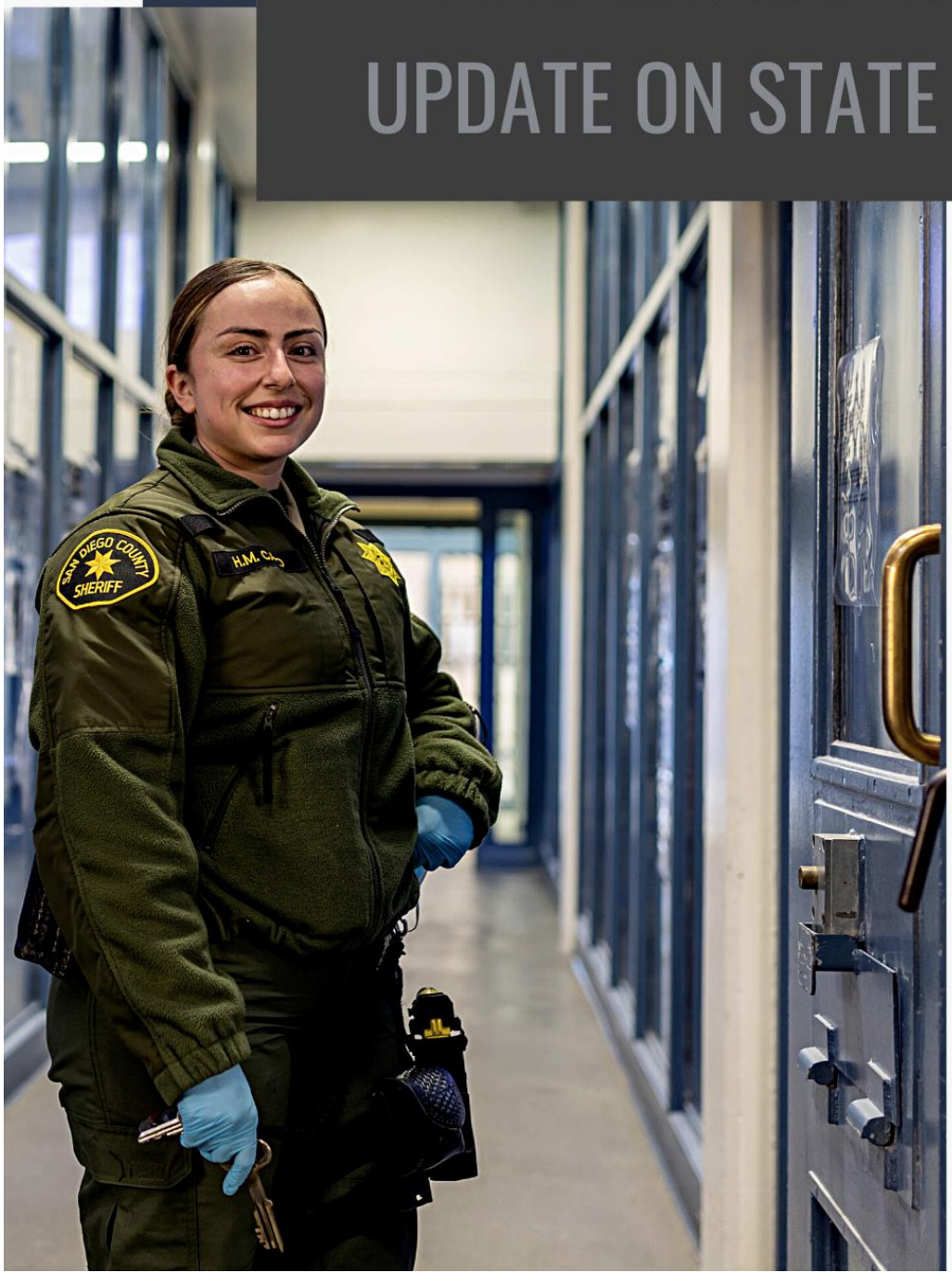
SAN DIEGO COUNTY
SHERIFF'S DEPARTMENT

PROGRESS REPORT

UPDATE ON STATE JAIL AUDIT



2023

Committed to Improving

A Progress Report One-Year After the State Audit on County Jails

On February 3, 2022, the California State Auditor released their report to the Governor and legislative leaders titled: "*San Diego County Sheriff's Department: It has failed to Adequately Prevent and Respond to the Deaths of Individuals in Its Custody*" (Audit Report)[1]. The report provided findings over the last 15-years on data, protocol, and prevention procedures related to in-custody deaths of incarcerated individuals in the care of the San Diego County Sheriff's Department (Sheriff's Department).

