

# Preventable Deaths in Orange County Jails



**GRAND JURY 2017-2018**

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## **SUMMARY**

Like people on the outside, jail inmates die. However, over the last three years, 44% of custodial deaths in Orange County jails may have been preventable. Delays in treatment, failure to identify health threats at intake, failure to diagnose serious mental illness, and lack of timely referral to a healthcare professional have increased the chances that an inmate will not make it out alive. Modest changes in procedures at a relatively low cost could improve survival rates.

## **REASON FOR THE STUDY**

Death in jail, whatever the cause, often provokes public suspicion because of the perceived adversarial relationship between inmates and the correctional system. In July 2017, the Grand Jury read in local newspapers about an inmate allegedly killed by his cellmate inside the Orange County Men's Central Jail. This incident prompted the Grand Jury to research other custodial inmate deaths to identify ways to improve inmates' health and longevity. While safety and security are important in the jail system, inmate health care is also essential and is a critical function that jails must provide under challenging circumstances.

## **METHOD OF STUDY**

The Grand Jury's research began by reviewing the Orange County District Attorney's (OCDA) Custodial Death Investigation Reports. During the period 2014-2017, thirty-four inmates died in custody or within hours of release; these cases were selected for study. After a thorough review of each OCDA report, the Grand Jury reviewed the following documents for comprehensive details on each of these deaths:

- medical intake forms completed by Correctional Health Services (CHS) personnel at the Intake Release Center (IRC)
- all hospital or medical records created during the inmate's incarceration

- autopsy and toxicology reports
- CHS Morbidity/Mortality Review (MMR), required by law within thirty days of an inmate's death
- inmate jail records from the Orange County Sheriff's Department (OCSD)

In its study of the thirty-four deaths, the Grand Jury reviewed a total of 138 reports issued by six County sources.

Particular attention was given to the amount of time in custody before death. The Grand Jury considered active medical conditions and psychological factors at time of intake, medical history, including drug or alcohol addiction, and documented cause of death. Circumstances during incarceration were studied: medications, promptness of medical care, housing assignments, and treatment when a medical emergency alert (man down) was called. Hospital and emergency room records were reviewed, as were medical record procedures, involvement of deputies and medical personnel, and the implementation of any corrective action.

Members of the Grand Jury toured all Orange County jail facilities. They visited the Central Men's Jail and IRC to analyze the medical operations in detail, and toured the toxicology unit in the Orange County Crime Laboratory.

Grand Jury members attended three Coroner Case Reviews in August 2017, November 2017, and March 2018, covering seventeen custodial deaths. They also attended a Sheriff's Department Inmate Death Review.

Interviews were conducted with members of CHS management and personnel who oversee all inmate health care for the County jails. The Orange County District Attorney's office was also interviewed. The Grand Jury examined the County's process for reporting autopsies.

The Grand Jury reviewed the June 2017 report, "Orange County Jails," issued by the American Civil Liberties Union of Southern California. The Grand Jury obtained from the state Attorney General details of all custodial death cases filed by the OCSD.

Because federal law protects the privacy of medical records, the Grand Jury issued three subpoenas to obtain crucial medical details on the inmates who died.

Additional information came from newspaper articles, websites, and government reports. These resources can be found in the Reference and Appendix sections at the end of this report.

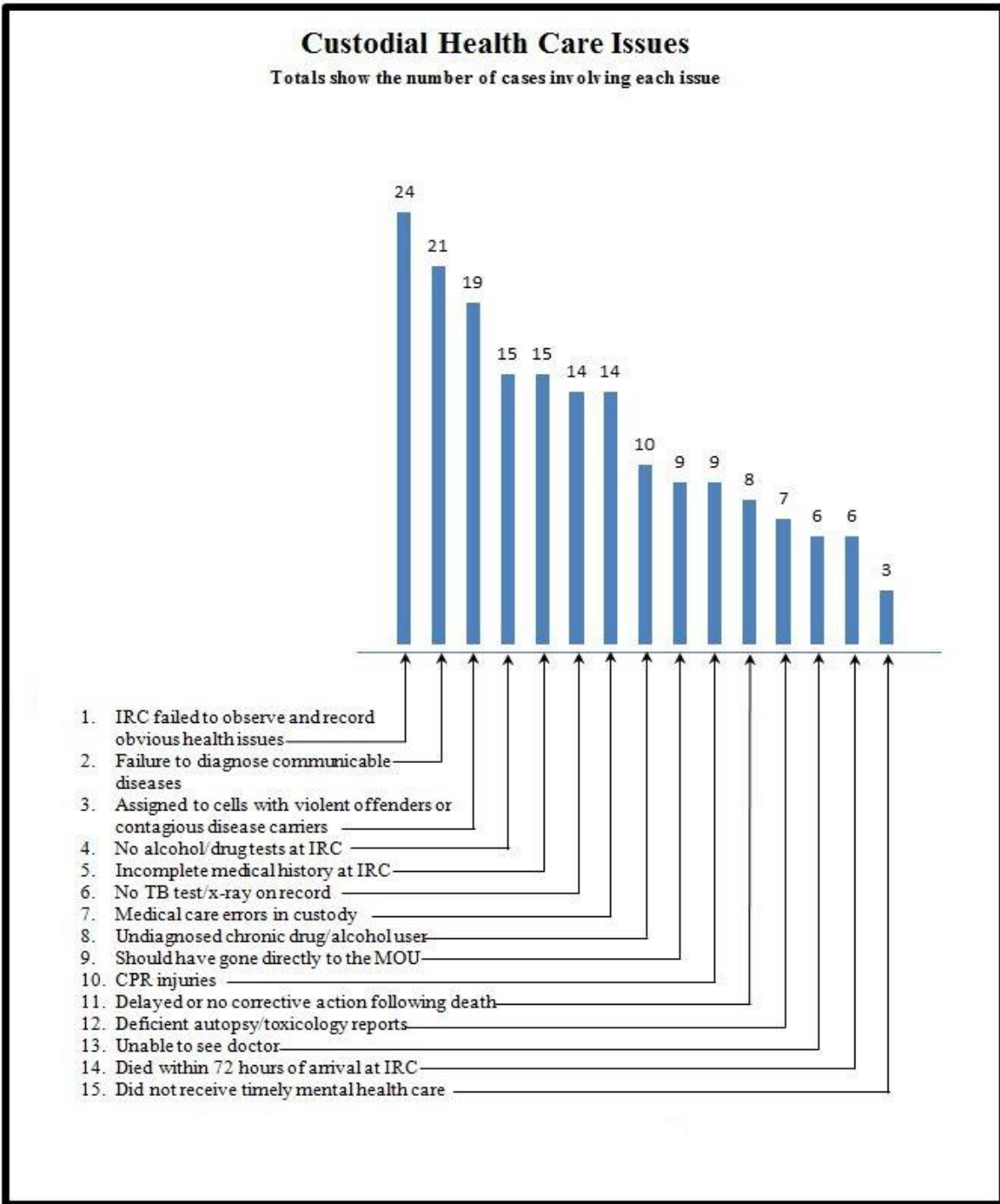
## **BACKGROUND AND FACTS**

Of the thirty-four deaths under study, fourteen could be attributed to natural causes that occurred prior to or during incarceration, including cancer, liver or heart disease, stroke, etc. One death was a suicide and one was a murder committed inside a jail cell. The cause of death of three inmates was unable to be determined. In the remaining fifteen cases, death may have been preventable.

