Another Death in Our Jail

Summary

For the third consecutive term, the Grand Jury is compelled to investigate yet another death at the Main Jail. There have been six deaths since October 2012, the most recent that of a 23-year-old mother on September 29, 2015.

The tragic death of this young woman comes as the Sheriff-Coroner and Santa Cruz County Board of Supervisors are in the process of selecting a new medical services provider. The 2012–2016 provider is California Forensic Medical Group, Inc., whose existing contract began shortly before the first of these deaths.

This report reviews the death of Krista DeLuca in the Santa Cruz County Main Jail, the medical policies and procedures related to her death, and the existing medical services contract for the Santa Cruz County detention facilities.

The Grand Jury strenuously reasserts that significant revisions must be made to existing jail policies and procedures and to the contract with the medical services provider to prevent future deaths. The Grand Jury further advocates retaining independent medical oversight of the medical services provider, accreditation of medical services at the detention facilities, and a thorough review of the existing medical services provider.

Background

On September 17, 2012, the provider of medical services at the jail changed[1] from the Santa Cruz County Health Services Agency (HSA) to the California Forensic Medical Group, Inc. (CFMG), a for-profit company. The 2012–2016 medical services contract[2] with the Sheriff-Coroner, authorized and approved by the Santa Cruz County Board of Supervisors, expires on September 16, 2016. The contract covers the County Main Jail, Blaine Street, and Rountree detention facilities. Mental health treatment is provided by the Santa Cruz County Health Services Agency.

The Sheriff-Coroner has the responsibility to ensure emergency and basic health care for all inmates. This can not be abrogated by contracting out the fulfillment of these essential medical services.

The County is currently reviewing responses to a Request for Proposals for a new medical services contract. The Grand Jury has issued two previous reports related to deaths in the jail and the contract between the Sheriff-Coroner and CFMG: *Five Deaths in Santa Cruz*[3] in 2014 and *Medical Services at the Jails*[4] in 2015.

The 2014–2015 Grand Jury recommendations made and responses received concerning jail medical services included:[5]

R1. *The Sheriff-Coroner should designate qualified personnel to oversee the medical services contract provisions and compliance*

with standards.
***Response: Will not be implemented** [with explanation].*

R2. *The Sheriff-Coroner should obtain independent oversight of its jail medical services by medically qualified personnel.*
***Response: Will not be implemented** [with explanation].*

R5. *The Sheriff-Coroner should require, at the time of contract renewal, that the jail medical services provider obtain and maintain California Medical Association-Institute for Medical Quality accreditation for the Main Jail, Blaine Street and Rountree detention facilities.*
***Response: Requires further analysis** [with explanation].*

We find the Sheriff's responses unsatisfying.

There have been six deaths in the Main Jail since October 2012. The sixth and most recent death occurred on September 29, 2015. It is important to note that not all of the six inmates died while under the direct medical care of CFMG.

Santa Cruz Main Jail In-Custody Deaths from October 2012 through March 2016

Name	*Age*	*Date of Death*	*Reported Cause of Death*
Richard Prichard	59	10/06/12	Heart attack
Brant Monnett	47	11/20/12	Narcotic overdose
Bradley Dreher	47	1/13/13	Asphyxiation by hanging
Amanda Sloan	30	7/17/13	Asphyxiation by hanging
Sharyon Gibbs	65	11/5/14	Natural causes
Krista DeLuca	23	9/29/15	Aspiration pneumonia, dehydration from opiate withdrawal

Sources: Five Deaths in Santa Cruz[3] in 2014*, Medical Services at the Jails*[4] in 2015, and the autopsy report for Krista DeLuca.[6]

Two of those deaths have been related to the withdrawal or detoxification from controlled substances (opiates) while under the medical care of CFMG. The Grand Jury has the authority to evaluate the Sheriff's Office, the detention facilities, the policies and procedures reviewed and approved by the Sheriff's Office, and the contract between the Sheriff''s Office and CFMG. The Grand Jury does not have the authority to investigate the California Forensic Medical Group, Inc., a for-profit company.

Death rates for jails are collected by the U.S. Bureau of Justice Statistics. For the years 2000–2013 death rates at local jails have ranged from 123 to 151 per 100,000 inmates per year.[7] During this 13 year period, 82% of local jails had zero deaths recorded.[7] The Santa Cruz County jail population is roughly 500.[8] Therefore, we could expect at most three deaths in our jails in four years; there have been more than twice that number of deaths in the four years under the 2012–2016 contract.

