Attachment D

FATAL HEAD INJURY AT THE NORTHERN BRANCH JAIL

A Custody-Related Death Investigation

SUMMARY

Approximately seven hours after his initial booking at the Santa Barbara County Northern Branch Jail on August 29, 2024, an inmate (AAO) suffered a traumatic head injury when he fell from standing height onto the linoleum floor of his housing unit due to an apparent seizure. After spending 19 days in the hospital and undergoing significant medical intervention, AAO was pronounced dead on September 17, 2024.

The 2024-2025 Santa Barbara County Grand Jury (Jury) investigated the facts and circumstances surrounding AAO's arrest and subsequent booking, intake health screening, incarceration, and injury at the Northern Branch Jail. In this case, the Jury found deficiencies and limitations relating to the intake screening process and the electronic health record, which ultimately meant that medical staff could not and did not make fully informed decisions regarding AAO's health needs and risks when he arrived at jail. The Jury further identified a lack of communication regarding inmate health risks an area of concern. The Jury offers its findings and recommendations with the intention of improving system-wide operations at our local jails.

BACKGROUND

The Grand Jury's Purpose in Death-in-Custody Investigations

Pursuant to its duties outlined in California Penal Code §919(b), the Santa Barbara County Grand Jury investigates the deaths of inmates that occur within Santa Barbara County's jails, including the deaths of those who were hospitalized following an in-custody incident or injury. The Jury's death-in-custody investigations are conducted with the primary aim of improving the conditions of and the care provided to inmates within Santa Barbara County's correctional system.

Narrative and Timeline of the Present Case

This Report details the case of inmate AAO—a Spanish-speaking man who was 40 years old at the time of his death. AAO suffered from homelessness, struggled with alcohol use, and had been incarcerated in the County's jails on multiple occasions in, but not limited to, the years 2022, 2023, and 2024.

On August 29, 2024, at approximately 11:30 a.m., AAO was arrested by officers of the Santa Maria Police Department on a felony no-bail warrant for a violation of probation. At the time, AAO was calm, cooperative, and seemingly sober. He was taken into police custody without any

use of force. Of note, AAO was asked in Spanish by arresting officers if he needed or wanted medical attention and answered that he did not have any issues requiring attention. AAO was transported directly to the Northern Branch Jail (NBJ) and arrived at approximately 12:30 p.m.

Medical staff completed AAO's medical receiving screening within 40 minutes of his arrival at the NBJ. Medical staff briefly reviewed AAO's known medical history before joining him in an exam room, noting that AAO had a history of alcohol withdrawal as reported on the receiving screening form from his last incarceration and an alcohol withdrawal alert in his chart. AAO spent approximately seven minutes in the exam room and reportedly communicated with medical staff by means of an English-Spanish interpreter on a language line. During this health screening interview, which consists of over 70 questions that require verbal answers from the patient, AAO denied having any chronic or acute medical problems. While answering affirmatively that he is a user of alcohol, he denied having experienced withdrawal relating to his drinking. AAO's mood was notably anxious to medical staff during this intake.

Based on his answers and the RN's observations, AAO was medically cleared by approximately 1:10 p.m. for placement in a holding cell. The intake medical staff did not communicate any information regarding the patient's history of alcohol withdrawal, nor did she communicate her finding that the inmate was demonstrating notable signs of anxiety. At this time, deputies removed AAO's handcuffs, and following a quick pat-down search, he joined another inmate in a holding cell in the booking area. AAO's six-hour stay in this holding cell was punctuated by two short excursions: one at approximately 3:30 p.m. for a 10-minute classification interview with a custody deputy, and a second at approximately 4:20 p.m. for fingerprinting and a photograph. At around 4:55 p.m., a third inmate joined them in the holding cell. At 5:00 p.m., deputies delivered a packaged dinner to AAO in the holding cell, which he readily consumed. Overall, in the course of those six hours in the holding cell, AAO was anxious and frequently fidgeted with his hands, though he retained the ability to follow the instructions of custody deputies and communicate with others.

