# Independent Study of In-Custody Deaths

# in San Diego County Jails

# Supplemental Material

The Mountain-Whisper-Light: Statistics & Data Science

**April 2026**

# Independent Study of In-Custody Deaths in San Diego County Jails
# Supplemental Material

Prepared for CLERB

By

The Mountain-Whisper-Light: Statistics & Data Science

Nayak Polissar, Ph.D.

Cheryl Brown Hill, J.D.

Nirnaya Miljacic, MS, PhD

Patricia A. Way, Ph.D.

Michele Deitch, J.D., M.Sc.

**April 2026**

# TABLE OF CONTENTS

SDSD In Custody Death PRA (Reference No. S000257-012224) ..... 4

SDSD Population PRA (Reference No. S000257-012224) ..... 8

SDSD Mental Health PRA (Reference No. S000894-031324) ..... 11

SDSD Staffing PRA (Reference No. S002147-061824) ..... 16

SDSO Policies and Programs CPRA (Reference No. S003984-102424) ..... 22

SDSO Consolidated CPRA (Reference No. S003985-102424) ..... 27

INTRODUCTION TO STUDY MINI-REPORTS ..... 32

MINI-REPORT for Item 2a ..... 32

MINI-REPORT for Item 2b ..... 53

MINI-REPORT for Item 2c ..... 69

MINI-REPORT for Item 2d ..... 86

MINI-REPORT for Item 2e ..... 99

**The Mountain-Whisper-Light, Inc.**
1827 23rd Ave. East, Seattle, WA 98112-2913
Phone: (206) 329-9325 • Fax: (206) 324-5915
Cell: 206-349-9325
E-mail: nirnaya@mwlight.com

January 22, 2024

San Diego Sheriff's Department
CPRA Request
John J. Duffy Administration Center
9621 Ridgehaven Ct.
San Diego, CA 92123
sdsheriff.govqa.us

Dear CPRA Officer:

As per the California Public Records Act (CPRA), we are writing to request a copy of records regarding in-custody deaths in the San Diego County Jails. There are two sections of our request, detailed below. **Section A**. **In-Custody Death Statistical Data** requests information preferably in a .txt, .csv, .xls, or .xlsx format. We have included the In-Custody Deaths (2023) table on page 3 below as an example. **Section B**. **In-Custody Death Reports Nonstatistical Data** requests information for reports and documents rather than compiled spreadsheet data. To the extent possible, please send all of the requested information electronically as attachments via email at this address: nirnaya@mwlight.com.

Please also provide a guide or data dictionary with your reply, so that we can determine the accurate meanings of the column names and entries. We would also like to get the name and contact information of someone familiar with the data, so that we can follow up, should we have questions or need clarification. Our contact information is listed below, should you have any questions about these requests. Thank you for your time and attention to this request.

Sincerely,

Nirnaya Miljacic
Biostatistician
**The Mountain-Whisper-Light: Statistics & Data Science**

**1827 23rd Avenue East**
**Seattle, WA  98112**
nirnaya@mwlight.com

**Section A. In-Custody Death Statistical Data:**

1. The requested in-custody death data is itemized below for all in-custody deaths, starting with 1/1/2012 through to the present date. The Sample Table below is an example of a layout that is convenient for analysis, though we will accept the data in whatever format you maintain it. The Sample Table includes some—but not all—of the data items we are requesting. If there is any data below that you do not have, please send what you do have, and, if any of the requests will take longer for your response, please send the more readily available data separately and sooner.

a. Incident Date;

b. Incident Location;

c. Decedent's Name (with, if possible, first, last and middle name or middle initial separated by commas);

d. Decedent's Inmate Number;

e. Decedent's Age;

f. Decedent's Race/Ethnicity;

g. Decedent's Gender;

h. Decedent's Custody Status;

i. Decedent's Projected Release Date;

j. Decedent's Classification Status;

k. Location Where Death Occurred;

l. Manner of Death;

m. Cause of Death;

n. Contributing Conditions;

o. How Injury (or Cause) Occurred;

p. Date In-Custody Status Began (or Date of Booking);

q. Arrest Offense and/or Criminal Charges Filed;

r. Bail Amount (where applicable);

s. Length of Sentence (where applicable);

t. Realigned Population Status (whether part of realigned population or not);

u. Name of Hospital Where Death Occurred (where applicable);

v. Type of Housing Unit where Decedent Resided Immediately Prior to Death (e.g. dormitory, single cell, double cell, restricted housing, infirmary, etc.);

w. Date of Death (if different from incident date);

x. NARCAN/Naloxone Deployment (yes or no);

y. Residence/mailing address or housing location or homeless shelter at booking.

**Sample table** (taken from Homicide, In-Custody Deaths, Officer Involved Shootings San Diego County Sheriff https://www.sdsheriff.gov/resources/transparency-reports):

## In-Custody Deaths (2023)

| Incident Date | Incident Location | Subject Name | Subject Age | Subject Race | Subject Gender | Custody Status | Location Where Death Occurred | Manner of Death | Cause of Death |
|---|---|---|---|---|---|---|---|---|---|
| 2/1/2023 | VDF | Thuresson, Ryan Patrick | 33 | White | Male | Sentenced | Local Hospital | Accident | Combined Fentanyl and Fluorofentanyl Toxicity |
| 2/21/2023 | SDCJ | Shuey, Robert | 67 | White | Male | Booked Awaiting Trial | County Jail | TBD | TBD |
| 4/17/2023 | VDF | Faulkner, Eddie | 53 | Black | Male | Booked Awaiting Trial | County Jail | Accident | Acute fentanyl, trazodone, and gabapentin intoxication, with contributing hypertensive and atherosclerotic cardiovascular disease |
| 5/3/2023 | LCDF | Adamson, Patricia | 63 | White | Female | Booked Awaiting Trial | County Jail | TBD | TBD |
| 5/16/2023 | HGU | Aguirre, Maximillian | 71 | Hispanic | Male | Booked Awaiting Trial | Local Hospital | Natural | Hypertensive arteriosclerotic cardiovascular with contributing pneumonia and renal failure |
| 5/28/2023 | LCDF | Bartolacci, Roselee | 32 | Black | Female | Booked Awaiting Trial | County Jail | TBD | TBD |
| 6/26/2023 | HGU | Heimark, Paul Arthur | 66 | White | Male | Sentenced | Local Hospital | TBD | TBD |
| 6/28/2023 | SDCJ | Ornelas, Pedro Junior III | 27 | Hispanic | Male | Booked Awaiting Trial | Local Hospital | Suicide | Anoxic-ischemic emcephalopathy due to resuscitated cardiopulmonary arrest, due to asphyxia, due to hanging |
| 6/29/2023 | HGU | Davis, Zeke | 43 | White | Male | Awaiting Booking | Local Hospital | TBD | TBD |
| 7/20/2023 | SDCJ | Carlton, Timothy Aaron | 53 | White | Male | Sentenced | County Jail | TBD | TBD |
| 7/19/2023 | GBDF | McDowell, Jonathan | 47 | White | Male | Booked Awaiting Trial | Local Hospital | TBD | TBD |
| 9/28/2023 | SDCJ | Bach, Keith Galen | 63 | White | Male | Booked Awaiting Trial | County Jail | TBD | TBD |
| 11/12/2023 | HGU | Altmark, Donald | 71 | White | Male | Booked Awaiting Trial | Local Hospital | TBD | TBD |

2. The name of the decedent and the total number and dates of telephone calls, emails, in-person and video visits for each person who died in custody starting with 1/1/2012 through to the present date.

3. The name of the decedent and the number and description (and dates) of inmate incidents and/or assaults against staff for each person who died in custody starting with 1/1/2012 through to the present date.

4. The name of the decedent and the number and description (and dates) of inmate incidents and/or assaults against another incarcerated person for each person who died in-custody starting with 1/1/2012 through to the present date.

**Section B. In-Custody Death Reports Nonstatistical Data:**

5. All 30-Day Medical Review reports for all in-custody deaths with the name of the decedent starting with 1/1/2012 through to the present date.

6. All CIRB In-Custody Death Information Release forms with the name of the decedent for all in-custody deaths starting with 1/1/2012 through to the present date.

7. All Homicide Investigation reports with the name of the decedent for all in-custody deaths starting with 1/1/2012 through to the present date.

8. Death certificates for each person who died in-custody starting with 1/1/2012 through to the present date. (And the name of the decedent and the data from death certificates for each person who died in-custody from 1/1/2012 through to the present date in table/spreadsheet format (or .txt, .csv, .xls, or .xlsx format) if available.)

9. All non-medical request forms submitted by each person who died in-custody starting with 1/1/2012 through to the present date, including the decedent's name.

10. All Requests for Medical Service forms submitted by each person who died in-custody starting with 1/1/2012 through to the present date, including the decedent's name.

11. All grievance forms submitted by each person who died in-custody starting with 1/1/2012 through to the present date, including the decedent's name.

# SDSD Population PRA (Reference No. S000257-012224)

**The Mountain-Whisper-Light, Inc.**
1827 23rd Ave. East, Seattle, WA 98112-2913
Phone: (206) 329-9325 • Fax: (206) 324-5915
Cell: 206-349-9325
E-mail: nirnaya@mwlight.com

January 22, 2024

San Diego Sheriff's Department
CPRA Request
John J. Duffy Administration Center
9621 Ridgehaven Ct.
San Diego, CA 92123
sdsheriff.govqa.us

Dear CPRA Officer:

As per the California Public Records Act (CPRA), we are writing to request a copy of records on population data in the San Diego County Jails. There are two sections of our request, detailed below. **Section A**. **Population Statistical Data,** requests data, preferably, in a .txt, .csv, .xls, or .xlsx format. In **Section B**. **Population Nonstatistical Data**, the request is for reports and documents rather than compiled statistical data. To the extent possible, please send all of the requested information electronically as attachments via email to this address: nirnaya@mwlight.com.

Please also provide a guide or data dictionary with your reply, so that we can determine the accurate meanings of the column names and entries. We would also like to get the name and contact information of someone familiar with the data, so that we can follow up, should we have questions or need clarification. Our contact information is listed below, should you have any questions about these requests. Thank you for your time and attention to this request.

Sincerely,

Nirnaya Miljacic
Biostatistician
**The Mountain Whisper Light Statistics & Data Science**
**1827 23rd Avenue East**
**Seattle, WA 98112**

nmiljacic@mwlight.com

**Section A. Population Statistical Data:**

1. On-hand population data on the 1st of each month from 1/1/2012 through 1/1/2024 with the following information for all inmates at all jail facilities. We prefer the information with the columns (a. through o.) in a single table/spreadsheet, such as a .txt, .csv, .xls, or .xlsx format, but we will accept the data in whatever format you maintain it. If there is any data below that you do not have, please send what you do have, and, if any of the requests will take longer for your response, please send the more readily available data separately and sooner.

a. Inmate's Name (first, last name and middle initial or middle name—separated by commas);

b. Inmate's Number;

c. Inmate's Age;

d. Inmate's Race/Ethnicity;

e. Inmate's Gender;

f. Inmate's Custody Status;

g. Inmate's Projected Release Date;

h. Inmate's Classification Status;

i. Date In-Custody Status Began (or Date of Booking);

j. Arrest Offense and/or Criminal Charges Filed;

k. Bail Amount (where applicable);

l. Length of Sentence (where applicable);

m. Realigned Population Status (Part of realigned population: yes or no);

n. Name of Jail Facility;

o. Type of Housing Unit (e.g. dormitory, single cell, double cell, restricted housing, infirmary, etc.).

2. Daily population count for each facility for each day starting with 1/1/2012 through to the present date.
3. Daily population count for each of the different kinds of housing units within each jail facility, e.g. solitary confinement, dormitories, cell blocks, medical/infirmary, general population, alternative programs, etc. starting with 1/1/2012 through to the present date.

4. All Realigned Population data ("Imprisoned County Jail" population) for each jail facility starting with 1/1/2012 through to the present date. Daily preferred, but weekly or monthly would be acceptable.

5. The total number of people entered into custody (booked), total number transferred, and total number released from custody each day starting with 1/1/2012 through to the present date. Daily preferred, but weekly or monthly would be acceptable.

6. Daily breakdown of the of the inmate population by arrest offense and/or criminal charges starting with January 2012 through December 2023. Daily preferred, but weekly or monthly would be acceptable.

**Section B. Population Nonstatistical Data:**

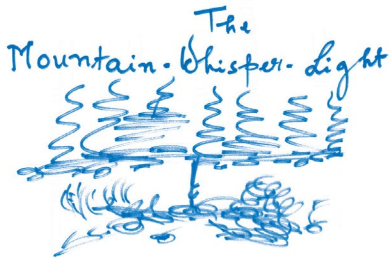
7. Definition of rated capacity and overcapacity.

8. The rated capacity for each of the jail facilities for each year starting with 1/1/2012 through to the present date.

9. The specific dates when the rated capacity changed for any of the jail facilities starting with 1/1/2012 through to the present date.

10. Detention Services Monthly Population Reports starting with January 2012 through December 2020.

# SDSD Mental Health PRA (Reference No. S000894-031324)




**The Mountain-Whisper-Light, Inc.**
1827 23rd Ave. East, Seattle, WA 98112-2913
Phone: (206) 329-9325 • Fax: (206) 324-5915
Cell: 206-349-9325
E-mail: nirnaya@mwlight.com

March 13, 2024

San Diego Sheriff's Department
CPRA Request
John J. Duffy Administration Center
9621 Ridgehaven Ct.
San Diego, CA 92123
sdsheriff.govqa.us

Dear CPRA Officer:

As per the California Public Records Act (CPRA), we are writing to request a copy of records and data regarding mental health services in the San Diego County Jails. There are two sections of our request, detailed below: **Section A**. **Mental Health Statistical Data** requests information preferably in a .txt, .csv, .xls, or .xlsx format; **Section B**. **Mental Health Policy and Procedure Questions** requests responses to specific questions about current practices related to incarcerated people's mental health needs**.**

If there is any data requested that you do not have, please send what you do have that covers this topic, and, if any of the requests will take longer for your response, please send the more readily available data separately and sooner. To the extent possible, please send all of the requested information electronically as attachments via email at this address: nirnaya@mwlight.com.

Please also provide a guide or data dictionary with each dataset in your reply, so that we can determine the accurate meanings of the column and row names and all data fields. We would also like to get the name and contact information of someone familiar with the data, so that we can follow up, should we have questions or need clarification. Our contact information is listed below, should you have any questions about these requests. Thank you for your time and attention to this request. All data and documents will be used to support the San Diego Sheriff's Department (SDSD) in its effort to prevent inmate deaths.

Sincerely,

Nirnaya Miljacic
Biostatistician
**The Mountain-Whisper-Light: Statistics & Data Science**
**1827 23rd Avenue East**
**Seattle, WA 98112**

nirnaya@mwlight.com

**Section A. Mental Health Statistical Data**

1. What is the annual mental health budget for the Detention Services Bureau starting with January 1, 2012, through to the present date?

2. Describe the steps in the intake mental health screening processes for each year, starting with January 1, 2012, through to the present date, including the title(s) and professional mental health license(s) of the employee or contractor involved in each stage of that process.

3. Please describe the protocol each year for identifying, housing, and meeting the needs of incarcerated people who pose a risk of suicide at intake, starting with January 1, 2012, through to the present date.

4. Please list the initial and any “refresher” trainings that intake staff have received to identify people who present a risk of suicide each year starting with January 1, 2012, through to the present date.

5. Is there any point after booking where staff are trained to identify people who appear to be at risk of suicide? If so, please list any such initial and any “refresher” trainings that staff have received each year starting with January 1, 2012 through to the present date.

6. Please describe the collaborations that the Detention Services Bureau has had with County Behavioral Services and/or County Health and Human Services each year starting with January 1, 2012, through to the present date. For example, has there been any kind of check done during the intake process to see if the person being booked has received county mental health services previously?

7. Please provide the number of incarcerated people each year who previously received County Behavioral Health Services (BHS) and/or County Health & Human Services Agency (HHSA) treatment prior to booking and the dates of that treatment starting with January 1, 2012, through to the present date.

8. Please describe the processes that have been in place each year for incarcerated people who want to request mental health assistance after booking, including the titles of the people evaluating the request, and the titles of the people with the authority for ultimate approval or denial of the request(s) starting with January 1, 2012, through to the present date.

9. Please provide the names of all psycho-social and therapeutic programs related to mental health offered at the detention facilities, including the JBCT (jail-based competency treatment), with the following information for each year starting with January 1, 2012, through to the present date:

a. a brief description of the program;

b. the year that each program started;

c. the year that each program ended (where relevant);

d. the number of participants per year per program;

e. the name of the jail facilities where the program is/was offered;

f. the specific dates that each program was offered;

g. the number of people on any waiting list on the first of each month for each program for each year.

10. Please provide the names of the people who died in-custody who also participated in any psycho-social or therapeutic mental health programs, including the JBCT, with the name of the specific program(s) they participated in and the duration of their participation, starting with January 1, 2012, through to the present date.

11. Please provide a list of all cell types/housing types used for mental health treatment (e.g. safety, inpatient psychiatric security, enhanced observation, step down unit cells) starting with January 1, 2012 through to the present date, with the following information:

a. a brief description of its purpose;

b. name of the jail facility where located;

c. the type of equipment available in the cell (e.g. type of bed, toilet, sink, wastebasket);

d. items permitted to be kept in the cell (e.g., clothing, linens, books, other supplies);

e. time permitted outside of the cell;

f. time permitted outdoors;

g. the amount of visitation time permitted;

h. whether in-person and contact visitation is allowed;

i. the amount of time allowed for phone calls.

12. Please provide a list of all cell types/housing types that have been used during times of overcrowding for a different classification of incarcerated person than their intended purpose starting with January 1, 2012, through to the present date.

13. Please provide the names of the people who died in-custody who were in cells/housing for mental health treatment, the specific cell types/housing types, the start and end dates of their stay in each, starting with January 1, 2012, through to the present date.

14. What have been the different designations, categories, or diagnoses used for incarcerated people with mental health needs starting with January 1, 2012, through to the present date?

15. What policies have been in place each year to allow people with a mental health diagnosis who have been taking prescription medication prior to jail admission to continue on that same medication without interruption starting with January 1, 2012, through to the present date? Have family members been able to provide properly identified prescription medication to jail authorities following booking to allow for seamless pharmaceutical care?

16. What policies have been in place each year about whether sworn staff are made aware of the incarcerated people who have mental diagnoses starting with January 1, 2012, through to the present date? What have been the procedures for ensuring that all appropriate staff are advised? Have clinical staff been involved in the plan for care or treatment?

17. What policies have been in place for identifying people who are intoxicated at intake for each year starting with January 1, 2012, through to the present date? What has been the protocol for handling situations where the person is intoxicated?

**Section B. Mental Health Policy and Procedure Questions**

18. Do staff receive any counseling or other services for secondary trauma after an in-custody death occurs? If so, describe the services and include the years that such services have been offered since January 1, 2012, through to the present date.

19. Do incarcerated people receive any counseling or other services for secondary trauma after an in-custody death occurs? If so, describe the services and include the years that such services have been offered since January 1, 2012, through to the present date.

20. Are incarcerated women eligible for placement in the JBCT program? If so, please provide the date that eligibility began.

21. Has SDSD/Detention Services Bureau received National Commission on Correctional Health Care (NCCHC) accreditation or certification? If so, please provide the date of accreditation/certification.

# SDSD Staffing PRA (Reference No. S002147-061824)

The Mountain-Whisper-Light, Inc.

1827 23rd Ave. East, Seattle, WA 98112-2913
Phone: (206) 329-9325 • Fax: (206) 324-5915
Cell: 206-349-9325

E-mail: nirnaya@mwlight.com

June 18, 2024

San Diego Sheriff's Department
CPRA Request
John J. Duffy Administration Center
9621 Ridgehaven Ct.
San Diego, CA 92123
sdsheriff.govqa.us

Dear CPRA Officer:

As per the California Public Records Act (CPRA), we are writing to request a copy of records regarding staff and facilities in the San Diego County Jails. There are three sections of our request, detailed below. **Section A**. **Staffing/Personnel Statistical Data** requests information preferably in a .txt, .csv, .xls, or .xlsx format. **Section B**. **Staffing/Personnel Nonstatistical Data** requests reports, contracts, or documents rather than compiled statistical data. **Section C. Staffing/Personnel Questions** requests responses to specific questions about current staffing/personnel practices**.**

If there is any data requested that you do not have, please send what you do have, and, if any of the requests will take longer for your response, please send the more readily available data separately and sooner.

For each dataset or file please also provide a guide or data dictionary with your reply, so that we can determine the accurate meanings of the column and row names and entries. Our contact information is listed below, should you have any questions about these requests. Thank you for your time and attention to this request.

Sincerely,

Nirnaya Miljacic

Senior Biostatistician
The Mountain-Whisper-Light: Statistics & Data Science
1827 23rd Avenue East
Seattle, WA 98112
nirnaya@mwlight.com

**Section A. Staffing/Personnel Statistical Data**

1. The functional title of all SDSD Detention Services Bureau contracted and staff personnel on duty each day, starting with January 1, 2012, through to the present date, with the following information for each person (note, if this attendance record is not available on a daily basis, please provide it on a weekly or monthly basis):

a. the title of their position;

b. the rank of their position;

b. their race;

c. their gender;

d. the start date of their employment;

e. the end date of their employment (if applicable);

f. whether it was/is a permanent or contractual position; if contracted, vendor name;

g. whether it was/is a part-time or full-time position;

h. the number of total hours worked per week;

i. the number of hours of overtime per week;

j. whether it was/is a sworn staff or civilian (or equivalent) position;

k. whether it included or includes supervisory responsibility;

l. whether it included or includes jail facility management authority;

m. the division(s) or department in which they worked or currently work;

n. any professional certifications and/or licenses (e.g. medical, mental health) they held/hold.

2. Describe the different types of shift systems that have been in place from January 1, 2012, through to the present date. Please provide the following information for each different type of shift system for each facility within the San Diego County Sheriff's Detention Services Bureau since January 1, 2012:

a. the total number of staff scheduled to be on duty during a shift;

b. the start and end time for each shift;

c. the number of shifts per jail facility and per units within jail facilities, if they differ;

d. the start and end dates of each type of shift system that has been in place since January 1, 2012.

3. The staff turnover figures, including firings, resignations, retirements, etc. at each jail facility for each year starting with January 2012, through to the present year.

4. Regarding vacancies for each contracted and staff personnel position starting with January 1, 2012, through to the present date, please provide:

a. the functional title of the position in which there was a vacancy;

b. the start and end date of the vacancy;

c. the jail facility and location within the jail for each vacancy;

d. the measures taken to make sure that the vacant posts or roles were covered;

e. Whether any non-custodial staff such as clerical or program staff have been assigned to cover custodial responsibilities at any time and the dates on which this occurred starting with January 1, 2012 through to the present date.

5. List the names of all companies/vendors that SDSD Detention Services Bureau has contracted with for personnel or services related to personnel starting with January 1, 2012, through to the present date, with the start and end date (where applicable) of each contract. Indicate the service provided by the vendor.

6. The following contract information for all contracted staff in a supervisory role starting January 1, 2012, through to the present date:

a. the contracting company for whom they worked;

b. the start and end date of each contracted supervisor's contract;

c. the average pay for each contractual supervisory position;

d. whether the staff contract was extended;

e. the number of times the contract was extended (if applicable);

f. whether any contract renewals are anticipated for current contracted supervisors;

g. whether the contracted supervisor was converted to a permanent employee.

7. For trainings required for detention staff starting with January 1, 2012, through to the present date, please provide the following information:

a. the title(s) of the required training(s)/course(s);

b. the positions for which the training is offered/required;

c. the length of the training/course;

d. the required frequency for taking the training (e.g. one time per year);

e. the name(s) of the instructors for this training and their credentials.

8. The documented frequency of sworn officer rounds in each different security-level unit in each jail facility for the following days:

a. each of the days that an in-custody death occurred;

b. the day that is one week before a death occurred, starting with January 1, 2012, through to the present date.

9. Please describe your staff and contractor screening process for entering, exiting, and reentering all jail facilities (and any units within facilities, if applicable) and provide all dates for which staff and contractors have been screened starting with January 1, 2012, through to the present date, including the following information per date:

a. the number of staff and contractors screened and the number of times screened;

b. the number of staff and contractors not screened;

c. the items for which screening is conducted (i.e. contraband items);

d. whether contraband items were detected/confiscated on each date;

e. what is done with confiscated items;

f. whether any disciplinary measures were taken when contraband was detected;

g. whether the detected items would result in employee or contractor termination.

**Section B. Staffing/Personnel Nonstatistical Data**

10. All organization charts for San Diego Sheriff's Department for each year starting with January 1, 2012, through to the present date. Please include a separate chart for the executive department and a separate chart for detention facilities as well as a combined chart for each year, with the following information:

a. each staff person's name;

b. the staff title;

c. whether permanent or contractual employee.

11. Provide a copy of any EEOC reports that were filed starting with January 1, 2012, through to the present date.

12. A copy of all contracts with companies/vendors that SDSD Detention Services Bureau has contracted with for personnel or services related to personnel starting with January 1, 2012, through to the present date.

13. A copy of the contracts for all personnel contracted to work with SDSD Detention Services Bureau starting with January 1, 2012, through to the present date.

**Section C. Staffing/Personnel Questions**

14. Describe the staff supervision model (e.g. direct or indirect) that was followed in each facility and each security-level unit within each facility for every year starting with January 1, 2012 through to the present date.

15. How have staff been assigned for supervision of the facility if an indirect model of supervision is followed?

16. Describe the process used to assign staff to different housing units or other roles, and any changes in that process, starting with January 1, 2012, through to the present date.

17. Describe the policy for the frequency of sworn officer rounds in each different security-level unit in each jail facility on the first of each month starting with January 1, 2012, through to the present.

18. The names of all contracted and staff personnel who were assigned to and who responded to the locations where in-custody deaths occurred starting with January 1, 2012 through to the present date (if names are unavailable, please provide the functional title for each person).

19. The name(s) of the SDSD staff responsible for overseeing each Mental Health Provider contract starting with January 1, 2012 through to the present date.

20. The names of all contracted supervisors of all Licensed Mental Health Clinicians on contract starting with January 1, 2012 through to the present date.

# SDSO Policies and Programs CPRA (Reference No. S003984-102424)

**The Mountain-Whisper-Light, Inc.**
1827 23rd Ave. East, Seattle, WA 98112-2913
Phone: (206) 329-9325 • Fax: (206) 324-5915
Cell: 206-349-9325
E-mail: nirnaya@mwlight.com

October 23, 2024

San Diego Sheriff's Department
John J. Duffy Administration Center
9621 Ridgehaven Ct.
San Diego, CA 92123
sdsheriff.govqa.us

Dear CPRA Officer:

The purpose of this California Public Records Act (CPRA) request is to obtain information and data about any and all activities and/or initiatives that the San Diego County Sheriff's Office implemented over the last 12 years to prevent (or reduce) the number of in-custody deaths. We seek this information as part of a larger study to identify causes and further opportunities to prevent in-custody deaths in the San Diego County detention facilities.

This CPRA request seeks data concerning all of the programs that were developed and implemented by the San Diego County Sheriff's Office (SDSO) to prevent in-custody deaths and the policies and procedures that were enacted for that purpose. This includes, without limitation, the actual programs approved by the San Diego County Board of Supervisors, San Diego Sheriff's Office, as well as actions and recommendations made by entities such as the Attorney General, Auditor of the State of California, San Diego County Citizens' Law Enforcement Review Board (CLERB), Critical Incident Review Board (CIRB), San Diego Grand Jury, Board of State and Community Corrections (BSCC), Disability Rights of California and other federal, state, public, and private entities.

Sincerely,

Nirnaya Miljacic , Biostatistician
**The Mountain-Whisper-Light: Statistics & Data Science**

**1827 23rd Avenue East**
**Seattle, WA 98112**
**nirnaya@mwlight.com**
This CPRA seeks policies and procedures recommended and/or enacted in any and all jail facilities under SDSO's jurisdiction and information about vendors, state entities and others who have been involved in preventing or reducing in-custody deaths.

The period of time in interest for this CPRA request is January 1, 2012 through to the present date. We prefer to receive just the information requested below rather than the records themselves that are sufficient to convey the requested information.

**Identification of All Programs Implemented**

1. Please provide all of the following information, or alternatively, records sufficient to convey all of the following information, for all activities, initiatives, efforts, policies, procedures, and programs implemented specifically to prevent in-custody deaths at jail facilities under SDSO's jurisdiction between January 1, 2012 and the present date (collectively "Activities" or "Activity"):
    a. The name of the Activity (if named);
    b. A brief description of the Activity and its purpose;
    c. Date that the Activity started or became effective;
    d. The name of each jail facilities where the activity was implemented;
    e. Whether the Activity was implemented by the Sheriff's Office or a contractor;
    f. If the Activity was implemented by a contractor: (i) the name of the contractor, (ii) the date(s) of the contract(s) and all contract extensions, and (iii) the name of the contract manager or administrator;
    g. Date of any amendments, revisions, or changes to the Activity. (For example, SDSO has indicated that in partnership with Naphcare, it will begin revising policies and procedures with the intent of implementing them into jail operations in 2023);
    h. Brief description of any amendments, revisions, and changes to the Activity;
    i. Date Activity was completed or ended, or current status if not completed or ended;
    j. The specific policies and procedures developed and enacted to implement the Activity; and
    k. Any data about the Activity's impact on preventing in-custody deaths and estimate of the number of in-custody deaths the Activity prevented.

