San Diego County
SHERIFF'S DEPARTMENT

The California State Auditor (CSA) conducted an examination of the San Diego County Sheriff's Department's detention facilities and the care being provided to individuals in our custody. The evaluation reviewed in-custody deaths at San Diego County Sheriff's Department jails over the last 15 years.

Of the in-custody deaths that occurred, almost 50 percent were a result of natural causes and about 45 percent were a result of accidental deaths, to include suicides and overdoses. During calendar years 2020 and 2021, Sheriff's Department employees in the jails responded to 314 incidents of suspected opioid overdose and deployed 848 doses of NARCAN (an opioid antagonist) saving hundreds of lives.

We appreciate the CSA taking the time to review our current policies and making recommendations for ways we can improve the care provided to individuals housed in our facilities.

The CSA has made several recommendations for ways we can improve the services we currently provide. Their recommendations are in the following areas:

- **Intake Screening**
- **Medical & Mental Health Follow-Up**
- **Safety Checks**
- **Sworn Discovery of Medical Emergency**
- **In-Custody Death Follow-Up**
- **Critical Incident Review Board**
- **Citizen's Law Enforcement Review Board Integration**

Intake Screening

CSA Recommendations:

Revise its intake screening policy to require mental health professionals to perform its mental health evaluations. These evaluations should include a mental health acuity rating scale to better inform individuals' housing assignments and service needs while in custody. The Sheriff's Department should communicate the acuity rating as it assigns to individuals to all detentions staff overseeing them.

The Sheriff's Department concurs with the auditor's assessment that Qualified Mental Health Providers (QMHP) are the more appropriate staff to conduct the mental health screening portion of the intake process. We thank the San Diego County Board of Supervisors for approving the funding for additional staffing. We're currently in the process of recruiting and hiring licensed mental health clinicians to fill these positions.

Additional staffing will allow us to provide a comprehensive screening process utilizing the electronic health record, in accordance with National Commission for Correctional Health Care (NCCHC) standards. Some identified QMHP staffing duties would be to conduct the Behavioral Health (BH) screening, complete a risk/needs assessment, to include substance use disorder (SUD). The assessment would determine a behavioral health acuity rating, schedule psychiatric appointments, schedule follow up QMHP appointments, assess for the need of placement into our Inmate Safety Program (ISP) and obtain Release of Information authorizations.

QMHPs and nursing staff working in collaboration at the initial intake assessment and throughout a patient's incarceration promotes a comprehensive whole person model of care.

Create a policy requiring health staff to review and consider each individual's medical and mental health history from the county health system during the intake screening process.

Currently, San Diego County does not have an interconnected health information exchange. However, our health staff does have access to the Health and Human Services Agency- Cerner Community Behavioral Health (CCBH) as of April 2021. QMHPs can review records at any point in the patient's stay. The planned integration of a QMHP into the intake process for behavioral health screening will fulfill this recommendation.

In addition to having access to review community behavioral health records, the Sheriff's Detention Services Bureau contributes to this community database by recording and entering mental health care provided while the patient is in our custody as part of the county's continuum of care.

Our staff also has access to the Health and Human Services Agency – San Diego Immunization Registry (SDIR) to verify a patient's vaccination status. SDIR is limited to vaccinations given in San Diego County.

Medical & Mental Health Follow-Up

CSA Recommendations:

Revise its policy to require that nurses schedule an individual for an appointment with a doctor if that individual has reported to the nurse for evaluation more than twice for the same complaint.

The Sheriff's Department concurs with the auditors' assessment that a revision is necessary to address the process for medical/mental health referral after two requests. The Sheriff's Medical Services Division intends to implement this recommendation. When a patient presents for health care services more than two times with the same complaint and has not seen a provider, they will receive an appointment to do so.

Revise its policy to require that a nurse perform and document a face-to-face appraisal with an individual within 24 hours of receipt of a request for medical services to determine the urgency of that request. Revise its policy to require that a member of its health staff witness and sign the refusal form when an individual declines to accept necessary health care.

The Sheriff's Department concurs a timely medical response to patient concerns is extremely important. We are committed to the health and well-being of our patients, and are developing safeguards to ensure a timely, efficient re-engagement of both medical and mental health services.

We're currently focused on a more nursing centric model. For health staff, we are in the process of embedding nursing staff at the ward level, assigning nursing staff to most housing units in support for the Primary Care nursing model. Nurses will be there to perform face-to-face assessments of their assigned patients (on the floors and during sick call) and involved in counseling and advocacy efforts for every refusal.

Revise its policy to require more frequent psychological follow up after release from the inmate safety program to at least monthly check-ins.

The Sheriff's Department will reevaluate our policies reference psychological follow-ups. We currently adhere to the recommendations set forth by Dr. Lindsay Hayes, a nationally recognized expert in the field of suicide prevention within custodial settings. The Sheriff's Department's current planned expansion and hiring of additional mental health professionals will allow for more frequent encounters with patients in our care.

