Attachment H

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SANTA BARBARA COUNTY

BILL BROWN
Sheriff-Coroner

CRAIG BONNER
Undersheriff

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Phone (805) 681-4100 · Fax: (805) 681-4322
www.sbsheriff.org

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Buellton, CA 93427
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66 S. San Antonio Road
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4436 Calle Real
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(805) 554-3100

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Santa Barbara Division
1105 Santa Barbara Street
P O Box 690
Santa Barbara, CA 93102
Phone (805) 568-2900

Santa Maria Division
312 E. Cook Street, "O"
Santa Maria, CA 93456
Phone (805) 346-7430

August 25, 2025

Stacy Mezzetta de Cossio
Foreperson
2024-2025 Santa Barbara Civil Grand Jury
Grand Jury Chambers
Santa Barbara County Courthouse
1100 Anacapa Street
Santa Barbara, California 93101

Re: Response to the Santa Barbara County Grand Jury Report Entitled "Another Suicide in Santa Barbara County Jail."

Dear Foreperson, Mezzetta de Cossio,
Enclosed, please find the Santa Barbara County Sheriff's Office response to the 2024-2025 Santa Barbara County Grand Jury Report entitled "Another Suicide in Santa Barbara County Jail."

As requested in the report, the Sheriff's Office responds to Findings 1, 2, 3, 4, 5, 6 and 7 and Recommendations 1a, 1b, 1c, 1d, 2, 3a, 3b, 4, 5a, 5b, 6a, 6b, 7a, and 7b.

Should you have any additional questions, please feel free to contact me at (805) 681-4100.
Sincerely,

BILL BROWN
Sheriff-Coroner
Enclosure

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Santa Barbara County Sheriff's Office
Response to the Santa Barbara County Grand Jury 2024-2025 Report
"Another Suicide in Santa Barbara County Jail"
Findings and Recommendations
Santa Barbara County Sheriff's Office: 60 Days
Finding(s): 1, 2, 3, 4, 5, 6 and 7
Recommendation(s): 1a, 1b, 1c, 1d, 2, 3a, 3b, 4, 5a, 5b, 6a, 6b, 7a, and 7b

Finding 1: CC should not have been transferred to an observation cell with a telephone cord.

Sheriff's Office Response: Disagree partially with an explanation
The cell that CC was placed into on the morning in question was not a cell typically used for observation. That is because all of the cells typically used for observation were occupied. While CC was placed into a cell with a telephone and cord, the phone's cord had been shortened to approximately 12 inches. This was the shortest telephone cord that the service provider offered as a replacement, and, at the time, was believed to be ligature resistant. These were installed in an effort to prevent suicides following an assessment conducted by custody and Wellpath staff, in consultation with the telephone services provider.

Recommendation 1a: The Grand Jury recommends that the Sheriff's Office will not place an inmate deemed by mental health staff to have been recently suicidal in an observation cell that contains a telephone cord. To be implemented no later than January 1, 2026.

Sheriff's Office Response: Has been implemented, with a summary of the implementation actions taken.
Immediately following this incident, the Sheriff's Office initiated a telephone cord removal project to initially include all the holding cells located in the IRC, and cells in New East housing (single cell restrictive housing) that could potentially be used for Mental Health Observation. The work was completed on 11/25/24. The Sheriff's Office and Wellpath also formalized a process in which

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the mental health professional (MHP) and the Lead Supervisor confer on appropriate placement for individuals placed on observation.

Recommendation 1b: The Grand Jury recommends to the Sheriff's Office that if no cordless mental health observation cells are available when stepping down a potentially suicidal inmate from a safety cell, a Jail mental health provider should seek to transfer that inmate to the closest facility that can offer adequate protection. To be implemented no later than January 1, 2026.

Sheriff's Office Response: Has been implemented, with a summary of the implementation actions taken.
The Sheriff's Office formalized and implemented a specific suicide watch step-down procedure, including collaborative safety cell clearances at both the Main Jail and NBJ in December 2024. The Sheriff's Office and Wellpath also formalized a process in which the MHP and the Lead Supervisor confer on appropriate placement for individuals placed on observation.

Recommendation 1c: The Grand Jury recommends to the Sheriff's Office that if no cordless mental health observation cells are available when stepping down a potentially suicidal inmate from a safety cell in the Main Jail, a Jail mental health provider must contact the County's psychiatric holding facility, the Crisis Stabilization Unit, a local hospital, and the Northern Branch Jail to determine if a bed offering an appropriate level of care is available. To be implemented no later than January 1, 2026.