During the extensive 6-month audit, representatives from the State Auditor's Office were provided access to Sheriff's Department records of in-custody deaths, policies, procedures, facility maintenance, and staff. The Department was cooperative and transparent during the audit review process. Upon the release of the Audit Report, and its accompanying recommendations, the Sheriff's Department issued a detailed response to each recommendation providing further information and context as it aligned to the bigger effort of improving the custodial setting in county jails[2].

Over the course of the past year, the Sheriff's Department remained steadfast in its commitment to improving conditions in county jails. The Sheriff's Department is undergoing changes to improve its healthcare service delivery model by renovating aging facilities, increasing staff, and implementing new programs and initiatives. The goal of these changes is to improve overall health care and treatment for those in our custody, improve rehabilitation opportunities, and reduce recidivism.

"Accountability, transparency, and the genuine commitment to doing better are the drivers to creating a new level of care to individuals in custody while supporting the needs of our detentions team."
Sheriff Kelly Martinez

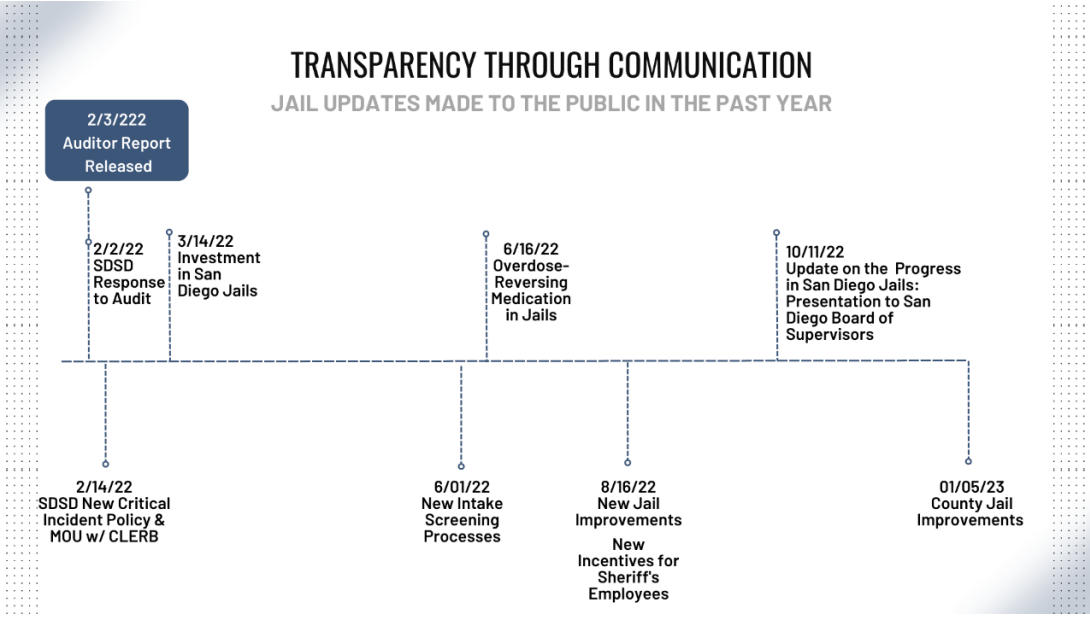
[1] **California State Auditor Report on San Diego County Jails https://www.bsa.ca.gov/reports/2021-109/index.html**
[2] **Sheriff's Department Response to State Audit of County Jails https://www.sdsheriff.gov/home/showpublisheddocument/4717/637794797354130000**

Holding Ourselves Accountable and Transparent

Throughout our history and especially in the past year, the Sheriff's Department has made a concerted effort to keep representatives from the San Diego State Legislative Delegation apprised of areas of interest, while maintaining lines of communication with the San Diego County Board of Supervisors (Board) and our communities. The Board has received updates on the progress of implementing new programming and initiatives across the jail system to prevent further deaths, in addition to hosting a formal Board Meeting presentation focused on the progress being made in San Diego County jails. Board support of the Sheriff's Department initiatives and investment in improving jail infrastructure and services, while bolstering staffing needs, demonstrates the collective sense of urgency and attention to improving the safety and security for those in our custody.