At approximately 7:20 p.m., AAO was taken from the holding cell and escorted to a dress-in room, where he took a shower and received jail clothing. Exiting the dress-in room at 7:45 p.m. in clean clothing, AAO was escorted by two movement deputies to the booking area to undergo a full-body x-ray scan. At this time, AAO's eyes appeared glassy and bloodshot. Once deputies had established that AAO was clean of any contraband, he joined another inmate for an escort to their assigned housing cells in B-Unit. At approximately 7:50 p.m., the two movement deputies handed off AAO and the other inmate through a sallyport (a controlled access point) to the custody deputy who was supervising B-Unit. During this initial period of over seven hours, there was no documentation of any handoff communication between staff regarding AAO's alcohol withdrawal alert or his anxiety, which was noted during the receiving screening.

Within a minute of walking into the housing unit, AAO became unresponsive while standing. Having noticed AAO's blank stare, bloodshot eyes, and dilated pupils, a deputy in B-Unit began waving his hands in front of AAO's face in an attempt to get his attention. Within seconds, AAO jolted his right arm upward, became rigid, and fell, striking the left side of his head on the linoleum floor without any attempt to break or cushion his fall. AAO continued to seize on the floor as blood flowed from his head.

After a man-down radio call, other custody staff and medical staff arrived within two minutes. During this time, AAO was conscious but disoriented and at times combative towards those providing emergency care. Following the application of a cervical collar at 7:55 p.m., a group of custody staff and medical staff remained with AAO until he was loaded on a gurney by paramedics, removed from the NBJ, and taken to the local hospital at approximately 8:20 p.m.

Emergency surgery after his arrival at the hospital revealed severe brain damage from bleeding due to recent head trauma. AAO spent the last 19 days of his life at Marian Regional Medical Center in Santa Maria, succumbing to the complications of his head injury on September 17, 2024. Both the Coroner's report and treating physicians concluded that AAO's death could only have been caused by brain injury from his fall in the jail. The Coroner's report and autopsy report revealed that AAO fell because of a seizure, though the cause of his seizure remains unknown.

METHODOLOGY

The Jury obtained the information contained in this Report from a number of sources:

- The Jury reviewed the documentation provided by the Santa Barbara County Sheriff's Office (SBSO) of AAO's stay at the NBJ. This documentation included booking and classification documents, internal emails, audio recordings of interviews, security camera recordings of AAO's movements inside the NBJ, and, soon after, AAO's autopsy report.
- The Jury surveyed AAO's health records—both those maintained by California Forensic Medical Group, Inc. (Wellpath) as well as those generated by AAO's stay at Marian Regional Medical Center after his injury
- The Jury considered the County's previous and current contracts with Wellpath, the *Murray* Remedial Plan, reports on the County's progress in implementing the *Murray* Remedial Plan, several policy manuals, and previous Grand Jury reports
- The Jury consulted several published guidelines, including the National Commission on Correctional Health Care's (NCCHC) *Standards for Health Services in Jails* (2018), the American Society of Addiction Medicine's (ASAM) *Clinical Practice Guideline on Alcohol Withdrawal Management* (2020), and the U.S. Department of Justice's (DOJ) *Guidelines for Managing Substance Withdrawal in Jails* (2023)

- The Jury inspected the Northern Branch Jail and followed the path taken by AAO through the facility
- The Jury received a demonstration from medical staff on the electronic health record (EHR) software employed by Wellpath
- The Jury examined the bodycam and dashcam footage of AAO's arrest
- Finally, the Jury conducted over 20 interviews with individuals knowledgeable of the events and matters at issue in this Report, including custody staff and Wellpath medical staff who interacted with AAO on the day of his injury. Other individuals questioned include medical staff who provided emergency care to AAO at the hospital and Coroner's Bureau staff who worked on AAO's case after his death.

DISCUSSION

The following sections of this Report detail the Jury's observations about the intake health screening process at the jails, the organization and display of important health history in the EHR maintained by Wellpath, the process for initiating withdrawal monitoring for at-risk inmates, the health-related training required for custody staff, and the sharing of patient medical information between medical staff and custody staff. These observations are joined by the Jury's analysis of how the facts of AAO's case indicate deficiencies and limitations in some of these areas.