Figure 1 summarizes healthcare issues identified by the Grand Jury, many of which may have contributed to the thirty-four custodial deaths.

Throughout this report, some of the fact patterns relating to individual inmates have been altered to avoid providing information that could identify the individual whose medical conditions or cause of death are being described. No changes alter the descriptions of care given or how that care relates to the Grand Jury's findings and recommendations.

Figure 1: Custodial Health Care Issues



Source: Adapted from OCDA Custodial Death Letters

## **Correctional Health Services**

Correctional Health Services (CHS), a division of the Orange County Health Care Agency, provides medical services to inmates inside the jails. This agency employs five full-time medical doctors, thirteen full-time nurse practitioners, and over 120 licensed vocational nurses and registered nurses. Appendix 1 contains a flow chart detailing the healthcare process in the jails and recommended changes for improvement.

## **Intake Release Center Procedures**

### ***Acquiring Medical Data***

CHS first evaluates and documents an inmate's health at the IRC. Nurses stationed behind a security screen ask incoming inmates an extensive list of medical questions in a noisy, large, and open area. Both nurses and responding inmates use loud voices and sometimes must repeat themselves to be heard. Confidential questions are asked of the inmates pertaining to addictions, mental health issues, sexually transmitted diseases, HIV, and Hepatitis (HEP) B and C. Incoming inmates may be reluctant to fully disclose private information when other inmates are sitting only a few feet away. The federal Health Insurance Portability and Accountability Act provides Americans with assurances that their health information is confidential, but the IRC questioning process makes this almost impossible to achieve.

### ***CHS Health Intake Form***

CHS uses a multi-page medical questionnaire for each arriving inmate (See Appendix 2). If an individual returns to the jail system, a new medical questionnaire is completed for each incarceration and the information is updated in the medical database. For the thirty-four cases examined, the medical intake form was difficult to read due to extremely small font size. There is no section for a medical care plan of action initiated by a doctor or nurse practitioner to define an inmate's course of medical treatment. Some of the cases in the study had missing, incomplete, or unclear health data or treatment records.

### *Urine Drug Screen Tests*

Urine drug screen test kits are kept at the IRC medical station. However, urine drug screening is not routinely performed on inmates entering the IRC, even though inmates are known to be a high-risk group for alcohol and drug use. Necessary medical care may be delayed or compromised for incoming arrestees who do not receive this test. These test kits detect twelve of the most commonly used drugs (see Table 1), providing healthcare professionals quick, inexpensive, and reliable test results.

Early urine drug screening greatly aids in intervention and subsequently guides medical planning and treatment. Six of the thirty-four inmates died within seventy-two hours of arrival at IRC, in some cases due to undiagnosed drug intoxication or delayed treatment. Urine tests done at intake could have been useful in averting these outcomes.

**Table 1: Twelve Panel Drug Screening and Detection Periods**

<b>Drug</b>	<b>Detection Period, Days</b>	<b>Street Names</b>
Cocaine	2-4	coke, crack, blow, nose candy, snowball, tomado
Marijuana	15-30	pot, grass, weed, hash, Mary Jane, dope
Opiates	2-4	heroin, morphine, opium, smack, thunder, hell dust
Amphetamines	2-4	Adderall, Dexedrine, speed, uppers
Methamphetamines	3-5	meth, crank, ice, chalk, black beauties, crystal meth
Phencyclidine (CPC)	7-14	PCP, angel dust, boat, tic tac, zoom
Benzodiazepines	3-7	Valium, Xanax, Librium, Ativan, Halcion, Diazepam
Barbiturates	4-7	barbs, downers, Amytal, Nembutal, Seconal, Tuinal
Methadone	3-5	fizzies, amidone, chocolatedhip cookies
Oxycodone	2-4	Percocet, Percodan, OxyContin, Tylox, Vicodin, oc, ox oxy
MDMA	1-3	Ecstasy, beans, adams, hug, drug
Propoxyphene	1-2	Darvocet, Darvon

Source: Various Suppliers of Drug Tests



### ***HIV / Hepatitis B / Hepatitis C***

Blood is not drawn or tested during the IRC process, so blood-borne diseases such as HEP B, HEP C, and HIV are not detected. Unless an incoming inmate informs medical personnel of these diseases during the intake interview, the jail personnel would not know of the inmate's positive infectious status, putting others at risk. Testing for these diseases is done only at the time of autopsy. A review of the thirty-four custodial death cases found that thirty-two had no documentation on the Health Intake Form of any test performed to detect if the inmate was positive for these conditions. When the Grand Jury reviewed toxicology records following the autopsies, it discovered that two inmates were HIV positive, one was HEP B positive, and sixteen were HEP C positive.

### ***Chest X-ray***

CHS performs a routine chest x-ray to detect tuberculosis (TB) when an inmate arrives at IRC. Fourteen of the thirty-four reviewed cases had no record that an x-ray had been done, or any result noted. It cannot be verified that the results of a chest x-ray were normal if there is no report stating that finding. The Grand Jury determined that two of the thirty-four inmates had lung and heart conditions that could have been diagnosed through the chest x-ray, but were not because x-rays are reviewed for TB only.

### ***Quick Visual Body Exam***

During the intake process, inmates receive a quick visual exam while fully clothed. Critical health conditions can go undetected when inmates are not required to disrobe for a visual exam. The Grand Jury's review discovered two illustrative cases, detailed below, which resulted in death.

Prior to incarceration, an inmate was prescribed a blood-thinning medication following cardiac surgery. However, when he arrived at IRC he did not communicate his medical condition to the intake nurse. Medical personnel were unaware of the long incision in the inmate's chest wall since it was underneath his clothes. He did not receive blood-thinning medication during his incarceration. Within a few days of arrival, he was sent to the hospital, immediately diagnosed as having had a stroke, and later died. Had a visual exam been performed at IRC, the obvious chest scar would have alerted the health care professionals, and appropriate care could have followed.