    Activities may include, without limitation, facility (building, jails, trailers, etc.) improvements; staffing changes; policy, procedure, and program adoptions and changes, changes in equipment, changes in medical supplies, renovations to add or change space to existing structures for redesign to better accommodate different uses for the space, additional inventory, etc. Attached please find **Appendix A** for reference, which is a non-exhaustive list of activities, initiatives, efforts, policies, procedures, and programs found on SDSO's website that may be responsive to this request.

2. Please list all programs, policies, initiatives, procedures, and activities to address in-custody deaths in any and all San Diego County jail facilities recommended by any and all oversight or accountability entities, government agencies and nonprofits, including, without limitation: San Diego County Grand Jury, Auditor of the State of California, Office of the Attorney General, Board of State and Community Corrections, County of San Diego, Department of Justice, and the Citizens Law Enforcement Review Board, Disability Rights California, and National Commission on Correctional Health Care. Please also note whether SDSO has implemented the recommendation or not. In the alternative to providing a list with the foregoing information, please provide records sufficient to convey all of the foregoing information.

3. Please provide all of the following information, or alternatively, records sufficient to convey all of the following information: A list of all SDSO position titles or the names of all employees who are responsible for any part of the implementation process of any Activity. Below is a partial list that you can update and complete:
    a. Chris Miedico – Medical Services Administrator; and
    b. Melissa Quiroz – Mental Health Director.

This information is sought to assist the San Diego County Citizens' Law Enforcement Review Board (CLERB) in discharging its duties under the San Diego County Code (SDCC) and Charter. As you know, SDCC section 340.15 requires "all officers and employees of the County" to give CLERB "complete and prompt cooperation" when it is discharging its duties. The assertion of discretionary exemptions to disclosure under the CPRA is inconsistent with this legal obligation. If you assert any type of discretionary exemption to disclosure, then with your response please also explain how your choice to assert that exemption rather than cooperate with CLERB does not violate SDCC 340.15.

**Appendix A**
**Policies and Procedures PRA**

a. Deployment of drug-sniffing dogs to help prevent illegal drugs from being smuggled into jails;
b. Booking Process reforms;
c. Medical Services reforms;
d. Record-keeping reforms;
e. Mental Health Treatment reforms;
f. Drug and Re-Entry Services reforms;
g. Addition of 24/7 Mental Health Staffing;
h. Opening of new facility – Rock Mountain (additional sleeping quarters);
i. Renovations to existing facilities;
j. Addition of Mental Health Case Management Clinician Job Classification;
k. Initiation of ADA Sign Language program to assist deaf people in their custody (including interpreters);
l. Updates to the way SDSOprotects employees and detainees from COVID;
m. Partnership with Department of State Hospitals (DSH)to implement Early Access Stabilization Services) Program to treat individuals who have been deemed incompetent to stand trial and are awaiting placement in an inpatient psychiatric bed in a DSH facility or Jail-Based Competency Treatment Program;
n. Filling of vacant staff positions;
o. Retention of current employees by offering new incentives such as increased pay for working nightshifts;
p. Adding a Certified Nurse Assistant (CNA) position;
q. Entering into a five-year initial contract with Naphcare to provide medical and mental health services in SDSD facilities;
r. Initiating or starting medicine sooner by accessing StatCare, a telemedicine provider when a provider is not on-site and a consultation is needed. This system will be used to reduce wait times for medical and mental health requests and share pharmacy records with SureScript to minimize time patients go without their prescribed medications.
s. Entering into Memoranda of Understanding (“MOUs”) to allow trained CLERB staff to respond to scenes related to in-custody death incidents and deputy-involved shooting cases where death occurs or is likely;
t. Creation of Correctional Healthcare Workgroup partnership between SDSD and County Health and Human Services Agency (HHSA) to study best practices in Correctional Healthcare to reduce community care impacts;
u. Provision of Mental Health Clinicians, psychologists, psychiatrists and psychiatric technicians with access to Cerner Community Behavioral Health (CCBH), an electronic records system that facilitates their review of patient records while assisting with community care coordination;

v. Implementation of a Medication-Assisted Treatment (MAT) Program, a medication-based detoxification program for opioid and alcohol withdrawal, for in-custody individuals suffering from substance abuse disorder where participants in the program are offered a treatment program complete with counseling and behavioral health services and expansion post-release;
w. Transition to a "primary care" nursing model with patient-centered approach with care at respective jail housing units instead of a centralized clinic;
x. Update of medical request form;
y. Addition of face-to-face assessments once a request has been received pre-NCCHC (National Commission on Correctional Health Care) standards;
z. Implementation of voluntary urine drug screenings during the booking process and counseling and documentation for all medical refusals;
aa. New intake protocols requesting urine samples from those arrested who show signs of substance abuse on a voluntary basis;
bb. Implementation of in-depth mental health screening for every individual during the booking process;
cc. Expansion of the use of narcotic detection dogs with the ability to detect the presence of Fentanyl;
dd. Placement of Naloxone inside all detention facilities and on individual staff members;
ee. Centralization of mail delivery process;
ff. Purchase of additional body scanners;
gg. Purchase of additional TruNarc devices (on-site narcotics testing);
hh. Deployment of body-worn cameras;
ii. Electronic Monitoring Device Pilot Program (medical distress);
jj. Implementation of weekly wellness checks to higher risk and more vulnerable members of the jail population in their actual living environment by a multidisciplinary team of sworn, medical, mental health and reentry services staff; and
kk. Use of Radio-Frequency Identification (RFID) wristband.

# SDSO Consolidated CPRA (Reference No. S003985-102424)

**The Mountain-Whisper-Light, Inc.**
1827 23rd Ave. East, Seattle, WA 98112-2913
Phone: (206) 329-9325 • Fax: (206) 324-5915
Cell: 206-349-9325
E-mail: nirnaya@mwlight.com

October 23, 2024

San Diego Sheriff's Department
CPRA Request
John J. Duffy Administration Center
9621 Ridgehaven Ct.
San Diego, CA 92123
sdsheriff.govqa.us

Dear CPRA Officer:

The purpose of this California Public Records Act (CPRA) request is to obtain further information and data to augment prior information and data that we received from the San Diego County Sheriff Office (SDSO). We seek this information as part of a larger study to identify causes and further opportunities to prevent in-custody deaths in the San Diego County detention facilities. The study period starts with January 1, 2012 and extends through to the present date.

Sincerely,

Nirnaya Miljacic
Biostatistician
**The Mountain Whisper Light Statistics & Data Science**
**1827 23rd Avenue East**
**Seattle, WA 98112**
**nmiljacic@mwlight.com**

Please provide all of the following information, or alternatively, records sufficient to convey all of the following information:

1. Monthly information for each SDSO jail facility starting with January 1, 2012 through the present date of:

   a. Number of new mental health cases opened, as of the last day of each month;
   b. Number of inmates receiving medication for treatment of mental illnesses, as of last day of each month;
   c. Number of inmates assigned to mental health beds, as of the last day of each month; and
   d. Total number of incarcerated people seen at inmate sick call, as of the last day of the month.

**Note: In a previous CPRA response, SDSO referred us to the following website for in-custody mental health information: https://jpjdreporting.bscc.ca.gov/jps-query, yet this BSCC site does not provide the requested information at the level of each SDSO jail facility and is therefore unresponsive to this request.**

2. The total monthly (or daily) number of bookings and releases per facility starting with January 1, 2012 through to the present date.

3. The total number of monthly (or daily) readmissions per facility starting with January 1, 2012 through to the present date.

4. The date and severity of all assaults on staff and/or contractors by incarcerated people, including the number of staff and/or contractors involved as well as the facility where it took place, starting with January 1, 2012 through to the present date.

5. The total number of COVID-19 cases of incarcerated people by the date of diagnosis and the facility where the incarcerated person resided at the time of diagnosis.

6. During the COVID-19 pandemic:

   a. Any and all SDSO policies and procedures regarding visitors, volunteers, and other nonessential personnel entering the jail facilities during the COVID-19 pandemic.

b. Identification of all periods of time in which visitors, volunteer, or nonessential personnel were not permitted in the jail facilities during the COVID-19 pandemic.

7. For all detention facility programs where incarcerated people routinely leave the facility grounds—for purposes such as employment or medical treatment (i.e. not an official "release" from incarceration)—and then return to the jail facility, please provide: (a) the name of the program, (b) the name of each facility with this program, (c) a brief description of the program, and (d) the dates and numbers of incarcerated people who left and returned on that date starting with January 1, 2012 through to the present date.

8. The names of the people who have applied for compassionate release, the number of times they have applied with the dates of their applications, whether they were granted compassionate release and, if so, the date of that release. If available, the date that the compassionately released person died or was readmitted to a San Diego County jail facility.

This information is sought to assist the San Diego County Citizens' Law Enforcement Review Board (CLERB) in discharging its duties under the San Diego County Code (SDCC) and Charter. As you know, SDCC section 340.15 requires "all officers and employees of the County" to give CLERB "complete and prompt cooperation" when it is discharging its duties. The assertion of discretionary exemptions to disclosure under the CPRA is inconsistent with this legal obligation. If you assert any type of discretionary exemption to disclosure, then with your response please also explain how your choice to assert that exemption rather than cooperate with CLERB does not violate SDCC 340.15.

# COUNTYWIDE NextRequest CPRA

**COUNTYWIDE PRA-7/22/24**

Under contract with the San Diego County Citizens Law Enforcement Review Board (CLERB, The Mountain Whisper Light is conducting an independent study to prevent in-custody deaths in the San Diego County detention facilities. We request any and all relevant data that the following departments may have, starting with January 1, 2012 through to the present date. We have submitted similar requests to the San Diego Sheriff's Department (SDSD) via their Public Records Center and seek to supplement those requests with data that is maintained by your agency that will be relevant to our study.

Where possible, please provide the following information, preferably in data set format (e.g. .txt, .csv, .xls, or .xlsx, advise as to the file structure, provide definitions, fields, etc.):

**Department: Behavioral Health Services:** Any and all available data about people who used Behavioral Health Services and who were also detained in any San Diego County Detention Facility between January 1, 2012 through to the present date. Any available data about people who used Behavioral Health Services and who died in-custody in any San Diego County Detention Facility starting with January 1, 2012 through to the present date. Names, locations within the facility where such persons were housed and identifying information that is not subject to confidentiality concerns would be appreciated along with reason services were requested and outcome of treatment.

**Department: Medical Care Services:** Any and all available data about people who used any of Medical Care Services' wellness delivery systems and who were also detained in any San Diego County Detention Facility between January 1, 2012 through to the present date. Any available data about people who used Medical Care Services' wellness delivery systems and who died in-custody in any San Diego County Detention Facility starting with January 1, 2012 through to the present date. Or any available data from Medical Care Services' Office of Justice-Involved Health starting with January 1, 2012 through to the present date.

**Department: Homeless Solutions and Equitable Communities:** Any available data about people who used Homeless Solutions and Equitable Communities services and who were also detained in any San Diego County Detention Facility between January 1, 2012 through to the present date. Any available data about people who used Homeless Solutions and Equitable Communities services and who died in-custody in any San Diego County Detention Facility starting with January 1, 2012 through to the present date.

**Department:** Department of Housing and Community Development Services: Any available data about people who used the Department of Housing and Community Development Services and who were also detained in any San Diego County Detention Facility between January 1, 2012 through to the present date. Any available data about people who used the

Department of Housing and Community Development Servcies and who died in-custody in any San Diego County Detention Facility starting with January 1, 2012 through to the present date.

**Department: Office of Financial Planning (or Auditor and Controller or Clerk of Board of Supervisors):** Any available data about the total budget, medical budget and mental health budget for the San Diego County Detention Services Bureau starting with January 1, 2012 through to the present date. Identify any specific funding received to address in-custody deaths as well as regular budget funding and increases to address in-custody death and jail improvements including, but not limited to, additional **jails** staffing, facility improvements, medical supplies, additional medical staffing, vendor contracts to provide medical staffing and facility improvements. Please note that these are examples of data we consider relevant but not meant to be an all inclusive list. The data should include items received and expenditures made in response to the State Auditor's Report.

# MINI-REPORT for Item 2a

The Mountain-Whisper-Light, Inc.

September 8, 2025

**INTRODUCTION TO STUDY MINI-REPORTS**

On September 12, 2023, The Mountain-Whisper-Light (TMWL) entered into a contract with the Citizen's Law Enforcement Review Board of San Diego, CA (CLERB) to conduct a study on the causes of in-custody deaths in San Diego County Detention Facilities. As part of this study, TMWL aimed to identify opportunities to prevent deaths in those facilities. This task required TMWL to review and collect data to determine patterns and possible causes of death within the designated study period: January 1, 2012 through March 28, 2025.

Identifying a potential cause of death requires using detailed demographic and other data to compare incarcerated people who died in custody with those (similarly situated) who did not die while in custody. TMWL, upon the recommendation of the San Diego Sheriff's Office (SDSO), with CLERB's consent, pursued its search and investigation primarily through the California Public Records Act (CPRA) process and contacted SDSO through its Public Records Center online portal to request data and information concerning jail populations, in-custody deaths, jail operations, and other information that would assist in this study. TMWL later expanded its search to include other County agencies in July 2024, submitting multiple CPRA requests to the San Diego county-wide online portal. What follows is an account of TMWL's efforts to obtain this data through the CPRA process, inclusive of our efforts to obtain SDSO's cooperation in sharing such data. These efforts proved largely unsuccessful in terms of producing a rich and comprehensive study of the causes of jail deaths in San Diego County during the study period and how to prevent them in the future. Following this background information is our "mini-report" on the study questions in Item 2a of the amended contract, executed on October 4, 2024.

**BACKGROUND**

***CPRA Requests***

TMWL began by conducting thorough reviews of prior studies and reports on the past decade of in-custody deaths in the San Diego County detention facilities in order to produce comprehensive CPRA requests. Based on this research, TMWL generated

and submitted to SDSO's online Public Records Center a total of six detailed CPRA requests over the span of nine months, seeking information and data on many issues that might indicate patterns and possible causes of in-custody deaths. They are:

- SDSD[1] In Custody Death PRA (Reference No. S000257-012224),
- SDSD Population PRA (Reference No. S000257-012224),
- SDSD Mental Health PRA (Reference No. S000894-031324),
- SDSD Staffing PRA (Reference No. S002147-061824),
- SDSO Policies and Programs CPRA (Reference No. S003984-102424),
- SDSO Consolidated CPRA (Reference No. S003985-102424).[2]

See attached Appendix for complete copies of all six CPRA submissions.

Using the message tool within SDSO's Public Records Center, as per SDSO's stated procedure and preferred method of correspondence, TMWL also submitted multiple and related follow-up questions and requests for larger data sets than SDSO initially provided in response to the formal CPRA submissions. At times TMWL also submitted follow-up questions through CLERB's liaison to the Sheriff's Office. SDSO's responses to these queries were intermittent and ended on March 28, 2025.

### Attempts to Obtain SDSO Cooperation and Data

In proactive response to SDSO's initial delays and denials of data, TMWL also drafted and sent a letter directly to Sheriff Martinez on March 30, 2024, introducing the TMWL team and asking for SDSO's cooperation in obtaining the necessary data to conduct this study. TMWL drafted and sent a similar letter to CLERB on April 29, 2024, to be shared with their SDSD liaison. (See Appendix for both of these letters.)

These efforts with the support of CLERB COR resulted in a virtual meeting between TMWL team and SDSO's data team on May 22, 2024, with CLERB's COR (Contracting Officer Representative) attending, for the same purpose: SDSO's cooperation in obtaining necessary information and data to conduct this study. Participants at the

---

[1] Please note that TMWL is aware that SDSD has changed its name to SDSO. To the extent that its former name was used at the time of filing a CPRA, preparing a letter or document, TMWL will continue to use that name. Any new documents will include the name San Diego Sheriff's Office (SDSO). In this document and all future documents, the two entities are synonymous.

[2] This list of CPRA requests is formatted with the title of the document that TMWL submitted first followed by the SDSD Reference No. in parenthesis. Also in this report, we use CPRA and PRA interchangeably; in the beginning of the study TMWL used PRA most often, but shifted to using CPRA after working with CLERB counsel in August 2024.

meeting discussed the possibility of a non-disclosure agreement among parties in order for TMWL to obtain confidential individual-level data to adequately conduct this study; SDSO later denied this request.

Over the course of the fourteen (14) months that TMWL sought information and data through SDSO's Public Records Center, SDSO's responses ranged from statutory denials to repeated delays, with some provision of requested data in various formats, some of which proved substantial for limited but relevant statistical analysis.

Lastly, TMWL drafted and submitted requests for any and all relevant data from five different county departments via the countywide portal on July 26, 2024. They are:

- Behavioral Health Services,
- Medical Care Services,
- Homeless Solutions and Equitable Communities,
- Housing and Community Development Services, and
- Office of Financial Planning (or Auditor and Controller or Clerk of Board of Supervisors).

Each of these requests was closed without provision of data because they do not have any relevant data, except Behavioral Health Services through the Health & Human Services Agency (HHSA). CLERB COR and HHSA worked diligently to obtain the relevant data, and, after amending the contract for this study to protect the confidentiality of the data in question, CLERB shared the HHSA data with TMWL in late April 2025 via Box.com.

CLERB entered into agreement with specialized CPRA counsel to assist in obtaining SDSO data, analyzing SDSO responses, and verify government codes listed in SDSO denials. TMWL worked with CLERB's CPRA counsel since August 2024 to seek further cooperation from SDSO in obtaining necessary information and data to conduct this study. This collaboration began with a virtual meeting between CLERB's CPRA counsel and TMWL team, with COR attending, on August 21, 2024, to discuss all SDSO responses to the CPRA requests to date. As per this meeting, TMWL later submitted a copy of counsel's letter to the Sheriff with each of its open CPRA requests within SDSO's Public Record Center and subsequently shared with counsel all of SDSO's piecemeal responses and SDSO's final response letter. CLERB's CPRA counsel assisted TMWL team to formulate the last two of its six CPRA requests, fine-tuning the documents to optimize SDSO cooperation.

Taken together, these many efforts have required TMWL, CLERB COR and CLERB's CPRA counsel to invest a great deal of time on this study. TMWL's research team and

CLERB CPRA counsel have spent eighteen (18) months merely identifying and procuring the necessary data to conduct this study, with limited success. Figure 1 below represents the rate of response and the dates of substantive responses from SDSO for each of the six CPRA requests that TMWL submitted.

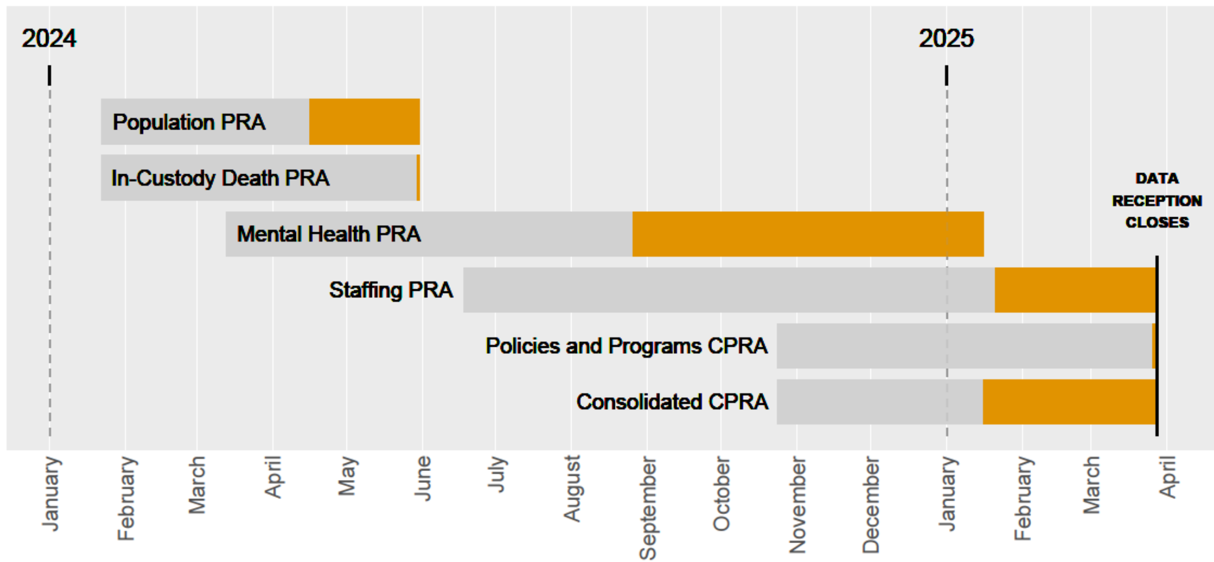



**Figure 1. Timeline of CPRA Requests and SDSO Responses.** Gray rectangles show wait times between submission date and the first substantive data response. Orange rectangles show wait times between the first and the last substantive response dates. For example, Population PRA was submitted on January 22, its first substantive response was received on April 16, 2024 and last substantive response was received on May 31, 2024. The data collection portion of this study ended on March 28, 2025.

MINI-REPORT for Item 2a

## *Study Questions Addressed*

This Mini-Report covers the following three study questions, as per Item 2a in the amended contract between CLERB and TMWL (CONTRACT 569176, MODIFICATION 4):

- Study Question 5.5.5.1 – [5.5.5. What institutional stresses are associated with IN-CUSTODY DEATHS, including:] Overcapacity of a jail facility?
- Study Question 5.5.5.2 – [5.5.5 What institutional stresses are associated with IN-CUSTODY DEATHS, including:] Processing of new admissions and releases?
- Study Question 5.5.8 – Does the race, gender or age of an [incarcerated person] play a role in the circumstances surrounding IN-CUSTODY DEATHS and subsequent investigations?

A request for data and information to address each of these study questions (among others) was submitted in our "SDSD Population PRA" and "SDSD In-Custody Death PRA" requests that TMWL submitted together to the SDSO Public Records Center online portal on January 22, 2024. Upon confirmation of receipt on the same date, SDSO renamed these requests Reference No. S000257-012224, designating them a single request.

TMWL made an additional attempt to obtain data and information to respond to these study questions by submitting "SDSO Consolidated CPRA" request to the SDSO online Public Records Center on October 24, 2024. SDSO confirmed receipt on the same date and designated it Reference No. S003985-102424.

Below we report on the relevant data sets received and preliminary findings for each study question herein, followed by challenges and initial recommendations based on these three study questions.

## <u>Mini-Report 2a Study Questions</u>

### *Study Question 5.5.5.1 – [5.5.5. What institutional stresses are associated with IN-CUSTODY DEATHS, including:] Overcapacity of a jail facility?*

<u>Data Sets and Preliminary Findings</u>

The most useful dataset that SDSO provided for TMWL to address this study question was the Hudler (Armstrong) Letters from 2012 through to April 2024 (the date of SDSO's response to this CPRA request), which contain a "Daily Inmate Population Report" for each day for each facility.

This is a collection of images (likely photographs of printed pages) embedded into .pdf files and often challenging to read, blurry etc., see Figure 2. SDSO provided Hudler (Armstrong) Letters with population data in this format. The useful information was extracted only after employing Artificial Intelligence-based image-recognition software. In total, 145 days are missing (including two whole months), and some of the numbers are unrealistically high (likely typos).

| Date:Tuesday, 05/24/2016 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| FACILITIES | SDCJ | GBDF | EMRF | LCDRF | SBDF | VDF | FAC8 | TOTAL |
| BSCC RATED CAP | 944 | 1380 | 760 | 832 | 386 | 825 | 200 | 5327 |
| Court Ordered Capacity* | 1044 | 1852 | 962 | 886 | 431 | 886 | 300 | 6361 |
| Total Mainline Beds | 1220 | 1852 | 962 | 886 | 573 | 947 | 300 | 6740 |
| Males in Custody | 985 | 1569 | 729 | | 422 | 671 | 137 | 4513 |
| Females in Custody | | | | 784 | | 69 | | 853 |
| TOTAL IN CUSTODY | 985 | 1569 | 729 | 784 | 422 | 740 | 137 | 5366 |
| Medical Beds Occup | 14 | 26 | | 10 | | 12 | | 62 |
| Psych Security Unit | 15 | | | 23 | | | | 38 |
| In Proc/Pending Release | 23 | 0 | 0 | 7 | 1 | 20 | 0 | 51 |
| SDPD@CJ and LCDF | 45 | | | 10 | | | | 55 |
| Br Trans & LC North | 90 | | | 0 | | | | 90 |
| ADJUSTED TOTALS | 843 | 1543 | 729 | 744 | 421 | 708 | 137 | 5125 |
| +/- Court Cap* | -201 | -309 | -233 | -142 | -10 | -178 | -163 | -1236 |
| +/- OF BSCC CAP | 41 | 189 | -31 | -48 | 36 | -85 | -63 | 39 |
| % OF BSCC CAP | 104% | 114% | 96% | 94% | 109% | 90% | 69% | 101% |
| Male Floor Sleepers | 0 | 0 | 0 | | 0 | 0 | 0 | 0 |
| Female Floor Sleepers | | | | 0 | | 0 | | 0 |
| Federal Inmates | 0 | 0 | 0 | 0 | 0 | 0 | | 0 |

**Figure 2. Sample Hudler (Armstrong) Population Table for 5/24/2016.** It is a photographic file showing blurred images common in this SDSO data offering.

These data contain daily population numbers of incarcerated people (with some dates missing) for each facility for the duration of the study. They were used to calculate the rates of in-custody deaths (number of deaths per 1,000 person-years[3]) for each facility, and to compare the rates of in-custody deaths among facilities, see Figure 3 below.

[3] A person-year is a unit calculated by multiplying the number of people in a study by the time each person spends in the study. For example, if there were 1,000 people in a study that lasted 2 years, the study would have collected 2,000 person-years of data.

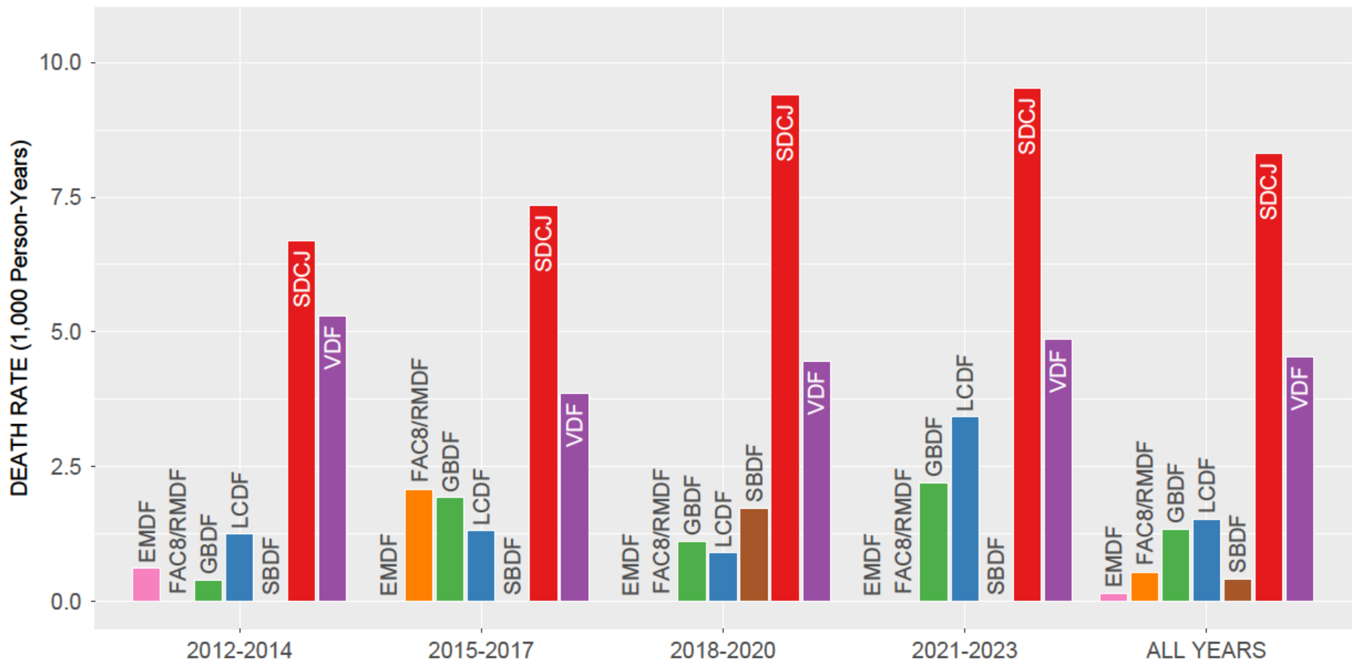



**Figure 3. Rate of In-Custody Deaths vs. Calendar time in individual facilities.** This rate represents the number of in-custody deaths that could be expected to occur if a facility were occupied by 1,000 incarcerated people on each day of one calendar year, designated above as "person-year."

The data reveal that facilities differ largely among themselves, that in-custody deaths are concentrated in two particular facilities, San Diego Central Jail (SDCJ) and Vista Detention Facility (VDF), and are comparatively rare in others.

The Hudler (Armstrong) Letters were also used to address the issue of overcapacity of a facility, where we investigated whether the probability of death of a single incarcerated person can be statistically associated with the total number of incarcerated people present in the same facility at that moment. This analysis was done for the two facilities with outstandingly high rates of in-custody deaths: SDCJ and VDF.

