COMMITMENT
INTEGRITY
LEADERSHIP

February 3, 2022
Report 2021-109
FACT SHEET

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San Diego County Sheriff's Department

It Has Failed to Adequately Prevent and Respond to the Deaths of Individuals in Its Custody

Background

Federal law requires county sheriff's departments to provide adequate medical care for individuals in their custody, and incarcerated people may request medical or mental health attention as needs arise. In California, the Board of State and Community Corrections establishes the minimum standards that local detention facilities must follow, and each jail system may create more specific policies for the safety and care of incarcerated individuals. Nevertheless, 185 individuals in the custody of the San Diego County Sheriff's Department (Sheriff's Department) died from 2006 through 2020—more than in nearly any other county in the State.

When someone dies in the custody of the Sheriff's Department, it investigates the death and performs internal reviews that can identify corrective measures. The Citizens' Law Enforcement Review Board (CLERB) is another key county entity that provides external oversight when an incarcerated individual dies in San Diego County.

Key Findings

- The Sheriff's Department has not taken sufficient steps to prevent the high number of deaths in its jails, and the Sheriff's Department's failure to consistently provide adequate medical and mental health care likely contributed to its high number of in-custody deaths.
  - » It did not always identify individuals' health care needs at intake, nor did it consistently follow up with those who needed such services.
  - » Detention staff performed insufficient safety checks, and it did not always provide prompt lifesaving measures to unresponsive individuals.
- The Sheriff's Department's inadequate policies are partly the result of weaknesses in statewide corrections standards.
- The Sheriff's Department has not consistently implemented the meaningful changes necessary to respond to the deaths of individuals in its custody.
  - » Its processes for investigating and reviewing in-custody deaths are ineffective, structurally problematic, and lacking in transparency.
  - » It has not implemented key recommendations from external entities related to incarcerated individuals' welfare and safety.
- Neither the Sheriff's Department nor CLERB has taken adequate action in response to the deaths of incarcerated individuals.
  - » CLERB has failed to effectively conduct independent, timely, or thorough investigations.
  - » Until recently, the county board provided insufficient oversight of CLERB.

Key Recommendations

- The Legislature should amend state law to require the Sheriff's Department to do the following:
  - » Revise its policies to align with best practices related to performing intake health evaluations, providing follow-up medical and mental health care, conducting safety checks, and addressing the other deficiencies we identify in this report.
  - » Develop a process to make public the facts discovered and recommendations made in response to all in-custody deaths.
- The Legislature should require BSCC to ensure that county sheriff departments have mental health professionals perform incarcerated individuals' mental health evaluations and have correctional staff conduct safety checks that are sufficiently robust to determine that incarcerated individuals are alive.
- CLERB should revise its rules and regulations by May 2022 to do the following:
  - » Prioritize investigations of the Sheriff's Department's in-custody deaths to ensure that it completes them within the statutory one-year time frame.
  - » Include among its responsibilities the investigation of all natural deaths that occur in the Sheriff's Department's custody.