Attachment F

PREVENTABLE DEATH AT THE NORTHERN BRANCH JAIL

A Death-in-Custody Investigation

SUMMARY

On the fifth day after her incarceration at the Santa Barbara County Northern Branch Jail on March 24, 2025, inmate CF, a 57-year-old woman, was found unresponsive in her cell and could not be successfully resuscitated. The autopsy report concluded that CF died because of peritonitis (infection in the abdominal cavity) caused by a perforated gastric ulcer.

The 2024-25 Santa Barbara County Grand Jury investigated the facts and circumstances surrounding CF's death at the Northern Branch Jail. The Jury found that CF had repeatedly complained of abdominal pain for the last two days of her incarceration. Moreover, the autopsy indicated that CF's stomach had perforated days before her death.

Throughout her incarceration, the medical care provided to CF did not meet numerous jail medical procedure requirements. For example, her complaints of pain were never appropriately evaluated, which meant that CF did not receive treatment. CF was never seen by a physician during her incarceration. Her requests for transfer to an emergency room were not documented nor acted upon by medical staff. As a result, a diagnosis of CF's perforated stomach was never made. Had CF's complaints been evaluated, she would have received treatment for her perforated ulcer, and her death could have been prevented.

While the Sheriff's Office released a statement that CF's death was unavoidable, the Jury concludes that there were opportunities to prevent this death.

BACKGROUND

Timeline of the Present Case

On Wednesday, March 19, 2025, CF, a Lompoc resident, was arrested at her home at 6:35 p.m. by Deputies of the Santa Barbara County Sheriff's Office (SBSO) on a felony no-bail warrant for possessing a firearm and ammunition as a prohibited person. During the booking process at the Northern Branch Jail (NBJ), Deputies documented that CF had chronic back injury, PTSD, and psychosis. During the health receiving screening, medical staff documented that CF denied lower abdominal pain. CF's self-reported prescription use of a narcotic pain medication for chronic back pain was noted during this screening. There was no documentation that CF had ever abused narcotic pain medication, nor that she otherwise utilized other narcotic drugs. CF also denied that she had ever experienced withdrawal symptoms related to her use of a narcotic pain medication.

CF was medically cleared by the registered nurse at 9:44 p.m. and was placed in a holding cell in the booking area at 9:55 p.m. Rather than bridge, or continue, CF's narcotic prescription, a nurse practitioner ordered via telephone that CF be placed on an opioid withdrawal monitoring protocol, which included prescriptions for medications to treat vomiting, nausea, and diarrhea and nursing assessments every eight hours. In addition, the telephone order included administration of acetaminophen (Tylenol) for pain. CF did not exhibit any signs of opioid withdrawal when she was first evaluated for symptoms at 1:00 a.m. on Thursday, March 20th. When the booking process was completed, CF was removed from the holding cell at 1:17 a.m. and was escorted to G Unit as a minimum-level, general population inmate.

On several different occasions throughout the day on March 20th, CF was evaluated for withdrawal symptoms, but scored so low on each assessment that it raised no concerns.

On March 21st, CF was transported to court for her arraignment along with another female inmate from G Unit. CF left the NBJ at 7:14 a.m. for her hearing, where she was remanded back to custody. She returned to jail at 3:54 p.m. Following her return to the jail on March 21st, CF was seen twice by registered nurses for opioid withdrawal assessments with no issues documented.

On March 22nd, CF was evaluated three times for opioid withdrawal symptoms, with no abnormalities found except an elevated resting pulse rate on two of the assessments.

