection dogs in jails would reduce or eliminate overdoses or overdose deaths, the Sheriff's Office did not find any factual evidence in the references used by the Grand Jury that drug detection dogs in a custody setting reduced or eliminated overdoses or overdose deaths. In fact, the reference used by the grand jury for Los Angeles County states clearly that they use drug detection dogs to reduce violence in their jails because drugs in jails are a type of currency and in-custody violence over drugs is a problem for them.

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)

Response: The Sheriff's Office partially disagrees with this finding.

Inmates routinely devise new and unique means to defeat any proactive means taken to prevent self-harm. Just like in the community, correctional health care and mental health care are constantly evolving to new and unique presentations, diagnoses, and methods of treatment.

Deputies and SSTs are trained in detection of suicidal behavior and suicide prevention through our Crisis Intervention Training (CIT) academy. The addition of suicide prevention posters with indicators of suicide ideation and different avenues of notifying jail staff will help inmates find alternate ways to notify staff of potential suicidal inmates. The TIMU identifies inmates at risk of suicide. The TIMU contacts willing inmate families to learn HIPPA compliant inmate triggers and de-escalation techniques. The TIMU creates inmate profiles with this information that is stored with the TIMU. The TIMU uses inmate profiles to create programs that reduce the inmate's risk of suicide.

In reference to the "See Something, Say Something" protocol referenced in Reference 51, this is a training given by the University of Michigan, Department of Public Safety & Security that discusses the types of incidents that should be reported and how to report them; personal safety, prevention and dealing with threats; and suspicious behavior. Reference 51 is a study completed by clinician-researchers at Harvard Medical School and Beth Israel Deaconess Medical Center. The study "results highlight the need to explicitly support patients and families to speak up in real time about perceived errors. Hesitancy to do so represents a real safety gap." The Sheriff's Office, as well as our correctional health care partner CFMG (Wellpath), have always sought out and valued the input of the patient (incarcerated person) to prescribe individual treatment plans for each patient. The Harvard Medical School study was completed using subjects from an urban academic hospital where family members were able to have face-to-face contact with the patient. This is not possible in a correctional setting. Family members are encouraged to, and often do, provide any input they have on an incarcerated person's current or historical medical conditions.

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)

Response: The Sheriff's Office partially disagrees with this finding.

Our current initial and follow-up medical and mental health screening assessments meet the NCCHC standards. However, as is seen not only in a correctional setting, but the community as well, obtaining a complete and accurate health history is only as good as the information being provided by the patient (incarcerated person).

In some cases, a patient's (incarcerated person) reported medical history at intake can be supplemented by community health records, however these are not immediately available to medical personnel during the intake process. Additionally, jail medical staff are often still reliant on a patient (incarcerated person) to report prior hospitalizations, surgeries, primary care providers, etc. Proactive searches for records are conducted in some instances after intake, however this requires significant time and personnel resources, and is not feasible to do universally.

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)

Response: The Sheriff's Office partially disagrees with this finding.

We agree that independent subject matter experts may be able to provide additional insight and increase transparency. However, it is our belief that adding members of the public in the reviewing of incarcerated person's deaths would be counterproductive. Members of the public are not afforded the same privileges and protections to review sensitive and protected medical and legal information discussed during our comprehensive reviews. The Sheriff's Office takes these privileges and protections with the utmost solemnity to protect the patient's (incarcerated person), and their family's, privacy.

The Sheriff's Office would like to reiterate its commitment to safeguarding the lives and property of residents of Ventura County and responding to public concerns in a manner which is fair, unbiased, lawful and promotes neighborhoods free from crime. The foundation of this commitment is built upon the Sheriff's Seven Pillars. Although all are equally important to the stability and success of our Mission, Pillar 6 – Providing Secure and Humane Detention for Incarcerated Individuals, is one that the Sheriff is Constitutionally mandated to do, and all Detention Services personnel, including contract personnel, are dedicated to mission accomplishment.