Upon arrival at IRC, an inmate volunteered various medical information including concern regarding pain at a wound site. However, since the area was underneath his clothes, the nurse did not look at it. In fact, an abscess had developed. A few days later, the inmate suffered significant symptoms and became septic. Jail personnel asked if he wanted to go to the hospital, but since he was being released, he declined the offer. He went to the hospital on his own immediately upon release. He was admitted to surgery upon arriving at the hospital, but he died due to complications of his infection.

### ***Incoming Medical Records***

In two special circumstances essential medical information is available for inmates arriving at IRC, but currently does not accompany them. In the first instance, when an arrest is made for a DUI, a test may have been given to determine alcohol or drug intoxication levels. In the second and more serious instance, an inmate is returned from a hospital stay without accompanying medical information. The jail therefore lacks information about procedures that were performed, prescribed medications, and the follow up treatment plan. Hours or even days can go by while CHS personnel track down important medical information, delaying treatment. Although the Grand Jury found that no death was directly attributable to the lack of medical records upon admittance, delayed or missing records substantially increase healthcare risks to inmates.

## **Medical Care During Incarceration**

Sheriff's deputies are often the first responders to inmate health issues, putting them in a position of having to assess the inmate's healthcare needs. This assessment is more difficult when inmates fail to cooperate. Inmates are a high-risk group and are likely to have health problems, including communicable diseases, which may impact the health of other inmates.

### ***Inmate Access to Medical Care***

Inmates request medical care by submitting a "pink slip"; CHS policy is to respond within twenty-four hours. (See Figure 3) However, meeting this timeline depends on the availability of CHS staff. In medical emergencies, inmates are transported to a hospital or emergency room.

Review of Sheriff's inmate logs and interviews of CHS staff showed that the inmates' requests to see a doctor normally are met within the required twenty-four hours. However, there are several problems with meeting this standard:

- Inmates may be unable, due to illiteracy or incapacity, to complete a pink slip request for medical care.
- Cellmates may deny assistance in completing the pink slip if the inmate is unable to complete it on their own.
- Deputies may fail to assist with completing the pink slip if needed.
- Inmates appearing in court may miss their scheduled medical appointment.
- The urgent medical need occurs on a weekend or holiday when no doctor or nurse practitioner is on site.

When not available on site, a doctor or nurse/practitioner is always on call for consultation. If an inmate is in a man down condition, the inmate's cellmate can use the emergency call button in the cell to summon help. Deputies will respond to apply lifesaving measures and send for on-duty medical staff.

Figure 2: CHS Pink Slip

County of Orange, CA ~ Health Care Agency ~ Correctional Health Services  
Confidential Patient Information (see California Civil Code 56, 10 and HIPAA, Title 45, CFR, Part 160 & 164, and CA W&IC Section 5328)

## Inmate Health Message Slip

Deposit in Medical box in your housing area

Official use only:  Entered

Name: \_\_\_\_\_

Booking Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Housing: \_\_\_\_\_

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**I AM REQUESTING TO BE SEEN FOR:**

<b>MEDICAL:</b> <input type="checkbox"/> I need to see the nurse for a medical concern. <input type="checkbox"/> I need contact lens supplies: <input type="checkbox"/> Solution (hard lenses) <input type="checkbox"/> Solution (soft lenses) <input type="checkbox"/> Contact lens case	<b>MEDICATION:</b> <input type="checkbox"/> Refill <input type="checkbox"/> Other medication issue Medication name: _____	<b>DENTAL:</b> <input type="checkbox"/> Toothache <input type="checkbox"/> Gum Problems <input type="checkbox"/> Denture Adhesive <input type="checkbox"/> Other (Specify) _____	<b>MENTAL HEALTH:</b> <input type="checkbox"/> Suicidal <input type="checkbox"/> Depressed <input type="checkbox"/> Anxious
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COMMENTS: \_\_\_\_\_

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\*I understand that by submitting this request, I am consenting to and authorizing procedures necessary for my health and wellbeing. Pursuant to Penal Code § 4011.2, inmates are charged a \$3.00 fee for each inmate-initiated medical visit. An inmate will not be denied medical care because of lack of funds.

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

F-154 (REV. 3/91-13)

Source: Orange County Correctional Health Services

### *The Medical Observation Unit*

The Medical Observation Unit (MOU) is a large one-room, ward-like facility where inmates requiring skilled nursing care are assigned. The MOU provides for patients' medical needs ranging from paraplegic to post-surgical care. CHS medical personnel observe and care for the patients twenty-four hours a day. Many inmates who should be assigned to the MOU are not because of the lack of urine screening and the difficulty in obtaining information about pre-existing medical conditions at IRC intake.

The second issue in the MOU concerns peripheral IVs, which are frequently fitted to inmates who require regular injections. These are not used to administer fluids because plastic drip lines

can be used as weapons. Instead, patients requiring IV hydration are sent to the hospital where deputies provide security to prevent drip lines from being used as weapons. The Grand Jury learned that in one instance the failure to administer IV fluids in the MOU caused dehydration, contributing to the inmate's death. If a deputy were stationed in the MOU instead of the hospital to allow the use of IVs, treatment could begin sooner and the expense of transportation and hospitalization could be avoided.

## **Errors Resulting in Harm**

### ***Housing Cell Assignments***

Inmate proximity in jail facilitates the spread of communicable disease. The Grand Jury's review of autopsy and toxicology reports revealed that CHS and OCSD were not aware that certain inmates had HEP B, HEP C, or HIV, which are spread by blood and other bodily fluids. Infectious skin conditions like scabies also can spread easily. Detection prior to housing assignment would assist in preventing the spread of these diseases.

Inmates housed with cellmates who have undiagnosed mental illness may be subjected to acts of violence. One such incident occurred in the thirty-four cases reviewed.