Overview of the Receiving Screening Process

Since 2017, Santa Barbara County has contracted with Wellpath to provide medical and mental healthcare to those incarcerated in Santa Barbara County's jails. As a part of its contractual obligations, Wellpath staffs the jails with Registered Nurses (RNs), who are responsible for completing initial health screenings of arrestees when they arrive at jail. RNs are instructed to complete these health screenings as soon as possible, and at a minimum, within two hours of an arrestee's arrival barring exigent circumstances. The RN completes a receiving screening form during this intake, which takes account of—but is not limited to—the arrestee's vital signs, current medications, mental status, chronic health conditions, and acute problems such as physical trauma or substance withdrawal. Apart from the taking of an arrestee's vital signs, a supplemental COVID test, and the listing of an arrestee's allergies and medications, the receiving screening consists of approximately 13 pages of binary (yes-or-no) and multiple-choice questions. While most questions require the arrestee to respond verbally, a series of observational questions require the RN to input answers directly. If the RN determines that the arrestee does not need immediate medical evaluation or care at a hospital, the arrestee will be cleared to enter custody in the jail.

The receiving screening form, once completed, becomes part of the health record that Wellpath maintains for each patient. If an arrestee has previous health records on file from prior

incarcerations, the RN is additionally required to review this history in the EHR during the intake screening process.

This immediate health screening serves a critical purpose: it is designed to enable jail staff to quickly obtain information on an arrestee's physical and mental health status before the arrestee is housed as an inmate, providing a means by which a new arrival's health needs can be addressed quickly and accommodated appropriately. In many instances, those who are cleared for housing at the jail still require monitoring, treatment, or accommodations for their conditions. Examples include inmates' needs for mobility devices, medications, and monitoring and treatment for potential intoxication and substance withdrawal symptoms.

Patient Medical History in the Electronic Health Record

One of the challenges inherent to the receiving screening process is its inevitable reliance on the self-reporting of health information. Simply put, arrestees are not always willing to disclose or able to recall all of the health information asked of them during the screening interview. While information from arresting officers and the RN's clinical observations and judgment are important supplements to any self-reported information, medical intake staff could also consult prior health records if an arrestee has been incarcerated in one of Santa Barbara County's jails within the past seven years. In AAO's case, his prior health records at the jail contained information that was crucial for evaluating his health risks and needs when he was brought to the NBJ on August 29, 2024.

AAO consistently indicated to jail medical staff over the course of many incarcerations that he was a long-time user of alcohol who still actively drank, and this was reflected on forms in the EHR. Additionally, the Jury found that AAO had suffered from delirium tremens as a result of alcohol withdrawal within the past year, and that such information could also be found in prior receiving screening forms in the EHR. These answers automatically generated a permanent alert in AAO's chart for alcohol withdrawal. AAO had also undergone alcohol withdrawal monitoring in the jail as recently as 2023 following an arrest for public intoxication. During that period of recognized withdrawal risk in 2023, AAO was prescribed a benzodiazepine to be taken every eight hours, evaluated every eight hours with a symptom severity scoresheet, given vitamins and minerals every 24 hours, and assigned to a bottom bunk for five days.

An additional risk factor that could have been recognized during intake involved the fact that AAO had suffered a head injury as a result of an altercation during a previous incarceration at the NBJ in March 2024. With a large bump on his left temple resulting in a moderate degree of discomfort, AAO was taken to an emergency room via ambulance. The Jury's investigation revealed that AAO had a history of brain injury dating back to at least 2021, though all such developments prior to the incident in March 2024 would have occurred outside of the jail and therefore would not have been noted in the EHR at the jail. This history was verified by evidence of old hemorrhage from

prior brain trauma noted during AAO's initial emergency brain operation at Marian Regional Medical Center following his seizure and fall at the NBJ. The March 2024 head injury was noted in the EHR, but only in a sick call note. In any case, the note recounting AAO's head injury from March would have been sufficient in itself to establish a history of head injury and possible traumatic brain injury when his medical records were reviewed upon intake on August 29, 2024.

