DEATHS IN CUSTODY IN SANTA BARBARA COUNTY JAILS

Our County Jails Meet Many Needs

SUMMARY

The Santa Barbara County Grand Jury investigates all deaths in custody within the geographical boundaries of Santa Barbara County. The 2023-2024 Santa Barbara County Grand Jury conducted a comprehensive review of six deaths of incarcerated individuals that took place while under the supervision of the Santa Barbara County Sheriff's Office. Among these deaths, three occurred during the tenure of the 2022-2023 Grand Jury. The remaining three deaths occurred during the current Jury's term. Of the six deaths, two were classified as suicides, two were classified as drug overdoses, and two were classified as multiple causes.

The Sheriff's Office is committed to implementing and maintaining current best practices in preventing deaths of anyone held in its facilities. Yet deaths continue to occur. In reviewing the six deaths for this report, the Grand Jury found that circumstances can be overwhelmingly difficult to manage. Illegal drugs enter the jails, incarcerated individuals are determined to commit suicide, and some inmates can have medical and mental health conditions that complicate desperate situations.

The Santa Barbara County Jails have become the main mental health institution, the main drug treatment center, and even at times the primary provider of health care for incarcerated individuals. In a jail system that is chronically understaffed, attention to acute details is compromised. To succeed in these roles, the jails need more resources, which may be provided by collaboration among County departments.

The Grand Jury investigations rely heavily on information provided by the Santa Barbara County Sheriff's Office. Completion of the investigations was greatly impeded by a lack of timely

cooperation by the Sheriff's Office. What follows is a thorough report based on the information the Jury was able to obtain. The Grand Jury believes the Sheriff is and remains committed to remedying these difficulties going forward.

METHODOLOGY

Pursuant to California Penal Code section 919(b), this Jury reviewed reports, documents, and other evidence provided to us by the:

- Sheriff's Office
- Wellpath (the County jails' contract medical provider)
- Public Defender's Office
- Probation Department
- County Executive Office
- District Attorney's Office
- Superior Court
- Coroner's Bureau

Interviews were conducted with individuals who provided evidence related to the deaths in custody, including nurses, mental health staff, and custody staff. Additionally, past Santa Barbara County Grand Jury reports were reviewed, as well as similar reports from other counties. Site visits to both jails were conducted, going twice to the Main Jail and twice to the Northern Branch Jail (NBJ).

BACKGROUND

The diversity of incarcerated individuals at the jails complicates the demands on custody staff. In order to understand the complex nature of needed care and attention in the jail, the Jury obtained a categorical list of incarcerated individuals on one day in May 2024 as an example. On this day, both jails combined held 776 individuals.

- General population 340
- Protective custody 397
- Restrictive housing 12
- Behavioral Health Units 27

Some of the needs and concerns of the above incarcerated persons include:

- Psychiatric/mental health 262
- Serious mental illness 46
- Incompetent to stand trial 7
- Suicide 4
- Drug withdrawals 49
- Alcohol withdrawals 29
- Medically assisted drug treatment 77
- Move with 2 deputies 1
- Strip search/body scan 14
- ADA 98
- Wheelchair/cane/walker 20
- Medical Equipment 54
- Gang 97
- Sex crimes 29
- Sex offender 26
- Pedophilia 16
- Arsonists 10
- Alternative lifestyle 11
- Transgender 2
- Dementia 1
- Homeless 242

Routinely, the jails host a number of individuals with chronic medical conditions. For the above date in May, the following were counted: hypertension (59), seizures (30), diabetes (27), asthma

(13), heart condition (12), infectious disease (11), blind (1), sleep apnea (3), and amputation/prosthesis (2).

Of all these justice-involved people, 28.2% have been sentenced and 71.8% were awaiting trial at the local courts.

Of the six deaths in custody, five of these deaths occurred within three days after intake.

DISCUSSION OF INDIVIDUAL CASE REVIEWS

MULTIPLE CAUSES

Arrestees who are experiencing medical issues may be taken to a hospital for clearance before entering the jail. Usually, they are taken to the jail once cleared from the hospital. Arrestees can also be taken directly to the jail. This decision is made in the field by the arresting officers.