The regression analysis of the data detailed below reveal that, on average, the probability of death of a single incarcerated person increases by 0.3% (CI: 0.03%-0.6%) when the population of SDCJ increases by one incarcerated person (when excluding deaths from COVID-19).

Each small, pale red dot in Figure 4. shows the incarcerated population of SDJC each day from January 2012 to April 2024. The thick red line is the same population

averaged over a few days to observe the changing trend in the data. Days when a death occurred in the facility are visually enhanced by a circle (instead of a small, pale dot) and colored according to the reported manner of death, shown in the key. The dashed line shows CSA (California Statistical Area) and the California Board of State and Community Corrections (BSCC) rated occupation cap, denoting periods of overcapacity. There were 91 recorded deaths in SDCJ in this timeframe.

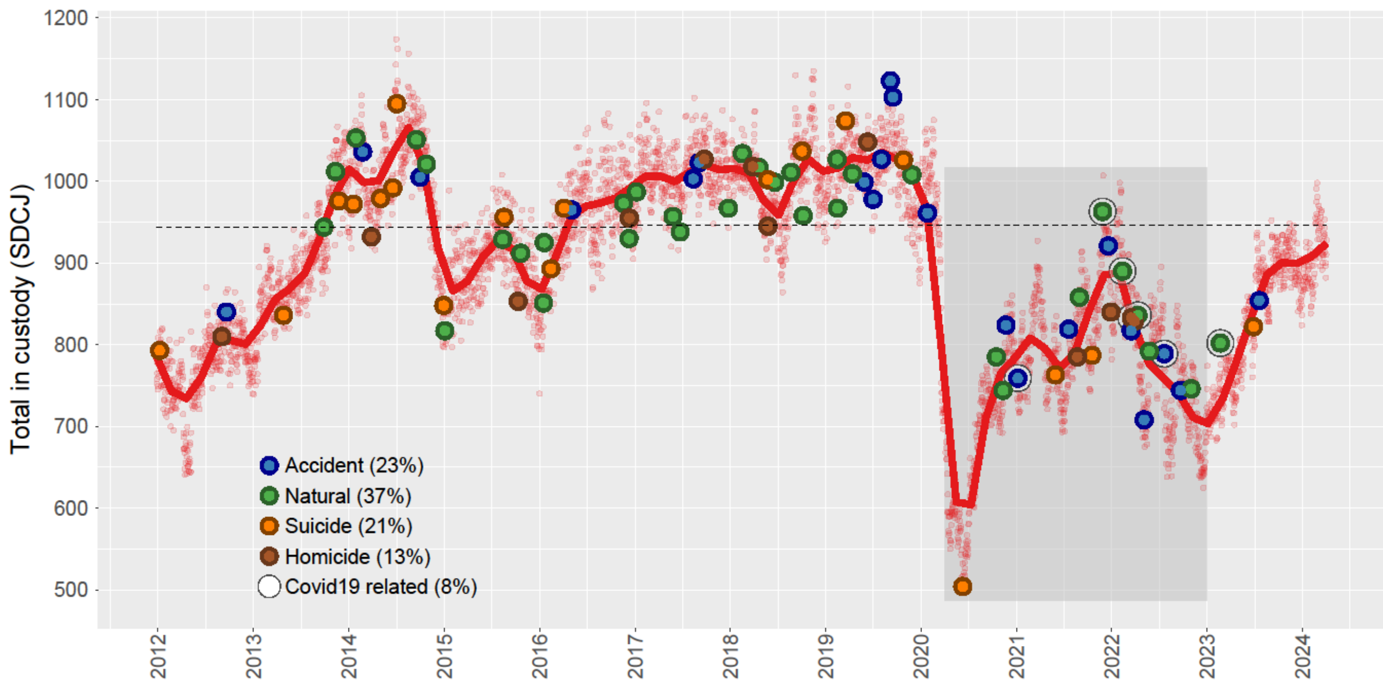



**Figure 4. Population and Instances of In-Custody Death in SDCJ, 2012-2024.** See the text for more details.

The darker Gray rectangle marks the days affected by COVID-19, and each death where COVID-19 was mentioned in the complementary notes is marked by the additional white halo. The days affected by COVID-19 were excluded from the analysis since they represent nonstandard times, leaving 67 deaths for this analysis and approximately 3.2 million person-days[4] in custody. The probability of any particular individual dying in custody on any particular day is therefore small. Nonetheless, this number increases on average by 0.3% with each new occupant added to the facility.

[4] Like a person-year, a person-day is a unit calculated by multiplying the number of people in a study by the time each person spends in the study. For example, if there were 1,000 people in a study that lasted 2 days, the study would have collected 2,000 person-days of data.

The association between SDJC population and frequency of in-custody deaths in the facility from 2012-2024 can be visually grasped in Figure 5. Here the discrete instances of incarcerated people's deaths are represented by a continuous trend that rises when deaths are clustered closer together in time and falls when deaths are sparser in time (via statistical technique called "kernel density estimation".) This frequency of death and population both rose and then peaked in early 2014, followed by a decline until early 2016, then steadily increased again until another peak in early to mid-2019.

In early 2020, the COVID-19 pandemic began and disrupted the usual functioning of the facility until 2023. Notably, even during the COVID-19 period (the darker gray region in Figure 5), the population and the frequency of deaths continued rising and falling together to a large degree.

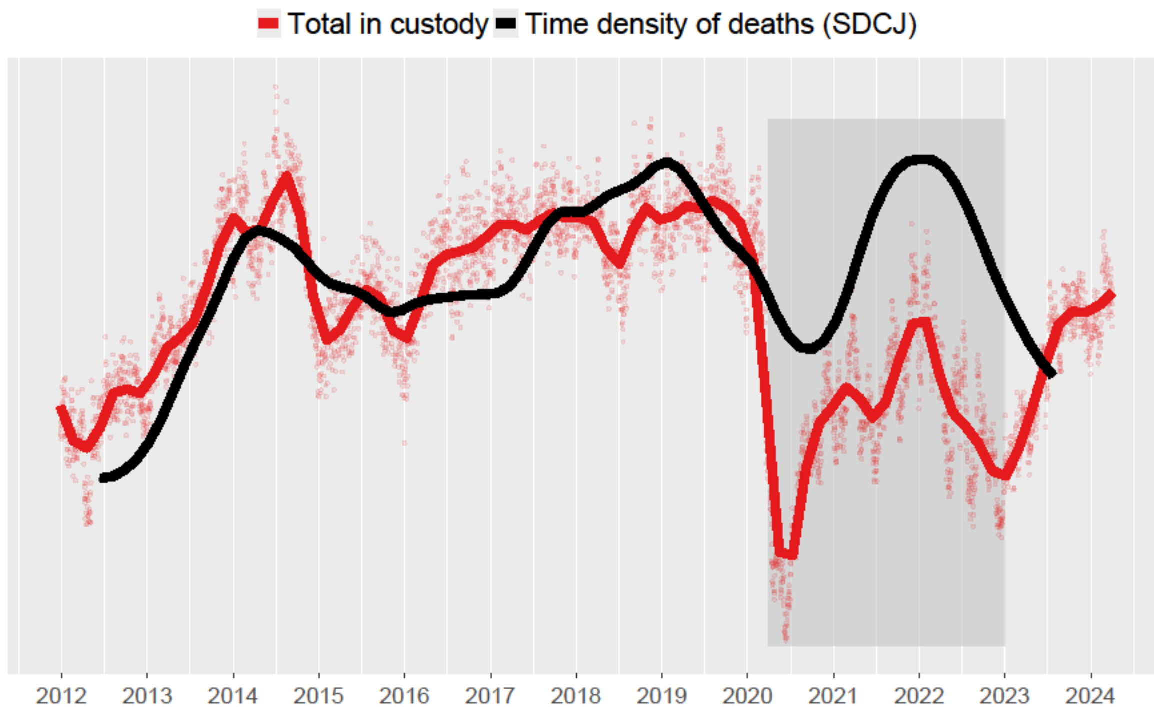



**Figure 5. Time trends of the Population and Frequency of In-Custody Deaths in SDCJ, 2012-2024.** Here values on the y-axis have no specific meaning, as both trend lines were vertically re-scaled as to maximally overlap during the pre-COVID years.

We repeated the same analyses for VDF from January 2012 to April 2024. However, no such association—or no increase in the rate of in-custody deaths with an increase in population—was found for this time period, either because this effect does not exist,

or because VDF lacks the statistically-required number of deaths for a similar effect to be statistically revealed.

### *Study Question 5.5.5.2 – [5.5.5 What institutional stresses are associated with IN-CUSTODY DEATHS, including:] Processing of new admissions and releases?*

Data Sets and Preliminary Findings

SDSO initially provided a spreadsheet on bookings and releases that was highly limited in its usefulness because it did not have facility-specific information. Additionally, we were sent booking counts that excluded bookings "medically rejected at intake that were not fit for jail/satellite booking (NFFJ/NFSB.)" These counts were not commensurate with the counts of releases, over longer times. After repeated inquiries, SDSO sent commensurate counts of bookings and releases. TMWL then requested facility-specific bookings and releases data on October 24, 2024 and received it on January 16, 2025. The analysis of this latter data is presented below.

The facility-specific datasets contain monthly counts of the booked and released incarcerated people by facility, from 2012-2024. Combined with information on daily population numbers in each facility (from the Hudler (Armstrong) Letters), we can also calculate the total monthly transfers of people between a booking facility and all other facilities. Since average population of any facility typically changes little over a month, transfers largely equal total monthly bookings minus total monthly releases.

Besides transfers, we also calculated the "flux" (or flow) of people through the detention facilities. This measure does not distinguish between a person coming into or out of a facility; it is instead a sum of monthly bookings, monthly releases, and the net monthly transfers.

SDCJ, VDF, and Las Colinas Detention and Reentry Facility (LCDF) are the only reported booking facilities, and these three have the highest in-custody death rates (Figure 3.). Figure 7. shows bookings, releases, transfers, and flux for these three facilities, both as monthly values (dots) and as time trends (lines) in the data. Releases happen also in George Bailey Detention Facility (GBDF), South Bay Detention Facility (SBDF), and East Mesa Reentry Facility (EMRF)[5], and are shown in that plot below in

[5] EMDF is also known as East Mesa Reentry Facility (EMRF).

Figure 7. as well. There are releases in FAC8[6], but these numbers are too small to be shown in plots.

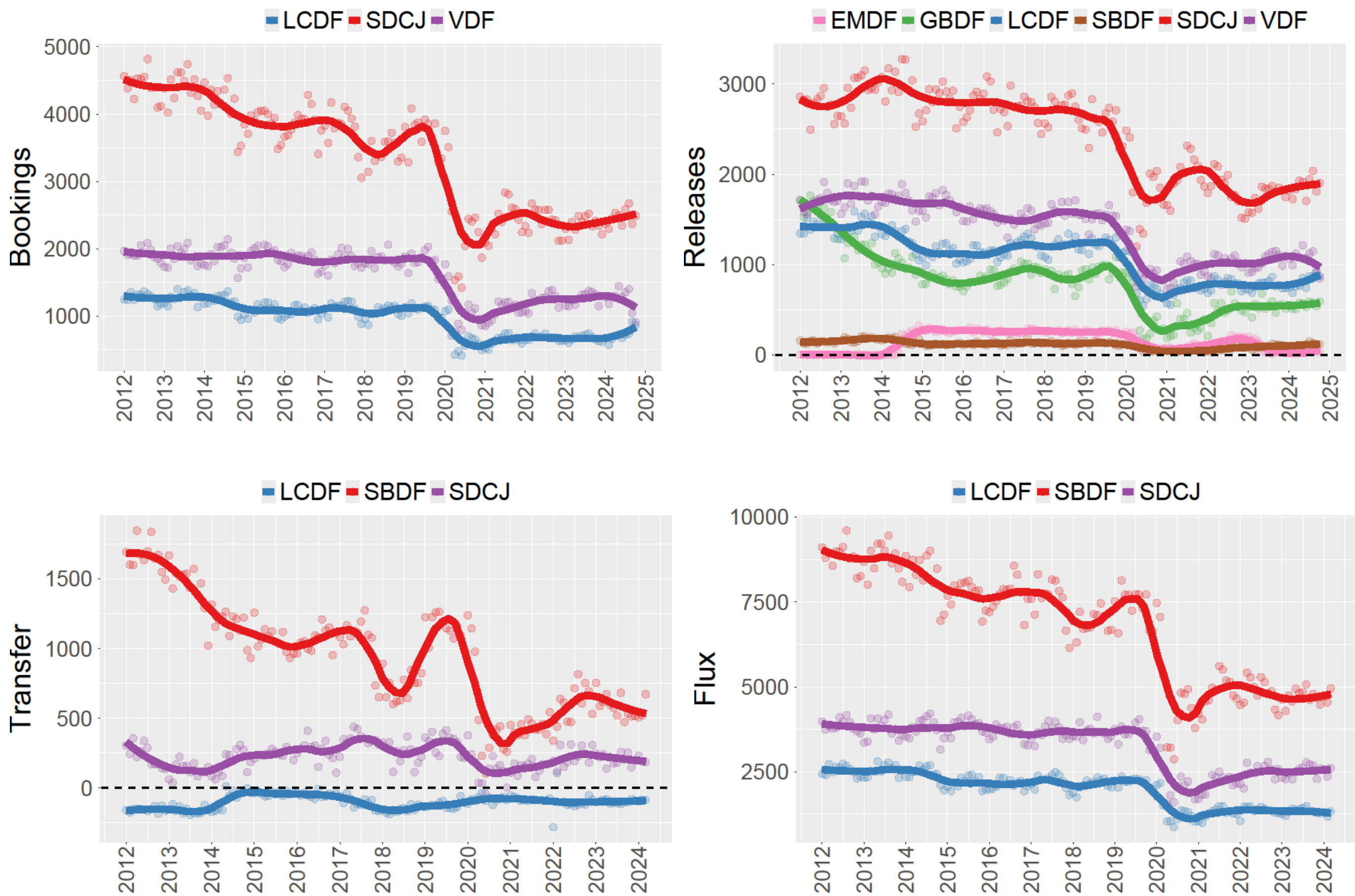



**Figure 7. Bookings (top left), releases (top right), transfer (bottom left) and flux (bottom right) versus calendar year for the selected facilities.** Dots are monthly values, thick lines are averages over nearby months, showing trends in the data.

None of the time patterns in Figures 7. correspond in an obvious way to the frequency of deaths in SDCJ and VDF. For example, although the bookings were decreasing in SDJC from 2012 to 2020, the frequency of in-custody deaths in the facility during this same time-frame was generally on the rise (Figure 5.). In all other facilities in-custody deaths are too statistically rare to examine, particularly without comparative data of those who did not die in custody.

[6] FAC8 is also known as the SDSO's Facility 8 Detention Facility. It is responsible for developing and providing services aimed at recidivism through a coordinated effort.

If TMWL had received the detailed data on all jailed persons, that would have enabled an analysis of repeated bookings and transfers on individual level, that is, how the individuals that died differed from those that did not die in terms of repeated bookings and transfers between facilities.

### *Study Question 5.5.8 – Does the race, gender or age of an [incarcerated person] play a role in the circumstances surrounding IN-CUSTODY DEATHS and subsequent investigations?*

Data Sets and Preliminary Findings

As of March 28, 2025—the date that CLERB set as the deadline for SDSO to complete all CPRA requests for this study—TMWL has not received data from SDSO that is sufficiently responsive to address this study question. Without facility-specific, individual-level demographic data for all incarcerated people in the San Diego County Detention Facilities for the duration of the study period, TMWL cannot identify differing factors between those who died in-custody and those who did not that may indicate possible causes of death.

To illustrate, 4% of all reported deaths happened during the day of incarceration ("day 0"), while 8% of all reported deaths happened during the very next day ("day 1"). This is shown in Figure 9, rightmost panel. A naïve conclusion would be that the rate of dying is doubled on day 1. However, each jailed individual was only partially present during day 0, maybe even very briefly if booked near the end of that day. In contrast, great majority of jailed individuals spent the full 24h of day 1 inside the jail. So, the lower number of deaths on day 0 may not be the result of specific conditions in the jail but due to the fact that many individuals spent that day mainly outside of jail (if they died there, that would not be in-custody death). To discern this, times of booking of all individuals (those who did die and those who did not die) is needed.

This illustrates a very general point that permeates this work: most of the death rates for individuals in categories and subcategories of various features that are being analyzed in this and other mini-reports are not calculable, thus potential causes cannot be suggested by statistically analyzing the acquired data. Most of the time, the acquired data is not enough by far.

SDSO only provided demographic data on the individuals who died in-custody. TMWL can therefore only provide descriptive analyses on these social demographic factors

for the 179 people who died in-custody during the study period, a partial presentation of which is below.

(a) Race

In the dataset of individuals that died in-custody, race categories are given as: White, Black, Hispanic, and Other. There are very few deaths in the Other group. The descriptives are shown in Figures 8-9.

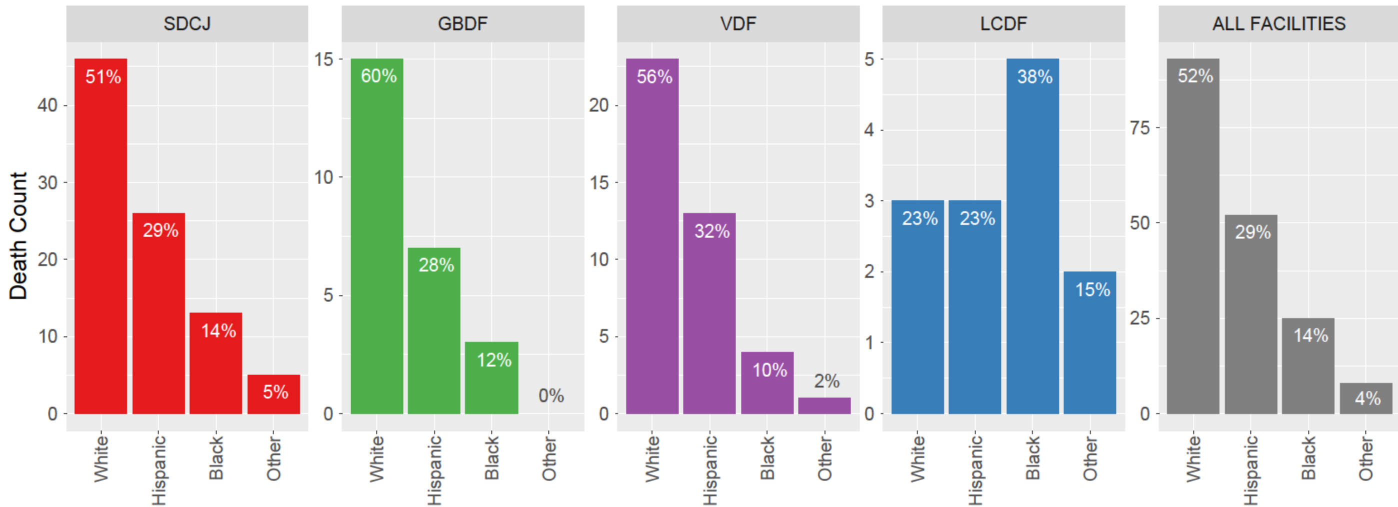



**Figure 8. Percentages of In-Custody Deaths by Racial Category.** The data is shown for the four facilities with highest in-custody death rates, and for all facilities together. Within each panel, the percentages sum up to 100%.

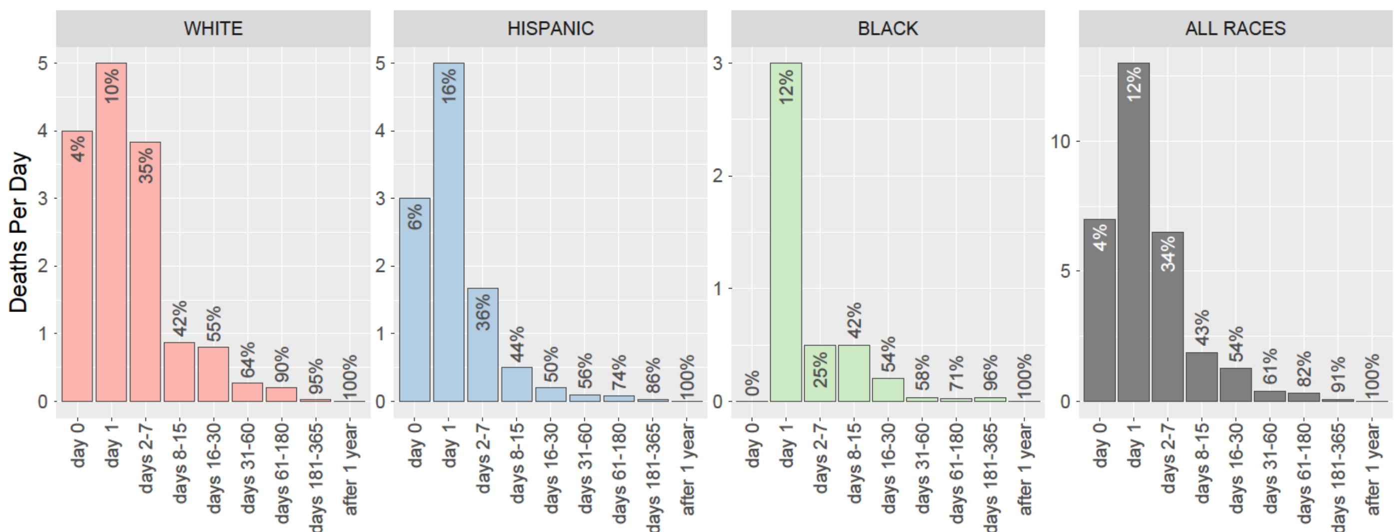


**Figure 9. Barplots of deaths per day (number of deaths divided by the number of days) vs. time since incarceration.** The data is shown for the three reported race categories and for all racial categories (including "Other"). "Day 0" is the day of incarceration, "day 1" is the very next day, etc. For example, half of all Hispanic deaths happened within the first month after incarceration.

Figure 9. shows that one third (34%) of all deaths occur within the first week after incarceration, and more than half (54%) of all deaths occur within the first month.

(b) Gender

In the dataset of individuals who died in-custody, gender categories are given as: Male and Female. LCDF is the only facility that houses people designated as female; all other detention facilities house people designated as male. Due to this partitioning, facilities act as proxies for these two gender categories (there is no data on incarcerated people who do not identify with either or both of these two categories).

All descriptives that partition people by facility automatically partition them by gender as well. For example, Figure 8. shows that the reported racial composition of females who died in-custody is rather racially homogeneous with the count for Black females being the highest. This is in contrast to the racial composition of males who died, which is rather heterogeneous and where the White category of people has the highest count. But the counts of in-custody deaths for LCDF are low, so differences may be due to play of chance.

(c) Age

Age range of individuals who died in-custody during the study period is 19 to 84 years. We partitioned the individuals into six age groups, from "under 25" to "65 or older." The descriptives are shown in Figures 10-11.

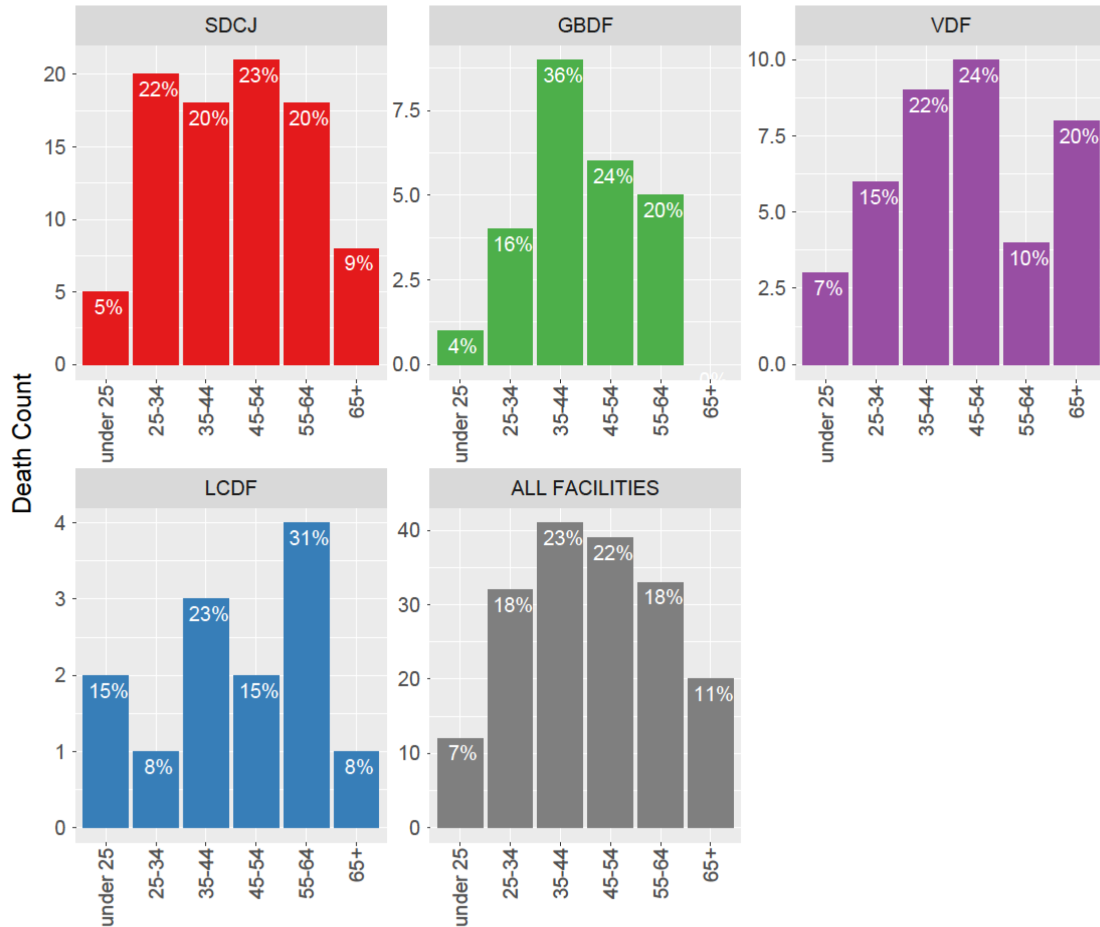



**Figure 10. Barplots of deaths counts with given percentages across age groups.** The data is shown for the four facilities with the highest death rates, and for all facilities together. Within each panel, the percentages sum up to 100%.

The age groups with the highest count of deaths is 35-44 years old, with 23% of all deaths. Age distributions of incarcerated people who died seem similar across facilities.

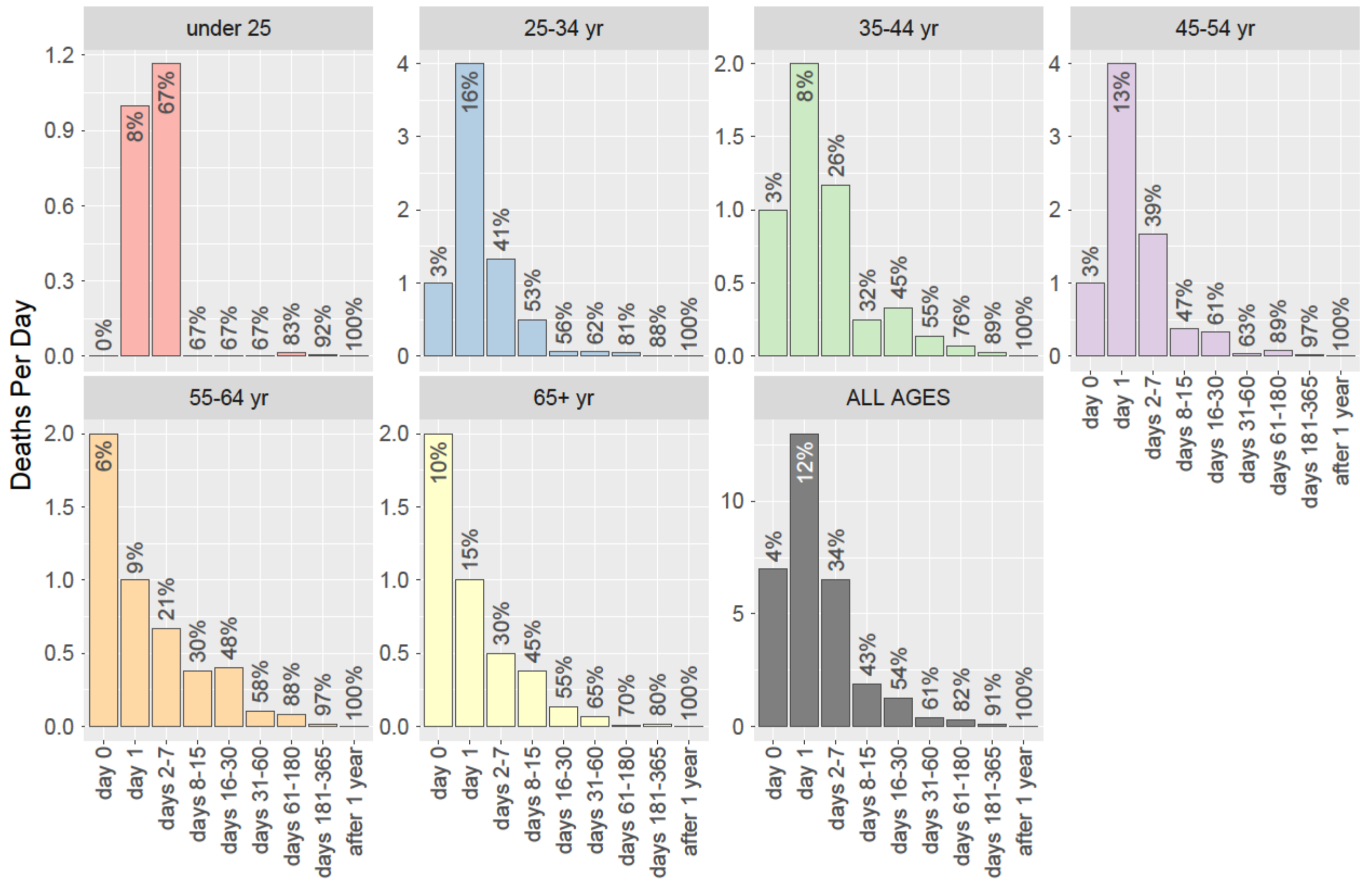



**Figure 11. Barplots of deaths per day (number of deaths divided by the number of days) vs. time since incarceration.** The data is shown for the six age groups and for all ages. "Day 0" is the day of incarceration, "day 1" is the very next day, etc. In each panel (or age category), the percentage bars show the cumulative proportion of all deaths up to and including that particular count of days in jail (so that the final bar marks 100% of all deaths in that category.)