Early on the morning of March 23rd, custody staff became aware that CF was causing a disturbance in her cell in G Unit. CF was observed to be hyperventilating, moaning, and screaming. At that time, CF described intense abdominal pain and arm pain and indicated that she believed she was having a heart attack. custody deputies removed CF from G Unit and brought her to a waiting cell in the NBJ's clinic at 5:23 a.m. While a member of medical staff reportedly evaluated her while she was in this waiting cell, the Jury has found no documentation in the electronic health record of that medical evaluation. In fact, the forms that nursing staff are expected to complete for documenting pain assessments were not utilized in response to this or any of CF's subsequent complaints of intense pain. The end result of CF's screaming and complaints of pain on the morning of March 23rd was her placement in a mental health observation cell. CF was not seen by a mental health provider until 11:30 a.m. that morning.

During the entirety of her 35-minute encounter with mental health staff on March 23rd, CF was moaning, grunting, and grimacing due to pain. CF stated that her "guts are all twisted up." At this time, the observation cell's floor appeared to be covered in various spots of spit mixed with vomit.

At 10:15 p.m., CF was again assessed by a member of mental health staff. CF again expressed that she was in a great deal of abdominal pain. Medical staff assessed CF at the request of mental health staff at this time. Medical staff stated that CF was experiencing opioid withdrawal symptoms.

During this assessment, a pain assessment form was not utilized, nor was a hands-on examination performed. After CF was administered Tylenol, she was willing to continue speaking with mental health staff for a brief period of time.

At 11:00 p.m., a member of medical staff conducted another withdrawal symptom assessment, this time documenting nausea, loose stool, diffuse discomfort, increasing anxiousness, and an elevated resting pulse rate. CF was repeatedly administered Tylenol each day from March 21st until her death. No other pain medications were administered. The Jury has found no documentation in the medical record whether CF's pain ever improved on this regimen.

On March 24th at approximately 8:15 a.m., CF was again seen by a member of mental health staff. CF complained of abdominal pain and requested to go to an emergency room. Although this request was relayed to medical staff, it was not acted upon. CF was cleared for stepdown from mental health observation, and was relocated at 8:55 a.m., returning to G Unit later that day.

CF took a shower upon returning to G Unit and then remained in her cell throughout the afternoon. Medical staff arrived in G Unit to perform another withdrawal symptom assessment at 3:00 p.m., though, at this point, CF could not walk to the exam room in G Unit where the assessment was supposed to take place. This was taken to be a refusal of clinical services, and the withdrawal symptom assessment was not performed.

At approximately 5:00 p.m., a custody deputy delivered a tray of food to CF in her cell for dinner. CF was sitting on her bed in the cell and made a grunting noise in acknowledgement of the food delivery. At 5:15 p.m., when the custody deputy returned to collect the tray, CF had not touched any of the food.

Only twenty minutes later, at 5:35 p.m., CF was discovered unresponsive in her cell, slumped over, with lips that had become blue in color. Lifesaving measures were immediately initiated by custody and medical staff, which included the use of an AED, chest compressions, five doses of Narcan, and two doses of epinephrine. These resuscitative measures were unsuccessful, and CF was declared dead at 6:11 p.m.

The autopsy report concluded that CF died because of a perforated gastric ulcer.

Gastric Ulcers

A gastric ulcer is a type of peptic ulcer that occurs on the lining of the stomach. It is basically a sore or lesion that forms due to an imbalance between the stomach's aggressive digestive acids and the protective mucus lining. Common causes include Helicobacter pylori (H. pylori) infection, long-term use of medications like ibuprofen or aspirin, excessive alcohol use, smoking, and/or chronic stress.

Perforation is a serious and life-threatening complication of a gastric ulcer. It happens when the ulcer erodes completely through the stomach wall, creating a hole. This allows stomach contents (acid, food, bacteria) to spill into the abdominal cavity, causing peritonitis—a severe infection of the abdominal lining. If untreated, perforation of a gastric ulcer invariably results in sepsis and death.

The signs and symptoms of perforated gastric ulcer include severe abdominal pain (often in the upper abdomen), rigid, board-like abdomen on physical examination, nausea, and vomiting.