Sheriff's Office Response: It will not be implemented with an explanation of why.
Since the telephone cords have been removed from three additional cells that may be used for observation, the Sheriff's Office does not anticipate there will be a situation that requires the level of response recommended by the Grand Jury beyond potentially transferring incarcerated persons to available space within the Sheriff's facilities (i.e. Main Jail to NBJ or vice versa). There are already protocols with specific clinical criteria for transfer to the Crisis Stabilization Unit or Psychiatric Health Facility, however, lack of step-down cell

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availability is not one of those criterium. Should another situation arise where there is no available step-down cell, alternatives will be explored by WellPath MHPs, Custody staff, and Custody Administrators, including re-evaluating current occupants of designated step-down cells for re-housing, transfer to the other Sheriff's jail facility, and/or constant supervision by Custody staff until a suitable cell is available, prior to any placement.
Recommendation 1d: The Grand Jury recommends that the Board of Supervisors negotiate a memorandum of understanding with San Luis Obispo County, Ventura County, Los Angeles County, and other neighboring counties in California setting procedures for transferring and accepting inmates with severe mental health disease when no other safe housing options are available. To be implemented no later than January 1, 2026.

Sheriff's Office Response: It will not be implemented with an explanation of why.

The Sheriff's Office does not anticipate the need for transferring incarcerated persons suffering from severe mental health disease to another county's facilities. As such, brokering agreements to accept and house our incarcerated persons with other counties is unnecessary. In order to require an agreement with other county facilities, we would need to exceed the capacity of appropriate facilities in our County, to include the Psychiatric Health Facility (PHF), Crisis Stabilization Unit and local area hospitals. Before seeking to send one of our incarcerated persons out of the County, the Sheriff's Office can request that BWell inquire into transferring non-incarcerated patients within its PHF or CSU to other counties, in order to free up appropriate bed space for incarcerated persons. In the highly unlikely event that such facilities were not available or appropriate, we would request assistance from adjacent County jails on an as-needed basis.

Finding 2: Wellpath staff failed to comply with existing policy requiring a psychiatric assessment while housed in a safety cell.

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Sheriff's Office Response: Disagree with an explanation.

This process is not necessary, because Sheriff's Office and Wellpath policies require a mental health evaluation by a qualified mental health professional (rather than a psychiatric evaluation conducted by a psychiatrist) within four hours of placement, with the exception of 11pm to 7am, when mental health staff are not on-site. If needed, mobile crisis would be called to conduct a mental health evaluation after hours.

CC had two separate placements within a safety cell, during which she was evaluated by Wellpath MHP's who utilized an evidenced-based suicide risk assessment. CC's mental health condition was variable and she was removed from a safety cell for both placements following the successful completion of collaborative safety plans. She was referred to a psychiatrist with a scheduled appointment on November 13, 2024, but she refused the visit.

Recommendation 2: The Grand Jury recommends that while an inmate is housed in a safety cell, the Sheriff's Office require a Wellpath psychiatrist conduct an evaluation of that inmate. Given that the recommendation is to follow existing policy, to be implemented immediately.

Sheriff's Office Response: It will not be implemented with an explanation of why.

Neither Wellpath's nor the Sheriff's Office policies require a psychiatric assessment for all individuals placed in a safety cell. This recommendation is not necessary, as existing policy requires a mental health *evaluation* by a qualified mental health professional within 4 hours of placement, with the exception of 11pm to 7am, when mental health staff are not on-site.

CC had two separate placements within a safety cell, during which she was evaluated by Wellpath MHP's who utilized an evidenced-based suicide risk assessment. CC's mental health status was variable and she was removed from a safety cell for both placements following the successful completion of

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collaborative safety plans. She was referred to a psychiatrist with a scheduled appointment on November 13, 2024, in which she refused the visit.

Finding 3: A Jail psychiatrist failed to evaluate, diagnose, or treat CC's severe psychiatric illnesses, which were serious shortcomings.

Sheriff's Office Response: Disagree partially with an explanation.

Although the psychiatrist was unable to complete their evaluation due to CC refusing to participate, the psychiatrist did prescribe mental health medication and rescheduled CC's appointment for an evaluation. Diagnoses and treatment require thorough assessments of the individual's symptoms over time, as outlined in the Diagnostic Statistical Manual (DSM-5). This was impossible due to CC's refusal to meet with the psychiatrist.

Recommendation 3a: The Grand Jury recommends that if the on-duty psychiatrist is not available to conduct what Jail medical and mental health staff deem to be an urgent evaluation of an inmate, the Sheriff's Office require Wellpath to designate another backup on-call psychiatrist to conduct such an evaluation. To be implemented no later than January 1, 2026.