Figure 11. suggests that for people who died younger than 25 years of age, the highest daily death counts is anywhere within 2-7 days from incarceration; for those who died at an age between 25 and 54, the single day with most deaths was first day after incarcerations; and for those who died at 55 and older, the single day with most deaths was the booking day. Thus, with the increasing age of those who died in-custody, the single "deadliest day" happens closer to the point of booking. However, days 2-7 after incarceration have by far the highest proportion of deaths among youngest (49% of all deaths under age 25) than in any other age category.

If TMWL had received the detailed data on all jailed persons, that would have enabled an analysis of race, gender and age as possible factors that affect death rates, as each category of race, gender and age, and possibly a combination of these categories

would have received its own death rate. A possible comparison would be, for example, how white males under age 25 compare to black males under 25 in terms of death rates.

### *Challenges in Addressing Study Questions in Item 2a*

As noted, the greatest challenge in addressing the three study questions in this mini-report was the procurement of useful data.

Within Reference No. S000257-012224, responses to the "SDSD Population PRA" request were delayed four times over the span of three months with the first substantive response on April 16, 2024. Responses to the "SDSD In Custody Death PRA" request were delayed seven times over the span of four months with the first substantive response on May 31, 2024.

These and later responses included many statutory denials, denials based on SDSO methods of collection or categorization of data that differ from requested data, some images of relevant data that TMWL needed to convert to a usable format for analysis, and referrals to the Board of State Community Corrections (BSCC) databases or archived SDSO webpages, with some analyzable data presented below.

With Reference No. S003985-102424 SDSO responses were delayed four times in the span of two and a half months, with the first substantive response on January 16, 2025. This first substantive response included facility-specific information on bookings and releases, addressed below. Later SDSO responses to this CPRA request came in February and March 2025, with (limited) data pertinent to study questions addressed in later mini-reports.

Despite insufficient provision of responsive data, all of TMWL CPRA requests have been marked as "Completed" in the SDSO's Public Records Center.

More meaningful analysis about the impacts of population overcapacity, bookings and releases, and social demographics on in-custody deaths in the San Diego County Detention Facilities is dependent upon having facility-specific, individual-level data about each incarcerated person in each facility for the duration of the study.

Without such data, we can present descriptive breakdowns of in-custody deaths by various categories and by facility, which is informative in its own right; however, this will not allow us to identify any differences between the population of people who died while in custody and those who did not die while in custody. This comparison—of a

variety of potential differences—could reveal patterns and possible causes of such deaths and thus increase the likelihood of preventing them in the future.

### *Observations for Study Questions in Item 2a*

Given the scarcity of data that was made available to TMWL, it was impossible to arrive at conclusions that would be helpful in establishing specific factors that caused the in-custody deaths so that we could determine how best to prevent these deaths in the future. Instead, we have included preliminary recommendations that are based on our observations. In this mini-report, we would like to highlight areas that might assist in answering this question and share some observations that are noted below under each study question.

**Summary of Observations (Descriptives)**

- Over one third (34%) of deaths occurred within the first week after incarceration.
- More than half (54%) of all deaths occurred within the first month of incarceration.
- The highest number of females who died in custody were Black (this could be a play of chance as all female counts are low).
- The highest number of males who died in custody were White.
- The age range of individuals who died in custody was 19-84.
- The age range with the highest number of deaths was 35-44 with 23% of all deaths.
- For those who were under age 25 when they died (49%), highest daily death counts were within 2-7 days from incarceration.
- For those who died between 25-54 years of age, the single day with the most deaths was the first day after incarceration.
- For those deaths of individuals 55 years and older, the single day with the most deaths was the booking day.

**Preliminary Recommendations From the Analyses - Explanations and Observations**

The main preliminary recommendation that TMWL makes from this study is that it is important that CLERB have the necessary legislative, jurisdictional, and/or administrative approval to obtain all individual-level, facility-specific data records

that SDSO maintains on all incarcerated people in their detention facilities, contemporarily and historically. Having access to this information would have made a world of difference in being able to compare a variety of factors between those who died in-custody and those who did not die in-custody during the study period. Instead, much of what we could do was limited to descriptive analyses only or was foreclosed because these other comparative data did not exist. The County of San Diego Board of Supervisors could explore the options to create a countywide data pool, which would allow different county departments to examine closely the necessary data for any study like this.

***Study Question 5.5.5.1 (Overcrowding)*** – The data demonstrates association between in-custody deaths and occupation (not necessarily overcrowding) in SDCJ. It would be helpful to compare the State's mandated capacity (occupation) limits for the detention facilities and the actual capacity at or around the time of deaths. This would include an analysis of the impact of transfers, flux, releases as well as the condition of the facilities on overcrowding. For example, it would be helpful to know whether the actual capacity of the facilities where the deaths occurred was at, above or below mandated occupation levels under state law and regulations as well as whether the facilities were constructed to accommodate short-term or long-term confinement or minimum, medium or maximum security. Also, housing those who committed minor crimes with those who committed major crimes because of housing constraints might be a factor.

The data demonstrates that, from 2012-2020 in the facility with the most in-custody deaths—San Diego County Jail—the probability of death of a single incarcerated person increased by 0.3% (CI: 0.03%-0.6%) when the population of the facility increased by one incarcerated person. This relationship existed whether the facility was over mandated capacity or not. TMWL believes that CLERB should work in whatever capacity possible to help reduce the total population in SDCJ, instead of the increase that it has experienced again since 2023 (post COVID-19).

***Study Question 5.5.5.2 (Bookings Processing and Releases)*** – It would be beneficial to this study to take a closer look at the differences among the three detention facilities that are responsible for processing admissions and releases to determine differences that would account for discrepancies in the rates of death. This would include training of staff, number of staff, policies and procedures among other non-administrative factors. Some considerations are whether any of the three facilities is operating at optimal population levels, or is one facility better staffed to address mental health, chronic illnesses and language barriers than the others. Also, is location of the detention facility a factor for determining the types of arrestees that are processed

there based on alleged crime committed or other factors such as whether the arrestee was unhoused

While there are no obvious connections between bookings, releases, transfers, flux and in-custody deaths in the three booking facilities, other findings are only observational in nature and reveal noteworthy areas for further exploration in terms of their potential relationship to in-custody deaths (and generally should be part of a historical record). For example, there seems to have been a jump in transfers from SDCJ in mid-2019 (Figure 7.), just after the peak of frequency of deaths in early 2019 (Figure 5.) and just before the COVID-19 pandemic slowed everything down in early 2020. Also, the bookings in VDF and LCDF were remarkably constant before COVID-19, while bookings in SDCJ were steadily decreasing at this same time interval, 2012-2020. More context and further study is needed to determine what these patterns reveal.

**Study Question 5.5.8 (Age, Gender and Race)** -This is an area that should be considered for future study. One questions is whether there is a comprehensive definition of race and gender that is used by all entities, including, but not limited to, arresting entities and detention entities. Does the potential incarcerated person determine his or her own race or gender independently or is it determined by the arresting or detention authorities? For example, arrestees may have self-identified as White when arrested and processed, although they appeared to be of Hispanic origin based on their language of communication, because in their country of origin, they were considered to be White and they may have been instructed to indicate White as their race in the United States.

While preliminary findings suggest that overcrowding may have an impact on in-custody deaths, the same cannot be said for processing of bookings and releases, and gender, race and age data which are inconclusive. Greater access to SDSO data is recommended as well as better cooperation between the California state agencies that would facilitate open review by a CLERB Analyst with the assistance of a statistics specialist without burdensome privacy and confidentiality blockades.

More direct and routine communication with SDSO's data team to identify existing records that would meet TMWL's CPRA requests or to answer questions it had about what they provided in response to our requests would have been appreciated. Greater cooperation on how to handle confidential data in a more effective manner would have resulted in more pertinent findings to answer the in-custody death study questions. TMWL offered to sign any necessary confidentiality or non-disclosure agreements but was denied.

## CONCLUSION

TMWL has prepared the above background and this mini-report to describe what it has done, to date, to address Item 2a. This mini-report includes a review and analysis of all data received up to March 28, 2025 from SDSO in response to CPRA requests, the CLERB Letter of Concern and data received from HHSA. The final report will include our findings, a description of the study methods, and recommendations for future studies based on the findings. The findings are summarized in the table below.

| ***QUESTION*** | ***FINDINGS*** |
|---|---|
| *General* | Facilities are very different in terms of in-jail deaths. SDCJ first and foremost, and then VDF to a lesser degree, are where the problem lies. |
| *Overcapacity* | In SDCJ: higher occupancy means higher death rate. In VDF, the same was not observed. |
| *Bookings and Releases* | Nothing was found that would correlate with death rates. |
| *Race, Gender, Age* | Only a descriptive analysis was possible: breakdown of death cases by facility and over categories of race, age, gender, and time in jail before death. |

# MINI-REPORT for Item 2b

The Mountain-Whisper-Light, Inc.

September 10, 2025

**MINI-REPORT for Item 2b**[7]

**Study Questions Addressed**

This Mini-Report covers the following study questions, as per Item 2b in the amended contract between CLERB and TMWL (CONTRACT 569176, MODIFICATION 4):

- Study Question 5.5.5.3 – [5.5.5. What institutional stresses are associated with IN-CUSTODY DEATHS, including:] Frequency of assaults on staff?
- Study Question 5.5.8 – Does the race, gender or age of an [incarcerated person] play a role in the circumstances surrounding IN-CUSTODY DEATHS and subsequent investigations? [8]
- Study Questions 5.5.1 – When are [incarcerated people] most vulnerable to the risk of death? Is it after they are first admitted to the jail, after they are found guilty of the crime, or based on another important event?
- Study Question 5.5.7 – Are IN-CUSTODY DEATHS more prevalent among those charged with a certain kind of crime?
- Study Question 5.5.13 – What are the IN-CUSTODY DEATH rates among [incarcerated people] with a history of homelessness?

A request for data and information to address each of these study questions (among others) was submitted in our "SDSD Population PRA" and "SDSD In-Custody Death PRA" requests that TMWL submitted together to the SDSO Public Records Center online portal on January 22,

[7] An "Introduction to Study Mini-Reports" was provided with MINI-REPORT for Item 2a, which includes background information on all of TMWL's CPRA requests as well as attempts to obtain SDSO cooperation and data for the entire study. The reader is referred to that document for the same background information regarding the study questions in this report.

[8] Please note that Study Question 5.5.8 is also listed under Item 2a in the amended contract and was addressed in MINI-REPORT for Item 2a. It is incorporated here by reference as if fully set forth below.

2024. Upon confirmation of receipt on the same date, SDSO renamed these requests Reference No. S000257-012224, designating them a single request.

TMWL also submitted a CPRA request to the county-wide portal on July 26, 2024 to the Department of Homeless Solutions and Equitable Communities and Housing and Community Development Services to obtain data to address the final study question listed above (5.5.13). This request was denied, since this agency is not the originator of the necessary data.[9]

TMWL made an additional attempt to obtain data and information to respond to these study questions by submitting "SDSO Consolidated CPRA" request to the SDSO online Public Records Center on October 24, 2024. SDSO confirmed receipt on the same date and designated it Reference No. S003985-102424.

Below we report on the relevant data sets received and preliminary findings for each study question, followed by challenges and initial observations based on this portion of the study (i.e. the study questions addressed herein).

### *Study Questions Item For 2b*

#### 5.5.5.3 – 5.5.5. What institutional stresses are associated with IN-CUSTODY DEATHS, including:] Frequency of assaults on staff?

<u>Data Sets and Preliminary Findings</u>

Data provided by SDSO on February 12, 2025 included a table image embedded in PDF, of the assaults on staff per detention facility from 2016 through 2024, see Figure 1. There is no individual-level information provided with this table—that is, no redacted or coded information about who the staff or incarcerated people in the referenced incidents were and no information about whether the incarcerated people involved died in-custody or not—and so there is very limited analysis that can be done.

TMWL also requested data about assaults or incidents between the people who died in-custody and other incarcerated people, as well as all grievance slips submitted by those who died in-custody in order to obtain more context about violence occurring in the facilities and its relationship to in-custody deaths. SDSO denied these requests in full. Therefore, all

[9] This county-wide CPRA request was closed on September 9, 2024 with this note: "Per your discussion with County of San Diego employees, this is now closed by your request." Instead TMWL team met with Christy Carlson, Director Business Assurance and Compliance for Health and Human Services Agency (HHSA), in September and December 2024. TMWL received access to HHSA data in April 2025; however, the data provided has no information regarding homelessness and is not relevant to the content of this mini-report.

references to "assaults" and "offences" in this section refer only to those against staff by an unspecified incarcerated person in the jails during the study period.

**Incarcerated Person vs Sworn & Non-Sworn | All Detention Facilities**

**2016 - 2024**

| Year | Assault Type | Occurred On | Offense | Detention Facility |
|---|---|---|---|---|
| 2016 | IP vs Sworn | Jan 7 2016 3:50PM | 243 (C)(2) - PC | George Baily Detention Facility |
| 2016 | IP vs Sworn | Jan 7 2016 9:15PM | 243 (B) - PC | Las Colinas Detention Facility |
| 2016 | IP vs Sworn | Jan 14 2016 7:30PM | 243 (C)(2) - PC | Vista Detention Facility |
| 2016 | IP vs Sworn | Jan 15 2016 4:31AM | 243.9 (A) - PC | Las Colinas Detention Facility |
| 2016 | IP vs Sworn | Jan 27 2016 3:55PM | 243 (B) - PC | Las Colinas Detention Facility |
| 2016 | IP vs Sworn | Jan 30 2016 9:18PM | 243 (C)(2) - PC | San Diego Central Jail |
| 2016 | IP vs Sworn | Jan 31 2016 4:35PM | 69 - PC | San Diego Central Jail |
| 2016 | IP vs Sworn | Feb 4 2016 12:30PM | 243 (C)(2) - PC | Las Colinas Detention Facility |
| 2016 | IP vs Sworn | Feb 5 2016 8:35AM | 245 (C) - PC | San Diego Central Jail |

**Figure 1. A portion of the table image containing the information shared about assaults 2016-2024.** For each assault, we have data about whether it involved sworn vs. non-sworn staff, date and time, offense code, and facility.

The basic descriptive statistics on offenses against staff are given in Table 1 below. Note that here "assault" and "offense" are not always interchangeable, as some assaults contained more than one offense, albeit rarely. For that reason, this analysis is based on offenses.

| OFFENSE | SDCJ | GBDF | LCDF | VDF | OTHER FACILITIES | TOTAL |
|---|---|---|---|---|---|---|
| Attack on Officer (69-PC) | 241 (34%) | 122 (36%) | 109 (32%) | 76 (34%) | 10 (37%) | 558 [1] |
| Battery (243-PC) | 218 (31%) | 87 (26%) | 121 (36%) | 67 (30%) | 7 (26%) | 500 [46] |
| Gassing (243.9-PC) | 187 (26%) | 99 (29%) | 85 (25%) | 57 (26%) | 4 (15%) | 432 [11] |
| Obstruction (148-PC) | 29 (4%) | 5 (1%) | 5 (1%) | 5 (2%) | 2 (7%) | 46 [1] |
| Armed Assault (245-PC) | 17 (2%) | 5 (1%) | 4 (1%) | 1 (0.5%) | 1 (4%) | 28 [0] |
| Other offenses | 17 (2%) | 19 (6%) | 13 (4%) | 16 (7%) | 3 (11%) | 68 [14] |

| ALL OFFENSES | 709 [38] | 337 [13] | 337 [12] | 222 [10] | 27 [0] | 1,632 [73] |
|---|---|---|---|---|---|---|

**Table 1. Counts (and % total) per facility and offense type (CA penal code given in parenthesis), of the 1,632 offenses recorded in the data about assaults on staff by incarcerated people.** In the bottom row and rightmost column, offenses involving non-sworn staff are given in square brackets. For example: in SDCJ there were 709 offenses total, out of which 38 were against non-sworn staff.

Among facilities, SDCJ not only has clearly the highest number of in-custody deaths (see Mini-Report 2a), but also, by far, the highest numbers of offenses against staff. Interestingly, VDF, despite also having many in-custody deaths, has a relatively small number of offenses against staff, notably fewer than George Bailey Detention Facility (GBDF) and Las Colinas Detention Facility (LCDF). Reported offenses against staff are also concentrated almost exclusively in these four facilities, with only 27 (1.7%) of all offenses against staff being recorded in all other facilities. This lack of pattern suggests that there is no discernable connection between offenses against staff and in-custody deaths. This bears out in the monthly and weekly breakdown of offenses against staff covered below.

Monthly offense counts and their longer trends are shown below in Figure 2. Although frequencies of offenses against staff did vary over time, these trends were not following the trends in frequency of deaths during the same time period, neither in SDCJ nor VDF. For example, in SDCJ, the frequency of offenses had a drop from mid-2017 to mid-2018 and stayed nearly constant throughout 2019-2021, frequency of deaths was steadily increasing from 2016-2019 then had a drop in mid-2020 likely due to facilities responding to COVID-19.

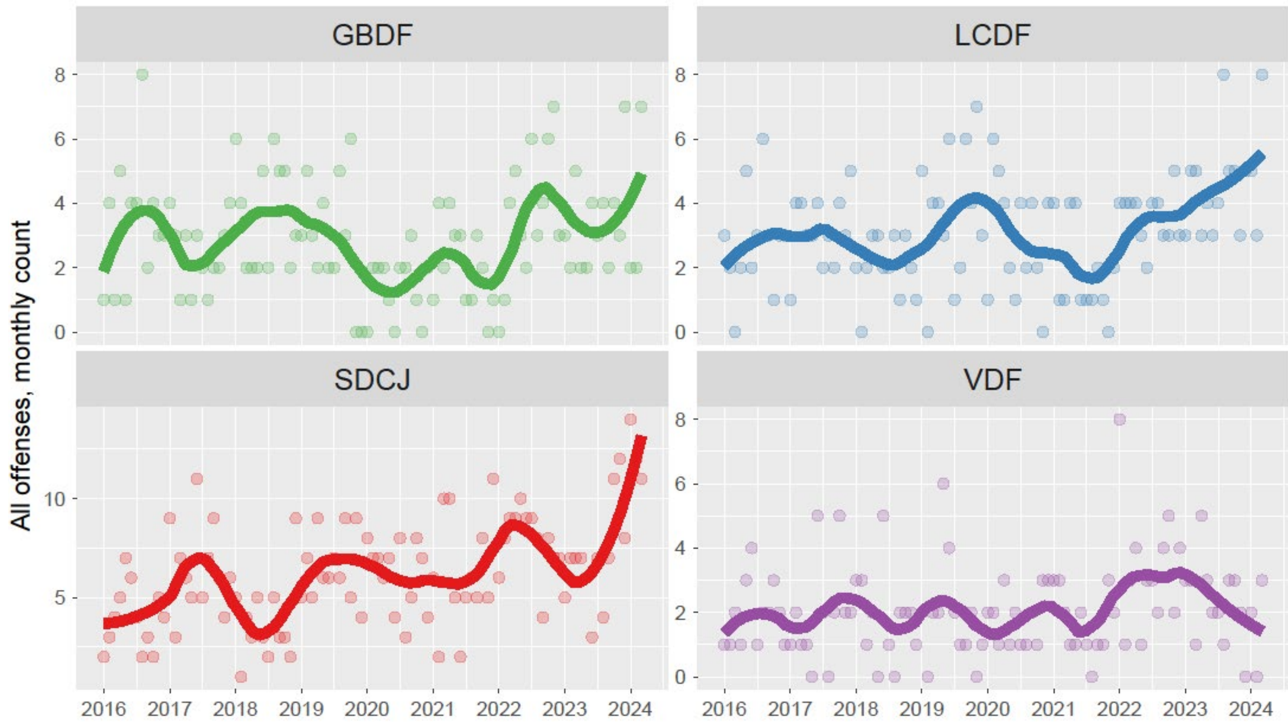



**Figure 2. Monthly counts of offenses against staff in selected facilities.** The counts are shown as dots, and thick lines are averages over nearby months, showing trends in the data.

**Figure 3** below shows offense distributions at the weekly level, with offenses given by the offense type so that the heights of all bars in the same category sum up to 1 (100%) across the 7 days. The weekly distribution of in-custody deaths is added to the figure. There is no obvious similarity between weekly distribution of deaths and that of any particular category of offenses. The same is with the weekly distributions of the sum of all offenses (not shown here).

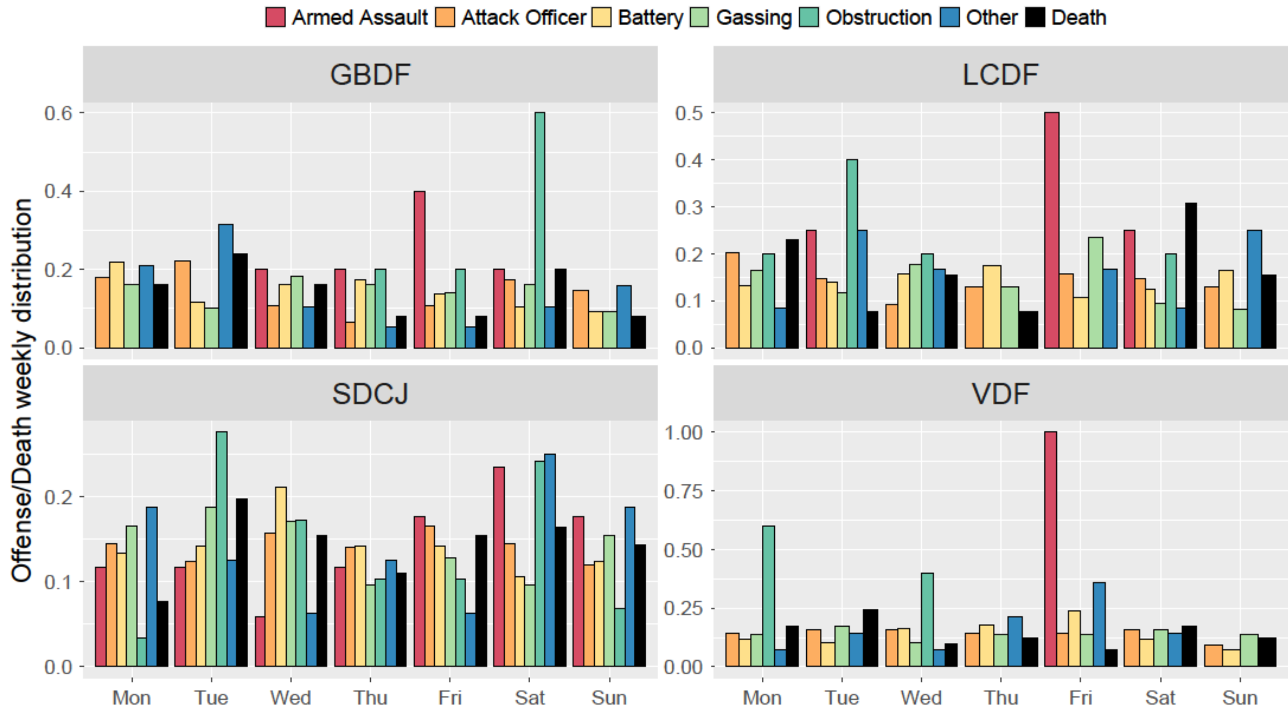



**Figure 3. Weekly distribution of offenses by type and deaths, in selected facilities.** All bars in the same category sum up to 1 (100%) across the 7 days.

Figure 4 shows offense counts by type at the hourly level. (Death data does not contain time of death, to compare.) In SDCJ and VDF the assaults are distributed more evenly around the clock, as compared to GBDF and LCDF.

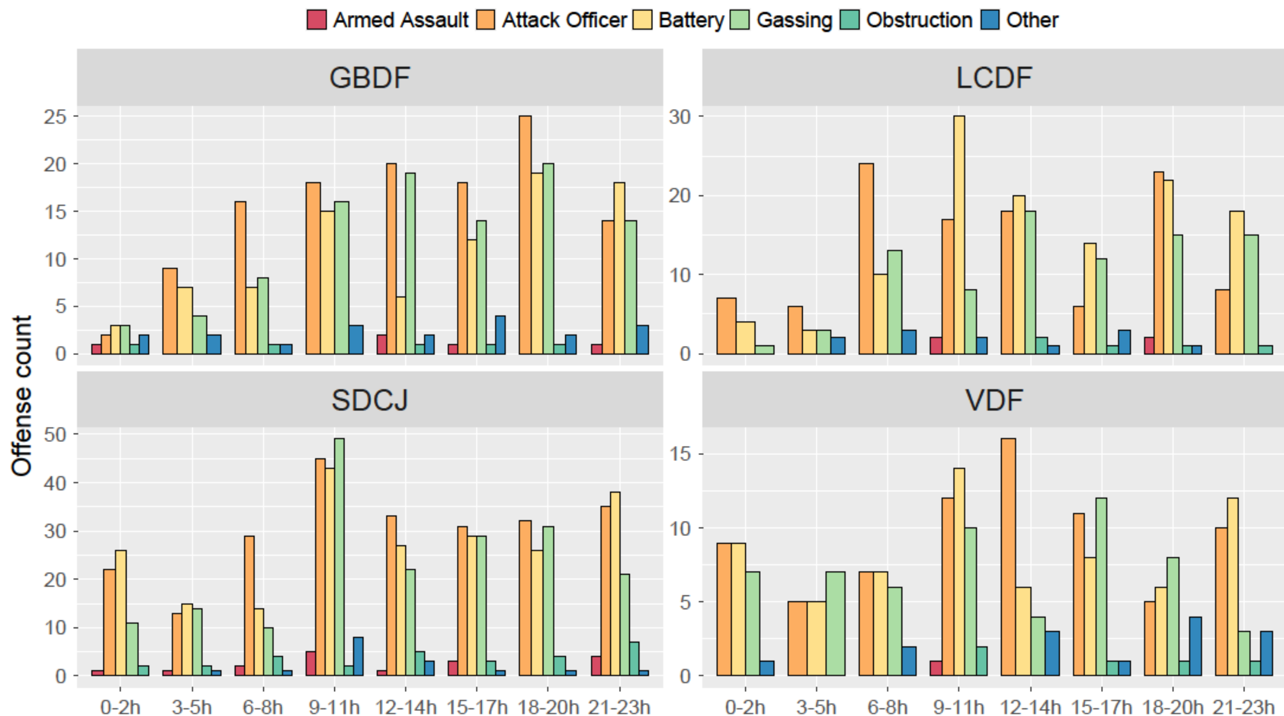



**Figure 4.** Hourly counts of offenses by type against staff in selected facilities.

In summary, no associations could be observed between frequency of offenses against staff and in-custody deaths using any of the different measures above. These events seem to be directed by largely separate factors, at least at this level of acquired data.

If TMWL had received the data on individuals involved in assaults, that would have enabled an analysis of whether, and to what extent, the involvement in assaults, and the timing of assaults, is correlated with dying in-jail.

### 5.5.8 – Does the race, gender, or age of an [incarcerated person] play a role in the circumstances surrounding IN-CUSTODY DEATHS and subsequent investigations?

See MINI-REPORT for Item 2a for a discussion of this study question which is incorporated here by reference as if fully set forth.

### 5.5.1 – When are [incarcerated people] most vulnerable to the risk of death? Is it after they are first admitted to the jail, after they are found guilty of the crime, or based on another important event?

Data Sets and Preliminary Findings

SDSO provided data and information for TMWL to do some descriptive analysis in response to this study question. Additionally, given the broad language of this study question (e.g. "...or based on another important event?"), it is also accurate to say that all of TMWL's efforts to obtain data and information for this study, which included questions about mental health, staffing, and policies and procedures, for example, are attempts to answer this study question but are addressed more directly in other mini-reports. See below for initial analysis on the temporal aspects of this study question.

As Table 2 shows, by far, most of the deaths (79%) occurred while awaiting trial. Approximately one in every seven deaths occurred after sentencing.

| Custody Status | Count | Percent |
|---|---|---|
| Booked - Awaiting Trial | 141 | 79% |
| Sentenced | 25 | 14% |
| Awaiting Booking | 3 | 2% |
| Booked - No Charges Filed | 3 | 2% |
| Unknown | 6 | 3% |
| Other | 1 | 1% |
| TOTAL | 179 | 100% |

**Table 2. Counts (and % total) of in-custody deaths per custody status.** The custody status is unknown in 6 cases.

Figure 11 shows the distribution of in-custody deaths in time after incarceration for various custody statuses and for all deaths (any status) collectively, and Figure 12 shows this distribution within selected facilities.

