Attachment B

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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, "Another Suicide in Santa Barbara County Jail: Inmate's Death Should Have Been Prevented"

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
"Another Suicide in Santa Barbara County Jail:
Inmate's Death Should Have Been Prevented"

The County values the thorough efforts of the Grand Jury in its investigation of CC'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 concluded that the County jails need additional funding but acknowledged that the County is constructing 384 new beds at the Northern Branch Jail, at an estimated cost of $165 million. Beyond the new jail facility, the County has continued to make enhancements to jail system staffing, oversight, and processes. The County funded the creation of County Health's Correctional Health Team, which since fall 2024 has facilitated independent monitoring of the California Forensic Medical Group/Wellpath (Wellpath) contract and regularly reports findings to all stakeholder authorities. County Health, in partnership with the County Behavioral Wellness Department (BWell) have enhanced the current audits under the new contract, which includes liquidated damages for noncompliance with performance measures. In April 2025, the County approved a $7 million increase to the Wellpath contract to provide 21.95 new full-time equivalent positions (a 55% staffing increase). The County has also implemented other process and facility improvements as discussed in the responses below.

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

The Board of Supervisors disagrees partially with an explanation.
At the time of the incident, Custody staff believed the cell CC was transferred to was ligature resistant.

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.

This recommendation has been implemented.
The County supports the utilization of cells that are adequately free of ligature risks for patients who are currently or recently under suicide precautions.

As of November 2024, telephone cords have been removed from all holding cells that may be used for individuals on mental health 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.

This recommendation has been implemented.

As stated above, telephone cords have been removed from all holding cells that may be used for individuals on mental health observation. The County emphasizes that any intervention taken for patients in a safety cell should be patient-specific and include consideration of all appropriate and available options for treatment, placement, and monitoring. This includes appropriate interventions for stepping-down from a safety cell, as well as escalation to a higher level of care when indicated. If no appropriate placement option exists within the facility to meet a patient's specific needs, the patient is to be transferred as indicated.

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.

This recommendation has been implemented.

As stated above, telephone cords have been removed from all holding cells that may be used for individuals on mental health observation. The Sheriff's Office works in conjunction with Wellpath and when appropriate BWell's Mobile Crisis Unit to facilitate patient-specific evaluation and consult to determine appropriate placement. If no appropriate placement option exists within the facility to meet a patient's specific needs, the patient is to be transferred as indicated.

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.

This recommendation has been implemented.

The County maintains a full continuum of care for the placement of persons with severe mental health issues with acute and subacute needs, including the utilization of available treatment beds in surrounding counties, when necessary and appropriate. The Sheriff's Office works in conjunction with Wellpath and BWell's Mobile Crisis Unit to facilitate evaluation and consult to determine appropriate placement.

The County is in the process of contacting neighboring counties to determine feasibility of entering into MOUs related to transferring and accepting inmates with severe mental health conditions at out-of-county inpatient facilities if in-county beds at the appropriate level of care are unavailable.

Finding 2

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

The Board of Supervisors disagrees partially with an explanation.

Existing Wellpath policy does not require a psychiatric assessment for all patients housed in a safety cell; psychiatric referral is made when clinically indicated. In this situation, Wellpath mental health staff made a psychiatric referral on November 11, while CC was exhibiting anxious behavior in a safety cell. A review of the medical record by County Health indicated that the Wellpath psychiatrist attempted to conduct a psychiatric evaluation, but there is a documented refusal by the patient. Patients maintain the right to refuse medical services, including assessment, during incarceration. Following the patient's refusal, a follow-up appointment with psychiatry was scheduled for the following week.

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.

This recommendation will not be implemented.

Although the intent of the recommendation is supported, psychiatric referrals should be based on clinical factors. Existing Wellpath policy does not require a psychiatric assessment for all patients housed in a safety cell; however, psychiatric referral is required when clinically indicated. Policy and protocol should reflect individualized and patient-specific interventions. Existing Wellpath policy requires a mental health assessment prior

to placement in a safety cell. As part of that assessment, referral to psychiatry is to occur when clinically indicated. Additionally, BWell Mobile Crisis is available for assessment and placement to a higher level of care as appropriate. The SLAs in the current Wellpath agreement include these provisions and are monitored for compliance by BWell.

Finding 3

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

The Board of Supervisors disagrees partially with an explanation.

Review of the medical record indicated the Wellpath psychiatrist attempted to conduct a psychiatric evaluation, but there is a documented refusal by the patient and a follow-up appointment was scheduled for the following week.

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.

This recommendation has been implemented.

There are clear and detailed protocols and policies guiding the identification, assessment, evaluation, and care of persons with current and past mental health conditions who are placed at the jails, beginning at booking/intake and ongoing as appropriate, including policies related to psychiatric referral and evaluation. Wellpath's staffing includes an on-duty psychiatrist as well as an on-call psychiatrist. Additionally, BWell Mobile Crisis is available for assessment and placement to a higher level of care as appropriate. The SLAs within the current Wellpath contract include ensuring that patient needs are addressed within established timeframes based on triaged acuity of need. The SLAs for mental health needs are currently assessed by BWell, and under the new contract effective April 1, 2025, SLAs include medical needs reviewed by County Health.

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.

This recommendation will be implemented.

Wellpath's existing policy regarding Receiving Screening requires the Qualified Health Professional (QHP) to review the patient's health record from prior incarcerations (if available) to ascertain a history of medical or mental health conditions. Wellpath can now also access patients' mental health history through BWell's electronic health record. While Wellpath is currently requesting medical and mental health records from outside providers when clinically indicated, by January 2026, Wellpath intends to implement a policy revision to reflect this existing practice.

