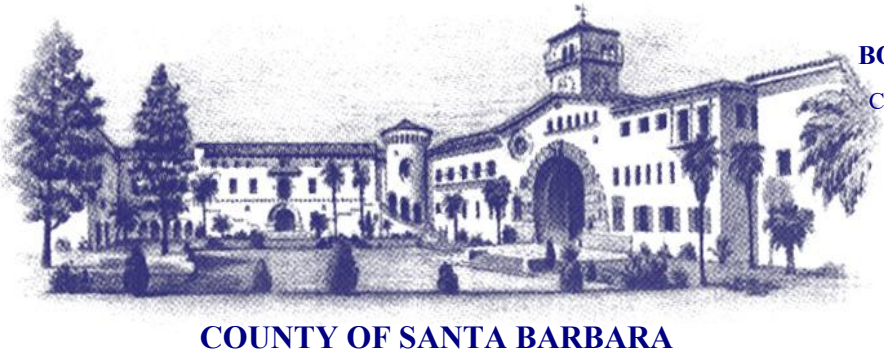
Attachment C



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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, "Preventable Death at the Northern Branch Jail: A Death-in-Custody 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
"Preventable Death at the Northern Branch Jail:
A Death-in-Custody Investigation"

The County values the thorough efforts of the Grand Jury in its investigation of CF's death. Every death in custody is a tragedy that merits careful assessment of how 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 on CF's death identified issues related to jail medical procedure requirements and asserted that CF's death could potentially have been avoided if her complaints of pain had been properly evaluated and diagnosed. As the responses below indicate, the County is aligned with the Grand Jury in its view that every incarcerated individual deserves timely and appropriate access to care. The County mandates such care through existing contractual requirements in the California Forensic Medical Group/Wellpath (Wellpath) contract, and has further elevated this as a Board priority by funding staff resources in the County Health Department to provide regular performance monitoring of Wellpath's contractual compliance.

Finding 1

CF repeatedly complained of abdominal pain for at least two days prior to her death, but these complaints were not assessed by medical staff in accordance with jail medical policy, procedure, and protocol.

The Board of Supervisors disagrees partially with an explanation.

Following County Health's medical record review, the patient's complaints of abdominal pain were not evaluated in accordance with all established protocols to ensure timely and appropriate care. However, Wellpath staff conducted an intake screening and regularly monitored and assessed CF for withdrawal.

Finding 2

Nursing staff at the Northern Branch Jail did not follow an evidence-based process to evaluate or treat CF for her abdominal pain, though such pain assessment forms were available and their use expected.

The Board of Supervisors disagrees partially with an explanation.

Although Wellpath nursing staff did not evaluate or treat the patient's complaints of abdominal pain in accordance with all established protocols, including a more thorough assessment and a focused physical exam, Wellpath staff conducted an intake screening and regularly monitored and assessed CF for withdrawal.

Finding 3

Inmate CF's death might have been prevented if she had received appropriate medical assessment in jail.

The Board of Supervisors disagrees partially with an explanation.

While receiving a more appropriate medical assessment may have prevented CF's death, it is also possible that the assessment might ultimately not have resulted in a different clinical outcome.

Recommendation 3a

The Grand Jury recommends that the Board of Supervisors direct County Health to thoroughly assess the medical care provided to CF by Wellpath. To be implemented by January 1, 2026.

This recommendation has been implemented.

As required by law, all in-custody deaths must undergo a mortality review. Following Board direction in 2023 to strengthen oversight of the jail healthcare services contract, the County and Wellpath collaborated to create a shared death review report inclusive of root cause analysis, findings, and measurable corrective action plans. The County and Wellpath expanded mortality reviews to increase information sharing and strengthen the structure, accountability, and inter-agency coordination. Additionally, County Health's Correctional Healthcare Team and the Behavioral Wellness Department actively participate in all mortality reviews, review all materials and medical records in advance of the reviews, and provide feedback and inquiry during the reviews. As part of the mortality review process for patient CF, County Health co-chaired the Death Review Committee and co-authored the formal mortality review submitted to the Board of State and Community Corrections (BSCC).

Recommendation 3b

Based on the investigation of the care provided to CF, the Grand Jury recommends that the Board of Supervisors direct County Health make public a report identifying opportunities for systemic improvements in the quality of medical care in the County's jails. To be implemented by January 1, 2026.

This recommendation has been implemented.

In 2023, the Board of Supervisors directed County Health to assume greater responsibility in monitoring and advising on the quality of care delivered by Wellpath in the jails. The Board authorized 1.5 FTE positions within County Health, which enabled creation of the Correctional Healthcare Team. The Team provides objective and independent performance

monitoring of the medical and mental healthcare services provided at the County correctional facilities.

County Health performs Wellpath medical record audits on a quarterly basis to assess compliance with contractual service level agreements, which at the adult jail facilities contain 13 measures assessing healthcare service areas including intake medical screenings, continuity of prescription medications, initial health assessments, infectious disease screening, and management of hypertension (high blood pressure).

County Health has identified several focus areas of healthcare monitoring activities in the jails, including review of policies and procedures, clinical adverse events and incidents with the potential to cause an adverse event, communicable disease management, and utilization management. The activities and findings for each of these focus areas are summarized in the Correctional Healthcare Services Monitoring Report publicly presented to the Board of Supervisors.