While alcohol withdrawal typically begins with milder symptoms such as tremors, anxiety, nausea, and sweating in the six to 12 hours after cessation or a significant reduction in alcohol intake, in some individuals—especially those with a history of withdrawal seizures, underlying seizure disorders, or brain injury—an alcohol withdrawal seizure might occur without any preceding signs or symptoms. While AAO was not placed on withdrawal monitoring following his intake screening despite his history and risk, the Jury discovered that medical staff did not notice all of this history while reviewing his chart at intake due to its organization.

There is no internal policy that governs how an RN is supposed to review a returning patient's medical and mental health history in the EHR during intake. However, the Jury learned that RNs, as a standard practice, are expected to review patient alerts, summary sheets, and previous intake forms prior to conducting the receiving screening interview. In AAO's case, a review of his medical history consistent with this typical practice was completed. However, the note describing AAO's head injury from March 2024 could not have been readily noticed during intake because the injury was not included in his master problem list, in a separate list of alerts, or in any previous receiving screening forms. In fact, AAO's master problem list in the EHR was completely blank despite his prior head injury at the NBJ and his known alcohol use and withdrawal history.

The County's previous and current contracts with Wellpath state in section 10.4 (under Exhibit A, Statement of Work) that the contractor "shall maintain a comprehensive and accurate Problem List in each medical record." The importance of that provision is obvious. Incomplete problem lists can compromise quality of care and put patients at risk. And while AAO's medical record as a whole contained a great deal of information regarding the general state of his health and health risks, an informed decision about AAO's risk-based need for alcohol withdrawal monitoring should not have required an RN at intake to read every note, form, and flowsheet in his extensive medical record. Accurate and comprehensive problem lists, alerts, and other summary sheets should allow RNs conducting intakes to better review, identify, and address the specific needs of returning patients without the need to search the entire medical record for possible health issues and other concerns.

Per a Service Level Agreement (SLA) outlined in Exhibit H of the County's new contract with Wellpath, approved by the Board of Supervisors on April 1, 2025, the County has identified incomplete master problem lists as an area of concern. If Wellpath does not achieve a 90 percent

compliance threshold in ensuring that inmates "have an accurate problem list in their medical records," the organization may face monetary penalties moving forward.

Initiation of Withdrawal Monitoring and Treatment

Previous Santa Barbara County Grand Jury reports have found that the first few days of an inmate's incarceration are the most critical, and the Jury finds that this case is no different. With the sudden need to adjust to a new lifestyle within the jail after an arrest, inmates' health—both physical and mental—might be put under a great deal of strain. Withdrawal from drugs or alcohol in new arrivals at the jail is a prime example of this.

The Jury collected data from the SBSO showing that of approximately 800 inmates at both of the County's jails on one day in March 2025, 175 were marked with an alert for drug withdrawal, and 68 had alerts for alcohol withdrawal. These numbers exclude an additional 48 alternative sentencing inmates, such as those on house arrest, who also have alerts for either drug or alcohol withdrawal. Per the NCCHC, intoxication resulting in subsequent withdrawal or related injury is one of the leading causes of death in jails. Such a common and potentially life-threatening condition requires clear, objective criteria for when an inmate should receive monitoring or treatment.

Current Wellpath policy states that the initiation of withdrawal monitoring or treatment is based on a patient's risk, history, and, ultimately, an order by a health care provider. An RN is required to evaluate a patient's risk and collect a history by asking a series of questions during the receiving screening. Specifically on alcohol use and withdrawal, the receiving screening asks the following questions:

- Do you use alcohol?
- Type?
- Amount?
- Date of last use?
- Frequency of use?
- Duration of use?
- Prior withdrawal (Tremors, Seizures, DTs)?
- Date of last withdrawal?
- Currently withdrawing?

AAO reported that he used alcohol during his two most recent intake screenings, one in May 2024 with the other being this most recent arrest in August 2024. In May 2024, AAO reported using alcohol one to five times per week, drinking three to four beers at a time. However, during his intake in August 2024, AAO reported only drinking one to three days per month, drinking one to two beers at a time. And while AAO reported having recently experienced delirium tremens during his May 2024 screening, he did not report any history of prior withdrawal episodes during his

August 2024 intake. Importantly, the date of AAO's last use of alcohol was left blank on his August 2024 receiving screening form; this omission left medical staff in the dark about a critical risk factor.