Sheriff's Office Response: Has been implemented, with a summary of the implementation actions taken.

The Sheriff's Office incorporated this requirement into the scope of work (Section 15.4.B) of the Agreement with Wellpath that was approved by the Board of Supervisor's on April 1, 2025.

Recommendation 3b: The Grand Jury recommends to the Sheriff's Office that if a stepdown inmate refuses to participate in a psychiatric evaluation, the on-duty Jail psychiatrist be required to obtain and review the inmate's mental health history. To be implemented no later than January 1, 2026.

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Sheriff's Office Response: Has been implemented, with a summary of the implementation actions taken.

Wellpath psychiatrists review the clinical records of patients prior to their scheduled visit with a patient, regardless of whether they were stepped down from a safety cell and regardless of the patient's decision to participate in the visit or not.

Finding 4: During CC's first approximately 23-hour stay in Safey Cell 3, the Sheriff's Office failed to ensure that Wellpath staff comply with policy requiring that the Mobile Crisis Unit be called after 12 hours in a safety cell.

Sheriff's Office Response: Agree

The Sheriff's Office, in partnership with County Health and BWell, monitor compliance of this requirement in the contract with Wellpath. In this instance, notification did not occur as specified in the contract.

Recommendation 4: The Grand Jury recommends that after an inmate spends more than 12 hours in a safety cell, the Sheriff's Office require that Wellpath staff always call the Mobile Crisis Unit to conduct an evaluation and document the call and its outcome in the Jail electronic health record. Given that the recommendation is to follow existing policy, to be implemented immediately.

Sheriff's Office Response: Has been implemented, with a summary of the implementation actions taken.

The current service contract includes these provisions and is actively monitored for compliance by Behavioral Wellness and the Sheriff's Office. Both entities review audits of this data monthly.

Finding 5: There was poor communication regarding CC's mental health history between Jail mental health staff, Mobile Crisis Teams, and outside healthcare providers who treated her.

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Sheriff's Office Response: Disagree partially, with an explanation.

While the Sheriff's Office acknowledges that communication could have been improved in this instance, there were communications made about CC with Mobile Crisis. Wellpath staff communicated with Mobile Crisis on 11/12/24 and requested an evaluation. Mobile Crisis responded and evaluated CC, who was found to not meet criteria for a 72-hour mental health hold (per 5150 Welfare and Institutions Code). Mobile Crisis then communicated this information to Wellpath.

Following the multi-disciplinary in-custody death review, Behavioral Wellness began providing access to their behavioral health records to Wellpath staff in order to improve collaboration, as it was noted that access to BWell records could assist in continuity of care.

Recommendation 5a: The Grand Jury recommends that the Sheriff's Office require additional training for Wellpath mental health providers regarding HIPAA regulations concerning inmates, including defining under what circumstances a mental health provider may legally contact outside mental health providers about an inmate's mental health history. To be implemented no later than January 1, 2026.

Sheriff's Office Response: It will not be implemented with an explanation of why.

WellPath staff are trained in HIPAA regulations and regularly contact outside mental health providers when there is a release of information from the patient allowing the exchange of information and records.

Recommendation 5b: The Grand Jury recommends that the Sheriff's Office require the on-duty registered nurses at the County's jails to request every

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newly arriving inmate at the time of intake to sign a written authorization to release their medical and mental health records and information. To be implemented no later than January 1, 2026.

Sheriff's Office Response: Will be implemented, with an implementation schedule.

Wellpath Registered Nurses conducting intakes of newly-arrived patients provide individuals with the opportunity to sign a universal release of information (ROI) that would allow them to communicate and receive records from other medical and mental health providers. This universal ROI was implemented in February 2025, however we have identified areas of improvement and are working to provide additional training to staff to refine this process. Refinement to the ROI process is expected to be completed by September 1, 2025.

Finding 6: Wellpath staff did not obtain critical health-related documentation from Cottage Hospital or Behavioral Wellness and therefore CC did not receive proper treatment in jail.

Sheriff's Office Response: Disagree partially with an explanation.

In this instance, discharge documentation was provided by Cottage Hospital. However, it did not contain the type of critical health-related information to which the Grand Jury refers. Such information can only be obtained via the use of a release of information that is signed by the patient. Since this incident, the Sheriff's Office has implemented a process to request discharge documentation from any hospital from which an incarcerated person has been treated, and to facilitate the transfer of health-related information when BWell has been called to evaluate an incarcerated person.