The reception process at the jails begins with a medical intake screening exam. According to Santa Barbara Sheriff's Office policy, all newly arrested inmates are subject to a medical questionnaire and vital signs check conducted by a registered nurse. Most arrestees comply, but some are unwilling or unable to answer all questions. The questionnaire primarily focuses on physical health, with a minor emphasis on mental conditions. If an incarcerated individual's responses indicate a need for further mental health evaluation, a mental health practitioner (MHP) may be called in.

Those who arrive at the jail are often not in good medical condition. The purpose of intake screening is to determine if the arrestee is in a genuine medical crisis. The two cases in this section of the report demonstrate how the mental state can conceal the physical condition to a dangerous degree. Both the NBJ and the Main Jail have physicians, although the doctor at the Main Jail is only on-site four days a week. While incarcerated individuals have prompt access to a nurse, if

they want to see a doctor, they fill out a request. They can be seen in two or three days, at most a week later. If an emergency arises, the incarcerated individual would be sent to a hospital.

The jail's medical provider, Wellpath, provides basic healthcare. Staffing is always a concern. The Public Health Department has begun to help monitor nursing care at the jails and work side by side with Wellpath. The intention is to have a Public Health Chief Correctional Health Medical Advisor, a Program/Business Leader-Physician, and a Correctional Health Quality Care Improvement Coordinator at the jails to oversee services, linking staff and administrators from Public Health and Wellpath. The duties of the Medical Advisor will include analyzing the root causes of in-custody deaths. The goal is to have quality care assessment that will begin with the initial screening. This partnership should lead to better evaluations before an incarcerated individual's condition leads to death.

JG died on December 28, 2022, age 34.

JG was on parole in a community sober living placement in Santa Maria on December 28, 2022, the day he died. JG called 911 early that morning stating that some of the residents at the sober living home were threatening him. JG was waiting outside when Law Enforcement Officers arrived. As he appeared to be under the influence of drugs or alcohol, his Parole Officer was notified. The Parole Officer then ordered JG to be taken into custody for a parole violation.

During his arrest, JG made several complaints of feeling unsafe. He was in a state of mental agitation. He was patted down, and the officer found that he had no weapons on his person. After being informed that he was under arrest, JG became more agitated and began to complain of pain. JG complained of chest and back pain multiple times, and said that he was afraid of being sexually assaulted in jail. The arresting officer considered taking JG to the hospital but made the decision not to do that.

He was transported to the NBJ before 9:00 a.m. to be processed. He appeared to become more confused, uncooperative, and angry as the process continued. He refused to leave the police car when they arrived at the jail, and three Custody Deputies cuffed him and placed him in a chair inside the intake portion of the jail.

JG’s chest pain was not mentioned to the intake Registered Nurse (RN) upon his arrival at the jail. Medical personnel attempted to complete his intake forms, but his agitated behavior further deteriorated. His vital signs were taken and only a few questions were completed before it was decided to put him in a mental health observation cell. Before that was accomplished, he began to spit, kick, and lash out. The decision was then made to take him to a safety cell to protect himself and others.

Custody Deputies transported him to a safety cell, and almost immediately after laying him on his stomach with his hands cuffed behind him, he became non-responsive. Jail and medical staff immediately rolled him over to give him Narcan, and he quickly regained consciousness. He then asked for water but started kicking and screaming when they tried to sit him up so he could drink. As soon as they got him prone on his stomach again, he became non-responsive and was again put on his side and given more Narcan. He stopped breathing, so life saving measures were started, and American Medical Response (AMR) was called. He eventually started breathing shallowly on his own, and when the ambulance arrived, he was taken to Marian Regional Medical Center in Santa Maria.

He was pronounced deceased just before 11:00 a.m. which was less than two hours after being processed at the jail.

The Santa Barbara County District Attorney's (DA) office investigated the circumstances surrounding JG's death for over a year and publicly released the results of that investigation on February 14, 2024. The DA’s report stated that the Intake Nurse had cleared him to be booked into jail. The DA's office concluded that JG's death was an accident, as did the Santa Barbara County Coroner’s Bureau in the postmortem exam report completed a week after JG's death.

The Coroner's Bureau listed four causes of death for JG, the primary being methamphetamine intoxication. Other significant contributing factors were listed as dilated cardiomyopathy, obesity, and physical restraint. The manner of death was listed as an accident.