Community dialogue has also taken place as the Sheriff's Department met with community advocates, racial justice groups, as well as the San Diego County Human Relations Commission. These mutually beneficial exchanges facilitated opportunities for not only the Sheriff's Department to educate and share our initiatives and actions which are underway to improve conditions, but to have meaningful dialogue with community members, especially those who advocate for families that had loved ones die while in custody.

While the State Auditor indicated "*no single entity has sufficient oversight authority over the Sheriff's Department to require it to make meaningful changes… we believe that the Legislature should direct the Sheriff's Department to implement the changes we detail below,*" the Sheriff's Department respectfully disagrees with this statement. Sheriff Martinez has and continues to keep the efforts of improving jails at the forefront of her priorities. She believes the only way to develop and maintain the public's trust and confidence in this process is to promote transparency through open and honest communication.



Progress Report on State Audit Recommendations

The following section provides an update on the progress the Sheriff's Department has been implementing as it relates to the recommendations provided in the State Audit. The Audit focused on many recommendations directed towards the State Legislature, the San Diego Sheriff's Department, the Board of State and Community Corrections, and the San Diego County Citizens' Law Enforcement Review Board. For the purpose of this progress report, the Sheriff's Department will speak to recommendations directly impacting its operations and the status of either the completion, the progress, and/or if other action has been taken.

Several policy changes provided in the following section have been standard practices of the Sheriff's Department, however, in early 2023, they will be codified into policy to align with the Department's goal of earning accreditation from the National Commission on Correctional Health Care (NCCHC).

RECOMMENDATIONS

Legislature—All Sheriff's Departments and the California Department of Justice

To ensure that all sheriff's departments accurately report deaths that occur from incidents or conditions in county jails, the Legislature should amend state law to require sheriff's departments to report to the attorney general individuals who are released from custody after being transported directly to a hospital or similar medical facility and subsequently die in the facility. It should also amend state law to require sheriff's departments to provide the attorney general with all facts concerning the death, such as the cause and manner. The California Department of Justice should annually publish this information on its website.

Since 2021, the San Diego County Sheriff's Department has been reporting to the California Department of Justice, if the Sheriff's Department became aware of any individual who was released from custody at a medical facility and subsequently died there. Additionally, in 2022, the Governor signed Assembly Bill 2761, which mandates sheriff's departments shall report the following information on their public internet websites (Penal Code section 10008(a)):

- The full name of the agency with custodial responsibility at the time of death;
- The county in which the death occurred;
- The facility in which the death occurred, and the location within that facility where the death occurred;
- The race, gender, and age of the decedent;
- The date on which the death occurred;
- The custodial status of the decedent, including, but not limited to, whether the person was awaiting arraignment, awaiting trial, or incarcerated; and
- The manner and means of death

The San Diego County Sheriff's Department on its own initiative has been providing similar data over the past two years in its public website www.sdsheriff.gov "Open Data Portal" and will be expanding its reports to include the additions listed in the new statute, which went into effect on January 1, 2023.

Legislature—San Diego Sheriff's Department

To ensure that the San Diego Sheriff's Department identifies individuals' medical and mental health needs at intake, the Legislature should require it to revise its policies to better align with best practices, as follows:

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

  The Department is actively moving toward providing 24-hour mental health care in the facilities, including the availability of mental health professionals during the intake process at the receiving facilities. This includes hiring additional mental health staff and contracting for services with our current provider, NaphCare. We have implemented in-depth mental health care screening for every individual during the booking process. This includes utilizing Qualified Mental Health Professionals and tools like the Columbia Suicide Severity Rating Scale (C-SSRS) to better evaluate suicide risk and refer individuals to the appropriate mental health resources sooner. This is documented in our electronic healthcare record keeping system for referral and tracking.

  We have looked at the viability of implementing a mental health acuity level rating scale[3] to assist in the housing process, however, they are very system-specific and through our research we have learned simply mirroring another county is not feasible. The San Diego Sheriff's Department classifies and houses our incarcerated population based on several criteria including but not limited to current charges, criminal sophistication, ability to maintain in main line housing, documented safety risks and past behavior/actions while incarcerated. Making the shift to housing individuals by acuity level would create a need for acuity-based housing for each classification level, to include those who need to be kept separate for security reasons, those in protective custody, and other unanticipated housing issues. With this model, there is also a larger potential for the use of administrative separation housing for those who cannot remain in the general incarcerated person population, something we would like to steer away from as it limits access to programming opportunities and rehabilitative services.