82% of deaths happened within the first 6 months in jail, both if dying while awaiting trial or dying after sentencing. Also, 9% of all deaths while awaiting trial happened after the first year in jail. The largest daily count of deaths while awaiting trial happened on the day after incarceration. The largest daily count of deaths after being sentenced happened during the second week in jail. All deaths with other statuses occurred within first two weeks in jail.

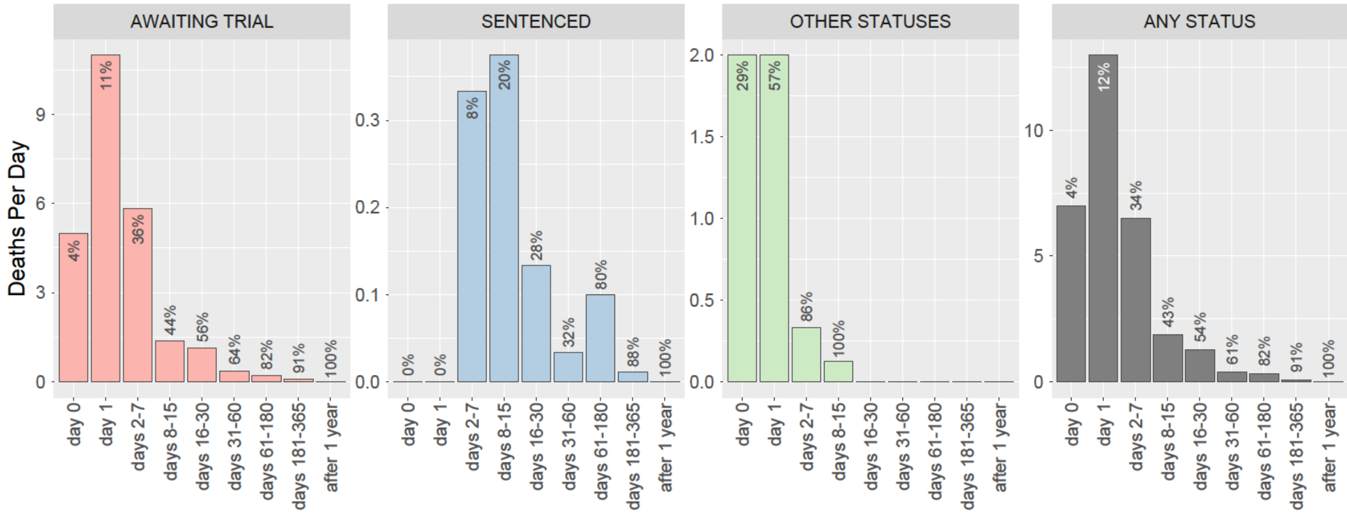



**Figure 11. Barplots of deaths per day (number of deaths divided by the number of days) per custody status vs. time since incarceration**. "Other statuses" group combines statuses: Awaiting Booking, Booked-No Charges Filed, Other, and status unknown. "Day 0" is the day of incarceration, "day 1" is the very next day, etc. In each bar, the percent mark shows the cumulative proportion of all deaths until and including that particular time in jail (so that the final bar marks 100% of all deaths in that category.)

The rightmost panel in Figure 11 shows the highest daily count of in-custody deaths occurring on the very next day after booking, with the daily counts of deaths remaining prominent during the whole first week after incarceration and then sharply declining. Also, 34% of all deaths occur within that first week in jail.

In LCDF, there is a notable increase of daily counts of deaths among incarcerated people during their second month in jail (24% of all deaths in LCDF occur during that month). Between the facilities, the deaths occurred the latest in GBDF, where within the first 6 months in jail only 28% of deaths occurred.

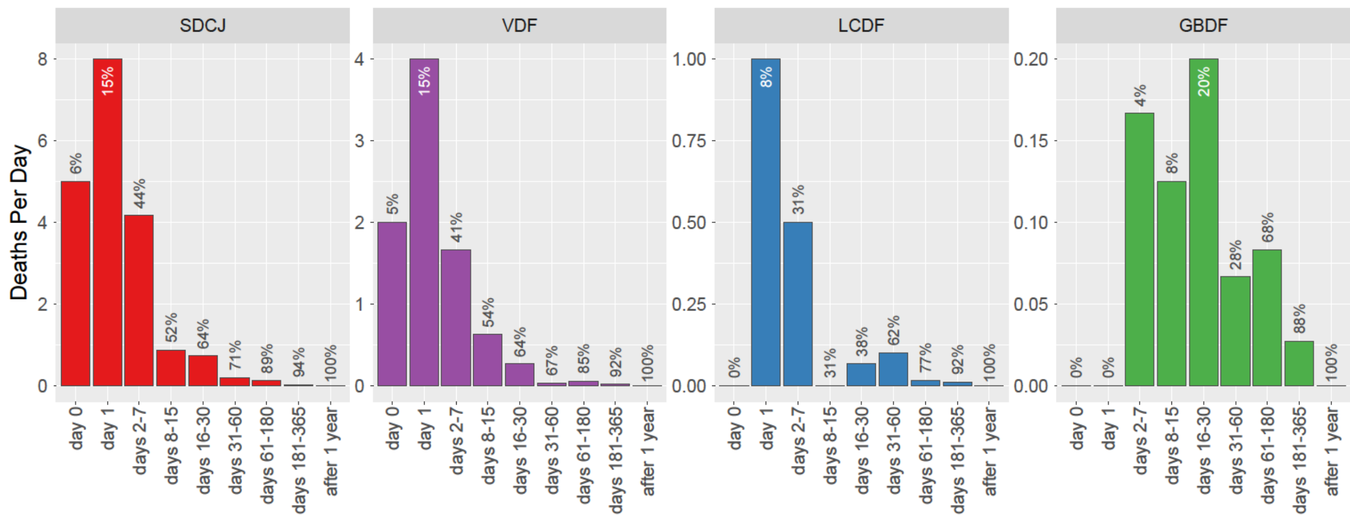



**Figure 12. Barplots of deaths per day (number of deaths divided by the number of days) in selected facilities vs. time since incarceration.** "Day 0" is the day of incarceration, "day 1" is the very next day, etc. In each bar, the percent mark shows the cumulative proportion of all deaths until and including that particular time in jail (so that the final bar marks 100% of all deaths.)

A closer look at the data shows that in GBDF, which had no deaths on Day 1, the deaths occurred on Days 16-30 after some adjustment to incarceration. This may indicate administrative issues, including placement and health factors that should be considered for future investigation.

If TMWL had received the detailed data on all jailed persons which would include the length of stay in jail, that would have enabled an analysis of custody status and time spent in jail as possible factors that affect death rates, as each category of custody status and time in jail, and possibly a combination of these categories would have received its own death rate. A possible comparison would be, for example, how individuals awaiting trial in SDCJ in the first week after incarceration compare to same individuals in the second week after incarceration, in terms of death rates.

### 5.5.7 – Are IN-CUSTODY DEATHS more prevalent among those charged with a certain kind of crime?

Data Sets and Preliminary Findings

SDSO provided local, individual-level information for only those who died in custody; for those who did not die in custody, SDSO provided only one ("contemporaneous") month of

this information for people who did not die in prison. So, we know that such data exists, but has not been made available to TMWL.

For those who died while in custody, SDSO provided data about the "custody offense" or the offense for which the person was detained. However, since TMWL does not have this same information for those who did not die, prevalence of deaths among different categories of detainees by their custody offense cannot be calculated. Thus, a potential relationship between custody offense and in-custody deaths cannot be established. Only a descriptive breakdown of deaths by custody offense and another feature, like facility or custody status, are possible at this time.

Also, it should be noted that the category of "custody offense" is not the same as a conviction; the vast majority of the people who died while in-custody in a San Diego County detention facility during the study period were awaiting trial; in other words, guilt had not been established. The descriptive analysis below is about reported custody offense only and not whether the offense was actually committed.

| Custody Offense | SDCJ | VDF | GB DF | LCDF | Awaiting Trial | Sentenced | All Deaths |
|---|---|---|---|---|---|---|---|
| Assault | 20 | 6 | 7 | 1 | 32 | · | 37 (21.6%) |
| Dangerous Drugs | 7 | 2 | 3 | 1 | 8 | 5 | 14 (8.2%) |
| Probation/Parole-Felony | 7 | 2 | 2 | 1 | 8 | 3 | 12 (7.0%) |
| Burglary | 3 | 4 | 3 | · | 8 | 3 | 11 (6.4%) |
| Narcotics | 6 | 3 | · | · | 7 | 2 | 10 (5.8%) |
| Willful Homicide | 5 | 1 | 2 | 2 | 8 | · | 10 (5.8%) |
| Other Sex Law Violations (2006-2013) | 4 | 4 | · | · | 10 | 1 | 9 (5.3%) |
| Other Drug Law Violations | 6 | 1 | 1 | · | 6 | 1 | 8 (4.7%) |
| Drive Under the Influence | 3 | 1 | 1 | 1 | 5 | 1 | 6 (3.5%) |
| Rape (2014-2015) | 1 | 4 | · | · | 6 | · | 6 (3.5%) |
| Drunk | 2 | 3 | · | · | 4 | · | 5 (2.9%) |
| Lewd or Lascivious | 2 | 3 | · | · | 5 | · | 5 (2.9%) |
| Weapons | 3 | 2 | · | · | 3 | 2 | 5 (2.9%) |
| Other Felony | · | · | 1 | 3 | 4 | · | 4 (2.3%) |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Robbery | 1 | 1 | 2 | · | 4 | · | 4 (2.3%) |
| Theft | 2 | · | · | 2 | 3 | 1 | 4 (2.3%) |
| Arson | 2 | · | 1 | · | 3 | · | 3 (1.8%) |
| Contempt of Court | 1 | · | 1 | 1 | 3 | · | 3 (1.8%) |
| Malicious Mischief | 3 | · | · | · | 3 | · | 3 (1.8%) |
| Petty Theft | 1 | 1 | · | · | 1 | · | 2 (1.2%) |
| Trespassing | 2 | · | · | · | 2 | · | 2 (1.2%) |
| Assault and Battery | 1 | · | · | · | 1 | 4 | 1 (0.6%) |
| CI/CO Ordinances | 1 | · | · | · | 1 | · | 1 (0.6%) |
| Failure to Appear/Non-Traffic | · | 1 | · | · | 1 | · | 1 (0.6%) |
| Forgery, Checks, Access Cards | · | · | 1 | · | 1 | · | 1 (0.6%) |
| Kidnapping | · | · | · | · | · | 1 | 1 (0.6%) |
| Manslaughter - Non Vehicular | · | · | · | 1 | 1 | · | 1 (0.6%) |
| Motor Vehicle Theft | 1 | · | · | · | 1 | · | 1 (0.6%) |
| Probation/Parole - Misdemeanor | 1 | · | · | · | 1 | · | 1 (0.6%) |
| TOTAL | 85 | 39 | 25 | 13 | 140 | 24 | 171 (100%) |

**Table 3. Counts (and % total) of the 171 reported in-custody deaths by the custody offense of the incarcerated person.** Statistics are shown for deaths in selected facilities and for all deaths. For 8 reported deaths, the custody offense is unknown and these deaths are not included here.

Table 3 shows that, among the reported in-custody deaths, the most frequent custody offense was assault, followed by drug-related offenses. Among people who died and were charged with assault, all were awaiting a trial, and represent 24% of all deaths in SDCJ, 15% in VDF, 28% in GBDF, and 8% in LCDF.

If TMWL had received the detailed data on all jailed persons which would include their custody offense, each of these categories could be associated with a death rate.

### 5.5.13 – What are the IN-CUSTODY DEATH rates among [incarcerated people] with a history of homelessness?

Data Sets and Preliminary Findings

This specific request was denied with the following statement: "The San Diego County Sheriff's Department does not categorize the information in the manner requested or the data is not available in the Jail Management System." A later response from SDSD noted that the San Diego County Department of Medical Examiner might have this data.

The two agencies contacted through the county-wide CPRA portal denied our requests, since they are not the originator of the data on people incarcerated in the county jails. This CPRA inquiry was closed on September 5, 2024. As noted above, TMWL has received data from the Health and Human Services Agency as a result of this CPRA request, but this data addresses different study questions on mental health, not homelessness (and will be addressed in MINI-REPORT on Item 2c).

There are no data sets to analyze for this study question.

### Challenges in Addressing Study Questions in Item 2b

The challenges in addressing the study questions in this report remain similar to those mentioned in the MINI-REPORT on Item 2a: the challenges of procuring useful data. (See, MINI-REPORT on Item 2a for more details.

More meaningful analysis about the impacts of assaults on staff, social demographics, length of incarceration, custody status, type of crime charged, or a history of homelessness on in-custody deaths in the San Diego County Detention Facilities is dependent upon having facility-specific, individual-level data about each incarcerated person in each facility for the duration of the study.

Without such data, we can present descriptive breakdowns of in-custody deaths by various categories and by facility (if provided), which is informative in its own right; however, this will not allow us to identify any differences between the population of people who died while in custody and those who did not die while in custody. This comparison—of a variety of potential differences—could reveal patterns and possible causes of such deaths and thus increase the likelihood of preventing them in the future.

TMWL has not yet pursued a CPRA through the county Medical Examiner since we do not yet have a comprehensive list of the people who did not die in custody during the duration of the

study; without this, there can be no useful analysis. Further, SDSO did not provide data with pre-arrest residence addresses of those incarcerated. Such data may permit identifying homeless or unhoused people (such as if the residence was a shelter, or there was no residence). There are, thus, no findings on the final study question in Item 2b at this time.

### Summary of Observations for Mini-Report 2b

- **SDCJ has the highest number of offenses against staff.**
- **VDF has a relatively small number of offenses against staff as compared to GBDF and LCDF.**
- **Most in-custody deaths (79%) occurred while incarcerated persons were awaiting trial.**
- **82% of deaths occurred with the first 6 months of incarceration. 9% of those incarcerated persons awaiting trial occurred after the first year of incarceration.**
- **The largest daily count of deaths while awaiting trial occurred the day after incarceration.**
- **The largest daily count of deaths after sentencing occurred during the second week of incarceration.**
- **All deaths of incarcerated persons with other custody statuses occurred within the first two weeks after incarceration.**
- **34% of all deaths occur within the first week of incarceration.**
- **The highest daily count of deaths occurs the next day after booking.**
- **24% of all deaths at LCDF occur during their second month of incarceration.**
- **28% of all deaths at GBDF occur within the first six months of incarceration. This may indicate administrative issues, placement and health factors that may be considered for future investigation.**
- **The most frequent custody offense was assault followed by drug-related offenses.**
- **Of the incarcerated persons who died and who were charged with assault, all were awaiting trial and represented 24% of deaths at SDCJ, 15% of deaths at VDF, 28% of deaths at GBDF and 8% of deaths at LCDF.**

Here, observations are shared that may lead to requests for data in the future to address them and proposed actions that might be taken to be taken in future studies.

The observations as they relate to the MINI-REPORT 2b Study Questions follow.

### *Additional Observations, Descriptives and Preliminary Recommendations*

**Study Question 5.5.5.3 Re: Institutional Stresses Associated with In-Custody Deaths and Assaults on Staff**

TMWL noted that one month's worth of rather detailed data was provided for people who did not die in prison. Therefore, this data exist for all incarcerated people who did not die in prison for the duration of the study and was not provided despite TMWL's request for this data.

Further study should be conducted concerning assaults by staff on incarcerated persons and between incarcerated people. Additionally, grievance slips for the incarcerated people involved in such offenses as well as those of all people who died in-custody would provide more context for violence occurring in the facilities and its potential impact on in-custody deaths. Such data may point to a need for additional staff training on this issue and whether there were aggravating factors such as physical and mental illnesses that led to these assaults. It suggests the need for targeted inspections to identify possible weapons in the possession of incarcerated people and transfers of such weapons or materials for making such weapons by visitors and staff to those who are incarcerated. Finally, a process review of the periodic rounds conducted by sworn personnel should be conducted.

**Study Question 5.5.8 – Role of Race, Gender and Age**

Observations concerning this Study Question were presented in Mini-Report 2a.

**Study Question 5.5.1 – Temporal Vulnerability of Incarcerated Persons to the Risk of Death**

The data provided revealed that a number of deaths occurred within the first 24 hours in all detention facilities except GBDF. This suggests that an analysis of all the detention centers should be conducted to determine whether admissions policies, staff training, the facility itself, available of staff for medical interventions and other factors play a role in this difference. Additionally, since the vast majority of people who died in-custody were awaiting trial, an exploration into the County's bail and pre-trial detention practices should be made to reduce in-custody deaths.

**Study Question 5.5.7 – Risk of Death and Custody Offense**

TMWL's observation, based on the data received, is that the custody offense of assaults is the most frequent offense among in-custody death. It is possible that crime classification, housing based on classification, differential staff treatment of incarcerated people depending on custody offense is a factor. Without more data, it is not possible to be more definitive about the possible relationship between custody offense and in-custody death.

**Study Question 5.5.13 – In-Custody Death Rates and Homelessness**

After numerous attempts, TMWL was unable to obtain any data concerning this Study Question. TMWL's observation is that such a relationship is possible but data is required to conduct a meaningful analysis.

**Summary of Preliminary Recommendations**

The following represents some preliminary recommendations based on the review of analysis of the limited data that was received for this study question.

If there is no data, suggestions are made regarding data that should be ascertained so that appropriate recommendations can be offered.

- While SDSO provided one month of data for incarcerated persons who did not die in custody, such data should be provided for the entire study period.
- A second look should be taken at the role of other factors such as the county's bail and/or pre-trial detention patterns and practices, ability of staff to address aggressive behavior in a nonviolent manner, drug addiction withdrawal, condition of arrestees when processed for admission, mental health and chronic illnesses, and training of admissions staff to identify other factors.
- Further study should be conducted concerning assaults by staff on incarcerated persons and between incarcerated persons.
- It is recommended to register the death time to allow comparison in a future study. This requires accumulating the data for a number of years to be usable for future study.
- A process review of the periodic rounds conducted by sworn personnel should be conducted.
- A review should be conducted of the role of other factors such as the county's bail and pre-trial detention patterns and practices, ability of staff to address aggressive behavior in a nonviolent manner, drug addiction withdrawal, condition of arrestees when processed for admission, mental health and chronic illnesses, and training of admissions staff to identify other factors.

## CONCLUSION

TMWL has prepared the above background and this mini-report to describe what it has done, to date, to address Item 2b. It has also included observations based on the data that was received and analyzed. The final report will include a full account of the study methods and recommendations for future studies. In summary, in this mini-report there are no clear findings coming from the received data, only descriptive breakdowns of deaths by custody status and custody offenses and their timing.

# MINI-REPORT for Item 2c

The Mountain-Whisper-Light, Inc.

Final Version 01/06/26

## MINI-REPORT for Item 2c[10]

***Study Questions Addressed***

This Mini-Report covers the following study questions, as per Item 2c in the amended contract between CLERB and TMWL (CONTRACT 569176, MODIFICATION 3):

- Study Question 5.5.2 – What are the IN-CUSTODY DEATH rates among [incarcerated people] with a history of mental illness?
- Study Question 5.5.3 – What is the underlying relationship between mental health services in jails and IN-CUSTODY DEATHS? Does having more available mental health services and related staff reduce IN-CUSTODY DEATHS?
- Study Questions 5.5.9 – What has been the impact of new programs enacted by the San Diego Sheriff's Department on IN-CUSTDY DEATHS over time?
- Study Question 5.5.11 – What is the role of county mental health services and other public services, such as public housing, on jail deaths?

A request for data and information to address each of these study questions was submitted in the "SDSD Mental Health PRA" request that TMWL submitted to the SDSO Public Records Center online portal on March 13, 2024. Upon confirmation of receipt on March 13, 2024, SDSO renamed the request Reference No. S000894-031324.

TMWL also sought data and information to address these study questions in the "SDSD Staffing PRA" request, submitted to the SDSO Public Records Center on June 18, 2024. Upon confirmation of receipt on the same date, SDSO renamed the request Reference No. S002147-061824.

---

[10] An "Introduction to Study Mini-Reports" was provided with MINI-REPORT for Item 2a, which includes background information on all of TMWL's CPRA requests as well as attempts to obtain SDSO cooperation and data for the entire study. The reader is referred to that document for the same background information regarding the study questions in this report.

Additionally, TMWL sought data and information to address these study questions in the "SDSD Policies and Programs CPRA" request, submitted to the SDSO Public Records Center on October 24, 2024. Upon confirmation of receipt on the same date, SDSO renamed the request Reference No. S003984-102424.

TMWL made a final attempt to obtain data and information from SDSO to respond to these study questions by submitting the "SDSO Consolidated CPRA" request on October 24, 2024. SDSO confirmed receipt on the same date and designated it Reference No. S003985-102424.

TMWL also submitted requests to the San Diego County countywide portal (NextRequest) on July 26, 2024 for information and data to address study questions 5.5.2 and 5.5.11. Through this request, TMWL received a data set from the Health and Human Services Agency in April 2025.

Below we report on the relevant data sets received from these requests and present preliminary findings for each study question related to mental and behavioral health. The analyses are followed by challenges, observations, and initial recommendations based on this portion of the study (i.e. the study questions addressed herein).

### *Analyses for Study Questions in Item 2c*

#### *5.5.2. - What are the IN-CUSTODY DEATH rates among [incarcerated people] with a history of mental illness?*

<u>Data Sets and Preliminary Findings</u>

The only data that TMWL received about any incarcerated person's mental health history came from San Diego County Health & Human Services Agency (HHSA). For the people who died in-custody during the study period, HHSA provided the most recent fiscal year in which someone received San Diego County mental health services. This allows for only a very limited snapshot of mental health treatment history, since it does not account for any private mental health services that any incarcerated person might have historically received (whether they died in custody or not), nor does it denote what kind of treatment was received, how often, or if it was sought and provided at any time before the fiscal year provided. Additionally, HHSA data did not include this same history of mental health treatment for any incarcerated person who did not die while in-custody during the study period.

The HHSA dataset is further limited by missing information in 48 out of the 179 known in-custody deaths that occurred during the study period: for 43 deaths included in the HHSA dataset the fiscal year entry is empty, and 5 known deaths are not included in the HHSA dataset. Also, there is likely erroneous information for 7 individuals who reportedly received mental health services in years after their deaths occurred. In total, the dataset provides useful information for 124 deaths of which 107

(86%) received county mental health services in the year that they died, and 17 (14%) did not receive county mental health services.

TMWL received no data from SDSO about the mental health history or treatment of any incarcerated person while in an SDSO detention facility during the study period. In relation to this study question (and others), SDSO provided the manner and means of death for each person who died while in-custody with no explicit category or designation for a death related to a person's history of mental illness. While TMWL recognizes that in-custody deaths by suicide or alcohol or drug overdose are not necessarily indicative of a history of mental illness, we cautiously offer the following analyses on deaths by Suicide (listed by SDSO as a manner of death) and Alcohol/Drug Overdose (listed by SDSO as a means of death) as places to look for a relationship between the possibility of a history of mental illness and in-custody death.[11]

All analyses herein should thus be noted for their severe limitations, caveats, and need for more study.

TMWL found 76 out of 179 deaths to be marked as Suicide or Alcohol/Drug Overdose in the SDSO data. Table 1. below shows the number of Suicide and Alcohol/Drug Overdose deaths among those who died in-custody during the study period.

| | ***SDCJ*** | ***VDF*** | ***All Facilities*** |
|---|---|---|---|
| *Suicide Deaths* | 19 (21%) | 10 (24%) | 39 (22%) |
| *Overdose Deaths* | 17 (19%) | 11 (27%) | 37 (21%) |
| *Suicide and Overdose Deaths* | 36 (40%) | 21 (51%) | 76 (42%) |
| *All Deaths* | 91 (100%) | 41 (100%) | 179 (100%) |

**Table 1. Counts (and % total per facility) of in-custody deaths related to suicides and overdoses, and all in-custody deaths.** The two selected facilities have the largest numbers of deaths among facilities. The bottom panel ("All Deaths") shows all deaths reported to TMWL (not just suicide or overdose deaths).

[11] SDSO data on in-custody deaths provides four types of "Manner of Death:" Accident, Homicide, Natural, and Suicide. The "Means of Death" category provides more description of the manner of death, with all "Alcohol/Drug Overdose" deaths listed as an "Accident" manner of death. There is no distinction between alcohol- and drug-related overdoses in the means of death category, but SDSO's "Cause of Death" category (not included here) includes details about specific substances involved in an overdose death.

Suicide and Alcohol/Drug Overdose deaths in Table 1 are non-overlapping; that is, no death was marked both as a suicide and an overdose death in the SDSO dataset. The table shows that suicides and overdoses are approximately equally frequent among recorded deaths in San Diego Central Jail (SDCJ) and Vista Detention Facility (VDF), which have the largest number of recorded in-custody deaths, and all facilities collectively. Additionally, suicides and overdose deaths together comprise 42% of all deaths. Specifically, in VDF, the combined suicides and overdose deaths are a bit more frequent and together comprise about half (51%) of all deaths in that facility.

Table 2. below shows the number of suicide and overdose deaths separately and together, alongside the total number of in-custody deaths during the study period and whether the person who died had received county mental health services (MHS) as per the HHSA data.

| | | ***MHS not received*** | ***MHS received*** | ***MHS post-death*** | ***MHS unknown*** |
|---|---|---|---|---|---|
| ***ALL FACILITIES*** | *Suicide Deaths* | 4 | 22 | 2 | 11 |
| | *Overdose Deaths* | 8 | 14 | 2 | 13 |
| | *Suicide and Overdose Deaths* | 12 | 36 | 4 | 24 |
| | *All Deaths (in all facilities)* | 17 | 107 | 7 | 48 |
| ***SDCJ*** | *Suicide Deaths* | 4 | 9 | 1 | 5 |
| | *Overdose Deaths* | 6 | 4 | 2 | 5 |
| | *Suicide and Overdose Deaths* | 10 | 13 | 3 | 10 |
| | *All Deaths (in SDCJ)* | 12 | 52 | 5 | 22 |

**Table 2. Counts of in-custody deaths related to suicides and overdoses and all deaths, according to whether they received SD County mental health services in the fiscal year of their death ("MHS received") or not ("MHS not received").** The upper panel reports deaths in all facilities, and the lower panel reports only deaths in SDCJ. For a number of deaths this information is missing ("MHS unknown").

Finally, some individuals have seemingly erroneous entries, stating that they received services in years after they died ("MHS post-death"). The bottom row in each panel ("All Deaths") counts all deaths reported to TMWL: 179 in all facilities in the top panel, and 91 in SDCJ alone in the bottom panel.

Looking at the above data collectively, it appears that the in-custody deaths of people who did not receive county mental health services were largely related to suicide or alcohol/drug overdose: in all facilities collectively, 12 out of the 17 (71%) people who died without reportedly receiving county mental health treatment died of either suicide or alcohol/drug overdose. In SDCJ alone, 10 out of 12 (83%) people who died without receiving county mental health treatment died of the same two kinds of deaths. This can be contrasted against the 107 people who died while receiving county mental health services: in all facilities collectively, 36 out of the 107 (34%) people died either by suicide or alcohol/drug overdoses, and in SDCJ alone 13 out of 52 (25%) people who reportedly received county mental health services died from suicide or alcohol/drug overdoses. Notably, research indicates that addiction is a complex brain disorder and a mental health illness that causes cognitive, behavioral and physiological symptoms.[12] However, mental health disorders don't always involve addiction. This issue is one that requires further study and we cannot make any preliminary observations or connections to the data presented other than what appears above. See below for an additional discussion of this descriptive data.

Below, Figure 1. shows the distribution of in-custody deaths in time after incarceration within selected facilities and all facilities. Compared to all deaths (see Mini-Report 2a, Figure 8., rightmost panel), deaths by suicide and alcohol/drug overdose occurred somewhat sooner after incarceration. For example, after the first week in jail, nearly half (49%) of all overdose deaths occurred and 41% of all suicide deaths, whereas a third (34%) of all deaths occurred after the first week.

Overdose deaths occurred particularly soon in SDCJ: after the first week in jail, 71% of all overdose deaths occurred. The median number of days spent in jail was 25 for all deaths, 17 for suicides, and 10 for overdose deaths (only 4 in SDCJ).

---

[12] A.I. Leshner, M.D, "Addiction is a Brain Disease, and it Matters," 2003, Paychiatryonline.org, Focus, Vol. 1, Number 2, https//doi.org/10.1176/foc.1.2. 190, April 1, 2003. Additionally, a number of articles on this subject were reviewed in publications by Mayo Clinic, American Society of Addiction Medicine and other periodicals.