JG had gained 105 lbs. in the nine months since his last incarceration. It is a fact that when an obese person is placed in a prone position with his hands cuffed behind him, a great deal of physical stress is placed on his heart, lungs, and airways, making it difficult to breathe. JG had become unresponsive both times he was restrained in a prone position.

A similar situation occurred in the Main Jail in January 2022 and was reported by the 2022-2023 Grand Jury: A Death In Custody – Lessons Learned

(See Findings and Recommendations 1, 2, and 3.)

LR died on September 3, 2023, age 37.

LR was arrested on the morning of August 31, 2023, due to a failed sobriety test administered after a motor vehicle accident. Before being taken to the Main Jail, LR was taken to Goleta Valley Cottage Hospital where he was treated for injuries sustained in the motor vehicle accident. He was cleared and released.

During his intake screening, LR stated that he used alcohol daily. It was not noted whether LR was in withdrawals at the time of the screening. LR also mentioned that he was not currently experiencing alcohol withdrawals and denied ever having experienced withdrawal symptoms. His intake screening was completed at 10:19 a.m. on August 31, 2023.

After initial placement in the Intake Reception Center (IRC), LR was transferred to a mental health observation cell (IRC H-5). Over the course of the following three days, LR's physical injuries appeared to worsen, and his cognitive abilities deteriorated. On September 2, a custody officer requested a mental health evaluation for LR. At approximately 2:20 p.m. that day, LR appeared confused and disoriented as to time. This worsened to include slowed speech and poor comprehension by the evening. His mood was anxious and he became withdrawn. His immediate, recent, and long-term memory were all impaired.

Jail protocols require safety checks at a minimum of every 15 minutes for safety and observation cells. At approximately 11:45 p.m. a custody deputy walked by IRC H-5 and noticed that LR

seemed to be asleep in a seated position and had a very pale face. The deputy called for assistance, and they entered the cell. LR was found to be unresponsive but with a pulse. The responding deputies started CPR and called for medical assistance.

Records show LR as having severe bruising, no pulse, no pupil dilation, and no chest rising/falling. AMR was called. A defibrillator detected no heartbeat at 11:57 PM. One dose of Narcan was administered with no result, and CPR continued. Paramedics arrived shortly after midnight.

At 12:36 a.m. LR was moved to an AMR gurney and taken to Cottage Hospital in Santa Barbara. LR died at Cottage Hospital on September 3, 2023, at 1:57 a.m. The cause of death was listed as alcohol withdrawal due to chronic alcoholism, alcohol abuse, and blunt force injury. The official manner of death was natural causes.

(See Findings and Recommendations 4, 5 and 6.)

OVERDOSE

The two overdose deaths in this next section of the report illustrate not only the problem of contraband in the jail, but also inadequate monitoring of those who enter the jail under the influence. Both inmates in this report had a history of multiple incarcerations over many years as well as long histories of drug addiction. Both deaths occurred within two days of being jailed.

The Crisis Stabilization Unit (CSU), under the direction of Behavioral Wellness, will be re-opening adjacent to the Main Jail with the goal of assessing "clients for Mental Health or Substance Use Disorders and any co-occurring disorders or medical services," as stated in the August 29, 2023 letter to the Board of Supervisors. This small eight-bed facility will be able to monitor people, including arrestees, who are in need of immediate care during withdrawals or other dangerous states due to drug or alcohol use. Working with an experienced provider could lead to accepting arrestees for the critical observation period when first entering the jail at the CSU.

The CSU in North County is at a distance from the NBJ. But the NBJ does have a medical unit with ten individual rooms where arrestees going through withdrawal could have access to immediate medical help when in crisis.

The jails have a highly regarded program for addictions: Medication Assisted Treatment Program (MAT). At the first indication of addiction, the intake nurse puts the arrestee on monitoring and will notify the doctor, making sure medications are available, and tries to get the incarcerated individual into MAT. However, there are not enough clinicians in this program to serve everyone in need at the jail, and there is a wait list. Some assistance may be available as more healthcare providers are trained to work with MAT, and the collaboration with Public Health may expand its role into MAT.