- **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.**

  Unlike many other counties, San Diego does not have a coordinated county health system or shared electronic health care records system. As a result, we cannot meet this recommendation as written. However, in May 2022, by way of our contract with NaphCare, jail medical staff continued using TechCare for all health care records. We were also able to gain access to SureScript, a system allowing

[3] A mental health acuity rating scale is an assessment tool used to identify the amount of mental health resources needed for an incarcerated person at the time of assessment, e.g., acute, moderately severe, severe, moderate, mild, minimum.

staff to verify prescription medication history to assist with identifying previously diagnosed medical and mental health treatment, facilitate dispensing medications sooner, and decrease the timeline to provide follow-up care. Medical and mental health staff also gained access to StatCare, a 24/7 telemedicine provider, available for use when a provider is not on-site, and a consultation is needed. This system is used to supplement provider staffing and reduce wait times for addressing medical and mental health requests.

In April 2021, Qualified Mental Health Providers (QMHP), such as mental health clinicians, psychologists, psychiatrists, and psychiatric technicians, were granted "read-only" access to Cerner Community Behavioral Health (CCBH), a system currently utilized by San Diego County Mental Health. This breakthrough allowed QMHP's to review records at any point in the patient's custody, including during intake, to assist with determining treatment while in custody and appropriate housing. Additionally, the Sheriff's Department and County of San Diego Health and Human Services Agency (HHSA) are currently working collaboratively to create an interface between Cerner and TechCare to improve health information accessibility to our providers. The sharing of information with our community partners will facilitate a bilateral continuity of behavioral health care between agencies to positively impact patient care and promote the coordination of community care.

In June 2022, the Department also implemented voluntary drug and alcohol screening at intake. This process supplements questions from medical staff at intake and is used to confirm if someone is under the influence of drugs or alcohol. The results along with Clinical Institute Withdrawal Assessment Alcohol Scale (CIWA) and Clinical Opiate Withdrawal Scale (COWS) scoring allow for better treatment and management of withdrawal symptoms starting at intake and following an individual through their participation in the medication-based detoxification program for opioid and alcohol withdrawal.

To ensure that the Sheriff's Department provides the necessary medical and mental health care to individuals incarcerated in its facilities, the Legislature should require it to do the following:

- **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.**

  In August 2022, the Department began the practice of requiring nurses to schedule an individual for an appointment with a provider upon receipt of two requests from an incarcerated individual regarding any condition. This is both a NaphCare protocol and National Commission on Correctional Health Care standard and will be adopted into the official department policies and procedures in early 2023.

- **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.**

  The nursing staff is currently doing face-to-face assessments within 24-hours of receipt of a request for medical services at the facilities. This process was implemented on December 15, 2022, and the practice follows National Commission on Correctional Health Care standards. This practice will be adopted into department policies and procedures in early 2023."

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

  The Department will be updating its policy in early 2023 which will integrate new language that will state: "*patients will be reassessed within 24-hours of being discharged from suicide watch by a qualified mental health professional or appropriately trained qualified health care professional on days where no qualified mental health professional is onsite*." This effort came about in late 2022 as part of the onboarding process with NaphCare. Therefore, the policies will require that Qualified Mental Health Providers follow-up with an individual within 24-hours of discharge from the Detentions Safety Program and will require at least monthly check-ins until the end of their incarceration.

- **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.**

  Patients have the right to refuse medical and mental health care while in Sheriff's custody. Every effort is made to accurately document care refusals by incarcerated persons and varies depending on the situation at-hand, for instance:

  Medication Refusals - In the event a patient refuses prescribed medication, the nurse will counsel them on the potential impact and try to convince them to take the prescribed medication. If the patient declines, they will be asked to sign the refusal form, which will be witnessed by the nurse. If the patient refuses to sign, the nurse will sign the form and the accompanying sworn staff member will sign as a witness. A copy of the form will be placed into the health records system (TechCare) for reference.

  Medical Appointment Refusal - The patient will be counseled by medical staff, which may include a provider or nurse, regarding the potential effects on their health of missing the appointment and try to convince them to attend. If the patient still refuses the appointment, the patient will be given an opportunity to sign the medical refusal form. In the event the patient refuses to sign the refusal form, the nurse will sign the form. A copy of the form will be placed into the health records system (TechCare) for reference.