Finding 4

During CC's first approximately 23-hour stay in Safety 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.

The Board of Supervisors agrees.

During CC's first safety cell stay, documentation does not reflect that Mobile Crisis was contacted.

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.

This recommendation has been implemented.

Current protocol requires Wellpath to contact Mobile Crisis for evaluation if a patient has been in a safety cell for 8 hours and is decompensating or showing no signs of clinical improvement, and to request an evaluation within 12 hours for all patients unless they are stepped down from a safety cell before that time. As of July 1, 2025, the Wellpath agreement contains an SLA requirement to refer individuals in a safety cell to a higher level of psychiatric care after 8 hours of no improvement or deterioration, with associated liquidated damages if non-compliance is assessed. This protocol supports individualized and patient-specific intervention for patients placed in a safety cell, and it is more stringent than the 12-hour timeframe stated within the *Murray v. County of Santa Barbara* Remedial Plan for individuals who are not improving.

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.

The Board of Supervisors disagrees partially with an explanation.
As indicated by the Grand Jury, communication could have been improved related to the patient's mental health history.

Here, requesting records related to the psychiatric evaluation from Cottage Hospital was not required by existing policy. Wellpath intends to implement a policy revision to request medical and mental health records from outside providers when clinically indicated.

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.

This recommendation will not be implemented.
Protected Health Information (PHI) may be shared for the treatment of inmates in a correctional institution under certain circumstances authorized by law. Therefore, obtaining a Release of Information (ROI) is unnecessary in some situations. However, pursuant to current protocol when seeking records from outside providers, Wellpath staff do request patients to sign an ROI, for purposes of promoting consent and transparency, facilitating seamless information sharing, and given that outside providers have historically not recognized permitted disclosures.

The County agrees that greater awareness regarding the application of HIPAA in a correctional setting would benefit the incarcerated population and may allow for increased information sharing. However, the County believes that the above-recommended additional training would not address the Grand Jury's intent. The County will work with all stakeholders, including local hospitals and providers, to expand awareness and understanding regarding the permissible disclosure of PHI in correctional care settings.

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 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.

This recommendation will be implemented.

HIPAA permits sharing of PHI with a correctional institution when necessary for the provision of healthcare and for health and safety purposes; thus, obtaining an ROI for every patient is unnecessary. However, ROIs are still requested from patients for the reasons described above. As stated in the Sheriff's response to the Grand Jury, patients are currently requested at intake to sign a universal ROI that would allow Wellpath staff to communicate about and receive the patient's records from other medical and mental health providers. The Sheriff further indicates that areas for improvement to this process have been identified and additional training is being provided to refine the process, with completion expected 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.

The Board of Supervisors disagrees partially with an explanation.

If a patient requires hospital emergency department evaluation and clearance, Wellpath staff review the provided hospital clearance forms. Here, existing policy did not require CFMG/Wellpath to request hospital records. CFMG/Wellpath intends to implement a policy revision to request medical and mental health records from outside providers when clinically indicated.

Additionally, at the time of this incident, limited Wellpath staff were provided access to BWell's EHR. Since that time, the access has been expanded to additional staff, and Wellpath is now in the process of mandating staff access for all registered nurses and mental health staff, including psychiatry.

Recommendation 6a

The Grand Jury recommends that the Sheriff's Office require Wellpath staff to contact outside healthcare providers, such as hospitals, physicians, and clinics, to obtain inmates' health records in a timely manner following intake. To be implemented by January 1, 2026.

This recommendation will be implemented.

The County supports reinforcing the expectation to obtain relevant medical and behavioral health records when clinically indicated, particularly for patients recently hospitalized or assessed in an emergency department. By January 2026, Wellpath intends to implement a policy revision to request medical and mental health records from outside providers when clinically indicated.

As stated above, CFMG/Wellpath clinical staff have since been provided access to BWell's EHR to improve information sharing. Wellpath is in the process of mandating staff access for all registered nurses and mental health staff, including psychiatry.

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.

This recommendation will be implemented.

Wellpath is working to ensure the current EHR (CorEMR) is CalAIM-compliant, which will require interoperability to share patient health information with outside providers, as required for the County's implementation of the California Advancing and Innovating Medi-Cal (CalAIM) Justice-Involved Initiative by October 2026. Additionally, the County is evaluating implementing a new EHR, which would be able to share information amongst various County departments and community providers. Through the upgraded EHR and participation in the Health Information Exchange, for patients served by outside providers the information from those visits could be incorporated into their health record.

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.

The Board of Supervisors disagrees with an explanation.

Each Santa Barbara County correctional facility provides sufficient cells to meet currently anticipated census and acuity needs, and policies and protocols exist to transfer patients who exceed the level of care provided within the correctional facility.

A standard minimum number of observation cells in correctional facilities does not exist in California. For comparison purposes, there are generally only 2-4 observation cells for an entire prison population of approximately 3,000-4,000. In contrast, the County currently maintains 6 observation cells for a population of approximately 750-800.

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.

This recommendation has been implemented.

As stated above, the County maintains sufficient cells, including safety and observation cells, to meet census and acuity needs. Additionally, the Sheriff's Office has removed telephone cords from all cells that may be used as 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.

This recommendation has been implemented.

According to the Sheriff's response to the Grand Jury dated August 25, 2025, the Sheriff's Office formalized and implemented a specific suicide watch step-down procedure in December 2024 and subsequently further refined this process. They anticipated completing staff training and implementing the refined procedure by September 1, 2025.