Jail inmates are a medically vulnerable population, whether due to poor health habits, poverty, old age, lack of medical care or, as in the case of Krista DeLuca, drug or alcohol addiction. The Sheriff's Office is responsible for the health care of inmates and our investigation made note of the efforts taken by Corrections Officers in providing humane assistance and care to these fragile inmates. What the Grand Jury found to be so disturbing in Ms. DeLuca's case was that she was under medical care during the four-day period in which she slowly died. Ms. DeLuca did not die from a drug overdose; this 23-year-old woman died from complications from an ostensibly medically supervised drug withdrawal.

Six inmate deaths have occurred at the Main Jail since October 2012, two of which were related to opiate withdrawals or detoxification while under the medical care of CFMG.

Scope

The focus of this report is to review three issues: the most recent death in the jail, the medical policies and procedures reviewed and approved by the Sheriff's Office related to that death, and the existing medical services contract between Santa Cruz County and California Forensic Medical Group, Inc. The following documents were examined:

- The contract between the Sheriff-Coroner and CFMG[2]
- Four medical policies approved by the Sheriff's Office related to the death:
  - Pre-Detention Medical Evaluation/Intake Health Screening
  - Chronic Care
  - Chemically Dependent Inmates
  - Reporting In-Custody Deaths
- The 2013–2014[3] and 2014–2015[4] Grand Jury reports
- The autopsy report[6] for Krista DeLuca
- Title 15 Inspection of the Main Jail by the Health Services Agency, April and May 2015[9]
- The Federal Bureau of Prisons, Clinical Practice Guidelines, *Detoxification of Chemically Dependent Inmates,* February 2014[10]

Interviews were conducted and the Grand Jury toured and inspected the Main Jail.

The Grand Jury does not have the authority to investigate the California Forensic Medical Group, Inc., a for-profit company.

Investigation

Death

Krista DeLuca was taken into custody on September 25, 2015, and died four days later in the County Main Jail on September 29, 2015. The autopsy stated the cause of death was:

> *Acute aspiration pneumonia, dehydration and probable electrolyte imbalance due to protracted vomiting associated with opiate withdrawal and opiate dependence from chronic heroin abuse.*[6]

In common terms, this says in part that Ms. DeLuca died after four days of vomiting, depleting her body of essential minerals and hydration, ultimately inhaling her own vomit and developing pneumonia.

As an inmate of the County Main Jail, Ms. DeLuca was under the medical care of CFMG. For a chronology of the four days of events leading to her death see Appendix A.

After reviewing the records from the jail and conducting interviews, the Grand Jury found that the Corrections Officers at the facility followed their policies and procedures and provided both professional and compassionate care to Krista DeLuca. The Grand Jury has jurisdiction to investigate the Sheriff-Coroner's oversight of the CFMG contract, but the Grand Jury does not have authority to investigate CFMG directly. The Sheriff's Office has not issued a public report on Ms. DeLuca's death and the actions or inactions of CFMG.

Medical Policies and Procedures Approved by the Sheriff-Coroner

As part of the contract between CFMG and the Sheriff-Coroner, the *Medical and Mental Health Care Procedure Manual* is reviewed and approved by the Sheriff's Office prior to its implementation. Four policies were reviewed by the Grand Jury for compliance to California Title 15 requirements for adult detention facilities:

1. *Pre-Detention Medical Evaluation/Intake Health Screening*
   This policy meets the requirements of Title 15.[11]
2. *Chronic Care*
   This policy meets the requirements of Title 15.
3. *Chemically Dependent Inmate Policy*
   This policy does not meet the requirements of the Title 15, Section 1213, which states in part:

   > *The responsible physician shall develop written medical policies on detoxification which shall include a statement as to whether detoxification will be provided within the facility or require transfer to a licensed medical facility. The facility detoxification protocol*

shall include procedures and symptoms necessitating immediate transfer to a hospital or other medical facility.

The Grand Jury found that the *Chemically Dependent Inmates Policy* does not specify what symptoms necessitate immediate transfer to a hospital or other medical facility. The policy does not address how chemically dependent inmates are identified other than self report or staff report.

Also missing from this policy is the use of an objective opiate withdrawal screening tool such as the Clinical Opiate Withdrawal Scale (COWS).[12] This simple 11 item questionnaire provides an objective measurement of the stage and severity of an inmate's opiate withdrawal and helps staff with treatment decision making.

4. *Reporting In-Custody Deaths*

   This policy meets the requirements of Title 15.