  Mental Health Refusal - If the patient refuses to meet with the Mental Health Clinician (MHC) at first attempt, the MHC will sign the refusal and have the patient sign the refusal as well. If the patient is unwilling to sign the refusal the MHC will sign the form as well as the accompanying sworn staff member, who will sign as a witness. A copy of the form will be placed into the health records system (TechCare) for reference. Additionally, the MHC will mark the scheduled appointment as "complete" and document as "refused" in their electronic health record and reschedule for a second attempt. Subsequent refusals may require additional follow-up.

  Psychiatry Appointment Refusal - If the patient refuses to meet with a psychiatrist, the rescheduling process is handled by Naphcare, and may include in-person or tele-psychiatry appointments.

To ensure that sworn staff properly perform safety checks, the Legislature should require the Sheriff's Department to do the following:

- **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.**

  Safety checks shall be conducted at least once within every 60-minutes. Efforts are made to not disturb a sleeping incarcerated person and still comply with the requirements of looking at the individual for any obvious signs of medical distress, trauma, or criminal activity. However, sleep patterns of the entire incarcerated population vary throughout the day, and it is not feasible to have a policy requirement that incorporates not waking an individual. Checking for obvious signs of medical distress or trauma may require waking the individual as some sleep in such a manner that it is difficult to meet the policy requirements without doing so.

  Hard count is conducted twice per day (1000-1200 and 2100-2300 hours). This count involves verbal or physical acknowledgment to the deputy from each incarcerated person. Another mechanism is through the visual verification of the incarcerated person's identity by comparing the person's wristband photo to the person's face to the Jail Information Management System record.

  There are four soft counts (0400-0500, 0600-0700, 1700-1800, and 1830-1930). The soft counts coincide with mealtimes and the start or end of shift. All soft counts require verbal or physical acknowledgment from each incarcerated person and count of the number of incarcerated persons in the module/area/unit. The incarcerate person needs to respond during these counts and disturbing sleep may be necessary.

- **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 members perform.**

  Current policy requires a sworn supervisor to review safety checks of one complete shift from each team on an ongoing monthly basis. The Jail Information Management System (JIMS) Area Activity Logs and corresponding video footage shall be utilized for the review of safety checks. Sergeants already review the JIMS Logs twice per shift and the Lieutenant once per shift. Video footage may vary on quality and availability depending on facility. As the body-worn camera program expands across all detention facilities, the Sheriff's Department has been able to supplement facility CCTV footage and can capture audio interaction between deputies conducting checks with incarcerated persons. The completed reviews are documented and reviewed via chain of command by the facility commander for which the review was conducted. Once reviewed and approved, records of the reviews are electronically retained at each facility for two years. Facilities are not limited on the number of reviews

that can be conducted. Supplemental reviews may be conducted by whichever means the facility commander finds appropriate.

To ensure that department staff promptly respond to unresponsive individuals, the Legislature should require the Sheriff's Department to revise its policies to require that sworn staff members immediately start CPR without waiting for medical approval, as safety procedures allow. The Legislature should also require that the Sheriff's Department provide sworn staff with additional training for starting CPR immediately and how to properly alert medical staff.

Since April 2016, Detentions Policy required sworn staff to immediately call for a medical response, activation of 9-1-1 emergency medical services, and initiate CPR, as needed. In December 2022, the policy section reading, "*Absent rigor mortis or post-mortem lividity, all inmates with a potential for resuscitation shall be provided basic life saving measures*," was removed to address the State Audit's concern regarding sworn staff failing to initiate CPR given what they believed were exceptions as listed above. This change was also addressed in the Detentions Training Unit's CPR/First Aid Class, which includes how to properly communicate via radio for 9-1-1 and medical staff notification of an emergency, as well as initiate CPR and utilize the Automated External Defibrillator (AED) as appropriate. To emphasize the importance of implementing these changes, Command Staff regularly attends the required CPR First Aid Training classes to reinforce these changes to staff in training and is supplemented by ongoing collaborative training involving sworn and medical staff in emergency response at each facility.