When arrestees enter the jail and look for access to contraband drugs, they have sometimes been able to find drugs that could kill them. However, it is important to note that no jail deaths due to overdoses have occurred since May 2023. New screening technology and the use of drug sniffing canines have contributed to saving as many as 200 lives in the jails. Despite the fact that the jails are adding new and advanced detection technology, the existence of contraband in the jails may always be a problem.

RU died on May 25, 2023, age 45.
RU was arrested at his home on four felony counts including possession for sale of over one pound of methamphetamine, two ounces of fentanyl, and more than an ounce of heroin.

He was booked into the Main Jail in the afternoon of May 24, 2023. In his initial screening RU stated that he used methamphetamines, fentanyl and heroin every day. He said that he was going through withdrawal at that time and had done so before. The information was entered and triggered an Active Withdrawal Alert into his screening report and signed him up for Clinical Opioid Withdrawal Scale (COWS) checks every eight hours.

With the alert for withdrawals and the COWS inscription, RU was under an observation schedule. During his COWS check at 7:00 a.m. on May 25, he refused to give a urine sample.

RU may have had access to contraband drugs in his jail unit. A post-mortem review of jail videos showed RU talking with other incarcerated persons. Those individuals went to another cell where something was passed under the door and then brought to RU.

RU had another COWS check at 3:00 p.m. When a dayroom program became available at 4:00 p.m., RU did not come out of his cell.

At 10:50 p.m. a Wellpath nurse and a Custody Deputy went to his cell for a COWS check. RU was unresponsive, foaming at the mouth, and had no pulse. CPR was started, and an ambulance was called at 10:58 p.m. He was administered Narcan three times. AMR declared RU deceased at the scene at 11:25 p.m.

The toxicology report showed polysubstances as the cause of death. RU's manner of death was listed as accidental.

DL died on May 29, 2023, age 57.

On May 27, 2023, DL was pulled over for a window tint violation. Upon contact with DL, deputies observed drug paraphernalia inside the vehicle, which led to a probable cause search that resulted in finding 35 grams of fentanyl, 1 gram of cocaine, scales, assorted drug paraphernalia and over $600 in cash. He was arrested in Santa Maria and brought to the NBJ, where he was booked on drug-related charges, including felony possession of narcotics for sale, felony transportation of a controlled substance, misdemeanor possession of narcotics and possession of drug paraphernalia. DL had been jailed over a dozen times between 1988 and 2015 for drug related charges.

On the day of DL's death, vital signs were checked at 8:00 a.m. At 2:00 p.m. a deputy and a nurse began testing inmates for COVID. DL did not appear at the check-in for the test, so the officers went to his cell looking for him. They found DL lying unresponsive on the floor of his cell and "pale blue." A radio call for deputies went out at 2:12 p.m. Two deputies and medical personnel responded. Calls for first aid and emergency services went out at 2:15 p.m.

Two deputies and medical personnel moved DL from his cell and began CPR with AED equipment. Two doses of Narcan were given. Jail staff rotated performing chest compressions until the Fire Department arrived at 2:17 p.m. AMR arrived at 2:22 p.m. Paramedics continued life-saving measures. At 2:46 p.m. all measures were stopped, and DL was pronounced dead at that time.

At 3:30 p.m. a forensics team arrived, consisting of a Detective Sergeant and a Criminal Investigation Detective who processed the scene. A suspicious powder was found, which turned out to be Gatorade. Their inspection ended at 4:34 p.m. That night, the whole unit was searched from 9:00 p.m. to 11:30 p.m. Video footage of the housing unit showed no narcotics passed around that day, and no narcotics were found.

Toxicology reports confirmed a polysubstance intoxication was the cause of death. The official manner of death was listed as accidental.

(See Finding and Recommendation 6.)

SUICIDES

Many incarcerated individuals have mental health issues and/or drug and alcohol problems. Being arrested and incarcerated is an extremely stressful experience and may exacerbate depression and other mental health issues already affecting the individuals in custody.

Accordingly, attempted suicides are not uncommon. Safety cells, which place inmates in an environment where they cannot be a danger to themselves or others, are effective in preventing suicides. Their use is, however, restricted because they can only be held for a limited duration. Direct observation of inmates at all times could significantly reduce the opportunity for suicide attempts, but staffing and facility issues make that option impossible.