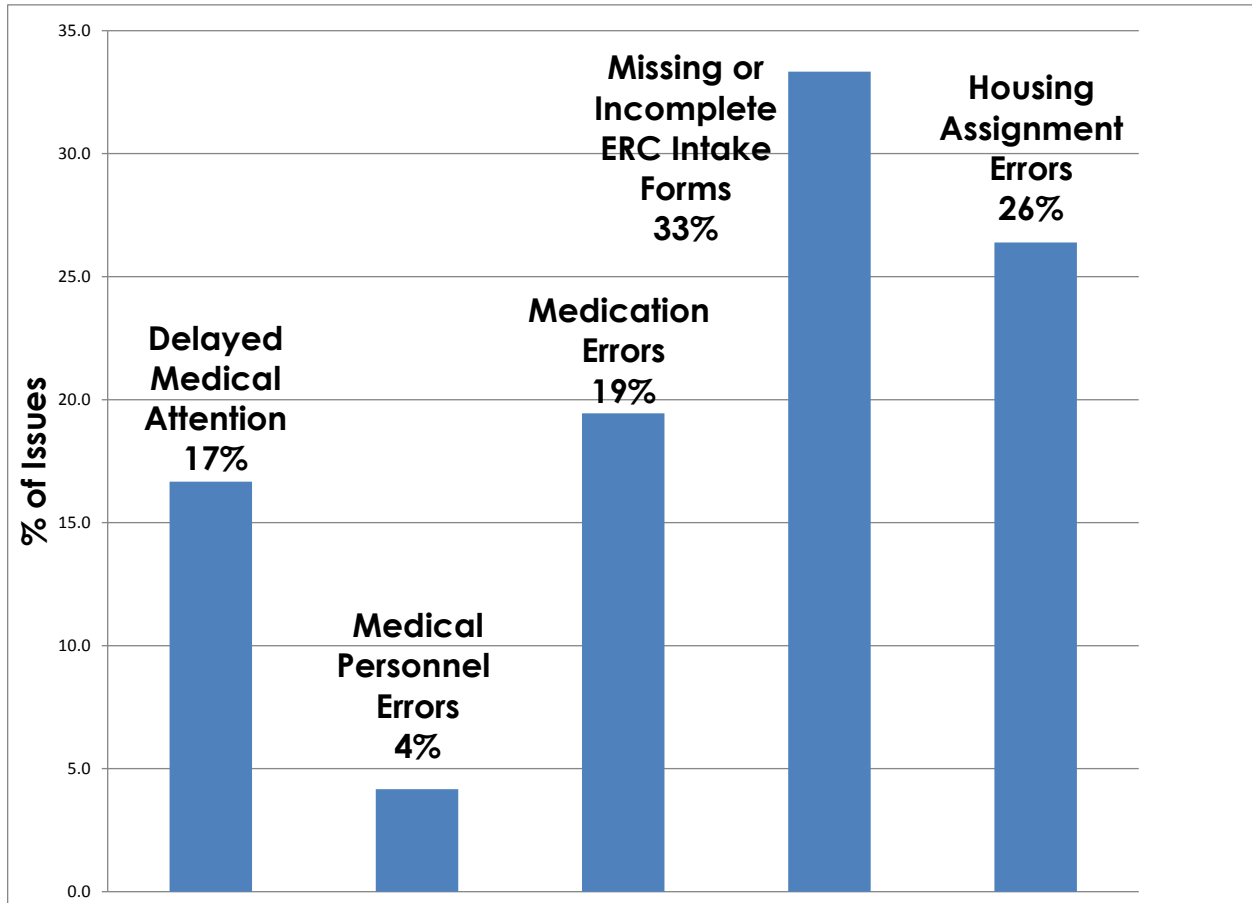
### ***Deficient Healthcare Delivery***

The Grand Jury's investigation identified a number of problems with healthcare delivery in the thirty-four custodial deaths reviewed, problems which can be extrapolated to the entire jail population:

- delayed medical attention
- medical personnel errors
- medication errors
- missing or incomplete IRC intake forms
- housing assignment errors

The relative number of occurrences of these deficiencies impacting inmate health care is shown in Figure 4.

Figure 3: Health Care Error Summary



Source: 1 Data from Reports Issued by Orange County District Attorney, Sheriff's Department and Health Care Agency

As required by state regulations, CHS convenes a Morbidity/Mortality Review (MMR) within thirty days of an inmate's death (Appendix 3: CCR Title 15 1046). This review summarizes the inmate's incarceration medical history and explores how the system, as well as actions of individuals, could be improved. The Grand Jury noted that the MMR process provided increased scrutiny of care in the period under study. MMRs in 2017 were more comprehensive, including improved medical event summaries, improved CHS staff training, and database enhancements.

### ***Medical Personnel Errors***

Two specific cases of medical diagnostic errors resulting in death were reviewed.

The medical staff in a jail facility failed to diagnose the cause of an inmate's persistent and increasing chest pains and shortness of breath. Breathing exercises and psychological treatments were prescribed. Accurate diagnosis was delayed, and the inmate died.

An inmate processed through the IRC late on a Friday evening did not receive an initial physical exam. Shortly after being assigned to a cell, the inmate began to cry and complain of persistent pain. Pain medication was administered, but the symptoms persisted. The on-call doctor was not consulted; an appointment was scheduled for Monday morning. Eventually, the inmate was in a man down condition. CPR was administered but the inmate died. The autopsy report revealed a tear in the patient's aorta, causing massive internal bleeding.

### ***Major Complications of CPR***

CPR is an emergency procedure that combines chest compressions with ventilation in an effort to restore breathing and maintain blood flow to the brain. A man down response begins with CPR, which can be initiated by a deputy, healthcare worker, or paramedic. Nine of the twenty inmates who received CPR suffered three or more broken ribs, a broken sternum, or damaged internal organs – an excessive amount of damage according to the American Heart Association Guidelines.

Two inmates received CPR while in hospitals, and seven received CPR from jail personnel. In one instance at the OC Central Jail, CPR resulted in seventeen fractured ribs, the perforation of one of the heart chambers, and over three pints of blood flooding the chest cavity.

## Coroner's Reports for Feedback Improvement

### *Complete Autopsy and Toxicology Reports*

The National Association of Medical Examiners (NAME) is a professional society which establishes standards for the conduct of death investigations. Among these standards are the following:

- An objective forensic autopsy, with findings that include toxicology tests, special tests, microscopic examinations, etc.
- Stated opinions by a forensic pathologist that pertain to the cause and manner of death

In accordance with NAME, Los Angeles and Riverside Counties expect the forensic pathologist to write a report that includes the cause of death, the manner of death, and their opinion regarding both. In contrast, the Orange County District Attorney's office does not require forensic pathologists to comment on the toxicology report or to render an opinion on the cause or manner of death. Without the toxicology report, autopsy findings alone may be insufficient to determine the cause of death.

In one custodial death, an incoming inmate informed IRC that he had a specified illness and had abdominal pain. The IRC medical staff had the inmate transported to a local ER. The inmate was returned to the Central Jail within two hours without accompanying medical information. Within a short period of time the inmate was found dead in his cell. The toxicology report showed evidence of an acute health issue that would likely have been identified in the health records, and which could have been medically addressed. The pathology report listed seven findings that caused the inmate's death without any reference to this acute issue. Had it incorporated information from the toxicology report, the pathologist's report would have shown the primary or contributory cause of death to be this acute issue.



