SUICIDE IN SANTA BARBARA COUNTY MAIN JAIL
A Challenge for Law Enforcement and Health Professionals

SUMMARY

Pursuant to the authority provided by *Penal Code §919(b),* the Grand Jury (Jury) shall examine the operations of the jails within the County. The Jury regularly considers the facts and circumstances surrounding inmate deaths in custody, including suicide. This term, the 2021 Santa Barbara County Grand Jury investigated the death in custody of Inmate A, an inmate who hanged himself in his cell in early 2021, just 18 hours after he was arrested at his residence on a warrant issued by Ventura County for a misdemeanor offense. Inmate A was the fourth inmate to commit suicide at the Main Jail in less than three years.

In its investigation of the facts and circumstances surrounding the suicide of Inmate A, the Jury determined that the Main Jail intake process requires improvement with respect to recognizing potentially suicidal arrestees, effectively communicating their mental health status to other staff members throughout the process and providing timely mental health services during the nighttime hours. From the time of arrest through housing assignment in the Main Jail, arrestees are processed by a variety of Sheriff's Office deputies and Wellpath medical professionals. Process-driven improvements in training, communications, and staff availability have the potential to improve outcomes for future arrestees with mental health and substance abuse conditions.

Although the requirements of the Sheriff's Office Intake Screening Implementation Plan were not fully met, the Jury was pleased to note that improvements are currently underway at the Main Jail, and the new Northern Branch Jail has incorporated design and operational features that will improve the process and hopefully reduce the incidence of future suicides in custody.

INTRODUCTION

In early 2021, at approximately 2:35 PM, Inmate A, a 30-year-old male, fashioned a bed sheet into a ligature, placed it around his neck, and hung himself. He had been arrested 18 hours earlier and was placed in Inmate Reception Center (IRC) Cell 114 to await transport to Ventura County on a misdemeanor warrant. He was discovered shortly after he hung himself, and emergency assistance was promptly rendered. Inmate A was transported by ambulance to Cottage Hospital and pronounced dead shortly after arrival. The suicide was the fourth such death in custody in the Main Jail in less than three years.

Pursuant to the authority provided by *Penal Code §919(b)* to examine the operations of the County jails, the Santa Barbara County Grand Jury often reviews the circumstances surrounding deaths in custody and issues a report setting forth its findings and recommendations. Following the receipt of information from the Sheriff's Office pertaining to Inmate A's suicide, the Jury investigated the circumstances surrounding his death. In the following sections of this report, the Jury will describe the methodology it used in carrying out its investigation, relate its observations concerning the testimonial and documentary evidence it considered, make findings, and propose recommendations the Jury hopes will prove to be of value when implemented.

Unfortunately, in mid-July 2021, another inmate housed in the Main Jail committed suicide. This was

the fifth such death since April 2018. There is a nationwide increase in both mental illness and substance abuse among inmates. If that trend continues, it will impose ever increasing demands on correctional facilities to develop measures designed to safeguard and better treat the inmates housed there. The Jury hopes the findings and recommendations contained in this Report will assist the Sheriff's Office in that effort and help reduce the number of future deaths by suicide while in custody. In that regard the Jury is pleased to note the new Northern Branch Jail in Santa Maria is purposely designed to achieve that salutary result.

METHODOLOGY

In order to examine the facts and circumstances surrounding the death in custody of Inmate A, the Jury interviewed numerous people who had interfaced directly with him, beginning with the arrest at his residence on an evening early in 2021, until his suicide by hanging at the Main Jail in IRC Cell 114 at approximately 2:30 PM on the following day. Additional Sheriff's Office employees with knowledge of the circumstances were also interviewed. These interviews included Sheriff's patrol and custody deputies and staff and supervisory employees of California Medical Forensic Group (Wellpath), the private contractor engaged to provide medical and mental health services at County jails.

In addition, the Jury reviewed a variety of documents provided by the Sheriff's Office, including several eye witness statements taken during the subsequent internal investigation, Main Jail records pertaining to Inmate A, tapes of telephone calls made to 9-1-1, tapes of two telephone calls he made to his girlfriend from the night he was booked and incarcerated, the Coroner's Office Autopsy Report, Sheriff's Office policies and procedures, and the contract between Santa Barbara County and Wellpath. The Jury confirmed the statements made in these reports with the appropriate interviewed individuals. The Jury also reviewed the July 2020 Stipulated Judgment requirements resulting from the settlement in the *Murray v. County of Santa Barbara*[1] case with a focus on the Intake Screening Implementation Plan.