Within the existing circumstances and limitations, the Sheriff's Office exercises many systems and procedures to prevent suicides. Those systems and procedures are continually under review and

improvement. As an example, the Public Defender's Office has begun a holistic approach with arrestees entering the jails. At the NBJ, representatives from this Office meet with the newly incarcerated for an in-depth conversation to understand their needs. From this discussion, a plan can be developed to incorporate applicable programs into their schedule. This personal approach acts as an intervention, and it may divert some arrestees from suicidal ideation. A connection with the incarcerated is maintained until discharge.

PG died on October 21, 2023, age 64.

PG was arrested by the Santa Barbara Police Department and booked into the Santa Barbara County Jail on September 29, 2023, on charges of assault with force/possibility of great bodily injury. On October 3, 2023, additional charges were filed for probation violation and DUI. PG had a long history of arrests and incarcerations in Santa Barbara County dating back to 1986.

During intake PG denied any mental health issues, but he mentioned depression. PG also mentioned that he had cancer and was subject to withdrawal from alcohol. Medical staff was notified of his claim to have cancer.

PG's mental condition appeared unstable, and his behavior was erratic. Other incarcerated persons reported that he was sometimes belligerent, shouting at times. Also, his maximum-security status and arrest history included signs of aggressive behavior.

His initial housing location in general population was changed to NWC cell 3 (a single man cell in a mental health unit) on October 15, 2023, after other inmates asked that he be moved due to his poor hygiene. PG remained in that housing location until his death on October 21, 2023.

At approximately 5:30 a.m. on October 21, PG was observed in his cell by custody staff during a security check. At approximately 6:18 a.m. PG was discovered unresponsive, lying face down on his bunk. There was a strip of cloth tied around a part of the upper bunk and wrapped around PG's neck. He had turned his back to the door and gotten as close to the far corner of his bunk as possible. The ligature was tied to the front of his neck, where it would not be easily seen by someone on the other side of the door.

Custody Deputies moved PG to the day room floor and along with jail medical staff began life saving measures. AMR and fire personnel arrived at approximately 6:30 a.m. and took over medical treatment. In total, three doses of Narcan were administered. At approximately 7:00 a.m. PG was declared dead by AMR staff.

An autopsy was performed on October 26, 2023, by the Coroner's Bureau. The manner of death was listed as suicide, and the cause of death was determined to be hanging. A toxicology report showed no prescription or controlled substances.

SP died on December 31, 2023, age 61.

On December 28, 2023, a Santa Barbara County Sheriff Deputy was dispatched to St. Athanasius Orthodox Church in Goleta at the request of a concerned party who described a suicidal suspect. SP had threatened to end his life by jumping in front of a moving train or bus. During the field interview, SP expressed his desire to end his life due to being upset about his homeless status and frustrated by a lack of available resources to help him find stable housing.

A standard records check revealed an active warrant for SP's failure to appear in court on charges including receiving stolen property, vandalism, petty theft, possession of burglary tools, possession of a controlled substance, and disobeying a court order. SP was taken into custody without incident, transported to the Main Jail, and held on $40,000.00 bail. His arraignment was scheduled for January 2, 2024.

During SP's medical screening, the intake nurse recognized the need for additional mental health screening and summoned the Mental Health Practitioner (MHP) on duty. The MHP addressed SP's suicidal thoughts. SP responded by saying he would "find a way to do it." As a result, the MHP ordered SP to be placed in a safety cell to reduce the risk of self-harm and prevent any possible harm to custody staff.

After completing the screening process, Custody Deputies escorted SP to safety cell SC3, located within the Inmate Reception Center (IRC) 300. SP's clothing was removed, and he was provided

with a safety/modesty smock. He was locked inside the cell for observation at 12:00 p.m., with safety checks logged every 15 minutes, until 8:25 a.m. the following morning, December 29th, totaling nearly 21 hours of observation.

A mental health practitioner visited SP and spoke to him through the slot in the safety cell door. SP appeared anxious and disheveled, vehemently denying any suicidal intentions and requesting to be released from the cell. As a result, the MHP decided to move SP to a mental health observation cell (H6) where he would continue to be monitored for the next 24 hours. Crisis and Recovery Emergency Services (C.A.R.E.S.) was not contacted to evaluate SP at 12 hours as required by policy. Safety cell documents are used to record observed behaviors every quarter hour. It was noted that SP was visited by an MHP only once, one hour after being transferred to the observation cell. Subsequently, there was a gap before the next MHP assessment, during which time SP received medical staff visits for medication administration and vital checks on seven occasions. After the initial MHP visit, no further mental health check-ins occurred for almost 24 hours.