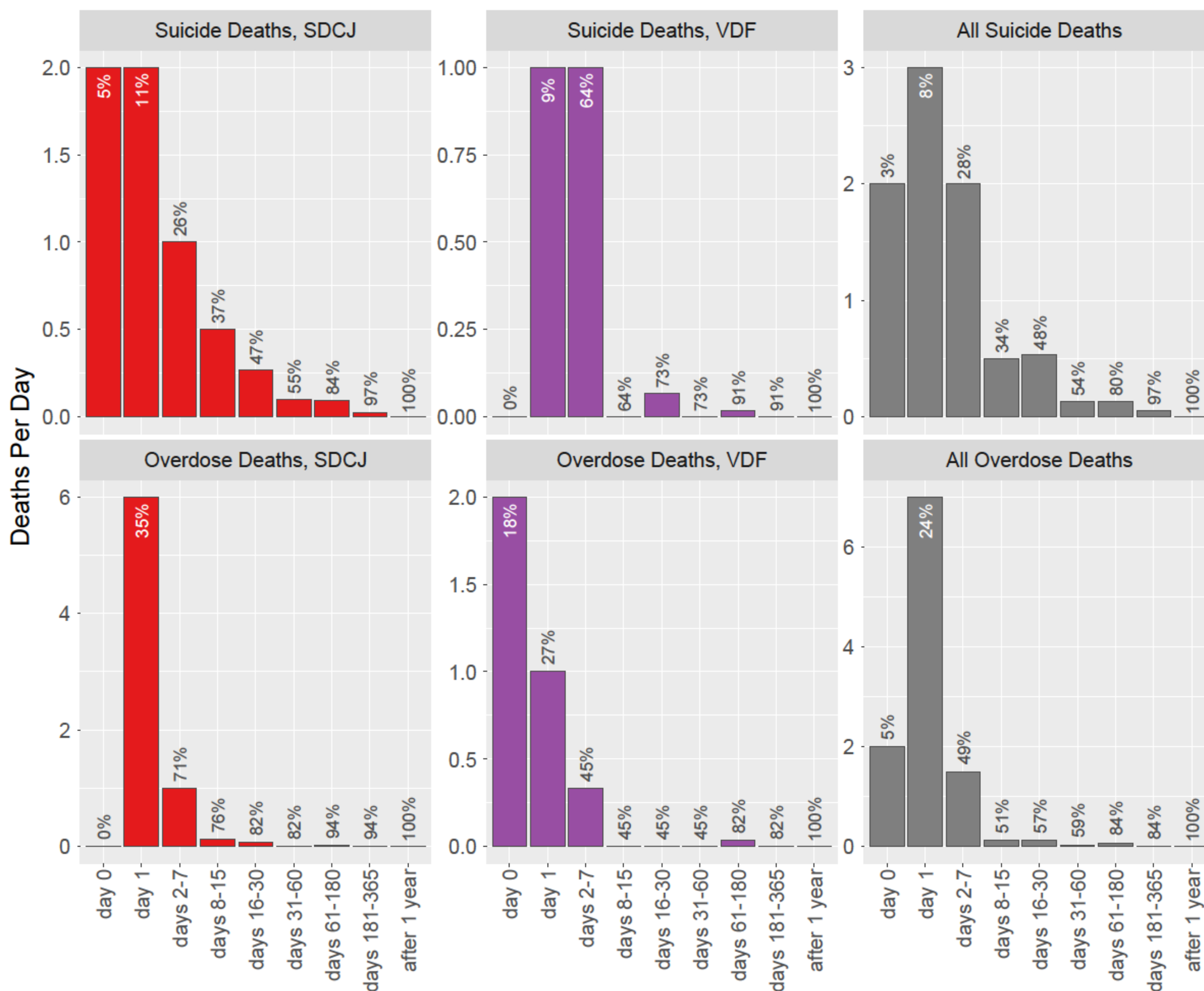



**Figure 1. Barplots of suicide and overdose deaths per day (number of deaths divided by the number of days) in selected facilities (and all facilities) vs. time since incarceration.** "Day 0" is the day of incarceration, "day 1" is the very next day, etc. In each bar, the percent mark shows the cumulative proportion of all deaths until and including that particular time in jail (so that the final bar marks 100% of all deaths.)

Reiterating the important point that in-custody deaths by suicide or alcohol or drug overdose do not necessarily indicate a person's history of mental illness, we offer the preliminary finding that, among reported deaths during the study period, those deemed Suicides and Alcohol/Drug Overdose were concentrated among individuals that reportedly did not receive county mental health treatment. It is possible that those same individuals received private mental health treatment, or perhaps even mental health treatment while incarcerated; this data was not provided and therefore limits this finding. TMWL also found with the existing data that deaths by suicide and overdoses—especially overdoses—tend to happen sooner after booking than other in-custody deaths.

### *5.5.3. – What is the underlying relationship between mental health services in jails and IN-CUSTODY DEATHS? Does having more available mental health services and related staff reduce IN-CUSTODY DEATHS?*

Data Sets and Preliminary Findings

Noting that "there is no designated budget specific to just mental health," SDSO provided a document with Medical Services Division budgets—under which mental health services are included—for each year within this study. This document shows total yearly expenditures for Mental Health services.

SDSO also provided more detailed information about mental health staff in response to TMWL "SDSD Staffing PRA," embedded within a great deal of information about all staff. These employee rosters list all employees at the end of each calendar year 2012-2024, with information about department/facility, job title, starting date, etc. Here, "Medical Services" employees belong to a particular department that is not associated with any particular facility. Among the job titles, three are related to mental health, and marked as:

- Sheriff's Det, Mntl Hlth Clin;
- Sheriff's Det,Cf Mntl Hlth Clin; and
- Sheriff's Det, MHCase Mgt Clin.

There may be other job titles, and some mental health provider positions were contracted and would not be included in the Employee Rosters.

As noted with the study question above, since TMWL has no data about the mental health status or treatment of any incarcerated individual, we offer analyses on those deaths identified as Suicide and Alcohol/Drug Overdose as possibly indicative of deaths related to mental health services and staff.

Figure 2. shows yearly counts of the employees in these three job positions, the total yearly mental health expenditure (in million-dollar units), and yearly counts of combined Suicide and Drug/Alcohol Overdose deaths in SDCJ and in all facilities, for the period 2012-2024. What seems striking here is the constant increase in the resources given to mental health, in terms of numbers of employees and the total expenditure. Yet during 2012-2024 these efforts seemingly had little effect on Suicide and Drug/Alcohol Overdose related deaths, at least in SDCJ where the problem of in-custody deaths is the most pressing.

Splitting this time period in two equal parts, 2012-2017 and 2018-2023[13], the combined suicide and overdose death counts in SDCJ splits between 16 combined deaths in the earlier time period and 20

[13] Note that TMWL does not have death counts for the entire 2024 year because our PRA requests for this data were submitted in early 2024 and SDSO provided the responding in-custody deaths dataset in mid-2024.

combined deaths in the latter time period. For all facilities taken together, this split is 37 and 39 respectively. So, in both cases the number of combined Suicide and Alcohol/Drug Overdose deaths was somewhat larger in the more recent set of years (2018-2023), the same set of years where more resources were put toward mental health-related budget and staffing. It seems that there is insufficient impact of these increased resources or perhaps that more time is needed to determine their impact.

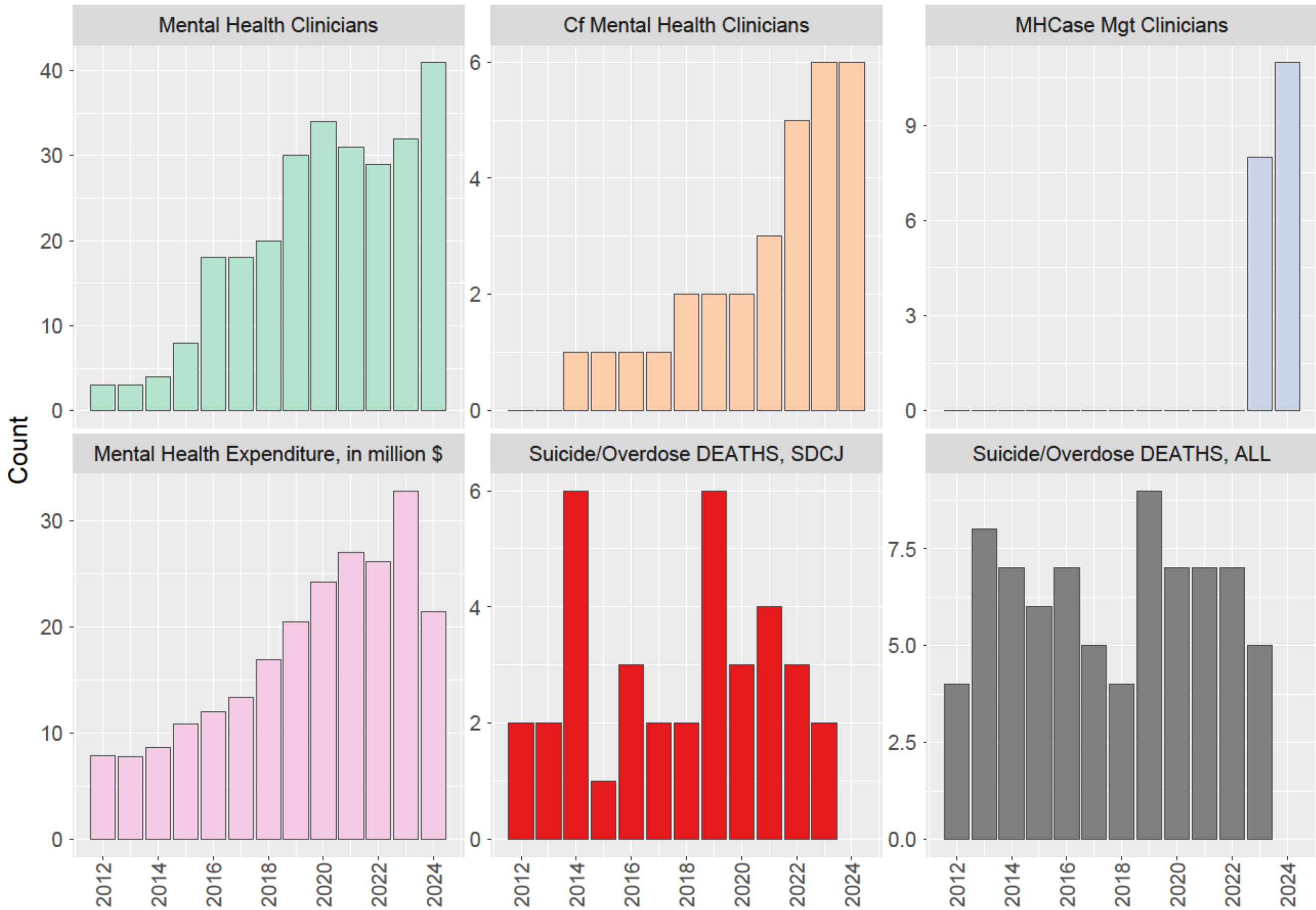



**Figure 2. Yearly counts of various quantities related to mental health.** Top row: number of employees in three job positions related to mental health. Bottom row: total mental health expenditure and combined suicide and overdose deaths in SDCJ and all facilities.

Finally, SDSO also provided the “Mental Health Beds” document, showing the number of incarcerated people assigned to mental health beds by facility at the end of each month from 2013 through 2024. Only two facilities have these beds, SDCJ and Las Colinas Detention Facility (LDCF). This information is also embedded in Hudler Armstrong letters, denoted as “Psych Security Unit.” SDSO provided no other information other than a mental health bed count as a count of those beds in use by incarcerated people assigned to them; that is, no information regarding treatment, duration of assignment to a

mental health bed, or whether any person who died in-custody had been assigned to such a bed at any time.

Figure 3. below shows the time evolution of the bed counts for the period 2013-2024. This evolution is shown as the number of beds both as the raw count and in 1,000 person-days units (counts divided by the changing jail occupation). In SDCJ, these trends do not seem to follow the trends in frequency of all deaths (see Mini-Report 2a, Figure 5) which had a smaller peak during 2014, and two larger ones near the beginning of 2019 and in early 2022 during Covid-19.

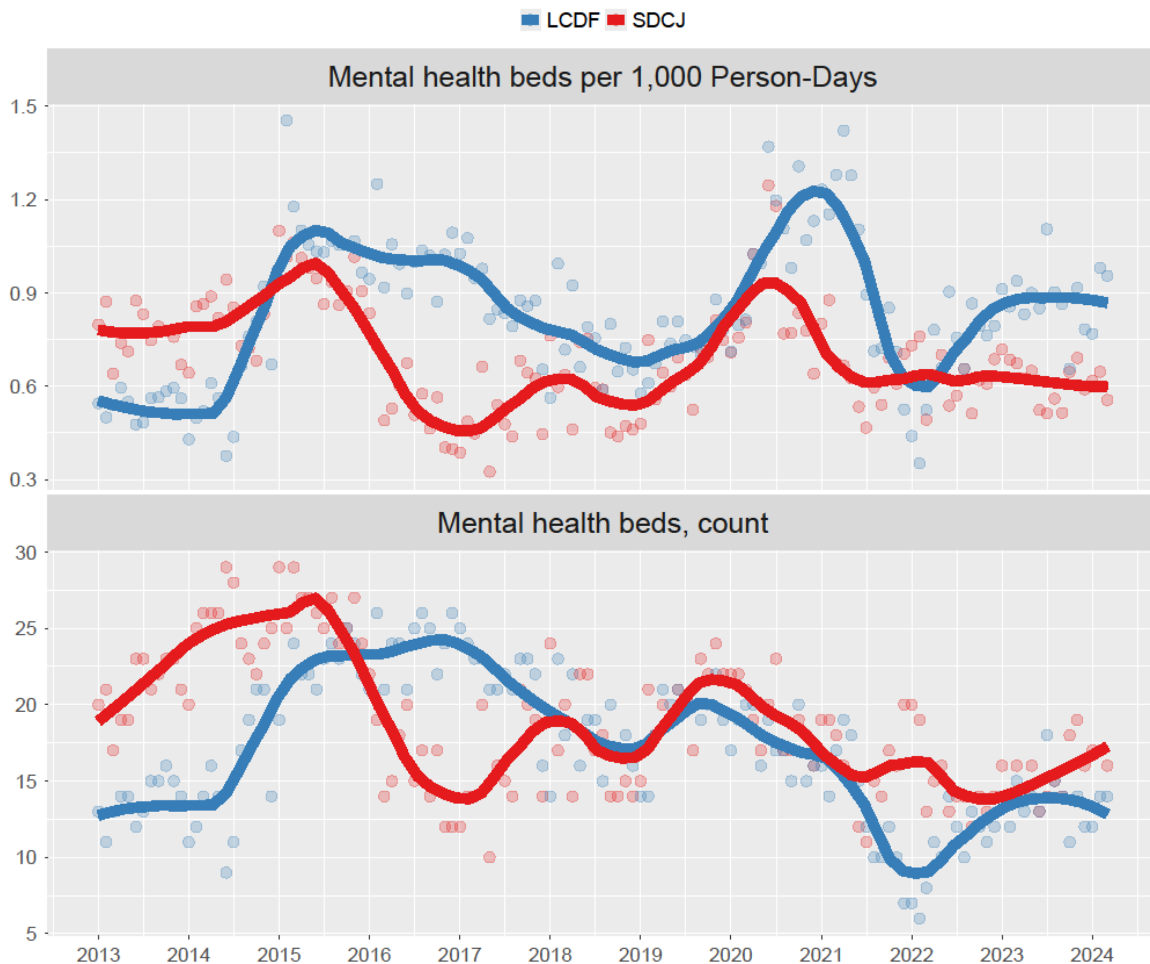



**Figure 3. Mental health beds, monthly counts (bottom panel) and rates per 1,000 Person-Days (top panel).** Dots are monthly values, thick lines are averages over nearby months, showing trends in the data. Only two facilities have these beds, SDCJ and LDCF.

Therefore, no obvious connection exists between the increase and decrease in mental health bed counts during the study period (shown above in Figure 3) and the increase and decrease in in-custody deaths analyzed in Mini-Report 2a. Still, these trends have historical value, as they may be useful for

some future eyeballing when more data is accrued and new ways of looking into these trends perhaps emerge. So, we present these historical trends here.

Figure 4 shows a more detailed breakdown of counts of Suicides and Alcohol/Drug Overdose deaths in SDCJ, per year. Over the years there seems to be a slight decrease in suicides and a concurrent slight increase in overdoses in this facility. Splitting the 2012-2023 period into two halves, the first half (2012-2017) had more suicides (11) than overdoses (5), while the second half (2018-2023) had more overdoses (12) than suicides (8). However, with total numbers this small, this reversal might be explained by play of chance.

It is not easy to notice a pattern or a trend connecting numbers of mental health beds and these deaths. Mental health bed counts were highest near the end of 2014 and near the end of 2019. During these two exact years, Suicide and Alcohol/Drug Overdose death counts were also highest. This correlation of counts (of beds and deaths) may be revealing some relevant trend in the data and yet it may not. Again, death rates among mental health compromised individuals cannot be established, and death counts alone cannot indicate if those rates were increasing or decreasing at any time.

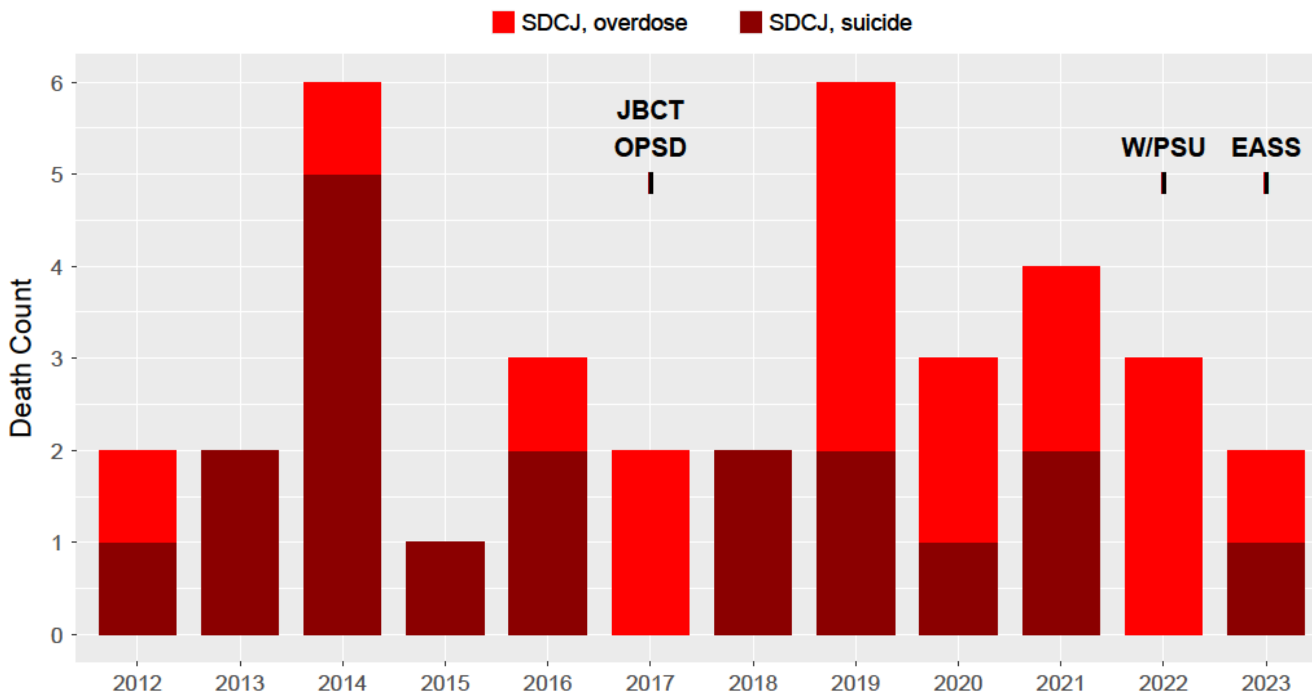



**Figure 4. Suicide and Alcohol/Drug Overdose death counts per year, in SDCJ.** The starting years of the mental health related programs enacted by SDSD (noted under Study Question 5.5.9) are marked above the bars.

Preliminary findings of the datasets provided suggest that adding additional resources, such as increased budget, mental health staff, or mental health beds does not necessarily have an impact on

decreasing deaths by suicide or alcohol or drug overdose. Such resources either need more time for an impact to occur, other resources or measures are needed, or deaths by suicide or overdose are not related to mental health resources as TMWL is cautiously suggesting. For example, it is too early to tell if the transition to a primary care nursing model or adding a Certified Nurse Assistant position has had any impact on in-custody deaths and any data in the possession of SDSO was not shared with TMWL.

### *5.5.9 – What has been the impact of new programs enacted by the San Diego Sheriff's Department on IN-CUSTDY DEATHS over time?*

Data Sets and Preliminary Findings

SDSO provided requested data on four mental health related programs: Jail-Based Competency Treatment (JBCT), Outpatient Step Down (OPSD), Early Access and Stabilization Services (EASS), and the Psychiatric Stabilization Unit (W/PSU). The data received included quick a description of the programs, their starting years, facilities involved, number of people in the program for a few most recent years, and a few side notes. All the programs are still running. Unfortunately, it is not clear how these programs were connected with people who died in-custody, if at all, as these programs were attended by small fractions of total populations of the related facilities, and those individual involvements and outcomes are unknown, since no individual-level data was provided about the participants.

The starting years of these programs are shown above in Figure 4: JBCT and OPSD started in 2017, W/PSU in 2022, and EASS in 2023. The splitting of the 2012-2023 timeline that was suggested in the previous section can now be coordinated with the introduction of these programs: 2012-2016 are the years before any of the programs existed, and 2017 and later on are the years with at least some of the programs running. Table 3 below shows average numbers of SDCJ suicide and overdose deaths per year during those time periods.

| ***SDCJ*** | ***2012-2016*** | ***2017-2023*** |
|---|---|---|
| *Suicide Deaths per year* | 2.2 | 1.1 |
| *Overdose Deaths per year* | 0.6 | 2.0 |
| *Suicide and Overdose Deaths per year* | 2.8 | 3.1 |

**Table 3. Counts of suicide and overdose deaths per year, in SDCJ, during the years before any of the programs started and during the years after some or all of the programs commenced.** The bottom row shows the sum of two upper rows.

Taking suicides and overdoses together, their yearly death counts were higher while the programs were running. This might suggest that the programs failed to achieve significant improvement. And yet, it

might be a hidden success if, perhaps, in the more recent years the jail populations included more mental-health related cases and the death tolls would be rising still higher without the programs installed. Due to the lack of data, these speculations must remain inconclusive. It is interesting, however, to note the shift in the trend of suicides versus overdoses: suicides halved (2.2 to 1.1) while overdoses more than tripled (0.6 to 2.0) in years of the programs running. Perhaps the programs succeeded to reduce potential suicides but failed to prevent (or even indirectly contributed to) overdose deaths?

SDSO has implemented more than the above four programs to attempt to reduce (or eliminate) in-custody deaths. In response to Reference No. S003984-102424 (TMWL "Programs and Policies" CPRA), SDSO provided online links to 37 SDSO programs about which TMWL asked; no analyzable data was provided. An initial analysis of the data provided in some of the links will be provided to the response to this study question in Mini-Report 2d where this study question is also included. To the extent possible, TMWL will present an even more complete analysis on the impact of these new programs on in-custody deaths in the final report. However, because to a large extent SDSO provided their responses in the form of press releases, it is doubtful that substantive, individual-level data will be included in them.

### ***5.5.11 – What is the role of county mental health services and other public services, such as public housing, on jail death***

<u>Data Sets and Preliminary Findings</u>

The data that TMWL received from San Diego County's Health and Human Services Agency is analyzed above in response to study question 5.5.2. TMWL attempted to obtain but received no data about any other San Diego County public service agency. Without such data, TMWL cannot address this study question beyond what is provided in response to question 5.5.2 above.

It would have been helpful, for example, to obtain the residential addresses of the people who died in-custody in order to prepare a preliminary analysis about public housing or homelessness and their relationship to in-custody deaths. This information was not made available to TMWL, although requested, for privacy and confidentiality reasons despite a nondisclosure clause in the contract that was added to obtain the confidential HHSA data on the provision of mental health services to those who died in-custody.

### ***Challenges in Addressing Study Questions in Item 2c***

The challenges in addressing the study questions in this report remain similar to those mentioned in the MINI-REPORT on Item 2a and the MINI-REPORT on Item 2b: the challenges of procuring useful data. For the four relevant CPRA requests that were submitted to the SDSO Public Records Center to address these study questions, there were significant, months-long delays in SDSO's responses. Responses included statutory denials of data, denials based on data categorization, piecemeal provision of some useful data (sometimes in image format), incomplete or erroneous data, and many referrals to SDSO or BSCC webpages or archived policy information.

An additional challenge was that other County departments are not the originators of the data needed for this study, and so our attempts to look to these agencies proved ineffective. After an adjustment to the county contract for this study to include a non-disclosure agreement, TMWL did receive confidential, individual-level data from HHSA about the people who died in-custody and the most recent fiscal year in which they used county mental health services. While somewhat useful, this data provided only a very limited snapshot of the impact of mental health history or treatment on in-custody deaths (noted in more detail above).

In order to address this concern, TMWL recommends that San Diego County consider establishing a protected countywide data pool for all county departments for their mutual use as a resource in conducting agency business. that involves data held by or in the custody, management and control of another agency. It would facilitate responding to CPRA requests, studies conducted by vendors contracted with state agencies to perform studies and greater cooperation among state agencies.  This would be ideal before the beginning of any follow-up study so these channels for additional information are set-up early and the value of their cooperation with the study established.  An In-Custody Death Cooperative Panel might be a working title for such a group.

More meaningful analysis about the impacts of incarcerated people's mental health histories; dedicated mental health services, staff, programs, and policies within the detention facilities; and other county public services on in-custody deaths in the San Diego County Detention Facilities is dependent upon having facility-specific, individual- and program-level data about each incarcerated person in each facility for the duration of the study. In the absence of such data, TMWL proceeded with analyses on deaths reported as Suicide (manner) and Alcohol/Drug Overdose (means), yet these are not necessarily indicative of a history of mental illness, nor is there any information about whether mental health treatment was offered or provided to these individuals while incarcerated. Furthermore, people who died of other manners of death, such as Natural or Homicide, could also have had mental health needs or treatment that may have had bearing on their deaths. The data on mental health beds is also limited in that assignment to such a bed tells us nothing about treatment nor the need for treatment among incarcerated people and the number of beds available.

In a vacuum of data about mental health assessment and treatment of incarcerated people—at any level, let alone individual-level, it is challenging to offer useful analysis or make any recommendations that may result in a reduction of in-custody deaths.

Without such data, we presented descriptive breakdowns of in-custody deaths by various categories and by facility (if provided), which is informative in its own right; however, this will not allow us to identify any differences between the population of people who died while in custody and those who did not die while in custody. This comparison—of a variety of potential differences—could reveal patterns and possible causes of such deaths and thus increase the likelihood of preventing them in the future.

**Observations**

In attempting to address whether a history of mental illness might be related to in-custody deaths (study question 5.5.2), it appears that receiving county mental health services makes a difference in deaths by suicide and alcohol or drug overdose deaths.

- Those who died in-custody who did not receive county mental health services died more often from suicide and drug or alcohol overdoses than those who did receive county mental health services. Some of the people who died in-custody who did receive county mental health services also died by suicide or overdose but at a lower rate than those who did not receive such services. More data about what kind of county mental health treatment, how often, and whether it was also provided to incarcerated people in the study who did not die in custody would shed more light on the relationship between a history of mental illness and in-custody deaths. If any records about the provision of private mental health services to incarcerated people is available, this could help provide an even more detailed picture of this relationship.
- Also, it appears that deaths by suicide and overdose happen sooner after booking than all deaths combined. Since these types of deaths are not necessarily indicative of a history of mental illness, it would be important to have more information about mental health records and screening at booking, diagnoses, housing, and treatment. Overdose deaths occur particularly early in SDCJ in comparison to all deaths combined and suicides in particular; it would therefore be helpful to have information about drug use or behavioral health history as early as possible at the time of booking. It would be helpful to assess the success of SDSO's screening and detoxification programs in preventing or reducing in-custody deaths.

In looking at mental health resources and their possible relationship to in-custody deaths (study question 5.5.3), our preliminary analysis shows that:

- there does not seem to be a decrease in deaths by suicide or overdose, despite increases in mental health budgets, staffing, and treatment (as "evidenced" by the provision of mental health beds). This may mean that more time is needed to see such an impact, more mental health resources are needed to decrease in-custody deaths, or that there needs to be more information about the mental health needs and treatment of incarcerated people to do this analysis.

Our review of the detailed data that SDSO provided about four programs related to mental health treatment (study question 5.5.9):

- Taking suicides and overdoses together, their yearly death counts were higher while the programs were running. This might suggest that the programs failed to achieve significant improvement. And yet, it might be a hidden success if, perhaps, in the more recent years the jail populations included more mental-health related cases and the death tolls would be rising still higher without the programs installed. Additional data is required to confirm these speculations; for now they must remain inconclusive.
- It is interesting, however, to note the shift in the trend of suicides versus overdoses: suicides halved (2.2 to 1.1) while overdoses more than tripled (0.6 to 2.0) in years of the programs running. Perhaps the programs succeeded to reduce potential suicides but failed to prevent (or even indirectly contributed to) overdose deaths?

Additional SDSO programs will be more fully addressed in Mini-Report 2d. For example, screening drug interdiction programs will be described and their impact will be analyzed if sufficient data was provided. We note, at the outset, that most if not all of the "data" that SDSO provided about new programming was updates about those programs in press releases, which are usually inadequate sources of the kind of data needed for analysis about the impact of the programs on in-custody deaths.

Finally, given that the HHSA data provided some important preliminary insight into the relationship between county mental health services and in-custody deaths, it stands to reason that:

- individual-level data about the provision of other county services to those who later were incarcerated in an SDSO detention facility and died in-custody (and those in the study period who did not die in-custody) would shed even more light on how in-custody deaths may be prevented. Such data would help to answer study question 5.5.11.