### **Peer Review Certification**

Participation in a nationally-accredited healthcare review organization has the potential to improve the inmate care that CHS provides. CHS is not audited by any accrediting organization. The National Commission on Correctional Health Care (NCCCHC) is available to review correctional health care delivered across the United States. Utilizing this agency or an equivalent would provide an independent assessment of performance. The NCCCHC can provide CHS the benefit of an accreditation of its performance and practices. Membership in this peer review organization has the potential to improve efficiency, inmate care, and inmate survival.

### **Conclusion**

Since the Intake Release Center is the gateway to health care in the jail system, it is imperative that health issues be identified there. Many other opportunities exist to improve the health care of inmates and prevent their deaths. The Grand Jury's Findings and Recommendations are intended to assist Correctional Health Services, in cooperation with Orange County Sheriff's Department and Orange County District Attorney's office, in achieving ongoing improvements to inmate health care.

## FINDINGS

In accordance with *California Penal Code* Sections 933 and 933.05, the 2017-2018 Grand Jury requires (or, as noted, requests) responses from each agency affected by the findings presented in this section. The responses are to be submitted to the Presiding Judge of the Superior Court.

Based on its investigation titled “Preventable Deaths in Orange County Jails,” the 2017-2018 Orange County Grand Jury has arrived at twelve principal findings, as follows:

F1. Failure to identify health threats at the Intake Release Center may lead to subsequent medical challenges that could be avoided.

F2. Because the Intake Release Center health assessment does not screen for drug or alcohol intoxication, some inmates have not been appropriately assigned to the Medical Observation Unit to monitor for potential overdose events.

F3. Failure to screen for mental illness at the Intake Release Center exposes other inmates to potential risk.

F4. Failure to detect Hepatitis B, Hepatitis C, and HIV at the Intake Release Center puts the jail population and staff at risk for these diseases.

F5. Inmate health care is compromised when the Intake Release Center x-ray screening is limited to the detection of tuberculosis and not used to identify other significant abnormalities, such as artificial heart valves and aortic aneurysms.

F6. Appropriate health care may be delayed when drug and alcohol screening test results collected by outside law enforcement agencies are not provided to the Intake Release Center with the arrestee.

F7. Appropriate health care is compromised when medical records, diagnoses and treatment plans are not provided by the hospital when the inmate returns to the Intake Release Center.

F8. Inmate care may be compromised because of the lack of a timely referral to a healthcare professional. This is especially problematic on weekends and holidays.

F9. There is no provision to administer intravenous fluids in the Medical Observation Unit, potentially subjecting patients to dehydration.

F10. The Orange County District Attorney does not require its forensic pathologists to comply with national standards, limiting potentially valuable information on cause and manner of death.

F11. Timely receipt of autopsy and toxicology reports provides important information that could assist Correctional Health Services in implementing needed changes.

F12. The Orange County Correctional Health Services' performance is not accredited by any peer review agency; consequently, it lacks the benefits of accreditation as a process improvement tool.

## RECOMMENDATIONS

In accordance with *California Penal Code* Sections 933 and 933.05, the 2017-2018 Grand Jury requires (or, as noted, requests) responses from each agency affected by the recommendations presented in this section. The responses are to be submitted to the Presiding Judge of the Superior Court.

Based on its investigation titled “Preventable Deaths in Orange County Jails,” the 2017-2018 Orange County Grand Jury makes the following fifteen recommendations:

- R1. By October 1, 2018, Correctional Health Services should use a urine drug screen test for all inmates at the time of intake to obtain a more accurate assessment of the inmate’s medical condition. (F1, F2)
- R2. By June 30, 2019, Correctional Health Services should perform universal Hepatitis B, Hepatitis C, and HIV tests at the Intake Release Center and make an appropriate decision for treatment, vaccination, and housing. (F1, F4)
- R3. By October 1, 2018, Correctional Health Services should require the radiologist to examine the Intake Release Center x-rays for any abnormalities in addition to tuberculosis to improve the inmate’s diagnosis and care. All x-ray test findings, including normal, should be recorded on the inmate’s health record. (F1, F5)
- R4. By January 1, 2019, the Intake Release Center health assessment should require the inmate to disrobe for a brief visual medical examination by a nurse practitioner or doctor. (F1)
- R5. By January 1, 2019, an improved Intake Release Center health assessment should be used to identify any condition requiring assignment to the Medical Observation Unit. (F1, F2)
- R6. By January 1, 2019, the medical intake form should include a summary section and a written plan of action to highlight the health conditions needing attention. (F1, F2, F3, F4)

R7. By October 1, 2018, the Orange County Sheriff's Department should require all outside law enforcement agencies' drug and alcohol test results to accompany the arrestee to the Intake Release Center. (F6)

R8. By October 1, 2018, Correctional Health Services should develop a plan to receive the medical records, diagnoses, and treatment plans from hospitals when an inmate returns to the Intake Release Center. (F7)

R9. By October 1, 2018, the results of the intake health assessment should be included in making appropriate housing assignments. (F1, F2, F3, F4)

R10. By January 1, 2019, Correctional Health Services and the Orange County Sheriff's Department should consider allowing the Medical Observation Unit to dispense intravenous fluids. (F9)

R11. By January 1, 2019, the Orange County Sheriff's and Correctional Health Services staff should ensure pink slips are responded to within twenty-four hours. (F8)

R12. By January 1, 2019, a nurse practitioner or physician should be on site for weekends and holidays, even if on a limited schedule, to address inmates' urgent care needs. (F8)

R13. By October 1, 2018, the Orange County District Attorney's office should require the forensic pathologist's report to follow the standards of the National Association of Medical Examiners (NAME) for custodial death autopsies. (F10)

R14. By October 1, 2018, Correctional Health Services should review the autopsy, toxicology, and pathologist's reports, as soon as they are available, for ways to improve healthcare processes. (F10, F11)

R15. By June 30, 2019, Correctional Health Services should seek accreditation from the National Commission on Correctional Health Care. (F12)

## RESPONSES

The following excerpts from the California Penal Code provide the requirements for public agencies to respond to the findings and recommendations of this Grand Jury report:

### §933(c)

*“No later than 90 days after the grand jury submits a final report on the operations of any public agency subject to its reviewing authority, the governing body of the public agency shall comment to the presiding judge of the superior court on the findings and recommendations pertaining to matters under the control of the governing body and every elected county officer or agency head for which the grand jury has responsibility pursuant to Section 914.1 shall comment within 60 days to the presiding judge of the superior court, with an information copy sent to the board of supervisors, on the findings and recommendations pertaining to matters under the control of that county officer or agency head or any agency or agencies which that officer or agency head supervises or controls. In any city and county, the mayor shall also comment on the findings and recommendations. All of these comments and reports shall forthwith be submitted to the presiding judge of the superior court who impaneled the grand jury. A copy of all responses to grand jury reports shall be placed on file with the clerk of the public agency and the office of the county clerk, or the mayor when applicable, and shall remain on file in those offices. . . . ”*

