Attachment A

BOARD OF SUPERVISORS
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COUNTY OF SANTA BARBARA

September 16, 2025

Honorable Patricia Kelly
Presiding Judge
Santa Barbara County Superior Court
County Courthouse
1100 Anacapa Street
Santa Barbara, CA 93101

Reference: Response to Santa Barbara Civil Grand Jury report titled, "Fatal Head Injury at the Northern Branch Jail: A Custody-Related Death Investigation"

Judge Kelly:

Please find attached the Santa Barbara County Board of Supervisors (Board) response to the above referenced Civil Grand Jury Report. As directed by the Grand Jury, all responses are provided in accordance with Section 933.05 of the California Penal Code (PC). Pursuant to PC Section 933 (c) and (d), responses are provided on behalf of the Board of Supervisors.

Sincerely,

Laura Capps, Chair
Santa Barbara County Board of Supervisors

cc: Santa Barbara County Board of Supervisors

Santa Barbara County Board of Supervisors
Response to the Santa Barbara County Grand Jury 2024-25 Report
"Fatal Head Injury at the Northern Branch Jail:
A Custody-Related Death Investigation"

The County values the thorough efforts of the Grand Jury in its investigation of AAO's death. Every death in custody is a tragedy that merits careful assessment of whether the system could have better served that individual, as well as a commitment to continual policy and process improvement. In this case, the Grand Jury's report raised issues related to the intake screening process, the electronic health record, and communication regarding inmate health risks as areas of concern. The Grand Jury's report also included a commendation on important steps taken by the County to implement oversight mechanisms at the jails to improve contractual compliance by California Forensic Medical Group/Wellpath (Wellpath), as well as the jails' adherence to national care standards. The County is aligned with the Grand Jury in its intention of continually improving system-wide operations at our local jails.

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.

The Board of Supervisors disagree partially with an explanation.

A problem list is generated by a provider when a diagnosis is made, either when a patient self-reports and/or upon assessment by the provider. Here, a problem list was not generated because at intake the patient was not under the influence of alcohol, and did not self-report symptoms or history of chronic conditions; traumatic brain injury; recent, regular, and heavy alcohol use; or other risk factors as stated in the Department of Justice (DOJ) Guidelines for Managing Substance Withdrawals in Jails. If any of this information had been reported, it would have triggered a referral to a provider which could have generated a problem list.

In prior incarcerations, a problem list was not generated because AAO was not seen by a physician as he did not report or exhibit chronic care symptoms, and he denied having a traumatic brain injury, substance use disorder, or other issues that would warrant a provider consult. During his March 2024 incarceration, AAO was involved in an altercation and required evaluation at the hospital because a jail medical provider was not on-site. There was no indication of a serious head injury at the time, and he was released from the hospital and did not return to jail. As such, a problem list was not generated as a result of this injury.

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.

This recommendation has been implemented.

The Service Level Agreements (SLAs) within the current Wellpath contract include maintenance of a current and accurate patient problem list within the electronic medical record. This SLA was added as a quality measure to the quarterly audit performed by County Health and Behavioral Wellness (BWell) beginning with the review period of April 1, 2025 through June 30, 2025; this quarterly audit is anticipated to be completed in September 2025.

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.

This recommendation has been implemented.

The current contract with Wellpath includes financial penalties for any non-compliance pertaining to master problem lists.

Finding 2

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

The Board of Supervisors disagrees with an explanation.

As reflected in the response to Finding 1, review of medical records from previous incarcerations indicated inconsistent self-reported alcohol use and withdrawal history. AAO's known medical history did not provide clear or consistent indicators of serious alcohol withdrawal risk. As per the DOJ guidelines, recent, regular, and heavy alcohol use or other indicators are prerequisites for withdrawal monitoring. AAO consistently denied heavy use and withdrawal symptoms in 12 of 15 prior bookings and showed no clinical signs of withdrawal in prior incarcerations. At intake, he reported infrequent alcohol use and no withdrawal history.

Based on AAO's clinical presentation at the time of intake, automatic placement on withdrawal monitoring would not have been warranted.

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.

This recommendation has been implemented.

The SLAs within the current Wellpath contract include ensuring that all incarcerated persons experiencing withdrawals are placed on withdrawal monitoring protocols and those that are meeting withdrawal monitoring thresholds are offered appropriate withdrawal management treatment. This is a quality measure in the quarterly audit performed by County Health and BWell beginning with the review period of April 1, 2025 through June 30, 2025; this quarterly audit is anticipated to be completed in September 2025.

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).

This recommendation has been implemented.

The current contract with Wellpath includes financial penalties for any non-compliance pertaining to withdrawal monitoring or treatment.

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.

The Board of Supervisors disagrees partially with an explanation.

The County recognizes the importance of timely and effective communication between medical and custody staff regarding persons at risk for alcohol withdrawal. The current practice is for the intake registered nurse to initiate a medical treatment order to indicate

that a patient is on withdrawal monitoring and outline necessary precautions (e.g., lower bunk assignment, electrolyte monitoring).

Specific to AAO, as with Findings 1 and 2, County Health's review indicates the treatment plan initiated from intake was based on the findings of the intake screening and the patient's presentation at that time. As stated earlier, based on AAO's clinical presentation at the time of intake, automatic placement on withdrawal monitoring would not have been warranted.

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 recommendation will be implemented.

The Sheriff's Office and Wellpath have a data sharing agreement in place to allow data sharing between the jail management system and the jail electronic medical record. However, the Sheriff's Office is awaiting integration with its updated jail management system in order to implement automated data sharing. The Sheriff's Office reports this will occur before January 1, 2026.