### *Preliminary Recommendations for Study Questions in Item 2c*

Based on the above observations, TMWL recommends communication, records-sharing, and collaborative treatment planning between SDSO and county agencies that have provided services to

people booked into a county detention facility, especially Health and Human Services. Potentially, this could extend to state agencies that provide health and human services as well. This collaborative process should take place during the intake process and be incorporated in the individualized treatment plan developed for each incarcerated person.

Additionally, since suicide and overdose deaths happen closer to booking, a booking process that attends to the needs associated with these kinds of death should be implemented as early as possible. Housing needs should be carefully assigned at intake (and reassessed routinely, particularly within the first month after booking), and sworn and unsworn staff should be trained to recognize signs of possible suicide activity in cells in general population and mental services housing units. Perhaps, policies and procedures should be reviewed in light of safety considerations in making housing assignments. We recommend additional focus on staff training and retraining (where relevant) to ensure that they are routinely informed of any safety issues related to intake and treatment plans and evolving evidence-based approaches to mental health treatment for incarcerated people. More data and analyses are likely needed to do all of this effectively.

As previously mentioned on page 15, more data and analyses are also needed to assess whether increased resources and what types of resources are effective in reducing in-custody deaths, and perhaps particularly deaths by suicide and overdose or other more clearly mental health-related deaths. Toward this end of obtaining more data or conducting more useful analyses:

- It would be helpful if SDSO maintained detailed data in its files concerning medical services provided to incarcerated persons and coordinate with contractors and other state agencies providing mental health services. It is noted that if SDSO started this process and retained a vendor to assist; accurate data must be maintained so analyses can be conducted to determine whether the programs and policies implemented are successful and resolving the mental and physical health needs of incarcerated persons.
- In connection with the above, it is recommended that CLERB's jurisdictional reach should be changed so that mental health clinicians are available to CLERB for interviews to review progress of programs and success of assistance provided to incarcerated persons.
- Clear definitions are needed for suicide, accidental, and overdose deaths to avoid overlap and provide better service and tracking; if there is a centralized county body that could set these definitions for their countywide use among agencies, this would facilitate consistent definitions for data-sharing and analysis across agency datasets.
- SDSO should be required to provide more detailed information on programs and policies that are implemented than quick press releases and links to press releases, websites and referrals to other state agencies. It would be helpful to have detailed information such as a full description of the programs, who will be responsible for implementation, numbers of incarcerated persons and staff impacted, proposed dates of implementation, etc.

- Perhaps there should also be an additional San Diego County entity that maintains a full archive of SDSO data, or perhaps CLERB staff should have the requisite permissions to obtain SDSO data.
- Effective and comprehensive privacy and confidentiality policies should be implemented that would enable vendors, contractors and CLERB access to all data that would facilitate the tasks they are required to complete to perform a complete and comprehensive study related to preventing in-custody deaths.

## CONCLUSION

TMWL has prepared the above background and this mini-report to describe what it has done, to date, to address Item 2c. The final report will include a full account of the study methods, findings, and recommendations for future studies.

# MINI-REPORT for Item 2d

January 9, 2026

## MINI-REPORT for Item 2d[14]

### Study Questions Addressed

This Mini-Report covers the following study questions, as per Item 2d in the amended contract between CLERB and TMWL (CONTRACT 569176, MODIFICATION 4):

- Study Question 5.5.4 – What role do law enforcement staffing levels play in the number of IN-CUSTODY DEATHS?
- Study Question 5.5.9 – What has been the impact of new programs enacted by the San Diego Sheriff's Department over time?[15]

A request for data and information to address Study Question 5.5.4 was submitted in the "SDSO Staffing PRA" request submitted to the SDSO Public Records Center on June 18, 2024. Upon confirmation of receipt on the same date, SDSO renamed the request Reference No. S002147-061824.

A request for data and information to address Study Question 5.5.9 was submitted in the "SDSD Mental Health PRA" request that TMWL submitted to the SDSO Public Records Center online portal on March 13, 2024. Upon confirmation of receipt on March 13, 2024, SDSO renamed the request Reference No. S000894-031324.

TMWL also sought data and information to address these study questions in the "SDSD Policies and Programs CPRA" request, submitted to the SDSO Public Records Center on October 24, 2024. Upon confirmation of receipt on the same date, SDSO renamed the request Reference No. S003984-102424.

---

[14] An "Introduction to Study Mini-Reports" was provided with MINI-REPORT for Item 2a, which includes background information on all of TMWL's CPRA requests as well as attempts to obtain SDSO cooperation and data for the entire study. The reader is referred to that document for the same background information regarding the study questions in this report.

[15] Please note that Study Question 5.5.9 is also listed under Item 2c in the amended contract. MINI-REPORT for Item 2c addressed only those programs that SDSO provided in response to the Mental Health CPRA, which is the focus of that mini-report. This report addresses SDSO's provision of information about enforcement staffing levels, new programs, procedures and policies.

Below we report on the relevant data sets received and preliminary findings for each study question; in the cases where there is no data to analyze, we include some of the relevant challenges within this section. Overall challenges are then summed up in the next section, followed by initial observations and preliminary recommendations, based on this portion of the study (i.e. the study questions addressed herein).

As noted, Study Question 5.5.9 was addressed in MINI-REPORT 2c regarding mental health related programming; to the extent that any analysis for this study question was not included in MINI-REPORT 2c, it is included here.

### *Study Questions for Item 2d*

#### 5.5.4 - What role do law enforcement staffing levels play in the number of IN-CUSTODY DEATHS?

Data Sets and Preliminary Findings

SDSO reported making several staffing additions to its sworn and unsworn teams as well as its contracting with several vendors to provide medical, mental health and security services over the study period. To the extent possible, these measures will be discussed in greater detail in TMWL Final Report. However, here we will highlight a few of the significant improvements regarding staff levels.

In response to this study question, SDSO provided Employee Rosters, as mentioned in mini-report 2c. These employee rosters list all employees present at the end of each calendar year 2012-2024, with information about department/facility, job title and starting date, for example. However, employment ending dates are not given, so we can observe individual staff members entering but not leaving the work force. Thus, the precise number of employees in any particular position is known only at the exact moment at end of the year when a yearly roster is taken and reported, and not on any other day within the year. This is unfortunate, as this setup allows for only a single datapoint representing the whole year, and variations within the year remain unknown. It would have been important, for example, to know the number of staff on the exact dates when someone died in-custody, along with the additional department/facility and job title information. Having only the year-end datapoint limits the statistical power to discern potential changes with time and time trends.

Among the job titles that SDSO provided, TMWL identified seven that are related to enforcement security in the jail:

- Deputy Sheriff,

- Deputy Sheriff for Detentions/Court Services,
- Detention Processing Supervisor,
- Retiree Non-Exempt Classified-Safety,
- Sheriff's Lieutenant,
- Sheriff's Sergeant,
- Sheriff's Sergeant - Detentions.

Table 1. shows the cumulative counts of staff members in these positions over different facilities, for the years 2012-2024. Some positions are not associated with the relevant jail facilities where deaths occur (mainly SDCJ and VDF), so the three truly relevant positions for this study are: Deputy Sheriff, Deputy Sheriff for Detentions/Court Services, and Sheriff's Sergeant – Detentions. We consider these three positions, taken together, as the "Enforcement Staff" in the rest of this report. Here, we exclude a very few occurrences of retired, safety-related officers that did perform some work inside the relevant facilities.

Among these job positions, Deputy Sheriffs for Detentions/Court Services are nearly 10 times more numerous than either Deputy Sheriffs or Sergeant-Detention staff members, in the two most relevant facilities (SDCJ and VDF), with Sergeant-Detention members being smallest in counts.

| *FACILITY* | *Deputy Sheriff* | *Deputy Sheriff for Detentions/Court Services* | *Detention Processing Supervisor* | *Retiree Non-Exempt Classified-Safety* | *Sheriff's Lieutenant* | *Sheriff's Sergeant* | *Sheriff's Sergeant - Detentions* |
|---|---|---|---|---|---|---|---|
| *SDCJ* | 272 | 2284 | 0 | 0 | 0 | 0 | 191 |
| *VDF* | 211 | 1558 | 0 | 4 | 0 | 0 | 130 |
| *GBDF* | 250 | 2015 | 0 | 0 | 0 | 0 | 198 |
| *LCDF* | 193 | 2020 | 0 | 2 | 0 | 0 | 189 |
| *EMRF* | 2 | 1295 | 0 | 0 | 0 | 0 | 108 |
| *SBDF* | 0 | 681 | 0 | 0 | 0 | 0 | 65 |
| *FAC8* | 0 | 247 | 0 | 0 | 0 | 0 | 15 |
| *RMDF* | 0 | 61 | 0 | 0 | 0 | 0 | 7 |
| *Other1* | 64 | 234 | 11 | 4 | 0 | 12 | 35 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| *Other2* | 47 | 814 | 0 | 8 | 0 | 4 | 82 |
| *Other3* | 182 | 636 | 286 | 1 | 5 | 29 | 16 |

**Table 1. Cumulative counts of enforcement staff members in different facilities, for the period 2012-2024.** Note that these numbers are sums over counts found in all yearly rosters, so the same person may be counted more than once if present in more than one roster. For example: 5 counts of Sheriff's Lieutenant position (bottom row) are in fact a single Lieutenant position that appeared in five yearly rosters.

Next, Figure 1. below shows in-jail death counts and enforcement staff counts over the years 2012-2023. Beside raw counts, we also show counts per Person-Year (PY), which is an important distinction because it takes into account changes in the size of jail population over time. For example, a single death occurring within a year in a facility occupied by 10 persons every day of that year would constitute, for that year: 1 death count and 1/(365*10)=0.00027 deaths per PY.

Normalized in this way, everything can be seen relative to a single person in-jail: how many deaths occurred per a single person and how many staff members were available to a single person in-jail.

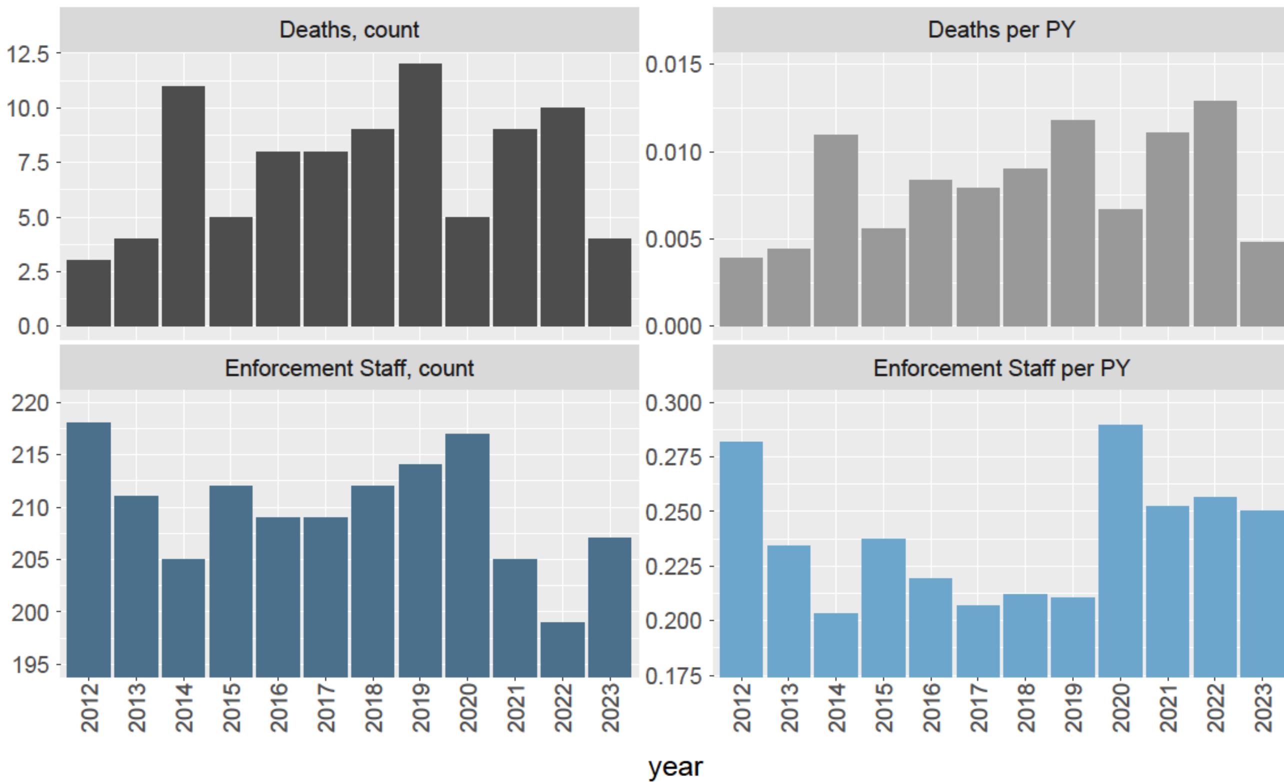


**Figure 1. Comparing in-jail deaths and enforcement staff levels in SDCJ, across years. The year 2024 is removed since TMWL has death counts and facility occupations only for a small part of that year.** Deaths and staff levels are given both as raw counts, and as counts per Person-Year (PY).

In Figure 1, the two panels on the left primarily show a historical record of in-custody death and enforcement staff counts and how these changed over the years. The two panels on the right serve to look for associations between their changes with time. In this, the three Covid-19 years, 2020-2022, must be excluded because they involve a number of deaths that occurred due to the disease and not strictly due the long-term in-jail conditions.

By simple observation by eye, the height of the bars in the two right panels seem connected. For example, the highest enforcement staff levels were in 2012 when deaths were at their lowest, while in 2014 and 2019 when deaths were at their peak (excluding COVID years), the staff levels were very low.

To make this connection more obvious, Figure 2 shows death counts plotted directly against staff counts, both expressed in PY. The left panel shows SDCJ results (red dots) and the right panel shows VDF results (purple dots). Each (red or purple) datapoint represents one whole year—cumulative deaths in that year and staff levels from that year's roster, both expressed in PYs. So, there are nine points on each panel, covering the nine years: 2012-2019 and 2023 (again, removing COVID years).

In SDCJ, a seemingly obvious decrease of deaths with increasing staff levels can be seen. We fitted the data to an exponential decline regression curve, shown as a gray band behind the dots. The p-value of the exponential slope term in the regression is 0.001, very strongly indicating that this declining trend is not the result of the play of chance but a real statistical association: more enforcement staff resulted in fewer in-custody deaths. Among the observed data, for every 10% increase of enforcement staff levels per PY, there was a 28% decrease in deaths per PY.

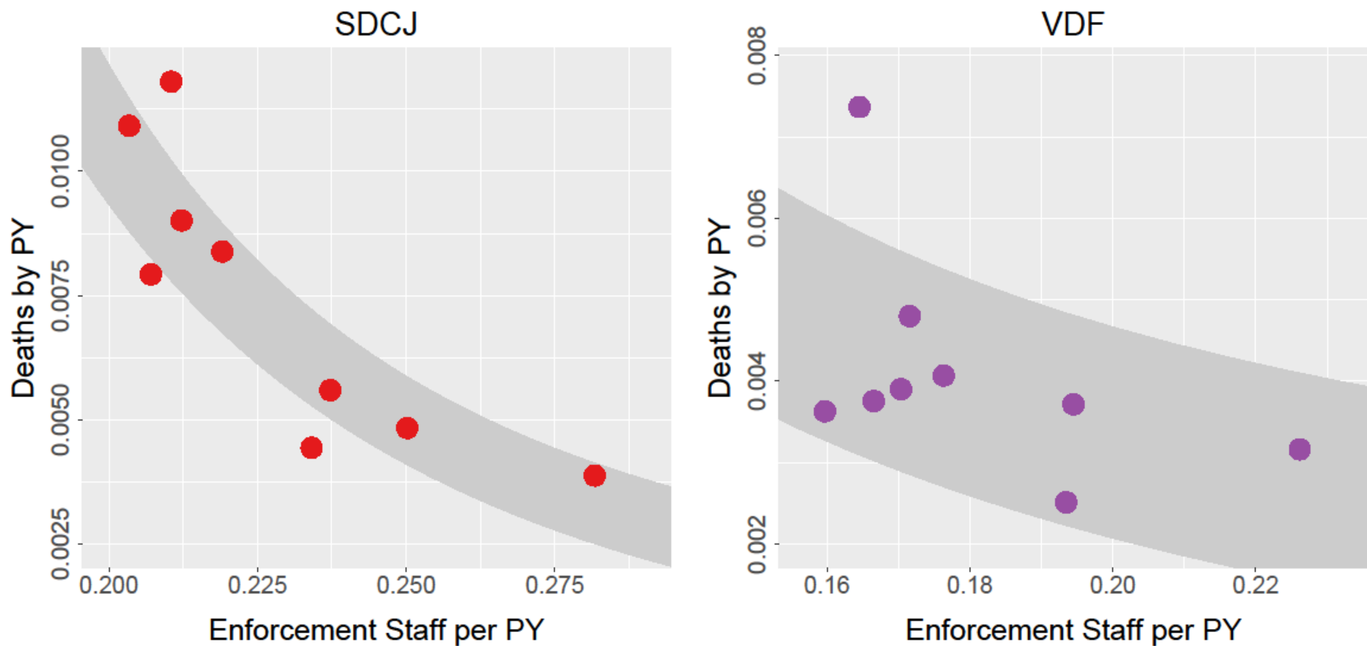



**Figure 2. In-jail deaths counts plotted against enforcement staff counts, expressed in PYs, in SDCJ (left panel) and VDF (right panel) facilities.** Behind the colored dots, a thick grey band illustrates the trend of exponential decline in the data, as a visual guide.

This result is not predictive by nature; that is, it only pertains to what was historically observed, and there is no guarantee that the trend may extend further to the left such that death levels would keep decreasing in the same way if staff levels were to keep increasing. Without knowing all relevant information and understanding some causal relations, a strict prediction cannot be made. **However, as a historical fact, the association is clear and, thus far, the most striking finding in this study.**

In VDF, death counts are fewer and, when spread across the years, their numbers are not large enough for a potentially similar trend to appear. *Visually it does seem that something similar in nature is emerging there. The death counts are also decreasing with increasing staff levels, but the points are more scattered and this trend cannot be stated with assurance. Repeating the same exponential regression, the p-value of the declining exponential slope is 0.14, indicating that this may easily be a play of chance and not a true trend.*

Also, in SDCJ, we can partition the enforcement staff members according to the three job positions involved, see Figure 3. For the Deputy Sheriff position, the same trend (more staff—fewer deaths) is not observed. Except for a single datapoint on far right (2023) the staff level was similar over the years while the death counts varied. The p-value of the regression slope is 0.61, and we may conclude that Deputy Sheriff staff

levels were too constant over the years to participate in the larger trend; that is, it is not observed in the data at hand that changing the number of Deputy Sheriffs affected deaths.

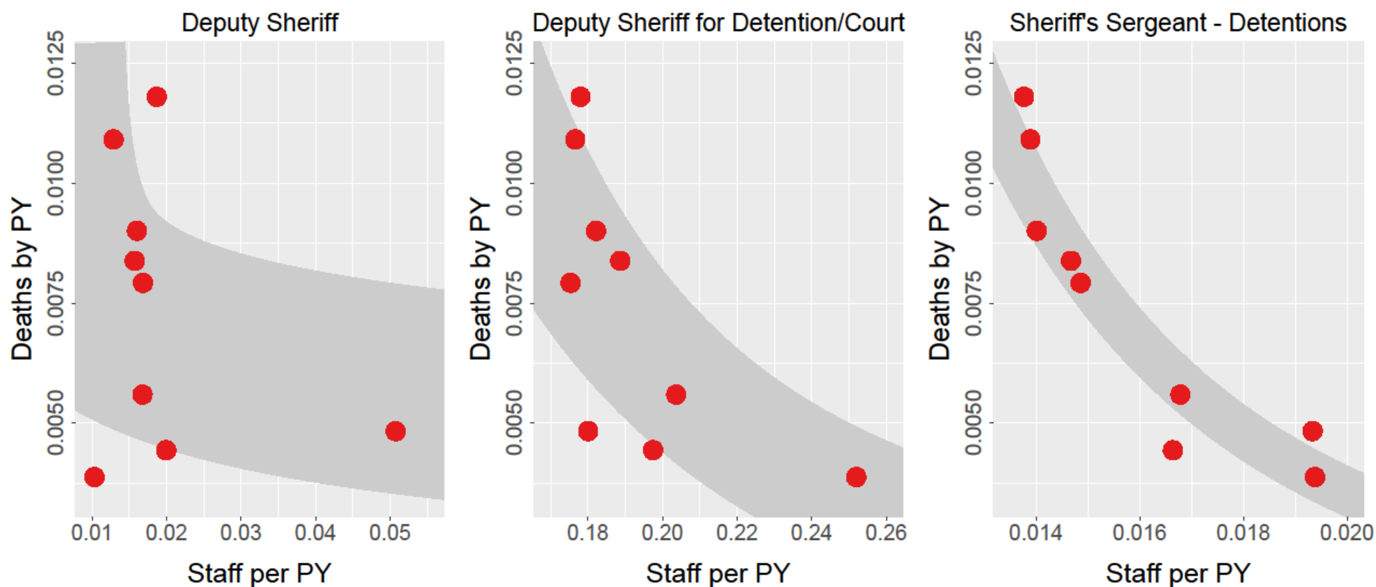



**Figure 3. In-jail deaths counts plotted against counts of staff in a particular job position, all expressed in PY, in SDCJ.** Like in Figure 2, behind the colored dots, a thick grey band illustrates the trend of exponential decline in the data. Where the trend is more obvious, the band is plotted thinner.

For the second job position, Deputy Sheriff for Detentions/Court Services, the same trend (more staff—fewer deaths) is there but it is less established: the p-value is 0.031. So yes, increasing the number of staff members in this position can be associated with decreasing deaths; however, there is more noise in the data (other factors affecting the numbers) than when all three positions are taken cumulatively.

Finally, the third job position, Sheriff's Sergeant – Detentions, shows the trend most clearly, with the p-value 0.0002, so this specific job position is the one that contributed the most to the observed trend. **In other words: even though the staff members at this job position were relatively few in numbers, it is very clear in the observed data that as their numbers (per incarcerated person) increased, the death counts (per incarcerated person) decreased. For every 10% increase of Sergeant – Detention staff levels per PY, there was 24% decrease in deaths per PY.**

It is now very tempting to conclude that increasing the numbers of Sergeants in Detentions would reap the most benefits in lowering deaths. This is where the current data point. However, it should also be

kept in mind that, in principle, all staff members work synergistically, and it is not certain that increasing only the numbers of these particular employees would be most beneficial without considering changes in other staff levels (or other types of changes, such as policy, programming, or population). This study observes historical data and numbers as they actually occurred, and any future, different, staff levels could be a new territory to observe again and then reconfirm or update these earlier findings.

In addition, TMWL investigated the following job titles related to providing medical services in the jail:

- Sheriff's Detentions LVN,
- Sheriff's Detentions Nurse,
- Sheriff's Detentions Supervising Nurse,
- Nursing Director, Sheriff's Detentions Facility,
- Sheriff's Certified Nurse Assistant,
- Assistant Medical Services Admin,
- Pharmacy Technician,
- Occupational Therapist II,
- Recreational Therapist.

Interestingly, none of these positions are reportedly associated with facilities that hold jailed individuals (SDCJ, VDF, GBDF, etc.) with almost everyone working in the facility marked "other 3" in the data. Among these positions, only three, Licensed Vocational Nurse (LVN), Nurse, and Supervising Nurse had any substantial presence over the years 2012-2023, averaging more than two employees per year. **For those three positions, we repeated the analysis given in Figures 1-3 above, attempting to associate death counts**

**per PY with staff counts per PY, but no statistically relevant association was seen.**

### 5.5.9 – What has been the impact of new programs enacted by the San Diego Sheriff's Department over time?

<u>Data Sets and Preliminary Findings</u>

SDSO, in its response to TMWL's PRA requests to address this study question, referred TMWL to approximately 38 links to programs featured on its website that presumably were implemented by SDSO to prevent future in-custody deaths. A sample of a few pages from SDSO's response with the links and responses to TMWL's CPRA requests is attached in Exhibit A.

TMWL has reviewed these links and concludes that SDSO offered them in response to the items listed in Appendix A of our Programs, Policies and Procedures CPRA (Reference No. S003984-102424). However, the information provided in the links did not include sufficient detail to permit TMWL to conduct a detailed analysis of TMWL's activities. For example, in a response concerning mental health programs implemented to address in-custody deaths, SDSO indicated that "during the month specified in 2023,

SDSO hired a specific mental professional or started conducting mental health evaluations during the intake process." However, in addition to a short general description of the program including of the position title, little else of substance was provided. TMWL in its CPRA, asked for such details as start date of programs, persons responsible for implementation, outcome, etc.

That CPRA is attached to this Mini-Report and includes Appendix A with our notations regarding SDSO responses. In the interest of brevity, because this is a mini-report, TMWL has included the data provided in some of the links. TMWL notes that SDSO appears to have provided some response to the majority of the Appendix A items in the form of Media. Relations Reports from its website. However, SDSO did not provide sufficient detail to the items listed in Appendix A. TMWL acknowledges that, in some cases, additional details were provided. For example, the Naxalone program is reported to have saved 66 lives of incarcerated people. Similarly, SDSO reported that there was a 45% decrease in drugs being mailed into county jails due to the implementation of its centralized mailing system and that 3,300 grams of heroin, methamphetamine, cocaine and fentanyl powder contraband were seized due to the implementation of its programs. However, specific dates, locations, personnel titles or updates for the remainder of the study period were not provided.

Without data for the full study period, it is impossible to draw definitive conclusions about the success or failure of the programs and their impact on preventing in-custody deaths. It would be helpful for SDSO to provide some data concerning the impact of the mental health personnel who were hired. Position titles and descriptions were provided but exact dates of hire and where they were assigned was not provided. The role of contractor medical staff, their numbers or placement locations was not provided. It would be helpful to know if they treated any incarcerated persons, the number they treated and suicide interventions they conducted, if any. Unfortunately, we were left to decipher press releases and press conference notes with limited success without the full details.

**Challenges**

The challenges in addressing the study questions in this report remain similar to those mentioned in previously submitted mini-reports: the challenges of procuring useful data in terms of delays and limited data provision.

SDSO delayed responses to Reference No. S002147-061824 eight times over the span of six months with the first substantive response on January 21, 2025 and subsequent partial responses and denials through March 28, 2025, when SDSO closed the request.

SDSO delayed responses to Reference No. S003984-102424 five times over the span of five months, providing online links to the programs in question on March 27, 2025, when it closed the request. No analyzable data was provided.

Despite insufficient provision of responsive data, all of TMWL CPRA requests have been marked as “Completed” in the SDSO’s Public Records Center.

More meaningful analysis about the impacts of staffing levels and new programming on in-custody deaths in the San Diego County Detention Facilities is dependent upon having date-specific information about staff counts and roles. Additionally, data is needed concerning facility and program-specific implementation and individual-level data about each incarcerated person who participated in any new programming for the duration of the study.

TMWL was unable to draw few meaningful connections or conclusions due to the scarcity of data for the entire study period and SDSO’s new focus on tracking successes in 2023 and presenting them to the public in press releases. Thus, it was difficult to analyze new policies and procedures as compared to old ones or assess the impact of new mental health personnel, services and drug interdiction programs on in-custody deaths.

Without such data, we can present descriptive breakdowns of in-custody deaths by various categories and by facility (if provided), which is informative in its own right; however, this will not allow us to identify any differences between the population of people who died while in custody and those who <u>did not die</u> while in custody. This comparison—of a variety of potential differences—could reveal patterns and possible causes of such deaths and thus increase the likelihood of preventing them in the future.

This mini-report gave another example of this fact: the revelation that some enforcement staff levels and deaths are strongly associated was made possible due to TMWL receiving Hudler-Armstrong letters. These letters contain minimal, facility-based, information about the people who <u>did not die</u> in jail: their changing total numbers. With that minimum, staff levels and deaths could be normalized to a single person present in the facility and their impacts through time, on that single person, compared.

## Observations

As noted above, one key observation was that there was a relationship between the number of Sergeants in the Detentions Division staff and a decrease in in-custody deaths. However, no statistically significant relationship with Nursing and/or medical staff could be determined due to insufficient data. Again, this highlights the importance of receiving detailed relevant data so that

appropriate analyses can be conducted. Any other lesser observations made below relate to possibilities and inferences that cannot be firmly established due to the paucity of data that was received.

- A greater number of enforcement staff has historically resulted in fewer in-custody deaths during the study period (excluding COVID-19 years); this is especially true for the Sheriff Sergeant – Detentions role, which shows the strongest historical relationship between more staff and fewer in-custody deaths.
- Using similar analyses as enforcement staff, no discernible historical relationship exists between the number of medical staff counts listed and in-custody deaths.
- We appreciate the Employee Rosters that identify new personnel by their start date, but also receiving the end date of each employee would notably increase the usefulness of the Rosters. Knowing the staffing levels and locations on the actual or approximate dates when people died in-custody would provide greater insight into this relationship.
- SDSO did not provide any data regarding its shift systems for its detention facilities. Such information would be helpful for an analysis of security, response time and personnel available to respond to emergencies and detailed policies and procedures during emergencies. This information would be helpful for an analysis determining if there are adequate staffing levels, security tours and safety checks being conducted.
- It would be helpful to know where new staff that has been hired are assigned. Employee Rosters contain information that indicates someone may be hired for the Medical Services Division but no data concerning where they were placed or their shift.
- In terms of programming, program start and end date, and details about participation numbers and individual-level information about participation would allow for analysis of their impact on in-custody deaths.
- While there is some descriptive information that indicates, for example, that urine screening of incarcerated people has been successful in detecting possible drug addiction, more detailed data is necessary to draw conclusions regarding overall impact on in-custody deaths.
- The same can be said of the screening program for all employees and visitors.