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)

Response: This recommendation will not be implemented because it is not warranted.

The Sheriff's Office wholeheartedly rejects this recommendation based on the fact that we already have oversight from two outside agencies whose sole purpose is to review, recommend best practices, and ensure implementation to maintain accreditation.

The Sheriff's Office has oversight from the Board of Community Corrections (BSCC) and the National Commission on Correctional Health Care (NCCHC). We are accredited by BSCC and are in the process of getting accreditation from NCCHC. The recommendation that the Sheriff's Office needs more oversight from the public and independent subject matter experts regarding jail deaths is duplicative.

The purpose of BSCC and NCCHC oversight and accreditation is to have independent subject matter experts from multiple disciplines continuously review our policies, procedures, and operations and provide evidence-based recommendations.

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)

Response: This recommendation has already been implemented.

Since May 2021, Detention Services staff (deputes and SSTs) and CFMG (Wellpath) employees have jointly conducted quarterly suicide prevention training to include "man-down" drills.

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)

Response: This recommendation has already been implemented.

The Sheriff's Office and CFMG (Wellpath) currently have effective communication protocols in place reference suicidal incarcerated persons. The Medical Captain and the TIMU Sergeant have weekly meetings with medical and mental health staff to review and update individual treatment plans based on all available objective factors to ensure effective treatment of underlying mental health disorders and provide a safe environment.

CFMG (Wellpath) provides the Sheriff's Office quarterly status reports that also include Continuous Quality Improvement (CQI) initiatives. These quarterly status reports are also reviewed by our contract monitor, NCCHC.

The Sheriff's Office and CFMG (Wellpath) are currently evaluating modifying process and program protocols to take into account the recent opening of the Health and Programming Unit and maximize opportunities for efficiency and process improvement that facility affords us.

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)

Response: The first part of this recommendation has not yet been implemented but will be implemented with an expected completion date of September 1, 2023. The second part of this recommendation will not be implemented as it is not reasonable.

Suicide prevention posters that align with Ventura County Behavioral Health suicide awareness and prevention will be added to the video monitors in the visiting area of each jail facility. The same posters will be added to the video monitors in the booking and release areas of the Pre-Trail Detention Facility, as well as being posted in housing unit common areas, tablets, and kiosks by the same date. Currently, it is not logistically feasible to add suicide hotline information to the beginning of each incarcerated person's phone call.

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)

Response: This recommendation has not yet been implemented but will be implemented with an expected completion date of October 1, 2023.

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)

Response: This recommendation requires further analysis.

The Sheriff's Office believes the need for dedicated passive-alert drug detection dogs at each facility is not warranted, based on prior experience with drug detection dogs at local jail facilities and the success of other jail drug relinquishment programs. However, the Sheriff's Office will further analyze this recommendation and provide the County Executive Officer and the Board of Supervisors with a proposal for such, if determined to be appropriate, by September 12, 2023.

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)

Response: This recommendation will not be implemented as it is not warranted.

The "See Something, Say Something" protocol referenced in Finding 09 is not applicable in a correctional setting. The Sheriff's Office already has a robust protocol to include the patient (incarcerated person), and family if willing and authorized, in the planning of their (patient) individualized treatment plan.

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)

Response: This recommendation has not yet been implemented but will be implemented March 2024.

It is the goal of the Sheriff's Office and CFMG (Wellpath) to provide the Board of Supervisors and the public with an annual report highlighting contract performance metrics to include training and suicide prevention efforts.

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)

Response: This recommendation has already been implemented. Refer to Finding-10 Response.

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)

Response: This recommendation has already been implemented. Refer to Finding-02 Response.

Thank you for the opportunity to respond to this Grand Jury report. If additional explanation is needed, please feel free to contact Assistant Sheriff Shane Matthews at 805-654-2305.

Sincerely,

Jim Fryhoff
Sheriff