As the DOJ suggests in its specific guidance for management of withdrawal in jails, any new arrival who is symptomatic, reports regular heavy drinking, or "reports past-week alcohol use and a history of complicated alcohol withdrawal," such as a history of delirium tremens, should be referred for immediate clinical assessment. The DOJ guidelines also state that any new arrival who reports to be a risk for withdrawal or who "reports recent alcohol use below the threshold specified for immediate clinical assessment AND does not report a history of complicated alcohol withdrawal" should still be monitored for the emergence of withdrawal symptoms.

While AAO's self-reported alcohol use patterns would not meet the definition of "unhealthy alcohol use" under ASAM's withdrawal guidelines, which Wellpath staff are required to adhere to under section 1.2A of the County's contract with Wellpath, his anxiety and affirmative answer to alcohol use at intake combined with his withdrawal history documented in the EHR were important factors to consider regarding potential treatment or monitoring. As ASAM's guidelines indicate, "evaluating risk as opposed to current presentation is recommended" since "signs and symptoms can escalate quickly, and the trajectory of alcohol withdrawal can vary considerably among patients."

Monitoring would have been beneficial in this case in at least one important way: It would have led to closer and regular evaluation by medical staff of AAO with a symptom severity assessment scale.

While the Jury learned that identifying when an essentially asymptomatic patient needs withdrawal monitoring can feel like a gray area for some intake medical staff, the County has recently taken steps to address this as an area of general concern. An SLA outlined in Exhibit H of the County's new contract with Wellpath requires that Wellpath "maintain a written policy to provide adequate monitoring to patients experiencing drug and/or alcohol withdrawal consistent with" the DOJ's guidelines outlined above, explicitly including "an evidence-based screening" upon intake for withdrawal risk. Wellpath could face monetary penalties in the future if it fails to meet a compliance threshold of 100 percent.

Health-Related Training for Custody Staff

The Jury recognizes that the custody staff in our local jails have an important and stressful job with demanding responsibilities: They work closely with incarcerated individuals day in and day out to help ensure the functioning of a fair and humane criminal justice system in the County. With the responsibility of supervising incarcerated individuals, custody staff by their position are the most readily available to identify inmate problems in the facility and are the first to respond to

emergencies. In that line of thinking, as the NCCHC states in its standards, custody personnel have an important part to play "in the early detection of illness and injury."

Per NCCHC standards, biannual health-related training for correctional officers is considered essential and is required for NCCHC accreditation. Required topics of training include, but are not limited to, acute manifestations of certain chronic illnesses, adverse reactions to medications, and intoxication and withdrawal. Section 10.2 of the County's contract with Wellpath as well as internal Wellpath policy promulgate guidelines for biannual training of custody officers that include all of the areas required for NCCHC accreditation. At the County's jails, it is Wellpath's contractual obligation to provide such trainings in ways that foster interaction between medical staff and custody officers. Additionally, section 1.2C of the Wellpath contract, both previous and current, specifically requires annual training on withdrawal:

> The Contractor shall ensure that all health care and custody staff are trained in recognizing the signs and symptoms of withdrawal from drugs, alcohol, and other substances in the period following reception and assignment to housing. Training shall be conducted annually at a minimum and include withdrawal timelines, signs and symptoms to a variety of substances common and uncommon to the local population.

Section IX of the *Murray* Remedial Plan also stipulates that custody staff receive training on "general correctional health care issues, including… recognizing different types of medical and mental health conditions and appropriate responses." Per the Remedial Plan, custody staff shall receive at least eight hours of such training biannually, and the "County shall keep records documenting all such trainings and training participants."

