

# Office of the Sheriff



## SANTA BARBARA COUNTY

### STATIONS

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

**Carpinteria**  
5775 Carpinteria Avenue  
Carpinteria, CA 93013  
Phone (805) 755-4452

**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

**Sheriff - Coroner Office**  
66 S. San Antonio Road  
Santa Barbara, CA 93110  
Phone (805) 681-4145

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

### COURT SERVICES CIVIL OFFICES

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

**Santa Maria**  
312 E. Cook Street, "O"  
P.O. Box 5049  
Santa Maria, CA 93456  
Phone (805) 346-7430

HEADQUARTERS  
P.O. Box 6427 • 4434 Calle Real • Santa Barbara, California 93160  
Phone (805) 681-4100 • Fax (805) 681-4322  
[www.sbsheriff.org](http://www.sbsheriff.org)

**BILL BROWN**

Sheriff - Coroner

**SOL LINVER**

Undersheriff

October 29, 2020

Pamela Olsen  
Foreperson  
2019-2020 Santa Barbara County Grand Jury  
Grand Jury Chambers  
Santa Barbara County Courthouse  
1100 Anacapa Street  
Santa Barbara, CA 93101

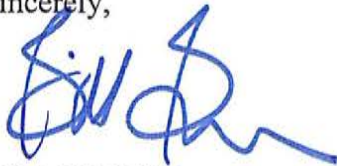
RE: Response to the Santa Barbara County Grand Jury Report Entitled  
*"Death in Custody 2019"*

Dear Foreperson Olsen:

Per your request we are re-sending the Santa Barbara County Sheriff's Office response to the 2019-2020 Santa Barbara County Grand Jury Report entitled *"Death in Custody 2019"*

As requested in the report, the Sheriff's Office responded to findings and recommendations in deaths 2.0, 3.0 and 4.0. Should you have any questions, please feel free to contact me at 681-4290.

Sincerely,



**BILL BROWN**  
Sheriff-Coroner

Enclosure: SBSO response

**Santa Barbara County Sheriff's Office**  
**Response to the Santa Barbara County Grand Jury 2019-2020 Report**  
**"Death in Custody 2019"**

2.0 B1 Death in Custody April 12, 2019

**FINDINGS AND RECOMMENDATIONS**

**Finding 1**

*B1 was accepted into the Main Jail despite his potentially life-threatening condition and inability to walk.*

**Response:** Agree.

**Recommendation 1**

*That the Santa Barbara County Sheriff enforce the policy regarding not admitting inmates to the Main Jail with life threatening medical conditions.*

**Response:** Has been implemented. WellPath provided updated training to reinforce the requirement of refusing admittance to inmates with potentially life-threatening conditions. reinforce

**Finding 2**

*When the on-call physician was unable to be reached on April 12, 2019, at 2:30 p.m., the inmate was not transferred to the local hospital emergency room.*

**Response:** Agree.

**Recommendation 2**

*That the Santa Barbara County Sheriff require all medical staff be instructed to transfer inmates to the local hospital emergency room when there is an emergency that is a life threatening or serious injury or illness and the on-call physician does not respond.*

**Response:** Has been implemented.

WellPath provided updated training to reinforce the requirement of immediate transfer to local hospital emergency room for inmates with potentially life-threatening conditions, if the on-call physician is unavailable.

**Finding 3**

*When the blood sugar level was determined to be 587mg/dl at 5:00 p.m., and the on-call physician did not respond, the inmate was not sent to the emergency room.*

**Response:** Agree.

**Recommendation 3**

*That the Santa Barbara County Sheriff ensure that medical staff follow policy and procedures when the on-call physician does not respond.*

**Response:** Has been implemented.

WellPath provided updated training to reinforce the requirement of immediate transfer to local hospital emergency room for inmates with potentially life-threatening conditions, if the on-call physician is unavailable.

#### **Finding 4**

*When Wellpath personnel responded to a man down emergency, they did not bring an emergency kit to the scene.*

**Response:** Agree.

#### **Recommendation 4**

*That the Santa Barbara County Sheriff ensure that Wellpath personnel bring an emergency kit whenever they respond to a man down notification.*

**Response:** Has been implemented.

WellPath has completed training with man-down drills. They have also implemented a debriefing process for all man-down incidents, that focuses on appropriate responses, responsibilities, and equipment protocols.

### **3.0 CI Death in Custody June 25, 2019**

#### **FINDINGS AND RECOMMENDATIONS**

#### **Finding 1**

*Following an accusation of being a child molester and being assaulted by other inmates, C1 was agitated and threatened suicide unless he received a permanent cell to himself.*

**Response:** Agree.

#### **Recommendation 1**

*That the Santa Barbara County Sheriff immediately place an inmate threatening suicide in a safety cell and monitor the inmate more frequently.*

**Response:** Has been implemented.

An order was issued by Chief Custody Deputy V. Wasilewski that the holding cells where C1 died by suicide were no longer to be used for temporary housing of individual inmates without constant staff supervision. In addition, staff have been directed to utilize alternative housing areas in the IRC, where there are staff posted, to await re-housing determinations.

#### **Finding 2**

*There was a significant date inaccuracy in both the Santa Barbara County Sheriff's letter and the Coroner's Report, giving the false impression that his incarceration was two months rather than fourteen months.*

**Response:** Agree.

### **Recommendation 2**

*That the Santa Barbara County Sheriff ensure that all reporting documents are complete and accurate.*

**Response:** Has been implemented.

There were several factors that contributed to this inaccuracy. They have been addressed.