Finally, the Jury examined official government reports relating to suicides in custody in general and reviewed prior Jury reports in which suicides in custody at the Main Jail in 2018 and 2019 were addressed and recommendations made. The Jury was given a tour of both the Main Jail and the Northern Branch Jail.

OBSERVATIONS

The following are the essential facts surrounding the death by hanging of Inmate A in early 2021, in IRC Cell 114 of the Santa Barbara County Main Jail.

Chronology

Based on a 9-1-1 call two days prior to the suicide, a welfare check was made to the home of Inmate A by Santa Barbara County Sheriff's Office patrol deputies. The situation was resolved and the deputies left. A warrant check had identified an outstanding warrant from Ventura County, but no arrest was made at that time because misdemeanor warrants may not be served in private residences between 10:00 PM and 6:00 AM. No record of this visit was entered into a database.

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[1] *Murray v. County of Santa Barbara*, Case Number 2:17-cv-08805-GW-JPR, U.S. District Court (C.D. Cal.).

The following day at 8:22 PM, Inmate A called 9-1-1, and the dispatcher initially reported he was not making sense. Inmate A reported he was being chased, that when he went to check his mail he saw people running to his back gate and that they might have firearms. He then told the dispatcher he was not under the influence, that he was detoxing from the previous use of meth, and that he might be suffering from the effects of withdrawal.

Seven minutes later a Santa Barbara County Sheriff's Office patrol unit arrived for a welfare check. At this point, the deputies had no knowledge of the 9-1-1 calls made the night before. The dispatcher then reported to the deputies that the subject was frantic and stuttering. The deputies checked the area but found no one there, despite his fears. Patrol deputies noted that Inmate A was fidgety, speaking rapidly, and sweating, all signs indicative of substance abuse. Inmate A reported to the deputy that he had been "clean" for a while but had relapsed and taken meth within the last 24 hours.

At 8:35 PM, a deputy determined there was a bookable warrant for Inmate A's arrest from Ventura County and that Ventura wanted to enforce it. Emergency personnel from American Medical Response (AMR) and the Santa Barbara County Fire Department arrived at 8:38 PM and were told by a deputy that Inmate A was detoxing. Inmate A allowed emergency personnel to check his vitals, insisted he did not need any treatment, did not need anyone to call a family member, and wanted to take an Uber to the Los Angeles area where his girlfriend was staying. The medical personnel found insufficient justification to hold him for medical reasons, and since Inmate A refused to go to the hospital, the arresting deputy felt Inmate A could safely detox in jail. Inmate A was arrested at 8:53 PM based upon the Ventura warrant.

Inmate A was then transported to the Santa Barbara County Main Jail by the arresting deputy via patrol car. He expressed relief at being removed from the location that frightened him, and the Jury concluded he was under the mistaken impression he could be booked and released later the same night. The arresting deputy reported that the conversation in the patrol car was "lighthearted." However, the deputy reported that Inmate A at times was delusional, and that the jail would be a safe place for him to detox.

Wellpath is the for-profit company under contract with Santa Barbara County to provide all in-jail medical care, including mental health services. The on-duty Registered Nurse (RN), a Wellpath employee, performed Inmate A's receiving screening upon his arrival. The RN reported that his behavior was appropriate, speech coherent, and mood unremarkable. The RN asserted that Inmate A stated he did not use drugs and was not in withdrawal. There was no prior information in the database regarding Inmate A, and his answers were taken at face value. Despite the arresting deputy's assertion that during the evaluation the RN was told Inmate A had been displaying paranoid behavior, the RN said they were not made aware of his behavior and the screening did not trigger a mental health alert or appointment.

Inmate A was booked on the Ventura misdemeanor warrant at 9:48 PM. The warrant listed two previous arrests, a bench warrant and driving with a suspended license, and bail was set at $5,000. The first time the classification deputy attempted to interview him, the deputy found Inmate A to be uncommunicative and paranoid. On his second interview attempt, Inmate A was able to answer all the classification questions, and the deputy reported that Inmate A told him he had past suicidal ideations but was not currently suicidal. Inmate A also told the deputy that he is withdrawing from meth. The classification deputy housed Inmate A alone in IRC Cell 114 per COVID-19 isolation protocol, with 30-minute security checks.

Inmate A made his first call to his girlfriend at 11:08 PM. He insisted he was not using, told her the deputies had done him a favor by bringing him in because of the strangers videotaping his house, and that he would be able to leave as soon as he was processed through the system. He also said he was scared and that he did not trust anyone, and they planned for her to pick him up when he was released.