At 9:00 a.m. on December 30, 2023, a decision was made to release SP from observation. The decision was based on SP's statement that he no longer had suicidal thoughts and his complaint about the lack of a mattress, blanket, or sweatshirt, causing him discomfort throughout the night. It was reasoned that someone concerned about their environment and seeking comfort was unlikely to harm themselves. SP was fixated on leaving the observation cell and voiced little more than that. Consequently, SP was reclassified into regular housing and transferred from the mental health observation cell to IRC 321. The standard process of developing a collaborative safety plan with an incarcerated individual prior to discharge from a mental health observation cell was not conducted. IRC 321 is located on a second-story tier. SP was housed alone.

On December 31, 2023, New Year's Eve, SP remained in IRC 321, awaiting his scheduled arraignment on January 2, 2024. At approximately 8:10 a.m. that morning, SP jumped off the second-story tier of the module. SP had no interaction with other incarcerated individuals housed in the module and was alone in the dayroom at the time of the incident.

Reviewing the surveillance footage, it was observed that SP exited his cell and approached the railing on the second-floor tier, outside his cell door. He leaned on the railing for approximately 17 seconds, appearing to contemplate jumping. Then, he turned left and walked to the adjacent side of the second-floor tier, climbing over the railing. The entire process, from leaning on the railing to climbing over it, took approximately 30 seconds.

Once SP positioned himself over the railing, he faced away from it while gripping it behind him. After about six seconds, in a deliberate action, he leaned forward and let go of the railing, jumping from the second tier. He leaned forward and downward, seemingly aiming to make contact with the floor below using his head and shoulders. Upon impact, SP immediately collapsed and became unresponsive, showing no further movement.

Initially, none of the incarcerated individuals housed in the module were aware that SP had jumped over the railing. Approximately one minute and five seconds later, an incarcerated person on the first floor noticed SP on the floor and attempted to use the intercom in his cell to notify the custody staff. The incarcerated individual was unaware that the intercom system was non-operational due to ongoing system upgrades in the IRC 300 Module. Additionally, the surveillance system providing video feed to the control module was not functioning correctly, and the electronic locks on the cell doors were also not operational and had to be locked and unlocked manually.

Since there was no video feed into the control module, there was no custody deputy stationed there. Incarcerated individuals began banging loudly on their cell doors to attract the attention of the custody staff. It was noted by the Jury that there were only 11 Custody Deputies on duty at the time of the incident. Optimal staffing is 19 Custody Deputies. The facility routinely operates with fewer positions filled. It took approximately 3 minutes and 20 seconds for the first custody staff member to arrive at the scene after SP's impact on the floor.

Upon entering IRC 300, custody staff observed SP on the ground and immediately called a "man down" code, alerting additional staff and medical personnel. AMR and fire department personnel arrived shortly after, and their combined efforts were able to revive SP.

AMR then transported SP to the Emergency Department at Santa Barbara Cottage Hospital. Despite emergency room efforts, SP's prognosis was determined to be extremely poor. A Do Not Resuscitate (DNR) order was subsequently issued by a family member. Shortly after, advanced life support measures were discontinued, and SP was pronounced dead at 3:16 pm on the last day of 2023.

Coroner's Bureau Detectives investigated the jail cell and the surrounding area where the incident occurred. The decedent's body was then recovered from the hospital and transported to the Coroner's Facility. An autopsy was performed on January 9, 2024, and the report listed the manner of death as suicide, with the cause of death being blunt force trauma.

(See Findings and Recommendations 7, 8, 9, 10 and 11.)

CONCLUSION

Two overdoses, two suicides, and two medically complicated incidents. These deaths in custody occurred in part due to insufficient observation, occasional lack of effective and timely communications between jail Custody Deputies and healthcare staff, and inadequate resources. In order to help those who enter the jail experiencing medical or mental health issues, there needs to be more custody officers, more healthcare attendants, and better housing and equipment. These improvements are difficult to obtain given the current job market and the burdened County budget.