The Grand Jury reviewed the *Detoxification of Chemically Dependent Inmates, Federal Bureau of Prisons Clinical Practice Guidelines, February 2014*.[10] The document provides guidelines for the medical management of withdrawal from addictive substances for federal inmates. The Grand Jury recommends this document be reviewed and evaluated by the Sheriff-Coroner and the applicable guidelines be incorporated into the Sheriff's Office policies and procedures.

Why did CFMG medical staff not transfer Krista DeLuca to a hospital?

The Grand Jury can not investigate this because actions by a for-profit contractor are not within our jurisdiction.

Contract between the Sheriff-Coroner and CFMG

The Grand Jury reviewed the existing contract between the Sheriff-Coroner and CFMG, which expires on September 16, 2016. Five areas of concern were noted:

1. *Responsibility for Health Care Services*

   The contract states (page 0172) the following regarding responsibility:

   Final medical judgements rest with the Medical Director of CFMG, or designee.

   The Sheriff-Coroner, who is ultimately responsible for emergency and basic health care services to all inmates, should have the ability to retain additional independent medical assessment for life-threatening or emergency circumstances.

2. *Compliance with CMA-IMQ Accreditation Standards*[13]

   The contract states (page 0172) the following regarding compliance with standards:

   > *All health care services will comply with Title 15, the CMA-IMQ Accreditation Standards for Adult Correction Facilities and all other applicable laws, regulations, codes and guidelines relating to health care services and programs in adult correction facilities in the State of California.*

   The contract does not specifically state CFMG must seek and obtain CMA-IMQ accreditation, only that they must comply with the accreditation standards. The Grand Jury found no documentation that the medical services at detention facilities under CFMG's management were compliant with CMA-IMQ accreditation standards.

3. *Detoxification Treatment*

   The contract states (page 0185-0186) the following relating to detoxification treatment:

   > *Inmates who are unresponsive and/or whose condition is deemed by CFMG health services staff as unsuitable for housing in the jail will be transported to either Dominican Hospital or Watsonville Community Hospital for treatment.*

   CFMG medical staff did not transfer Krista DeLuca to a hospital. The Grand Jury can not investigate this because actions by a for-profit contractor are not within our jurisdiction.

4. *Emergency and Catastrophic Costs*

   The contract states (page 0217) the following relating to emergency and catastrophic costs:

   > *CFMG will pay all hospital emergency/catastrophic medical care costs up to $15,000 per inmate for each medical/surgical inpatient episode.*

   The Grand Jury believes this is a disincentive to admit inmates to a hospital for necessary medical treatment, and recommends removing this clause from the contract, an action currently being considered by the Sheriff's Office.

> *The Board of Supervisors and the Sheriff-Coroner should thoroughly review and revise the existing medical services contract and critically evaluate the performance of the 2012–2016 medical services provider.*

5. *Outside Review of Contract and the Medical Services Contractor*

   There is no on-going independent county medical oversight of the detention facility medical services provider or contract compliance related to medical issues. The Grand Jury believes retaining medically qualified personnel familiar with medical services within institutions and contract compliance is necessary to ensure basic health care for all inmates.

Investigative Facts Summary

1. The Sheriff-Coroner has the responsibility to ensure provision of emergency and basic health care services to all inmates in Santa Cruz County detention facilities, even when contracting with a medical services provider for jail health care services.
2. The 2012–2016 contract with CFMG for medical services at the county detention facilities began on September 17, 2012, and ends on September 16, 2016.
3. There have been six inmate deaths in the Main Jail since October 2012.
4. The Santa Cruz County detention facilities are not accredited by the California Medical Association-Institute for Medical Quality. The contract states that all health care services will comply with the California Medical Association-Institute for Medical Quality standards, but there is no specific requirement for accreditation.
5. The Sheriff's Office and Board of Supervisors have the option of continuing with a private contractor for jail medical services or returning to the Santa Cruz County Health Services Agency.
6. The Sheriff's Office at times refers to placing at-risk inmates in the infirmary, when in fact they are placed in the Observation Unit. The Observation Unit is not an infirmary.
7. The most recent Title 15 annual inspection for detention facilities conducted by the Santa Cruz County Health Services Agency in April and May 2015 shows that compliance with the detoxification treatment requirements (Title 15, Section 1213) was marked as "not applicable."
8. The Sheriff-Coroner declined to implement most recommendations in the 2013–2014 and 2014–2015 Grand Jury Reports.
9. Sheriff-Coroner Watch Commanders have the authority to override the medical service provider's decision and escalate to a higher level of medical care in life-threatening emergency circumstances.

Findings

F1. There is no publicly available comprehensive report identifying the cause of Krista DeLuca's death, the activities of the Sheriff-Coroner's Office, and the activities of the medical services provider related to her death.