The diagnosis of a perforated gastric ulcer begins with obtaining a history from the patient of abdominal pain, and a physical examination showing abdominal tenderness. Diagnostic tests include an X-ray or CT scan of the abdomen, which shows fluid and air in the abdominal cavity.

The treatment of a perforated gastric ulcer is emergency surgery to close the perforation. Intravenous fluids and antibiotics are adjuncts to surgical treatment. If treated promptly, only a short hospital stay is usually required.

The prognosis of perforated gastric ulcer is excellent if treatment is instituted immediately, with a survival rate of approximately 90% in reported series.[1,2] However, if diagnosis is delayed, treatment is less successful, and death from sepsis is more likely.

Evaluation of Inmates in Pain at County Jails

Pain evaluation in county jails (or any correctional facility) must balance clinical care, security, and legal standards. Pain assessment is a mandatory requirement for the humane treatment of inmates, and should be performed following medical, ethical, and legal guidelines. As of 2025, the National Commission on Correctional Health Care (NCCHC) continues to utilize its 2018 edition of the *Standards for Health Services in Jails*. Section 11.2 of the County's contract with California Forensic Medical Group, Inc. (Wellpath), the contracted healthcare provider for the County's jails, requires that Wellpath attain and subsequently maintain NCCHC accreditation for both jails in the County. Elements of essential policy established in the *Standards* (J-E-07) are reflected in Wellpath policy.

Wellpath policy states that when inmates complain of pain either verbally or in writing, they must be evaluated in a clinically appropriate time frame. Furthermore, reaction to an inmate's reports of pain must be based on the patient's perceptions of their own pain. Initial triage and history must be performed by a qualified healthcare provider (registered nurse, nurse practitioner, physician's

[1] Arshad, Seyed A., Patrick Murphy, and Jon C. Gould, "Management of Perforated Peptic Ulcer: A Review," *JAMA Surgery* 160, no. 4 (2025): 450–54. https://doi.org/10.1001/jamasurg.2024.6724

[2] Noguiera, Carlos, et al., "Perforated Peptic Ulcer: Main Factors of Morbidity and Mortality," *World Journal of Surgery* 27, no. 7 (2003). https://doi.org/10.1007/s00268-003-6645-0

assistant, or physician) upon complaint. When a patient seeks health services more than two times with the same complaint, he or she receives an appointment to see a nurse practitioner, a physician's assistant, or a physician.

In terms of generally accepted clinical practices for pain assessment, the history gathered should include the location, intensity, and duration of pain. The type of pain should also be characterized (sharp, dull, burning, etc.).

Healthcare providers should employ evidence-based pain assessment tools to characterize the pain. These tools help ensure that the severity of the pain is documented, and that appropriate treatment is initiated. Such validated tools include:

- Numeric Rating Scale (0–10)
- Visual Analog Scale (VAS)
- Wong-Baker Faces Pain Scale (especially for those with communication difficulties)
- For non-verbal patients: use behavioral cues (grimacing, guarding, agitation)

Each pain assessment should be documented in a medical record. The documentation should include:

- Patient's reported pain level
- Clinical observations
- Vital signs
- Interventions taken (medications, referrals)
- Patient response

Patients should be immediately referred to a physician or for emergency care if:

- Pain is severe or escalating
- Pain does not improve after prescribed pain medication administration
- Pain is associated with serious symptoms (e.g., chest pain, bleeding, behavioral or neurological abnormalities)

METHODOLOGY

The Jury obtained the information contained in this Report from:

- Documents and other evidence provided by the Santa Barbara County Sheriff's Office and Coroner's Bureau. This evidence included, but was not limited to, booking and classification documents, security camera video recordings, audio recordings of internally conducted interviews, and CF's autopsy report.
- The health record maintained by Wellpath for CF during her incarceration
- The County's current and previous contracts with Wellpath and several policy manuals