### §933.05

*“(a) For purposes of subdivision (b) of Section 933, as to each grand jury finding, the responding person or entity shall indicate one of the following:*

*(1) The respondent agrees with the finding.*

*(2) The respondent disagrees wholly or partially with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reasons therefor.*

*(b) For purposes of subdivision (b) of Section 933, as to each grand jury recommendation, the responding person or entity shall report one of the following actions:*

*(1) The recommendation has been implemented, with a summary regarding the implemented action.*

*(2) The recommendation has not yet been implemented, but will be implemented in the future, with a timeframe for implementation.*

*(3) The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or study, and a timeframe for the matter to be prepared for discussion by the officer or head of the agency or department being investigated or reviewed, including the governing body of the public agency when applicable. This timeframe shall not exceed six months from the date of publication of the grand jury report.*

*(4) The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation therefor.*

*(c) However, if a finding or recommendation of the Grand Jury addresses budgetary or personnel matters of a county agency or department headed by an elected officer, both the agency or department head and the board of supervisors shall respond if requested by the grand jury, but the response of the board of supervisors shall address only those budgetary or personnel matters over which it has some decision-making authority. The response of the elected agency or department head shall address all aspects of the findings or recommendations affecting his or her agency or department.”*

Comments to the Presiding Judge of the Superior Court in compliance with Penal Code §933.05 are required from:

Responses Required:

***Findings:***

Board of Supervisors	F1, F2, F3, F4, F5, F6, F7, F8, F9, F11, F12
Orange County District Attorney	F10, F11
Orange County Sheriff-Coroner	F6, F7, F8, F9

***Recommendations:***

Board of Supervisors	R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R14, R15
Orange County District Attorney	R14
Orange County Sheriff-Coroner	R4, R7, R8, R9, R10, R11

Responses Requested:

***Findings:***

Correctional Health Services

F1, F2, F3, F4, F5, F6, F7, F8, F9,  
F11, F12

***Recommendations:***

Correctional Health Services

R1, R2, R3, R4, R5, R6, R7, R8, R9,  
R10, R11, R12, R13, R15



## REFERENCES

### Documents

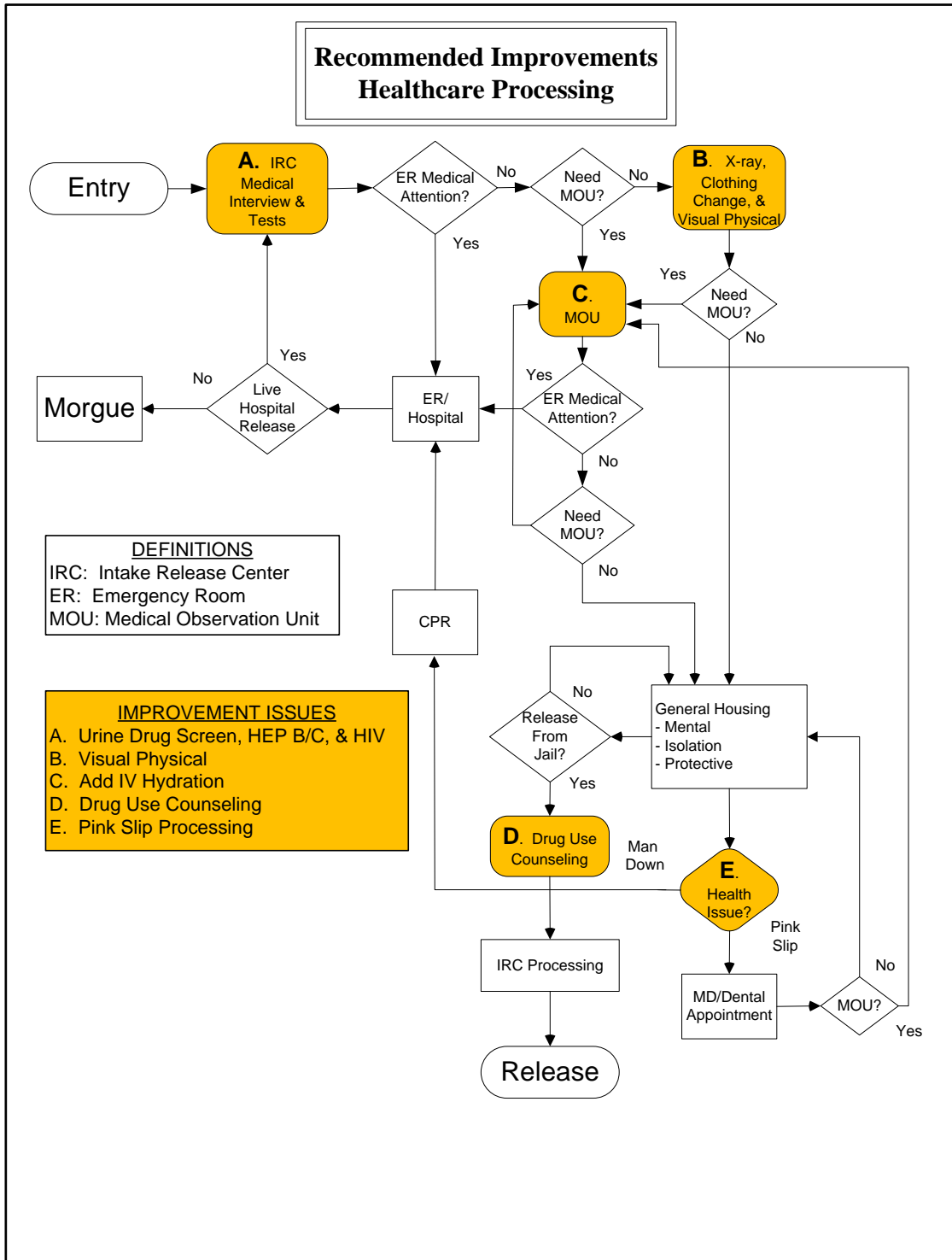
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Appendix

Appendix 1



Appendix 2



Orange County Health Care Agency  
550 N. Flower Street  
Santa Ana, CA 92703

5/23/2018 2:11:42 PM Pacific Daylight Time

RECEIVING SCREENING - Created on 5/23/2018 2:11:41 PM Pacific Daylight Time

PICTURE  
NOT AVAILABLE

Patient: test, test #: (T1209844) T1209844 Lang:  
DOB: 6/10/1985 (Age=32) Sex: Male Race:  
Housing: Court Date: Type:  
Status: NOT ACTIVE

Current Allergies

No Known Drug Allergy

Allergy information verified with inmate

TOBACCO SMOKING HISTORY

- Smoked GREATER than 100 cigarettes in lifetime.
- Smoked LESS than 100 cigarettes in lifetime.
- Unknown if ever smoked.