F2. There is no independent county oversight, by a qualified medical professional, of both the medical services provider (CFMG) and the contract.

F3. The 2012–2016 contract does not allow the Sheriff's Office to retain additional independent medical providers but the Watch Commander can override the medical service provider's decision and escalate to a higher level of medical care in life-threatening emergency circumstances.

F4. The 2012–2016 contract requirement that the jail medical services provider pay up to $15,000 per inmate admitted to a hospital may be a deterrent to admitting inmates in need of hospital medical care.

F5. The Health Services Agency completed the required 2015 annual Title 15 inspection of the Main Jail but did not identify if the facility was in compliance with the Detoxification Treatment requirements (Title 15, Section 1213).

F6. There is no documentation that the Santa Cruz County facilities have been evaluated for compliance with the CMA-IMQ medical accreditation standards for detention facilities.

F7. The *Chemically Dependent Inmate Policy* lacks objective measurement tools for assisting the medical staff with their clinical decision making and determination of when a patient requires a higher level of medical care.

F8. The *Chemically Dependent Inmate Policy* does not include procedures and symptoms necessitating immediate transfer to a hospital or other medical facility.

F9. The *Chemically Dependent Inmate Policy* and the Sheriff's *Medical and Mental Health Care Procedure Manual* lack guidance for when an inmate should be transferred to a hospital for a higher level of care or when an inmate should be placed on IV hydration.

F10. The *Detoxification of Chemically Dependent Inmates,* Federal Bureau of Prisons Clinical Practice Guidelines, February 2014, contains useful information related to recommended standards for the medical management of withdrawal from addictive substances.

F11. The Sheriff's Office at times refers to placing at-risk inmates in the infirmary, when in fact they are placed in the Observation Unit. The Observation Unit is not an infirmary. The Grand Jury finds this misnomer to be misleading to the public and endangering of the public trust.

Recommendations

R1. The Sheriff-Coroner should complete a comprehensive report of every jail death including, but not limited to: the cause of death; the activities of the Sheriff's Office and medical services provider related to the death; and recommendations, if any, for improvement. This report should be made available to the Board of Supervisors and the public. (F1)

R2. The Sheriff-Coroner should retain independent oversight of the jail medical service provider and their contract by medically qualified professionals. (F2)

R3. Prior to approving a new medical services contract, the Sheriff-Coroner and Board of Supervisors should thoroughly review the existing contract and evaluate the performance of the 2012–2016 medical services provider with the assistance of qualified medical personnel. (F1–10)

R4. The Sheriff-Coroner should revise the medical services contract to allow an independently retained medical provider to escalate medical care under life-threatening emergency circumstances. (F3)

R5. The Sheriff-Coroner and Board of Supervisors should delete the contract requirement that the medical provider pay up to $15,000 per inmate for each inmate emergency or catastrophic transfer to hospital care. (F4)

R6. The Health Services Agency should complete the annual 2016 Title 15 inspection and identify if the facility is in compliance with the Detoxification Treatment requirements (Title 15, Section 1213), as required by state law. (F5)

R7. The Sheriff-Coroner and Board of Supervisors should require in the contract that the medical services provider for detention facilities obtain and maintain accreditation from the California Medical Association-Institute for Medical Quality for adult detention facilities. (F6)

R8. The Sheriff-Coroner should require that the *Chemically Dependent Inmate Policy* include the use of objective measurements of opiate detoxification stages, such as the Clinical Opiate Withdrawal Scale (COWS), to assist the medical staff in making more objective decisions regarding treatment. (F7)

R9. The Sheriff-Coroner should work with the medical services provider to revise the *Chemically Dependent Inmate Policy* to comply with California Code of Regulations, Title 15, Section 1213, regarding procedures and symptoms necessitating immediate transfer to a hospital or other medical facility. (F8)

R10. Clear guidelines need to be established in the Sheriff's *Medical and Mental Health Care Procedure Manual* for when an inmate should be given a higher level care such as IV hydration or transfer to a hospital. (F9)

R11. The Sheriff-Coroner should review *Detoxification of Chemically Dependent Inmates,* Federal Bureau of Prisons Clinical Practice Guidelines, February 2014, and revise applicable Sheriff's policies and procedures to meet or exceed federal guidelines. (F10)

R12. The Sheriff-Coroner should stop referring to the Observation Unit as an infirmary unless major steps are taken to improve the medical services provided in this unit. Continuing to refer to this group of observation cells as an infirmary is misleading to the public and does a disservice to the public trust. (F11)

Commendation

C1. In this entire unfortunate situation, there is but one bright spot. The Corrections Officers who watched over Krista DeLuca during her last hours carried out their duties with professionalism and compassion for their charge by making small but meaningful efforts to preserve her dignity during her last hours.