Recommendation 6a: The Grand Jury recommends that the Sheriff's Office require Wellpath staff to contact outside healthcare providers, such as

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Phone (805) 686-5000

Sheriff – Coroner Office
66 S. San Antonio Road
Santa Barbara, CA 93110
Phone (805) 681-4146

Main Jail
4436 Calle Real
Santa Barbara, CA 93110
Phone (805) 681-4260

Northern Branch Jail
2301 Black Road
Santa Maria, CA 93455
(805) 554-3100

COURT SERVICES CIVIL OFFICES

Santa Barbara Division
1105 Santa Barbara Street
P O Box 690
Santa Barbara, CA 93102
Phone (805) 568-2900

Santa Maria Division
312 E. Cook Street, "O"
Santa Maria, CA 93456
Phone (805) 346-7430

August 25, 2025

hospitals, physicians, and clinics, to obtain inmates' health records in a timely manner following intake. To be implemented by January 1, 2026.

Sheriff's Office Response: Has been implemented, with a summary of implementation actions taken.

The Sheriff's Office incorporated this requirement into the scope of work (Section 1.1.C.8) of the Agreement with Wellpath that was approved by the Board of Supervisor's on April 1, 2025. The sharing of health records is contingent upon an incarcerated person authorizing the release of records through the use of the universal ROI.

Recommendation 6b: The Grand Jury recommends that the Sheriff's Office upgrade its electronic health record system to allow it to receive patient health information from outside providers via an industry-standard means of internet transmission. To be implemented by March 31, 2027.

Sheriff's Office Response: Requires further analysis, with an analysis completion date of fewer than 6 months after the issuance of the report.

The Sheriff's Office, in partnership with County Health, is exploring transitioning to a different electronic medical record system that would allow the capabilities identified. The County team has held several meetings to discuss potential electronic medical record vendors and the implementation of this project. Transitioning from one electronic medical record provider to a different electronic medical record is a very complex process. The Sheriff's Office will provide the Grand Jury with a response detailing its analysis and expected timeline by December 1, 2025.

Finding 7: The Sheriff's Office did not comply with the Remedial Plan outlined in *Murray v. Santa Barbara County* because it did not provide enough beds at all necessary levels of clinical care and security to meet the needs of inmates with serious mental illnesses, as in CC's case.

Office of the Sheriff

SANTA BARBARA COUNTY

BILL BROWN
Sheriff-Coroner

CRAIG BONNER
Undersheriff

P. O. Box 6427 · 4434 Calle Real · Santa Barbara, California 93160
Phone (805) 681-4100 · Fax: (805) 681-4322
www.sbsheriff.org

August 25, 2025

Sheriff's Office Response: Disagree with an explanation.

The Sheriff's Office disagrees with this finding because the section of the Remedial Plan in the *Murray v. Santa Barbara County* the Grand Jury is referencing (section 3.d.3.a) is specific to specialized mental health units. CC was not placed in a specialized mental health unit at that time because she was on mental health observation. Had she not been under observation, she would have been eligible to be placed into an available specialized mental health unit.

Recommendation 7a: The Grand Jury recommends that the Sheriff's Office provide and maintain safety and observation cells sufficient in number to meet ongoing demands.

Sheriff's Office Response: Has been implemented, with a summary of the implementation actions taken.

Since the telephone cords have been removed from cells intended to be utilized for observation (3 additional locations), the Sheriff's Office affirms that there are a sufficient number of safety and observation cells.

Recommendation 7b: The Grand Jury recommends that the Sheriff Office require custody staff to consider mental health staff's clinical input when determining placement upon discharge from a safety cell and document the reasons when clinical input is not followed.

Sheriff's Office Response: Will be implemented, with an implementation schedule.

The Sheriff's Office formalized and implemented a specific suicide watch step-down procedure, including collaborative safety cell clearances at both the Main Jail and NBJ in December 2024. The Sheriff's Office has refined this process and will complete training of staff and implement this refined procedure before September 1, 2025.

STATIONS

Buellton
140 W. Highway 246
Buellton, CA 93427
Phone (805) 686-8150

Carpinteria
5775 Carpinteria Avenue
Carpinteria, CA 93013
Phone (805) 568-3399

Isla Vista
6504 Trigo Road
Isla Vista, CA 93117
Phone (805) 681-4179

Lompoc
3500 Harris Grade Road
Lompoc, CA 93436
Phone (805) 737-7737

New Cuyama
70 Newsome Street
New Cuyama, CA 93254
Phone (661) 766-2310

Santa Maria
812-A W. Foster Road
Santa Maria, CA 93455
Phone (805) 934-6150

Solvang
1745 Mission Drive
Solvang, CA 93463
Phone (805) 686-5000

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