- Regularly smokes every day.
- Regularly smokes periodically, but consistently.
- Currently does not smoke.
- Not known if currently smokes.

MEASUREMENT:

Patient Refused

BP	Temp	Pulse	Resp	SaO2	BS	Pain	Height(ft)
/							0
Height(in)	Weight	BMI	MAP				
0							

OBSERVATION:

1. Is the inmate unconscious or showing signs of illness, injury, bleeding, pain or other symptoms implying need for emergency medical referrals?

- Yes
- No

Preventable Deaths in Orange County Jails

Pain Scale:

10. Have you fainted or had a head injury (eg. coma, concussion) in the past 72 hours?

- Yes
- No

**11. Do you have any of the following chronic conditions?**

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> None                          | <input type="checkbox"/> CAD/CHF/Valve Disease | <input type="checkbox"/> Diabetes     |
| <input type="checkbox"/> HIV/AIDS                      | <input type="checkbox"/> Asthma                | <input type="checkbox"/> Hepatitis B  |
| <input type="checkbox"/> Hepatitis C                   | <input type="checkbox"/> Thyroid Disease       | <input type="checkbox"/> Cancer       |
| <input type="checkbox"/> Seizure Disorder              | <input type="checkbox"/> Head Injury           | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> Depression            | <input type="checkbox"/> Bi Polar     |
| <input type="checkbox"/> Psychosis                     |  |                                       |

12. Have you ever been diagnosed with any other medical problems?

- Yes
  - No
- If yes, what?

13. Have you ever been diagnosed with any other mental health problems?

- Yes
  - No
- If yes, what?

14. Do you have any medical or mental conditions that you would like to speak with someone about in private?

- Yes
- No

15. Have you ever had a serious infectious disease in the past, like a bad skin infection?

- Yes
  - No
- If yes, what?

16. Have you been admitted to a hospital in the past year for a medical reason?

- Yes
  - No
- If so, what?

Preventable Deaths in Orange County Jails

Pain Scale:

10. Have you fainted or had a head injury (eg. coma, concussion) in the past 72 hours?

- Yes
- No

**11. Do you have any of the following chronic conditions?**

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> None                          | <input type="checkbox"/> CAD/CHF/Valve Disease | <input type="checkbox"/> Diabetes     |
| <input type="checkbox"/> HIV/AIDS                      | <input type="checkbox"/> Asthma                | <input type="checkbox"/> Hepatitis B  |
| <input type="checkbox"/> Hepatitis C                   | <input type="checkbox"/> Thyroid Disease       | <input type="checkbox"/> Cancer       |
| <input type="checkbox"/> Seizure Disorder              | <input type="checkbox"/> Head Injury           | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> Depression            | <input type="checkbox"/> Bi Polar     |
| <input type="checkbox"/> Psychosis                     |  |                                       |

12. Have you ever been diagnosed with any other medical problems?

- Yes
  - No
- If yes, what?

13. Have you ever been diagnosed with any other mental health problems?

- Yes
  - No
- If yes, what?

14. Do you have any medical or mental conditions that you would like to speak with someone about in private?

- Yes
- No

15. Have you ever had a serious infectious disease in the past, like a bad skin infection?

- Yes
  - No
- If yes, what?

16. Have you been admitted to a hospital in the past year for a medical reason?

- Yes
  - No
- If so, what?

## Preventable Deaths in Orange County Jails

37. Are you currently taking medications for a mental health problem?

- Yes  
 No

38. Do you know of any medical reason why you cannot work in jail?

- Yes  
 No

39. Additional Medical Information:

40. Female information was explained and given to inmate

- Yes  
 No  
 NA

41. Previously Incarcerated. If Yes, the following checked items were completed.

- Yes  
 No

Previous EMAR/ Flags were reviewed

Previous Problem List was reviewed

### Additional Screening Questions

1. Influenza Questions Asked?

- Yes  
 No  
 NA

1a. Do you currently have fever, chills or body ache?

- Yes  
 No

1b. Do you currently have a cough?

- Yes  
 No

1c. Do you currently have a runny nose?

## Preventable Deaths in Orange County Jails

No

NA

If yes, when was your last contact with this person or area?

### 3. Ebola Questions Asked?

Yes

No

NA

3a. Have you, or anyone you live with, traveled or lived in an area with known Ebola Viral Disease (EVD) in the last 21 days Sierra Leone, Liberia, Guinea, Nigeria, Democratic Republic of Congo, other?

Yes

No

If yes, to what country did you or the person you live with travel to?

3b. Have you had any direct skin contact or exposure to blood or body fluids of an EVD patient, relative or contact?

Yes

No

If yes, Is the patient symptomatic?

Yes

No

### 3c. Which of the following symptoms do you have?

Headaches

Abdominal pain

Fever

Weakness

Vomiting

Muscle Aches

Diarrhea

Unusual Bleeding

None

### 4. Measles Questions Asked?

Yes

No

NA



Yes

No

**James Musick:**

Yes

No

**Suicidal Precautions:**

Constant

Close (specify frequency):

Additional Brief Pertinent Comments:

### Appendix 3

§ 1046. Death in Custody.

15 CA ADC § 1046 BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS  
Barclays Official California Code of Regulations [Currentness](#)  
Title 15, Crime Prevention and Corrections  
Division 1, Board of State and Community Corrections  
Chapter 1, Board of State and Community Corrections  
Subchapter 4, Minimum Standards for Local Detention Facilities  
Article 4, Records and Public Information  
15 CCR § 1046

§ 1046. Death in Custody

(a) Death in Custody Reviews for Adults and Minors.

The facility administrator, in cooperation with the health administrator, shall develop written policy and procedures to ensure that there is an initial review of every in-custody death within 30 days. The review team shall include the facility administrator and/or the facility manager, the health administrator, the responsible physician and other health care and supervision staff who are relevant to the incident.

Deaths shall be reviewed to determine the appropriateness of clinical care; whether changes to policies, procedures, or practices are warranted; and to identify issues that require further study.

(b) Death of a Minor

In any case in which a minor dies while detained in a jail, lockup, or court holding facility:

(1) The administrator of the facility shall provide to the Board a copy of the report submitted to the Attorney General under Government Code Section 12525. A copy of the report shall be submitted within 10 calendar days after the death.