AAO's case demonstrates why such training is essential: He spent the vast majority of his approximately seven pre-injury hours at the NBJ interacting solely with custody staff and other inmates. In such a scenario, it is custody staff who are best positioned to notice any acute health needs that may have been missed during the receiving screening or that emerge or increase in severity soon after intake. As the DOJ recommends in its withdrawal guidelines, "custody staff should be alert to emerging signs and symptoms of withdrawal in individuals who initially screen negative, particularly in the first 72 hours after intake" because new arrivals "may not be forthright about recent substance use or withdrawal risk."

The Jury learned that when AAO was interacting with custody staff, his eyes were noticeably altered—glassy, bloodshot, and dilated, by several descriptions—for at least five minutes before his fall. However, these symptoms were not reported to medical staff before his fall. These symptoms are consistent with alcohol withdrawal, but only one person could recall associating in the moment the observed symptoms with drug or alcohol use, mentioning intoxication specifically.

Consequently, the Jury inquired into the extent of the health-related training actually performed for the benefit of custody staff. After extensive investigative efforts, which included the questioning of multiple supervisors and employees at both the SBSO and Wellpath, the Jury has found reason to believe that the jails in the County are currently meeting NCCHC biannual health-related training requirements.

As the County continues to pursue NCCHC accreditation for the NBJ, the Jury emphasizes that the purpose of such training per the NCCHC is to ensure that custody staff "are trained to recognize the need to refer an inmate to a qualified health care professional." While AAO's eye-related symptoms were noticed by custody, no action was taken to alert medical staff of the observation.

Sharing of Inmate Health Information

A 2022-23 Santa Barbara County Grand Jury report titled "Death on Electronic Monitored Home Release" touched on the issue of a lack of information sharing between the County's healthcare contractor at the jails and the SBSO and Probation Department. All County parties agreed in the aftermath of that report's publication that important exemptions in federal law under HIPAA allow information sharing when it is necessary to protect the health and safety of the patient or others.

Currently, there are certain instances in which medical staff share a limited amount of patient health information with custody staff to ensure inmate and staff safety. One such example of this practice is the use of a medical treatment order (MTO) when such a form is generated by medical staff. For example, if medical staff determine during intake that an arrestee needs to undergo sobering or withdrawal treatment, they will generate an MTO and provide a copy to custody by email to ensure that custody staff are aware of the patient's needs. Another potential example of information sharing, the Jury learned, are some of the alerts that appear in an inmate's file in the Jail Management System (JMS), which is used and maintained by custody staff. For example, alerts such as "diabetes" will appear in the alerts section of the JMS for a diabetic inmate. Computers located throughout both jails give custody staff ready access to the JMS, even within housing units in many instances.

Given the principle that custody staff have an important role to play in the detection of illness and injury, and should receive training to that effect, any basic information that could increase custody's awareness of an inmate's known areas of risk could save lives. As the DOJ asserts in its guidelines on withdrawal, both "health care and custody staff should be alert to… the risk of withdrawal in all new arrivals," and should therefore foster "a sense of teamwork" with each other to facilitate "a unified response to substance withdrawal."

In AAO's case, custody staff as a whole were not made aware of his alcohol withdrawal risk by medical staff directly or by an alert in the JMS despite the existence of AAO's alcohol withdrawal alert in the EHR. As a matter of fact, there is no current process or requirement for handoff

communication between the intake nurse and custody staff following medical evaluation. And while custody's interactions with AAO during the hours-long booking and classification process presented an opportunity to watch for possible signs or symptoms of withdrawal as they emerged, custody staff had no awareness that AAO was at any greater risk than any other inmate.

The ability for custody to preliminarily identify at-risk inmates through information sharing with medical staff, as allowed by law, would be valuable in cases where withdrawal monitoring or treatment was missed or not initiated at intake, as in AAO's case. A system of shared alerts and requirements for handoff communication could allow custody staff to gain awareness of inmates' need-to-know health risks within hours of their arrival at jail. Without such awareness, custody staff's ability to supervise and care for inmates with health concerns is undoubtedly compromised.

CONCLUSION

The first 72 hours of an inmate's arrival at jail is a time of particular sensitivity, requiring careful attention from medical staff and custody staff. In the course of this custody-related death investigation, the Jury identified a number of areas relating to the screening and observation of new arrivals at the County's jails that require improvement.