At 1:05 AM, two hours later, the Santa Barbara County Main Jail notified Ventura County that Inmate A had been booked on their warrant with bail set at $5,000, was ready for immediate pick-up, and that the last day for pick-up was four days later. At 2:06 AM, Inmate A made his second and final call to his girlfriend, telling her that he had just learned he would need bail money, and asking for her help in getting it. He said he was scared and just could not stay there in the jail. When his girlfriend said she could not help, he said he had to go and hung up abruptly. Inmate A appeared to become increasingly agitated when he realized he would not be going home soon. The Jury concluded that up until this point, Inmate A had thought that he would be processed and released on the same day.

By contract, Wellpath is not required to provide a mental health professional on site between the hours of 11:00 PM and 7:00 AM. The classification deputy reported speaking with an RN at 4:00 AM and left a Wellpath Mental Health Evaluation Form in the box for the Wellpath Licensed Marriage and Family Therapist (LMFT) scheduled to report for work at 7:00 AM. The deputy checked off "Signs of Psychosis" on the form, stated Inmate A was found to be paranoid and uncommunicative, and recommended he have a mental health evaluation. This was the first documented reference at the jail that Inmate A might be experiencing a mental health crisis. Although there was an on-call psychiatrist available during the night, no immediate action was taken to assist Inmate A and the form was placed in the Mental Health Box for the LMFT that would report for duty at 7:00 AM.

The IRC control room deputy is located in an enclosed booth on the second floor of the jail, conducts camera surveillance of the IRC halls and cells, and responds to intercom calls from inmates in the cells. The deputy on duty that night was only able to see a small corner of Inmate A's cell because of an intervening staircase, and never actually saw him. Inmate A called the deputy from his intercom on three separate occasions during the night. Because of a technical issue with the equipment, the deputy could not quite understand what Inmate A was saying, other than he did not want to be there. The deputy reported making reassuring comments to him, and sent another deputy to check on him.

At 7:26 AM, the LMFT picked up the form left by the classification deputy the night before. The LMFT interviewed Inmate A about two hours later and filed a Mental Health Structural Progress note at 10:05 AM that indicated Inmate A was disheveled, expressive, loud, angry, irritable, hostile, delusional, agitated and impulsive. The LMFT did not observe any indication of suicidal ideation, but recommended Mental Health Follow-up as needed or through a sick call. Inmate A had signed an Authorization and Consent to Medical Examination and/or Treatment form, but again no immediate action was taken to treat or assist him in his apparent distress.

At 2:30 PM, about five hours later, Inmate A was found hanging from a bed sheet in his cell by a custody deputy during a security check, who then reported a "Man Down in Cell 114." Within minutes life saving measures were initiated by the deputies and continued with the arrival of AMR and the Fire Department.

Inmate A remained unresponsive and was transported to Santa Barbara Cottage Hospital by AMR at 2:49 PM with life saving measures continued during transport by an AMR EMT and a member of the Fire Department. He arrived at the hospital at 2:57 PM, and life saving measures were assumed by the nursing staff there.

Inmate A was pronounced deceased at 3:32 PM by the attending physician. The Coroner's Office took possession of Inmate A's body and an autopsy was performed. The report stated that Inmate A's cause of death was hanging, other significant conditions, and methamphetamine intoxication.

Analysis

The Jury reviewed the circumstances of Inmate A's suicide in the context of the July 2020 Stipulated Judgment in the *Murray* case. That case concerned a class action lawsuit filed in 2017 against Santa Barbara County by an inmate advocacy group decrying the poor conditions in the County's jails. Specifically addressed were inmate health care and measures required to address those conditions. As part of that settlement, a Remedial Plan was created which, among many other subjects, provided an Intake Screening Implementation Plan designed to ensure that arriving prisoners are promptly screened for urgent health care needs. Specifically included as part of that screening process were a psychological evaluation of persons who present with signs of mental illness, a clinical evaluation of persons in need of detoxification, and use of a suicide risk assessment tool, all to be performed by a trained RN.

The RN who screened Inmate A using the Wellpath screening tool in a ten-minute interview upon his arrival at the intake found no evidence of mental illness or past or present drug use and no need for any special accommodation for mental health reasons. The RN stated that the only mental health issue observed at Inmate M's intake was a complaint that he suffered from insomnia. The RN concluded from the intake evaluation interview with Inmate A that there was nothing out of the ordinary from any other medical screenings the RN had performed in the past.