The Sheriff's Office and the jails can develop solutions by combining resources with other County departments. Behavioral Wellness, the Public Defender's Office, and Public Health are poised to be collaborative partners in observing, tending, and caring for those inside the jails. Santa Barbara County jails have the opportunity to create a better model for the County's principal mental health institutions, drug treatment centers, and healthcare centers that we call jails.

If you're having thoughts of suicide, please call the National Suicide Prevention Lifeline at 1-800-273-8255, or call or text 988 (Crisis and Suicide Lifeline). They have caring people available 24/7 to provide free and confidential support.

FINDINGS AND RECOMMENDATIONS

Finding 1

Being placed in a prone position while restrained contributed to JG's death.

Recommendation 1

The Sheriff's Office should review and reevaluate the use of prone restraint position with obese individuals.

Finding 2

The arresting officers failed to inform the intake staff that JG had complained of back and chest pain. This lack of communication was a missed opportunity to ascertain whether JG needed timely and appropriate medical care.

Recommendation 2

The Grand Jury recommends that the Sheriff's Office implement a mandatory communication protocol between arresting officers and jail medical intake staff. This protocol should ensure that arresting officers consistently relay all potentially relevant medical information to intake nurses, including any complaints of pain or existing medical conditions.

Finding 3

Custody Deputies removed JG from the medical intake screening process before it was

completed. The failure to prioritize JG's medical needs at intake raises serious concerns about the potential for harm to individuals in custody.

Recommendation 3a

The Grand Jury recommends that custody and medical staff develop improved communication protocols. This collaboration should ensure that medical intake screenings are consistently completed before individuals are removed from the process.

Recommendation 3b

The Grand Jury recommends revising the medical screening questionnaire to prioritize the most critical information. Specifically, a question like "Are you currently experiencing any pain or are you suffering from an acute condition?" should be placed as the first question on the questionnaire. This simple change could ensure that individuals with immediate medical needs are identified and addressed promptly.

Finding 4

LR's physical injuries and cognitive abilities worsened during his three days of incarceration at the Main Jail. An admitted alcoholic, he was not treated for alcohol withdrawal symptoms when examined by mental health or medical personnel.

Recommendation 4

Any incarcerated person who has admitted to prolonged and excessive alcohol consumption and begins exhibiting symptoms consistent with alcohol withdrawal must immediately be treated in a manner to reduce symptoms and monitored for continued physical and/or cognitive degradation.

Finding 5

When the Public Health Medical Advisor position has been filled, this medical professional will be working with Wellpath staff at the jails.

Recommendation 5

The Public Health Medical Advisor shall help oversee and advise treatment for medically compromised individuals entering the jails, especially during the critical first week of incarceration.

Finding 6

RU and DL suffered from drug addiction and died within two days of entering the jails.

Recommendation 6a

The Sheriff's Office should contract with Behavioral Wellness for a number of beds in the recently reopened Crisis Stabilization Unit next to the Main Jail, where arrestees can be consistently monitored.

Recommendation 6b

The Sheriff's Office shall direct medical staff at the Northern Branch Jail to hold a number of beds in the medical unit for those arrestees entering the jail who exhibit withdrawal symptoms.

Recommendation 6c

The Sheriff's Office shall work with Public Health and Behavioral Wellness to increase staffing of the Medically Assisted Treatment program at both jails.

Finding 7

SP spent over 12 hours confined in a safety cell without a mental health evaluation being conducted by a C.A.R.E.S. Mobile Crisis Unit during that time.

Recommendation 7a

To comply with its current policy, the Sheriff's Office should review and revise its protocols to ensure that timely mental health evaluations are conducted by a C.A.R.E.S. Mobile Crisis Unit for individuals retained in safety cells over the initial 12-hour limit.

Recommendation 7b

The Jury recommends that all procedures that are mandated by policy to be performed prior to the removal of an occupant from a safety or observation cell be incorporated as a checklist into the posted observation logs. A custody supervisor shall review the observation logs together with the checklist to ensure that each required step has been completed and upon such verification, the custody supervisor's signature releases the occupant.

Finding 8

There was a failure to initiate a collaborative safety plan with SP prior to his release from the mental health observation cell which is intended to provide support and decrease the chance of self-harm during a critical period of time.