To ensure that the Sheriff's Department properly assesses the reasons for each in-custody death and makes prompt changes as necessary in response, the Legislature should require it to revise its policy to specify the following:

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

  Department policy states: "*A medical review of every in-custody patient's death shall be conducted within 30 days*." The Department facilitates several reviews, including a review by the In-Custody Death Advocate and Department Investigation Coordinator within a week of an incident. This review encompasses a synopsis of the incident, response by involved employees, and an update to the investigation. This review is completed prior to the Critical Incident Review Board's (CIRB) presentation. CIRB presentations consists of affected facility command, Division of Inspectional Services, Homicide, and Department Command Staff. The preliminary review addresses initial areas of the appropriateness of clinical care; assesses whether changes to policies, procedures, or practices are warranted; and identifies issues that require further study. Due to the early nature of these reviews, neither of these reviews have access to the Medical Examiner's reports as those are unavailable at the time of the reviews.

  It should be noted that due to workload, the Medical Examiner's Official Cause of Death may take months to determine, which could affect the 30-day review report completed by the Chief Medical

Officer. Therefore, the Sheriff's Department finds its two reviewing mechanisms to be effective and necessary to identify policy violations, changes that need to be made, or deficiencies in training.

In-custody death response and prevention measures are highly scrutinized at all levels during the reviews and can include items related to response, training, and current policies and practices. Recommendations can be made by anyone in the chain of command including facility and Department Command staff, as well the In-Custody Death Advocate and Department Investigation Coordinator, the CIRB Board, and the Chief Medical Officer. Recommended improvements are tracked by the Division of Inspectional Services to ensure implementation.

- **When warranted, the report should specify recommendations for changes to prevent further deaths.**

In-custody death response and prevention measures are highly scrutinized at all levels during the reviews and can include items related to response, training, appropriateness of care, and current policies and practices. Recommendations can be made by anyone in the chain of command including facility and Department Command Staff, as well the In-Custody Death Advocate and Department Investigation Coordinator, CIRB Board, and the Chief Medical Officer. Recommended improvements are tracked by the Division of Inspectional Services to ensure implementation.

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

In-custody death response and prevention measures are highly scrutinized at all levels during the reviews and can include items related to response, training, appropriateness of care, and current policies and practices. Recommendations can be made by anyone in the chain of command including facility and Department Command Staff, as well the In-Custody Death Advocate and Department Investigation Coordinator, CIRB Board, and the Chief Medical Officer. Recommended improvements are tracked by the Division of Inspectional Services to ensure implementation.

To improve oversight of in-custody deaths and encourage meaningful action to prevent future deaths, the Legislature should require the Sheriff's Department to revise its policy to require that the Critical Incident Review Board review natural deaths.

On March 29, 2022, Sheriff's Policies and Procedures Section 4.23 was amended to require the Critical Incident Review Board review all in-custody deaths.

To increase the transparency of the Sheriff's Department's reviews of in-custody deaths, the Legislature should require the Sheriff's Department to either make public the facts it discusses and recommendations it decides upon in the relevant Critical Incident Review Board meetings or to establish a separate public process for internally reviewing deaths and making necessary changes.

Upon completion of the Critical Incident Review of an in-custody death, the Sheriff's Department will publish a brief synopsis of the facts it discussed of the incident, any recommendations or action items,

policy revisions resulting from the incident review, and the dates those items were accomplished. Currently, the Sheriff's Department is completing and posting these reviews for in-custody deaths that occurred beginning and after January 1, 2022.

To ensure that the Sheriff's Department provides complete and prompt assistance to CLERB's investigations, the Legislature should require the Sheriff's Department to do the following:

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

  On February 14, 2022, the Sheriff's Department signed a Memorandum of Understanding[4] to include a CLERB investigator in the death notification process.

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

  On February 14, 2022, the Sheriff's Department signed a Memorandum of Understanding to allow a CLERB investigator to have limited access to death scenes.

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

  The Sheriff's Department has a well-established record of cooperating with and supporting CLERB's investigations. We are responsive to CLERB subpoenas, sworn employees are required to respond to CLERB queries via electronic Sheriff's Employee Response Forms (eSERFs), and have the option to speak with CLERB investigators during in-person interviews.

Conclusion

The San Diego Sheriff's Department has leveraged the State Audit as an opportunity to reimagine the way services can be offered and delivered to those in its care and custody. Going beyond the audit recommendations, the Sheriff's Department has elevated its forward-thinking strategy by partnering with local and state entities to enhance its service delivery, address staffing shortfalls, bolstering medical and mental health care, creating new programming and processes, while using technology to our advantage.

[4] **SDSD and Citizen Law Enforcement Review Board MOU**