The Corrections Officer who was working at the booking desk was concerned for Ms. DeLuca's safety and kept her in booking so he could keep a closer watch on her. Corrections Officers in the Observation Unit made efforts to provide water and assistance while performing their required duties.

Responses Required

Respondent	***Findings***	***Recommendations***	***Respond Within/ Respond By***
Santa Cruz County Sheriff-Coroner	F1–F11	R1–R12	60 Days August 8, 2016
Santa Cruz County Board of Supervisors	F3–F5	R3, R5–R7	90 Days September 6, 2016

Definitions

- **Blaine Street:** *Blaine Street Women's Minimum Security Facility*, Santa Cruz County's minimum-security detention facility for women, located near the Main Jail.
- **CFMG:** *California Forensic Medical Group, Inc.,* a for-profit company.
- **CMA-IMQ:** *California Medical Association-Institute for Medical Quality.*
- **COWS:** *Clinical Opiate Withdrawal Scale*, an evaluation tool used to rate common signs and symptoms of opiate withdrawal and monitor those symptoms over time.
- **Detention Facility:** a place to house inmates, generally short term; jail.
- **EMS:** *Emergency Medical Services*
- **Grand Jury:** the *Santa Cruz County Civil Grand Jury.*
- **HSA:** *Health Services Agency*, a Santa Cruz County department.
- **Infirmary:** A building or part of a building for the treatment of the sick or wounded; a hospital; esp. the sick-quarters in a religious establishment, a school, workhouse, or other institution.

- **Inmate:** inhabitant of a correctional or detention facility, either sentenced by the courts or held before trial.
- **Main Jail:** *Water Street Maximum Security Jail*, the County of Santa Cruz's largest detention facility, located in the City of Santa Cruz.
- **Observation Unit:** A unit with sixteen locked down cells, most of which are under constant video surveillance by a central control room correctional officer. These cells are used for treatment and monitoring of inmates with medical and mental health concerns.
- **Rountree:** *Rountree Men's Medium Security Facility*, a medium detention facility for Santa Cruz County, located in Watsonville.
- **Title 15:** California Code of Regulations, Title 15, Division 1, Chapter 1, Subchapter 4, Minimum Standards for Local Detention Facilities.[9]

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Site Visits

Santa Cruz County Main Jail

Appendix A

Chronology of Events for Krista DeLuca, September 2015

Date	*Time*	*Event*
24th	11:45pm	Ms. DeLuca arrested by Capitola Police and transported to Main Jail.
25th	1:37am	Ms. DeLuca referred by Corrections Officers to medical staff after being identified as an "at-risk inmate" after Pre-Detention Medical Evaluation.
	–	Nurse took Ms. DeLuca's medical history and vital signs.
	–	Ms. DeLuca assigned to the general population (G unit) for housing.
26th	–	Ms. DeLuca placed on opiate withdrawal protocol during the evening.
27th	–	Nurse called to G Unit because Ms. DeLuca is complaining of difficulty breathing, nausea, and vomiting. Ms. DeLuca asks to go to the hospital but the nurse does not refer. Nurse prescribes Gatorade and deep breathing exercises. Ms. DeLuca transferred from G unit to booking area holding room #2 on medical watch for dehydration.
28th	12:30pm	Physician's Assistant (PA) notified that Ms. DeLuca was suffering from prolonged vomiting. The PA did not actually see her. Physician's Assistant prescribes an injection to control vomiting.
	12:51pm	Her symptoms improve.
	2:13pm	Oral hydration is encouraged and she is to remain on the OWD protocol.
	–	Ms. DeLuca moved to Observation Unit cell #13.
29th	5:00am	Ms. DeLuca given suppository by nurse to control vomiting.
	5:30am	Ms. DeLuca is visited by nurse, provided medication, vital signs not recorded.
No CFMG medical observations recorded after 5:30 AM		
	5:51am 6:20am 6:48am	Routine checks by Corrections Officers (approximate times).
	6:52am	EMS called for "possible seizure and cardiac arrest."
	7:00am	EMS from Santa Cruz City Fire Department arrives on scene.
	7:28am	Ms. DeLuca was pronounced dead at the Main Jail.

Sources: Santa Cruz Sentinel[14] and Autopsy Report for Krista DeLuca[6]