(2) Upon receipt of a report of death of a minor from the administrator, the Board may within 30 calendar days inspect and evaluate the jail, lockup, or court holding facility pursuant to the provisions of this subchapter. Any inquiry made by the Board shall be limited to the standards and requirements set forth in these regulations.

Note: Authority cited: Sections 6024 and 6030, Penal Code. Reference: Section 6030, Penal Code.

## Appendix 4

### Orange County District Attorney and Orange County Sheriff's Department

#### Operational & Procedural Protocol for Custodial Death Investigations

Effective Date: February 10, 2010

##### Purpose

To establish recommended uniform protocols for the investigation of custodial deaths.

##### Adoption

The operating protocol contained herein was officially adopted by the Orange County District Attorney and Orange County Sheriff's Department.

##### Justification / Need

The purpose of this protocol is to maximize the efficiency and effectiveness of an independent custodial death investigation conducted by the District Attorney in order to eliminate any perceived conflict of interest that may otherwise result. It is recognized that the custodial setting is a distinctive environment and the investigation of custodial deaths are unique. Consequently, these incidents receive a high degree of public scrutiny with regard to officer conduct and the involved agency's policies and procedures. It is essential that the investigation be complete, thorough, unbiased, and impartial to preclude any conjecture of impropriety.

In Orange County the offices of the Sheriff and Coroner are combined under one elected official. This dual role presents a unique circumstance with regard to custodial deaths, and can cause one to perceive a conflict of interest in these types of investigations.

Since custodial deaths generally involve multiple considerations, it is recognized that several separate, but parallel and often overlapping investigations may be conducted. To alleviate concerns of any real or perceived conflict of interest, the District Attorney's Office will take the primary investigative role in custodial deaths involving the Sheriff-Coroner. The District Attorney will also be involved as an independent third party overseeing the Coroner's function.

**Policy / Directive**

A custodial death is any death that occurs while the decedent is in the custody or control of an Orange County Sheriff's Department employee, or when the decedent is under orders of confinement in the Orange County Jail System or in any other county confinement facility or any other law enforcement confinement facility involving Orange County Sheriff's Department personnel, or where there is direct involvement by any Orange County Sheriff's Department personnel. The Orange County District Attorney's Office will investigate all custodial deaths and have primary responsibility for the investigation.

The District Attorney will assume primary investigative responsibility for the incident, however, Sheriff Department personnel may be requested to participate in all or select phases of the investigation. The District Attorney may request the Sheriff's Department to conduct the investigation into any underlying crimes involving non-Sheriff Department personnel. It is recognized that this is often necessary for the prosecution of involved suspect(s). The final responsibility for the investigation will rest with the District Attorney.

- A. Death following Release from Custody. In cases where a person dies following release from custody, the District Attorney shall be notified of the circumstances but may decline to respond.
  
- B. Serious Injury of Person in Custody which is Life-Threatening. In cases where an individual suffers serious injury which is life-threatening, while in the custody or control of a Sheriff's employee or incarcerated in the Orange County Jail system, the District Attorney shall be notified of the circumstances but may decline to respond.

**Agency Responsibility**

Orange County Sheriff's Department

1. In accordance with the Sheriff's Department procedures, internal and supplemental resources should be requested as soon as practicable.
  
2. The Sheriff's Department shall request an immediate investigation by the Orange County District Attorney's Office on all custodial deaths to determine the criminal culpability, if any, of those involved.
  
3. Any internal /administrative investigation will be conducted separately by the Sheriff's Department.
  
4. Additional resources such as psychological counselors and risk management response teams may be requested by the Sheriff's Department and should be accommodated to the extent reasonably practicable.

## Preventable Deaths in Orange County Jails

5. The Sheriff's Department shall provide to District Attorney personnel copies of all reports, videos, recordings, pictures, and other relevant material to the case.
6. The Orange County Crime Lab will function as the scientific investigative personnel; and will collect, photograph, and process all physical evidence as directed by District Attorney Personnel.
7. The Sheriff-Coroner shall permit any necessary autopsy to be performed by a pathologist under contract by the District Attorney. The pathologist will be provided all pertinent information concerning the investigation. An Orange County Coroner's pathologist may attend the autopsy as an observer. The toxicology examination will be accomplished by the Orange County Crime Lab. The Orange County Crime Lab staff will also provide identification and criminalist personnel for the autopsy.
8. Coroner's staff will function as an integral part of the investigative team pursuant to their established procedures and legal responsibilities. The Sheriff-Coroner will provide a Deputy Coroner Investigator to conduct the on-scene examination of the body and arrange for transportation of the body to the Coroner's facility. The Coroner's Office will coordinate the Coroner Case Review proceedings for presentation to the Sheriff-Coroner.

### Orange County District Attorney


1. The District Attorney will coordinate the activities of all participants at the scene and subsequent investigation. The District Attorney will conduct an independent investigation to determine potential criminal culpability by anyone involved in the incident.
2. District Attorney Investigators will collect reports from all investigative sources and will maintain a master case file of the incident. The District Attorney will be responsible for acquiring reports from other agencies pertaining to the arrest of the involved subject(s) and when applicable, witnesses involved in other pertinent incidents, acts and arrests, will be interviewed.
3. The District Attorney will arrange for an independent forensic pathologist from outside of the Orange County Coroner's Office to perform the autopsy. The District Attorney may also utilize any other pathologist and consult with other forensic, medical, and other experts as deemed necessary to conclude the investigation. It shall be the District Attorney's responsibility to secure such experts.
4. The Sheriff-Coroner's briefing and autopsy will be attended by District Attorney personnel. Death notifications of next-of-kin will normally be accomplished by the District Attorney; however, on request, the assigned Deputy Coroner may make the death notification.

5. At the completion of the investigation, the investigative package will be submitted for a legal review of the incident and written finding will be made as to case disposition and determination if there is any criminal culpability, on the part of anyone involved, in the incident.
6. Upon completion of the legal review, the District Attorney will provide the Sheriff's Department a complete copy of the investigative file.
7. The Coroner Case Review will be attended by a District Attorney Supervising Investigator and other District Attorney personnel as required.
8. The District Attorney's Office will have sole responsibility to review all discovery orders or requests for public records releases of District Attorney reports.

**Media Releases and Information Request**

- A. Unless otherwise agreed, the initial press release should be mutually coordinated between the Sheriff's Department and the District Attorney's office.
- B. The District Attorney's office will be responsible for the public release of any information regarding the investigation of an in-custody death.

The District Attorney's office will inform the Sheriff of information involving a member of the Sheriff's Department prior to notifying the media.

  
TONY RACKAUCKAS  
District Attorney

2/19/10  
Date

  
SANDRA HUTCHENS  
Sheriff-Coroner

3/4/10  
Date