An incomplete master problem list in the electronic health record, which meant that medical staff could not accurately assess whether AAO needed alcohol withdrawal monitoring or not, encompasses important areas where AAO's case demonstrates shortcomings in provided medical care at the County's jails. Two Service Level Agreements in the County's new contract with Wellpath demonstrate that the County is taking steps to correct these deficiencies. A lack of communication regarding withdrawal risk between medical staff and custody staff, or between their respective information systems, was also identified as an area of concern by the Jury.

With increased oversight by County agencies over Wellpath's operations at the County's jails following the signing of the new contract in April 2025, the Jury is increasingly hopeful that the concerns it raises in this Report will result in system-wide improvements at the jails.

COMMENDATION

The County has taken important steps to implement oversight mechanisms at the jails to improve Wellpath's compliance with the new contract and the jails' adherence to national care standards. The Jury commends the Santa Barbara County Board of Supervisors, the Sheriff's Office, the County of Santa Barbara Health Department, the Santa Barbara County Department of Behavioral Wellness, and their staff for their recent work in these pursuits.

FINDINGS AND RECOMMENDATIONS

Finding 1: Because of the lack of an accurate and comprehensive master problem list in AAO's electronic health record, Wellpath medical staff did not make fully informed decisions regarding AAO's health needs and risks when he came to the Northern Branch Jail on August 29, 2024.

Recommendation 1a: The Grand Jury recommends that the Board of Supervisors instruct the County of Santa Barbara Health Department to conduct systematic audits of inmates' charts in the electronic health record to determine the extent to which master problem lists maintained by Wellpath accurately and comprehensively reflect inmates' known health problems. To be completed by July 1, 2026.

Recommendation 1b: The Grand Jury recommends that if non-compliance is discovered in the form of incomplete or inaccurate master problem lists so as not to meet performance measures established by the Wellpath contract, the County exact monetary penalties pursuant to the Service Level Agreement (Area 5. Incarcerated Person Problem List) in the new contract.

Finding 2: AAO's known medical history at the jail provided clear indicators for serious alcohol withdrawal risk, but no such identification occurred.

Recommendation 2a: The Grand Jury recommends that the Board of Supervisors instruct the County of Santa Barbara Health Department to conduct audits to determine if Wellpath staff are appropriately identifying, monitoring, and treating at-risk inmates consistent with the U.S. Department of Justice's *Guidelines for Managing Substance Withdrawal in Jails*. To be completed by July 1, 2026.

Recommendation 2b: The Grand Jury recommends that if non-compliance is discovered in the form of missed cases of withdrawal monitoring or treatment, or performance of monitoring or treatment duties inconsistent with the U.S. Department of Justice guidelines so as not to meet performance measures established by the Wellpath contract, the County exact monetary penalties pursuant to the Service Level Agreement (Area 1. Withdrawal Management).

Finding 3: Custody staff were not aware that AAO had an alcohol withdrawal alert or history because it was not communicated to them by medical staff or by means of an alert in the Jail Management System, though such communication would have been valuable.

Recommendation 3a: The Grand Jury recommends that the Sheriff's Office require a standardized verbal communication process upon inmate handover from the registered nurse performing the health receiving screening to the relevant on-duty classification deputy, specifically

requiring the sharing of health-related findings or history insofar as necessary to provide for the health and safety of the inmate or others. To be implemented by January 1, 2026.

Recommendation 3b: The Grand Jury recommends that the Sheriff's Office develop a comprehensive and automatic system of shared health alerts between the healthcare contractor's electronic health record and the Jail Management System so that critical health-related alerts appear automatically in the Jail Management System. To be implemented by January 1, 2026.

This report was issued by the Grand Jury with the exception of a Grand Juror who wanted to avoid the perception of a conflict of interest. That Grand Juror was excluded from all parts of the investigation, including interviews, deliberations, and the writing and approval of this report.

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

Santa Barbara County Board of Supervisors – 90 days

Findings 1, 2, 3
Recommendations 1a, 1b, 2a, 2b, 3b

Santa Barbara County Sheriff's Office – 60 days

Findings 1, 2, 3
Recommendations 3a, 3b