## Preliminary Recommendations

**TMWL's strongest recommendation is consistent with its finding that a relationship exists between Sheriff's Sergeant - Detentions and death counts. This is discussed below. Other minor recommendations below relate to data gleaned from press releases and incomplete data that was provided but was insufficient to lead to statistically significant findings.**

- Since the significant findings regarding enforcement staff counts and in-custody deaths are historical only, more study on this relationship is needed to see if such a relationship could also be predictive. This report found a clear association between enforcement staff levels and in-jail deaths: the more staff that were present during a calendar year, the less deaths occurred during that year (per prisoner). More specifically, the increased numbers of "Sheriff's Sergeant – Detentions" staff are most clearly associated with lower death counts.
- In terms of obtaining the necessary data to thoroughly investigate the study questions in this report, TMWL recommends greater access to SDSO data, whether that means 1. ) that San Diego County Board of Supervisors expand the jurisdictional power of CLERB, such that CLERB has access to all SDSO data, or 2.) that some other San Diego County agency (e.g. California Office of Inspector General (OIG)) if established has access to SDSO data and then works with other approved County agencies or contracted third parties in order to share relevant data for study. We note that the San Diego County Board of Supervisors expanded CLERB's authority to include oversight of healthcare service providers in San Diego County jails. This was done through an ordinance. We also note that CLERB has a limited role in recommending policies to SDSO. TMWL believes that this recommendation is so important that it was worth all efforts to effectuate change so that access to all required data is possible that will facilitate processes, procedures and studies to determine how to decrease in-custody deaths. In light of this primary recommendation, we suggest the following:
    - SDSO should be required to provide detailed responses to CLERB data requests, inclusive of approved third party contractor requests. For example, it is not sufficient to reply that a mental health clinician was hired. The date of hiring should be provided as well as the location where the clinician will be placed, detailed job description, to whom the person will report, whether new policies and procedures have been developed to address mental health care and copies of them, how the clinician is expected to interact with incarcerated patients and frequency, any other agencies that will be involved in providing care to address any mental or chronic physical health issues that are presented. In the monthly employee rosters, we do have individual dates when they started to work (that column in the data is titled "JC Entry Date"). What is important is the dates when they stopped working.
    - Detailed data reports should be made available for review, annually, that track deaths prevented because of Narcan and when and where Narcan has been administered.
    - Similarly, data concerning confiscation of controlled substances by the Drug Interdiction Unit should be shared with CLERB periodically,
    - CLERB should be treated as a partner that will be involved in reviewing policies, procedures and activities to prevent in-custody deaths based on its investigations and death reviews.
    - CLERB should be included in discussions concerning renovating detention facilities and constructing new ones.
    - Intake and Booking are other key area where partnering with CLERB would be beneficial.

## Conclusion

The two study questions addressed in this Mini-Report deserve a more detailed review and follow-up in the future. The historical data suggests that concentrating on the role of enforcement staff members, their numbers and work conditions, could potentially be most beneficial for decreasing deaths.

There is every reason to believe that beside staffing levels, qualifications and shift systems too may be related to in-custody deaths. It is also possible that any new programming to prevent in-custody deaths may be functioning to do so, but specific information about these programs and its participants is needed in order to shed light on their effectiveness. This may be unveiled during the investigative process when all pertinent and related data in the possession, custody and control of SDSO is subject to review. The review function is connected to the oversight responsibility and data is instrumental to doing both effectively. A follow-up study should include these data in order to make significant contributions to reducing in-custody deaths.

CLERB may want to consider closer coordination with other state agencies that monitor in-custody deaths, provide mental health services to citizens of the state, including incarcerated persons. There are other examples that could be provided upon request.

# MINI-REPORT for Item 2e

The Mountain-Whisper-Light, Inc.

**MINI-REPORT for Item 2e[16] - Final Version (January 13, 2026)**

***Study Questions Addressed***

This Mini-Report covers the following study questions, as per Item 2e in the amended contract between CLERB and TMWL (CONTRACT 569176, MODIFICATION 3):

- Study Question 5.5.5.4 – [5.5.5. What institutional stresses are associated with IN-CUSTODY DEATHS, including:] Extraordinary events such as the COVID-19 pandemic?
- Study Question 5.5.6 – Is there a relationship between re-admission and IN-CUSTODY DEATHS at both an individual and facility level?
- Study Questions 5.5.13 – What are IN-CUSTODY DEATH rates among [incarcerated people] with a history of homelessness?[17]
- Study Question 5.5.14 – What is the impact of compassionate releases on the nature and number of IN-CUSTODY DEATHS?

A request for data and information to address these study questions (among others) was submitted in our "SDSD Population PRA" and "SDSD In-Custody Death PRA" requests that TMWL submitted together to the SDSO Public Records Center online portal on January 22, 2024. Upon confirmation of receipt on the same date, SDSO renamed these requests Reference No. S000257-012224, designating them a single request.

TMWL also sought data and information to address these study questions by submitting the "SDSO Consolidated CPRA" request on October 24, 2024. SDSO confirmed receipt on the same date and designated it Reference No. S003985-102424.

Additionally, TMWL submitted requests to Homeless Solutions and Equitable Communities and Housing and Community Development Services via the San Diego County countywide portal (NextRequest) on July 26, 2024 for information and data to address study question 5.5.13. These requests were denied as TMWL pursued data from the Health & Human Services Agency, which was

[16] An "Introduction to Study Mini-Reports" was provided with MINI-REPORT for Item 2a, which includes background information on all of TMWL's CPRA requests as well as attempts to obtain SDSO cooperation and data for the entire study. The reader is referred to that document for the same background information regarding the study questions in this report.

[17] Please note that Study Question 5.5.13 is also listed under Item 2b in the amended contract and was addressed in MINI-REPORT for Item 2b. It is incorporated here by reference as if fully set forth below.

received in April 2025 but did not include any relevant data to the impact of homelessness on in-custody deaths.

To date, TMWL has received insufficient data to respond adequately to these study questions. Below we report on the limited relevant data sets received and preliminary findings for each study question, followed by challenges, observations and initial recommendations based on this portion of the study (i.e. the study questions addressed herein).

### *5.5.5.4 – [5.5.5. What institutional stresses are associated with IN-CUSTODY DEATHS, including:] Extraordinary events such as the COVID-19 pandemic?*

Data Sets and Preliminary Findings

In relation to this study question, SDSO provided a list of confirmed positive COVID-19 test results by facility with their counts by week. As stated in that document, the list did not reflect the total number of active cases in custody at that time.

The starting date for the test results data is 3/15/2020, and the ending date is 6/1/2024, with the total of 5310 positive test outcomes, distributed over the facilities as:

| SDCJ | LCDRF | VDF | GBDF | EMRF | SBDF | FAC8 | RMDF | TOTAL |
|---|---|---|---|---|---|---|---|---|
| 1691 | 544 | 935 | 1331 | 466 | 327 | 3 | 13 | 5310 |

These raw counts are not of much interest in and of themselves but in their relation to the population of a facility in a given week: the number of positive tests relative to the number of individuals present in-jail. For the four selected facilities, Figure 1. shows the distribution in calendar time of those weekly counts given in units of Person-Week (PW), that is: positive test counts per week divided by the total facility population in a given week.

Note that the total population in a week is not equal to the number of distinct individuals present at any day during that week. Since TMWL has no data on individuals that did not die in-jail, the total population per week is calculated as the sum of daily occupations for each day of that week, so the same individual present on two consecutive days is counted twice. To illustrate, 0.01 positive tests per PW corresponds to a single positive test for every hundred persons present in-jail on any day during that week. Stated differently, 1% of the individuals present on any specific day during that week tested positive on that day.

SDSO also provided a dataset that denotes the Manner of Death, Means of Death, Cause of Death, Contributing Factors, and Key Issues for each person who died in-custody during the study period. Among the reported death cases, 13 were marked as related to COVID-19, as a cause of death, a contributing factor, or mentioned as one of the key issues.[18] Two of these were in GBDF, seven in SDCJ, and four in VDF. It should be noted that during the pandemic, it was generally challenging to clearly determine if a death was caused by or related (even remotely) to COVID-19, due to overlap with other health conditions and long periods of time before full recovery, so some of the in-custody deaths during the study period might have been related to COVID-19 even if not noted as such. Our analysis only includes those where COVID-19 is listed specifically in relation to an in-custody death in the dataset.

These deaths are added to Figure 1. below as black and white circles, placed at their times of occurrence on the horizontal time axis, and above the colored bars (the bars represent test counts per PW for each week).

[18] Nine of the 13 COVID-19 related cases are listed as a “Natural” Manner of Death in this same SDSO dataset; three were “Accident” and one “Homicide.” The Means of Death for nine is marked as “Not Applicable”, one is “I/C Drug Related”, one “Accident”, and two “Other.”

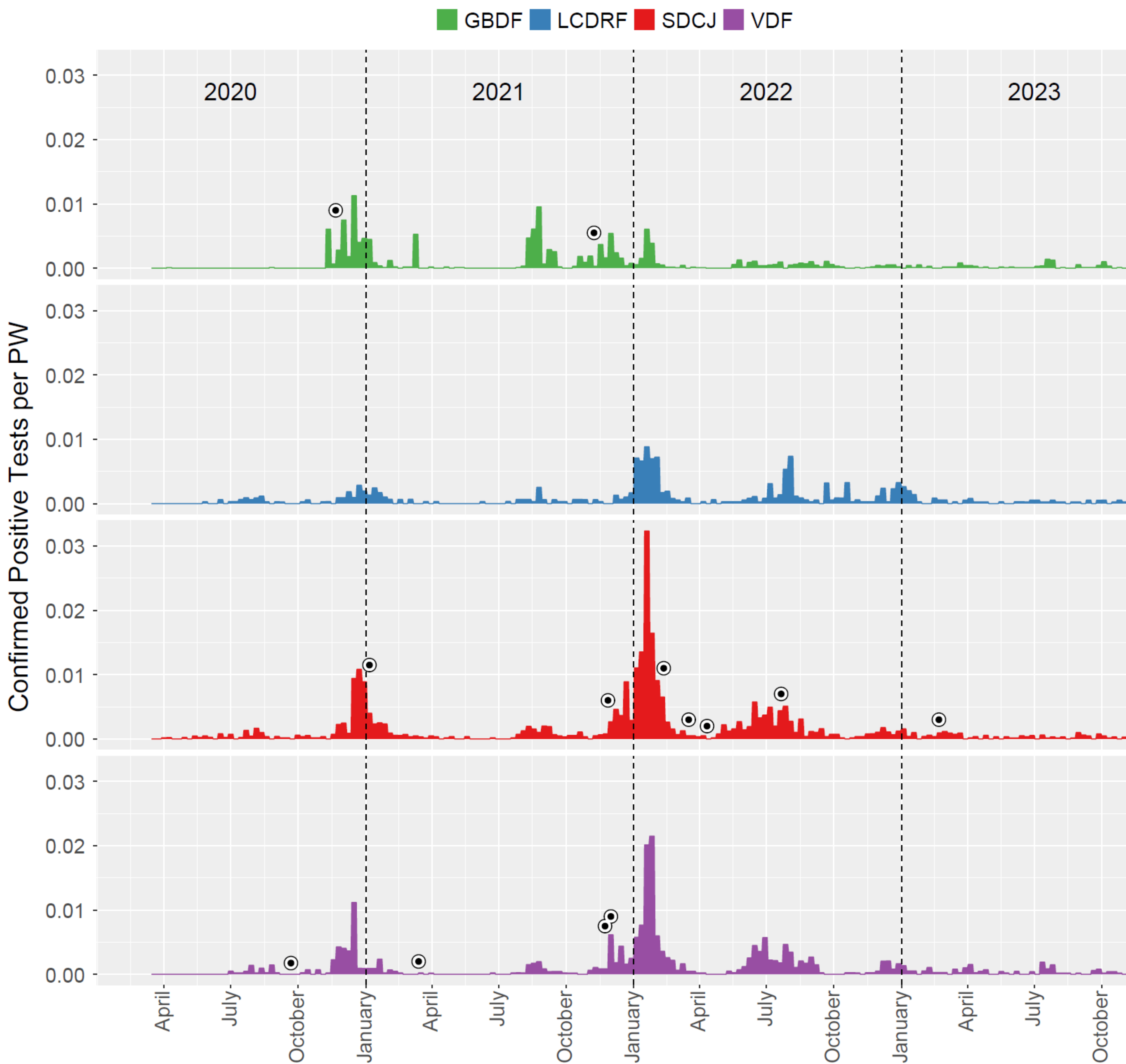



**Figure 1. Positive test counts per Person-Week (PW), in the few most relevant facilities.** The 13 deaths that are marked in the data as being connected to COVID-19 are shown as black and white circles, placed on the horizontal time axis at the time of their occurrence, and placed vertically somewhat above the colored bars. Calendar years are separated by vertical dashed lines.

It is not easy to draw conclusions from observing 13 death events; however, visually inspecting the timing between positive tests and the related deaths, it seems that dying specifically from COVID-19 was less facility-dependent than dying from all causes combined (where SDCJ and VDF clearly dominate among the facilities). For example, during the period from November 2020 to April 2021, all facilities experienced a wave of COVID-19 cases, and numbers of positive tests (per PW) were similar in GBDF, SDCJ and VDF, peaking at about 1% of positively tested individuals, and resulting in a single death in each facility during this period. A larger wave of cases in VDF clustered around February 2022 (peaking at 2% positively tested) resulted in two deaths, and a still larger wave in SDCJ (peaking at 3% positively tested) resulted in 3-4 deaths.

Knowing that these facilities have otherwise very different rates of dying (per jailed individual), the COVID-19 deaths seem less facility-specific in the sense of resulting from internal (largely unknown to TMWL) conditions inside a facility; these deaths might be explained, simply, by how quickly the disease spread within a facility. Facility LCDRF may be somewhat of an exception here, having zero COVID-19 related deaths while experiencing times when positive test counts were close to 1% of the daily population–but again, these specific deaths were small in number, so their zero count here might have been just a play of chance.

With COVID-19, facilities suddenly reduced their total occupancies and movements of detainees. Total occupancy in SDCJ experienced a sudden drop in early 2020 (Mini-Report 2a, Figure 4), returning to previous levels by early 2024. Similar drops in occupancy were seen in other facilities too, see Figure 2. Also, trends in bookings, releases, and transfers (Mini Report for Item 2a, Figure 7) experienced a dip in early 2020 then returned to their previous trends by 2023 or 2024.

These efforts to reduce numbers and dispersal of facility populations to avoid in-custody deaths from COVID-19 were, at best, partially successful. It is easy to see that the COVID-19 years (2020, 2021, 2022) brought about an increase of in-custody deaths relative to remaining jail populations in SDCJ. In Mini-Report 2a, Figure 5, this period was marked by a grey area. The time density of deaths (black line) follows closely the trend of total custody counts (red line) before COVID-19 years, but inside the grey area the time density of deaths separates and stands at the higher level, then in 2023 it seems to have returned to the previous levels, overlapping with total custody counts again.

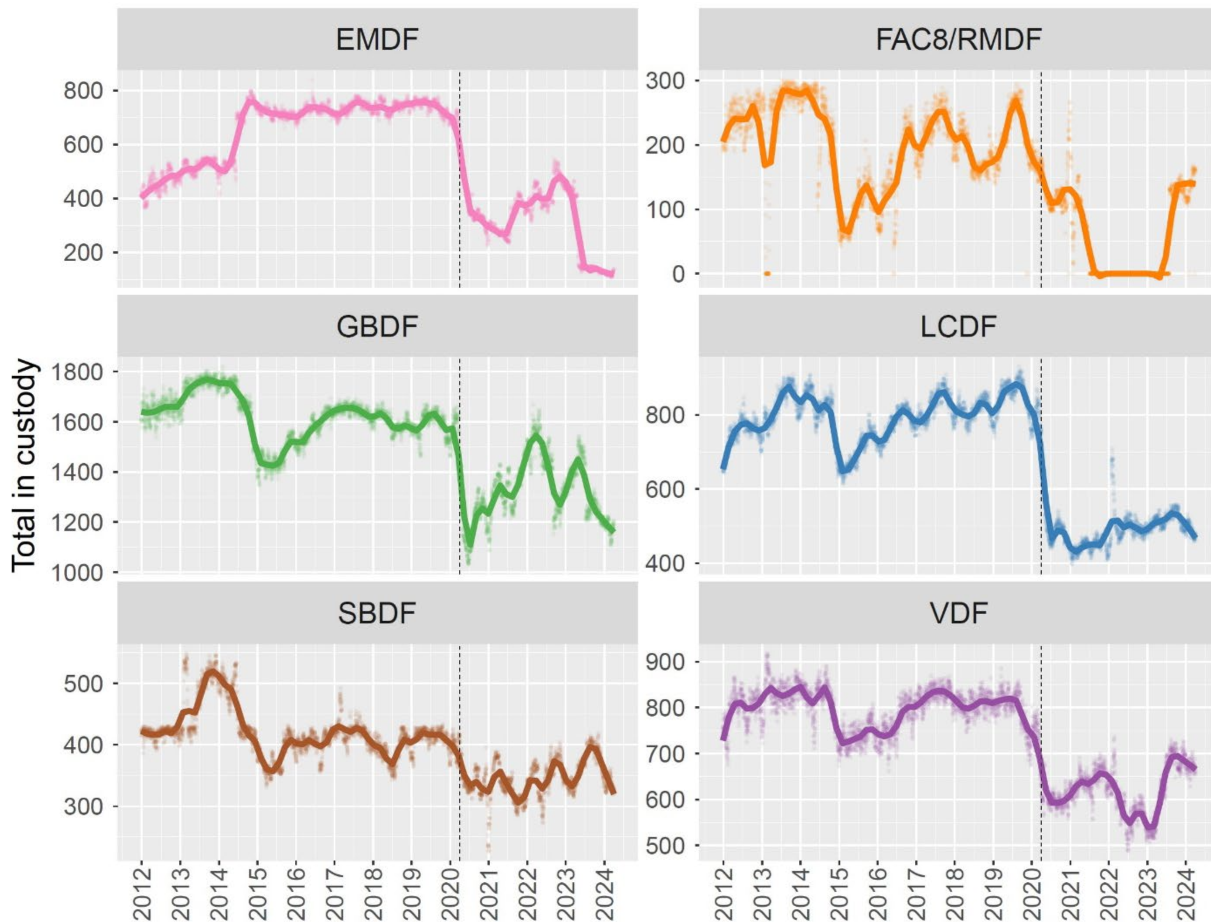



**Figure 2. Occupancy in various facilities (other than SDCJ) over years.** Tiny dots are daily occupancy values from Hudler-Armstrong letters, while thick lines show time trends. The beginning of COVID-19 period is marked with a vertical dash line. All facilities experienced a sudden drop in occupancy at that time.

During non-COVID years, the death rate of incarcerated individuals at SDCJ was clearly associated with the staffing level of Sergeant-Detentions staff (as displayed in Mini-Report for Item 2d, Figure 3). This is recreated in Figure 3. below, where nine red dots (death counts per Person Year during non-COVID years) are positioned along a definite trend (gray strip).

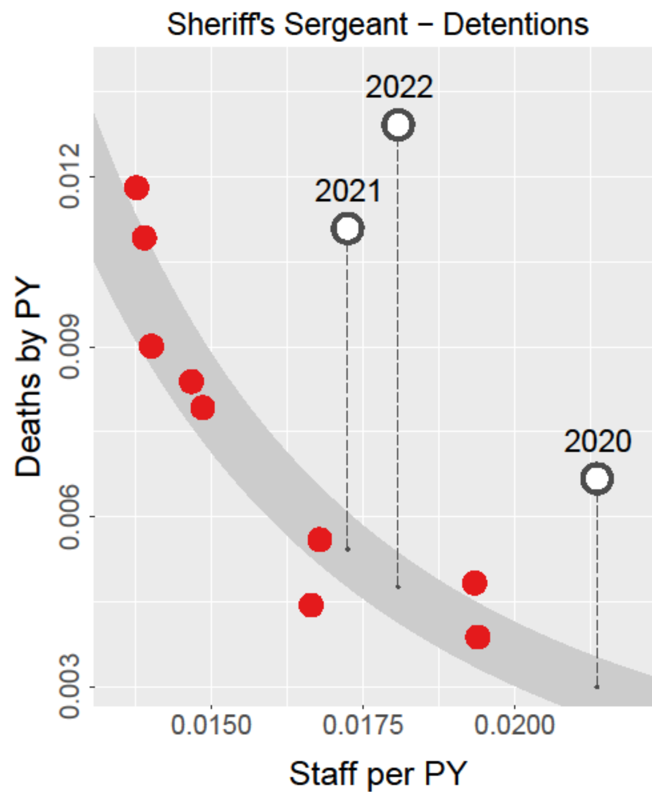



**Figure 3. In-custody death counts plotted against counts of Sheriff's Sergent-Detentions staff, all expressed in Person Year (PY), in SDCJ.** This is the Figure 3 from Mini-Report 2d, the rightmost panel, with three COVID-19 years added as white dots. The dashed lines indicate how much higher were the death rates during these years than their expected values (tiny black dots) if they followed the non-COVID years trend (thick grey strip).

When the three COVID-19 years are added to this plot (white dots), they are situated well above this non-COVID trend, as indicated by the dash lines.

The year 2020 has a death count per person year (PY) of about 0.007, which is more than twice the 0.003 value (small black dot below "2020" mark), which would be expected if the non-COVID trend was followed also in the year 2020, at the same level of Sergeant-Detentions staffing.

Similarly, the years 2021 and 2022 had death counts per person year PY of 0.011 and 0.013, while these would be expected to be around 0.005 during non-COVID

years,
at the same level of Sergeant-Detentions staffing.

So, we can roughly estimate that in SDCJ, the presence of COVID-19 more than doubled the rate of dying per incarcerated individual, at the same Sergeant-Detentions staffing level, as during the non-COVID-19 years.

### *5.5.6 – Is there a relationship between re-admission and IN-CUSTODY DEATHS at both an individual and facility level?*

Data Sets and Preliminary Findings

TMWL received no data whatsoever that would allow us to calculate re-admission counts and rates, whether of individuals who died in-custody or those who did not. As mentioned in Mini-Report 2b, at the beginning of section 5.5.7, SDSD is in possession of this individual-level data that includes re-admissions but provided only a single month's worth of this information, the month prior to TMWL's request for this data, which is unusable for analysis.

### *5.5.13 – What are IN-CUSTODY DEATH rates among [incarcerated people] with a history of homelessness?*

Data Sets and Preliminary Findings

This specific request for residential address information of incarcerated people was denied with the following statement: "The San Diego County Sheriff's Department does not categorize the information in the manner requested or the data is not available in the Jail Management System."

The two relevant agencies contacted through the county-wide CPRA portal denied our requests for information about incarcerated people and homeless services, since they are not the originator of the data on people incarcerated in the county detention facilities. As noted above, TMWL has received data from the Health and Human Services Agency as a result of this CPRA request, but the HHSA data addresses different study questions on mental health treatment history, not homelessness (and was addressed in MINI-REPORT on Item 2c).

There are no data sets to analyze for this study question.

### *5.5.14 – What is the impact of compassionate releases on the nature and number of IN-CUSTODY DEATHS?*

Data Sets and Preliminary Findings

In lieu of data to address this study question, SDSO provided the response below. There is no data to analyze for this study question either.

> "The California Public Records Act (CPRA) does not require a public agency to create a new record for the purpose of responding to a CPRA request. Haynie v. Superior Court, 26 Cal. 4th 1061, 1075 (2001) ("we find nothing in the [CPRA] itself that mandates any action other than opening for inspection the records identified as coming within the scope of the request or providing copies thereof at the expense of the person requesting copies. Preparing an inventory of potentially responsive records is not mandated by the CPRA."); Fredericks v. Superior Court, 233 Cal. App. 4th 209, 227 (2015) ("If the agency would be required to create a new set of public records in order to provide responses to a CPRA request, such agency action may be found to exceed its statutory duties."). Additionally, your request is denied in part pursuant to Government Code section 7923.600. Records of a law enforcement investigation, or any investigatory or security files compiled by a law enforcement agency are exempt from disclosure. Cal. Gov't. Code § 7923.600. Pursuant to Government Code section 7927.705, incorporating Penal Code section 13300 et seq. and California Constitution Article 1. This request seeks criminal history information, as defined by Penal Code section 13300, subd. (a), the production of which is prohibited by the terms of Penal Code sections 13300-13305."

### *Challenges in Addressing Study Questions in Item 2e*

The challenges in addressing the study questions in this report remain similar to those mentioned in each of our previously submitted mini-reports. SDSO provided no individual-level data about incarcerated people who did not die in custody during the study period, foreclosing opportunities to conduct crucial comparative analyses.

More meaningful analysis about the impacts of the COVID-19 pandemic, individual and facility level re-admissions, homelessness, and compassionate release on in-custody deaths in the San Diego County Detention Facilities is dependent upon having facility-specific, individual-level data about each incarcerated person in each facility for the duration of the study. Unfortunately, most of the requested data was not provided to TMWL for a variety of stated reasons, and SDSO declined to offer a non-disclosure agreement in order for TMWL to access such classified or protected data. With COVID-19, there are the added difficulties of determining a pattern from 13 deaths as well as the possibility that

other deaths may have been related to COVID-19, but insufficient knowledge about the disease limited precise measures.

Without such necessary data to adequately address the study questions in this mini-report, we present descriptive breakdowns of in-custody deaths by various categories and by facility (if provided), which is informative in its own right; however, this does not allow us to identify any differences between the population of people who died while in custody and those who did not die while in custody. This comparison—of a variety of potential differences—could reveal patterns and possible causes of such deaths and thus increase the likelihood of preventing them in the future.

Despite insufficient provision of responsive data, all of TMWL CPRA requests have been marked as "Completed" in the SDSO's Public Records Center.

An additional challenge was that other County departments are not the originators of the data needed for this study, and so our attempts to look to these agencies proved ineffective for these specific study questions.

### *Observations*

COVID-19 was an extraordinary event that happened once in the history of the world. Because SDSO did not provide TMWL with data that was responsive to its requests for the study questions presented in Mini-Report 2e, TMWL cannot make a sound recommendation for implementation in the event of a future extraordinary event.

We note that it is important to have a plan for future similar events. Good coordination with sister agencies is important as well as ensuring that the facilities can be adapted for multiple uses and are well-equipped with supplies and access to medical care to address the safety and protection of employees and incarcerated individuals in the case of a future infectious disease pandemic or other extraordinary medical event.

TMWL noted the following in its review of the COVID-19 data provided by SDSO:

1. It is generally difficult to, definitively, determine that a death was either caused by or related to COVID-19 because of overlap with other health conditions. Therefore, TMWL's analysis is limited to those cases specifically identified as deaths caused by COVID-19 in the dataset provided by SDSO.
2. The SDSO facilities observed were: GBDF, LCDRF, SDCJ and VDF. In GBDF, SDCJ, and VDF the COVID-19 deaths did not appear to be strongly facility-specific in the sense of long-term conditions inside each facility, and so the differences between rates of these deaths might be explained simply by the different penetration of the infection within each particular facility. LCDRF did not report any COVID-19 deaths, which might have been just play of chance.
3. Reducing the population of incarcerated individuals may have been only partially successful in reducing deaths. In SDCJ, a rough estimate is that overall deaths per person still doubled during

COVID years despite the reduction in overall population and less movement of incarcerated people in and out of the facility.

### *Recommendations for Study Questions in Item 2e*

Because there was so little data provided by SDSO in response to TMWL's CPRA requests related to the study questions in this report, this would be an appropriate area for follow-up by a future vendor. This failure to provide data, on the part of SDSO, highlights the importance of finding alternative ways to obtain this data and other information to fully address the study questions presented here in 2e and other study questions.

If there is a mechanism for interagency agreements for the release of confidential data, it should be employed by CLERB to obtain some of the missing data. For example, on the issue of homelessness, SDSO cooperation in providing address information for arrestees and incarcerated individuals may make it easier for a sister agency that addresses homelessness to determine if that individual has contacted it for services. To the extent that it might be fruitful to employ legislative means and the full cooperation of the Attorney General's Office to obtain and/or share data, it should be considered. Likewise, a consultation with the Auditor's Office might provide some insight into their efforts in this issue of in-custody deaths in the County detention facilities and their resources. Presently it appears to be too easy for SDSO to deny data requests and no means of enforcing the requests for data.

Finally, if there is a SDSO liaison who works with CLERB and attends CLERB Board meetings—as there was during this research study-- it would be helpful to request that the liaison play a more active role in responding to the needs of CLERB for more data and assistance in preventing in-custody deaths and enlarging their responsibility or replacing the position with someone who has more responsibility and could be helpful to CLERB.

## CONCLUSION

TMWL has prepared the above background and this mini-report to describe what it has done, to date, to address Item 2e. The final report will include a full account of the study methods, findings, and recommendations for future studies.