### **Finding 3**

*Omission of the dates of interviews conducted by Sheriff's Deputies make it difficult to assess the accuracy or recall of circumstances surrounding a death in custody.*

**Response:** Agree.

### **Recommendation 3**

*That the Santa Barbara County Sheriff ensure that the dates contained in investigative reports be stated and interviews completed as soon as possible after the event.*

**Response:** Has been implemented.

This was an isolated incident and has been addressed.

### **Finding 4**

*When walking by C1's cell, a Custody Deputy failed to observe the T-shirt tied to the bars.*

**Response:** Agree.

### **Recommendation 4**

*That the Santa Barbara County Sheriff ensure that Jail Custody staff are alert to items hanging from bars and take appropriate action.*

**Response:** Has been implemented.

The Sheriff's Office completed in-service training for all Custody staff in Suicide Prevention for the final quarter of 2019, which included instruction about items hanging from bars.

### **Finding 5**

*An inmate suicide threat was not reported to a supervisor.*

**Response:** Agree.

### **Recommendation 5**

*That the Santa Barbara County Sheriff ensure that all detention facility personnel inform their supervisor of any threats of suicide.*

**Response:** Has been implemented.

The Sheriff's Office completed in-service training for all Custody staff in Suicide Prevention for the final quarter of 2019. WellPath completed a suicide prevention policy review training with all healthcare staff during the same time period. Both trainings included instruction on the requirement to report all threats of suicide to supervisory staff.

### **Finding 6**

*CI's mental illness was not reevaluated for the ten months prior to his suicide.*

**Response:** Agree.

### **Recommendation 6**

*That Santa Barbara County Board of Supervisors provide psychiatric services to better serve mentally ill inmates in detention.*

**Response:** Has been implemented.

WellPath implemented new policies which require all psychiatric patients to have face to face visits with the psychiatrist before discontinuation of psychiatric medication. Patients with a serious mental illness diagnosis who refuse medication will be placed on a "special needs" population list. Patients on the special needs list are seen once a month by mental health clinicians.

## **4.0 D1 Death in Custody October 31, 2019**

### **FINDINGS AND RECOMMENDATIONS**

#### **Finding 1**

*A thorough review of D1's prior booking assessments would have revealed a history of drug use and suicidal ideations.*

**Response:** Agree.

#### **Recommendation 1**

*That the Santa Barbara County Sheriff direct staff to review all prior bookings and assessments at intake.*

**Response:** Has been implemented.

WellPath conducted remedial training for all staff on this topic.

#### **Finding 2**

*D1 was not started on treatment at the first mention of his statement of experiencing withdrawal symptoms*

**Response:** Agree.

#### **Recommendation 2**

*That the Santa Barbara County Sheriff ensure that Wellpath conduct remedial training of medical staff regarding withdrawal statements or recognizing symptoms.*

**Response:** Has been implemented.

WellPath conducted remedial training for all staff on this topic.

#### **Finding 3**

*After D1 refused medications, no follow-up assessment was scheduled.*

**Response:** Agree.

### **Recommendation 3**

*That the Santa Barbara County Sheriff require Wellpath conduct remedial training of medical staff regarding individuals who refuse medication.*

**Response:** Has been implemented.

WellPath conducted remedial training for all staff on this topic.

### **Finding 4**

*The inmate was housed in a cell that was not intended for mental health or medical observation.*

**Response:** Agree.

### **Recommendation 4**

*That the Santa Barbara County Sheriff Custody Staff house inmates displaying symptoms of mental illness in cells intended for mental health or medical observation.*

**Response:** Has been implemented.

Sheriff staff have been directed to utilize specific cells in specific locations to ensure that potentially suicidal inmates are monitored and housed in the safest possible manner.

### **Finding 5**

*D1 was housed in a cell with a long-corded wall-mounted telephone.*

**Response:** Agree.

### **Recommendation 5**

*That the Santa Barbara County Sheriff ensure that the Custody Staff not house inmates in cells with corded telephones.*

**Response:** Will not be implemented.

The statement by the Grand Jury is too broad. Inmates with no mental health or suicidal issues need not be subject to stringent physical plant limitations. The Sheriff's Office has, however, reduced the length of all telephone cords from an 18" cord, like the one D1 used in the successful suicide, to a 12" cord. The shorter cord does not allow for the ligature point and still provides inmates with a normalized telephone.

### **Finding 6**

*An initial mental health assessment was attempted, but D1 refused services and no referral to a psychiatrist was made.*

**Response:** Agree.

### **Recommendation 6**

*That the Santa Barbara County Sheriff ensure that Wellpath conduct remedial training of staff regarding medical and mental referrals at intake.*

**Response:** Has been implemented.

WellPath conducted remedial training for all staff on this topic.

**Finding 7**

*The radio call of Code 33 did not identify the nature of the emergency.*

**Response:** Agree.

**Recommendation 7**

*That the Santa Barbara County Sheriff direct all radio calls for medical emergencies be in plain language, including details of the symptoms encountered such as suicide by hanging, bleeding wounds, suspected overdose, etc.*

**Response:** Has been implemented.

Sheriff's staff have been directed to utilize "plain language" when radioing medical emergency calls for assistance.

**Finding 8**

*The required Responder Defibrillator (AED) Report was not found in the files provided to the Jury.*

**Response:** Agree.

**Recommendation 8**

*That the Santa Barbara County Sheriff ensure that Wellpath test all AEDs monthly and after each use and keep logs of the dates of these checks.*

**Response:** Has been implemented.

WellPath conducted remedial training for all staff on this topic.