Recommendation 8a

The Sheriff's Office shall ensure that the procedures outlined within its policy and its contract with Wellpath be completed prior to the removal of an occupant from a safety or observation cell.

Recommendation 8b

The Jury recommends that all procedures that are mandated by policy to be performed prior to the removal of an occupant from a safety or observation cell be incorporated as a checklist into the posted observation logs. A custody supervisor shall review the observation logs together with the checklist to ensure that each required step has been completed and upon such verification, the custody supervisor's signature releases the occupant.

Finding 9

Ongoing renovations and upgrades within the IRC 300 housing unit had resulted in the in-cell intercom system, certain video surveillance systems, and the electronic locking mechanisms being non-operational at the time of SP's death, causing delayed response times by custody and medical staff.

Recommendation 9

The Sheriff's Office should develop and implement more effective alternatives for visually monitoring incarcerated individuals and enabling emergency communication when the electronic surveillance and intercom systems are not functioning properly, including relocating incarcerated persons to other holding locations within the County jail system, increasing the frequency and duration of in-person safety checks and cell inspections by custody staff when electronic monitoring is unavailable, and stationing custody personnel within the housing unit to enhance direct supervision.

Finding 10

There were only 11 Custody Deputies on shift at the time of SPs' death. The level of safety inside jail facilities is directly affected by the number of Custody Deputies on duty. If more than one critical incident were to occur at the same time, it could be extremely difficult to manage.

Recommendation 10

The Sheriff's Office shall review its minimum staffing levels in the jail facilities.

Finding 11

SP, who had clearly expressed an intention to harm himself in any way that he could, was nonetheless placed in a cell located in a two-level housing unit, which provided SP with easy access and the means to jump to his death from the second level of the unit.

Recommendation 11a

The Grand Jury recommends that the Santa Barbara County Sheriff's Office immediately review and revise its incarcerated housing and classification placement protocols. Going forward, the Sheriff's Office must ensure that individuals who have made suicidal statements or exhibit a desire to harm themselves are never assigned to cells or housing units that offer ready access to methods of self-harm such as elevated areas from which an incarcerated individual could jump.

Recommendation 11b

To help mitigate the risk of incarcerated persons jumping or falling from elevated housing areas, the Grand Jury recommends that the Sheriff's Office explore the feasibility of installing physical barriers, such as safety netting or higher railings, in those locations.

Finding 12

The Public Defender's Office currently conducts an entry interview to establish a connection with newly incarcerated persons booked into the Northern Branch Jail, which continues until the incarcerated persons are discharged.

Recommendation 12

The Sheriff's Office shall work with the Public Defender's Office to initiate a similar program at the Main Jail.

Finding 13

The Grand Jury investigations of deaths in custody rely heavily on information provided by the Santa Barbara County Sheriff's Office. Completion of the investigations was impeded greatly by a lack of timely cooperation by the Sheriff's Office.

Recommendation 13

The Sheriff's Office shall promptly provide information to the Grand Jury.

Finding 14

Five of the six deaths in this report occurred within the first three days of entering the jail. The main factors for jail deaths involved issues of inconsistent and inadequate observation.

Recommendation 14

The Sheriff's Office, working in conjunction with Wellpath, Behavioral Wellness and Public Health, shall have procedures in place to more closely monitor at-risk incarcerated persons when they enter the jails.

Request for Response

Santa Barbara County Sheriff's Office – 60 days

Findings 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14

Recommendations 1, 2, 3a 3b, 4, 5, 6a, 6b, 6c, 7a, 7b, 8a, 8b, 9, 10, 11a, 11b, 12, 13, 14

Santa Barbara County Board of Supervisors – 90 days

Findings 5, 6, 12, 14

Recommendations 5, 6,c, 12, 14

Requirements for Responses:

Pursuant to California Penal Code §933 and §933.05, the Grand Jury requests each entity or individual named below to respond to the Findings and Recommendations within the specified statutory time limit.

Responses to Findings shall be either:

- Agree
- Disagree with an explanation
- Disagree partially with an explanation

Responses to Recommendations shall be one of the following:

- Has been implemented, with a summary of the implementation actions taken
- Will be implemented, with an implementation schedule
- Requires further analysis, with an analysis completion date of fewer than 6 months after the issuance of the report
- It will not be implemented with an explanation of why