Safety Checks

CSA Recommendations:

Revise the safety check policy to include the requirement for staff to check that an individual is still alive without disrupting the individual's sleep.

The Sheriff's Department will reevaluate current policy and incorporate best practices. We are exploring technologies to assist with monitoring a "proof of life" for individuals in custody with minimal sleep disruption. Our planned integration of Body Worn Cameras (BWC) into the custodial setting will greatly assist in showing the point of view each deputy has during the safety checks.

Develop and implement a policy requiring that designated supervising sworn staff conduct audits of at least two randomly selected safety checks from each prior shift. These audits should include a review of the applicable safety check logs and video footage to determine whether the safety checks were performed adequately. In addition, the policy should require higher-ranking sworn staff to conduct weekly and monthly audits of safety checks. The policy should also require each facility to maintain a record of the safety check audits that staff perform.

Line supervisors conduct electronic log reviews every shift. This review includes ensuring the timeliness of safety checks in accordance with established Policy & Procedures. Our current practice requires supervisors conduct video audits of random safety checks. These practices will be clearly defined and formalized into policy.

Sworn Discovery of Medical Emergency

CSA Recommendation:

Revise its policies to require that sworn staff members immediately start CPR without waiting for medical approval, as safety procedures allow.

Sworn staff members do not require approval from medical services to start CPR. Per DSB Policy and Procedure section M.6, "Any life-threatening medical emergency shall trigger a 911 request for a paramedic emergency response team. Sworn and health staff shall initiate emergency response and basic lifesaving measures until relieved by the paramedic emergency response team."

In-Custody Death Follow-Up

CSA Recommendations:

Staff will provide a written report of each 30-day medical review to its management.

The Sheriff's Department concurs with this recommendation.

When warranted, the report should specify recommendations for changes to prevent future deaths.

The Sheriff's Department concurs with this as it relates to the perspective of the Chief Medical Officer or the Director of Mental Health's review of the case.

The 30-day medical review should determine the appropriateness of clinical care; assess whether changes to policies, procedures, or practices are warranted; and to identify issues that require further study.

The Sheriff's Department concurs with this as it relates to the perspective of the Chief Medical Officer or the Director of Mental Health's review of the case. There are other processes currently in place to look for policy, training, or accountability issues following critical incidents.

Critical Incident Review Board

CSA Recommendations:

Revise its policy to require that the Critical Incident Review Board review natural deaths.

In July 2021, the Division of Inspectional Services (DIS), Sheriff's Legal Affairs, and CIRB board members evaluated potential updates to policy and procedures section 4.23 – Department Committees and Review Boards. This assessment included reviewing in-custody deaths deemed natural by the Medical Examiner's Office, as the auditors recommend. This, along with other changes are anticipated to be in a pilot phase beginning February 2022. Historically, if a natural death is deemed to have potential issues of any nature it may be presented to CIRB at the discretion of the board members. Also, the Chief Medical Officer and appropriate medical staff conduct a mortality/morbidity review of each in-custody death for their determination of any changes that are needed related to medical care for incarcerated individuals.

Require the Sheriff's Department to make public the facts it discusses and recommendations it decides upon in the Critical Incident Review Board meetings to establish a separate public process for reviewing deaths and making necessary changes.

CIRB presentations allow the Sheriff's legal advisor and the various commands the ability to review critical incidents to identify issues that should be addressed in various areas, including, but not limited to, training, policies, procedures, staffing, and equipment. The confidential environment provided by the CIRB is essential to the free exchange of ideas and concerns. Effectiveness and thoroughness would likely be diminished if the attorney-client privilege is removed, or information is required to be disclosed during pending, or anticipated litigation. Much of the information presented in CIRBs is intended for individuals who have a vast familiarity and understanding of law enforcement or detention operations, department policies, and state and federal laws, and may contain confidential information including criminal history, medical history, and peace officer personnel records.

Citizen's Law Enforcement Review Board Integration

CSA Recommendations:

Revise its policy to include CLERB in its immediate death notification process.

Revise its policy to allow a CLERB investigator to be present at the initial death scene.

We agree with this recommendation and this new procedure will be implemented this month, February 2022. CLERB officers will be notified and respond to death scenes related to in-custody-deaths and officer-involved shootings.

Revise its policy to encourage its staff to cooperate with CLERB's investigations, including participating in interviews with CLERB's investigators.

The CLERB has subpoena powers for in person sworn staff interviews. In 2003, the CLERB discontinued issuing Sheriff's Department sworn staff interview subpoenas and opted for written responses due to Public Safety Officers Procedural Bill of Rights (POBAR) conflicts where ultimately the interviews did not benefit the CLERB's investigations. The CLERB continues to have subpoena powers. This recommendation should be re-directed to the CLERB for its review to change its current practice and exercise its authority to issue subpoenas to Sheriff's sworn staff.

In conclusion, we welcome this audit and the recommendations set forth by the California State Auditor. We will consider every recommendation and implement appropriate changes to provide the best care for individuals in our custody.

Here's a link to the full JLAC report.