- Published guidelines, including the NCCHC's *Standards for Health Services in Jails* (2018) and the Federal Bureau of Prisons' *Pain Management of Inmates: Clinical Guidance* (2018)
- Published scientific resources on gastric ulcers and clinical standards for pain assessment
- Live interviews with individuals knowledgeable of the events and matters at issue in this Report, including employees of Wellpath, the SBSO, and the County of Santa Barbara Health Department (County Health)

DISCUSSION

For the two days prior to her death, CF repeatedly complained of intense abdominal pain, but the Jury found no indication that medical staff performed even rudimentary assessments of this pain. The Jury has found no medical documentation of the severity of her pain or its nature. Though CF was repeatedly given Tylenol, the Jury has found no documentation whether CF's pain was ever reduced following medication administration. In addition, the Jury has found no documentation that any medical professional physically examined CF for abdominal tenderness during her incarceration. CF was never referred to, or evaluated by, a nurse practitioner, physician's assistant, or physician following her many repeated complaints of pain to nursing staff.

CF's persistent complaints of pain were repeatedly left unaddressed by medical staff because they attributed her pain to the diagnosis of narcotic withdrawal. This perception led nursing staff to not appropriately assess her repeated pain complaints.

In the records provided to the Jury, there is no evidence that medical staff ever utilized any evidence-based process or form to document the severity and nature of CF's pain. The Jury learned that Wellpath nurses caring for inmates in the County's jails are expected to document pain assessments in the electronic health record utilizing standardized pain assessment forms, but this was never done in response to CF's repeated complaints of pain. The withdrawal assessment forms that were used to assess CF only evaluate the severity of specific opioid withdrawal symptoms after a withdrawal diagnosis has been made. In contrast, pain assessment forms are used to evaluate the intensity and characteristics of a patient's perceived pain; these two types of forms serve distinctly different purposes at the jails.

Though CF requested transfer to an emergency department just nine hours before her death, the Jury found no documentation that medical staff ever thoroughly evaluated whether this transfer was needed nor found any documentation explaining why the request was not honored. The Jury learned that such documentation should have been completed but was not.

The autopsy revealed that the cause of CF's death was from a perforated gastric ulcer. The nature of the fluid, inflammation, and adhesions in the abdominal cavity indicated that this perforation had occurred days before her death; this was the clear cause of CF's pain during her incarceration.

On March 25, 2025, the SBSO released a Notice of In-Custody Death to local media describing the circumstances of CF's death, and on March 27th, the SBSO issued a public update on the case. In the update, which was released the day following the initial autopsy examination, the SBSO stated that CF's death was unavoidable. In contrast, the Jury found that there were opportunities that might have prevented this death had the gastric perforation been discovered and treated. To date, the SBSO's statement that this death was unavoidable has not been revised.

CONCLUSION

After five days of incarceration in the Santa Barbara Northern Branch Jail, inmate CF died because of an untreated perforated gastric ulcer. For at least two days during her jail stay, CF repeatedly complained of pain, yet her pain was never appropriately evaluated. While the jail had established tools and forms to evaluate inmates' pain, these were never utilized, though their use was expected. Had an appropriate evaluation of CF's pain occurred, with subsequent treatment rendered immediately, CF's death could potentially have been avoided.

FINDINGS AND RECOMMENDATIONS

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.

Recommendation 1: The Grand Jury recommends that the Sheriff's Office require that qualified medical professionals assess and treat pain according to accepted medical standards and in accordance with existing policy, procedure, and protocol when inmates in the County's jails complain of pain.

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.

Recommendation 2: The Grand Jury recommends that the Sheriff's Office instruct all medical staff at the County's jails to utilize available evidence-based pain assessment forms to evaluate and document inmates' pain complaints.

Finding 3: Inmate CF's death might have been prevented if she had received appropriate medical assessment in jail.

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.

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 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 3a, 3b

Santa Barbara County Sheriff's Office – 60 days

Findings 1, 2, 3
Recommendations 1, 2