On the other hand, the three arresting patrol deputies, one of whom also transported Inmate A to the Main Jail from his residence, all observed that when he was interviewed and then arrested, Inmate A was highly agitated and clearly displayed signs of paranoia (hallucinating, feared people were watching his residence and were armed and trying to enter, etc.). He freely admitted to them that he had recently used drugs. The arresting/transporting deputy reported a belief, based upon training, that Inmate A was still high on drug use and not yet in withdrawal during the interview at his home. When Inmate A declined to go to the hospital for treatment, the deputies saw an immediate need to keep him safe while he detoxified and transported him to the Main Jail for intake processing.

In assessing for suicide risk, the Intake Screening Implementation Plan mandates that among the suicide risk factors to be considered, the RN's intake screening should take into account the "transporting officer's impressions about risk."[2] In Inmate A's case, it is disputed whether this information was shared as required. The transporting deputy said they informed the RN of Inmate A's paranoid behavior, but the RN denied being told of Inmate A's statements and did not observe any of the behaviors described by the patrol deputies. The evidence points to the fact that a significant breakdown in communication occurred at that point. As a result, the process from intake through housing failed to protect Inmate A.

As stated above, the classification deputy that night and the LMFT the next morning did note Inmate A's distress and agitation. However, urgent mental health/substance abuse care was not initiated as specified in the Intake Screening Implementation Plan. Inmate A denied he had any current suicidal ideation, and despite his behavior, as documented by the Custody Deputy and LMFT above, his denial

[2] "See *Murray v. County of Santa Barbara*, supra, Stipulated Judgement, Remedial Plan, "Suicide Prevention," Section IV B.(e), p. 24

was accepted at face value. Less than 18 hours after he arrived at the Main Jail, Inmate A was dead by his own hand.

Challenges

The Santa Barbara County Sheriff's Office faces an increasing challenge in keeping inmates with mental health and/or substance abuse problems safe while in custody. Part of a nationwide trend, the percentage of such inmates in the Main Jail population is significant. The Prison Policy Initiative website reports that 41 percent of persons incarcerated in locally run jails have been diagnosed with mental illness, and that suicides account for almost 30 percent of in-custody deaths.[3] The Santa Barbara County Department of Behavioral Wellness has reported that every year approximately 60 percent of inmates in the Main Jail had past contact with Behavioral Wellness, compared to the national average of 33 percent. It is often difficult to interpret problematic behavior as suicidal ideation if there is nothing already in the database system or stated outright by the inmate. It is also possible for communications to be incomplete in the rush to interview, book, and house detainees, as they move through the process changing hands among a variety of deputies and health professionals.

The best defense against errors in judgment affecting inmate safety are targeted processes and procedures, in-depth training, specified communication requirements, and application of lessons learned from any failures that occur. The Jury's investigation revealed that process improvements were needed in the areas of communication between deputies and medical professionals, training in the identification of potential suicidal ideation when it's not openly stated, the application of "urgent need for medical care" as defined in the Intake Screening Implementation Plan, and the availability of appropriate mental health professionals on a 24/7 basis.

Work has already begun in several areas that could help reduce future suicides within the Santa Barbara County jail system. After the death of Inmate A, the Main Jail received accreditation from the National Commission on Correctional Health Care, assuring it was in compliance with the NCCHC's Standards for Health Services in Jails. The Santa Barbara County Sheriff attributed the success to the collaborative efforts of the Sheriff's Office and its health care partner, Wellpath. A Sheriff's Office-Wellpath Risk Mitigation Committee has been established. Physical changes have been made to existing cells to inhibit suicide attempts. When inmates let the staff know that isolation and quarantine rules, driven by the COVID-19 pandemic, were contributing to the recent increase in suicide attempts, daily yard times were increased, computer tablets were made accessible, and journals and other art supplies were made available. The new Northern Branch Jail, scheduled to begin receiving inmates in the near future, will have a specialized unit of 32 beds designed to meet mental as well as medical health requirements. Among the most significant steps being taken to improve the delivery of mental health services at the County's jails are the on-going monitoring activities mandated by the settlement in the *Murray* case whose terms were set forth in paragraph 15 of the Stipulated Judgment.[4]

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[3] https://www.prisonpolicy.org/research/mental_health/ and https://www.prisonpolicy.org/blog/2021/06/23/jail_mortality/

[4] See *Murray v. County of Santa Barbara*, supra, Santa Barbara County Second Remedial Plan Status Report Compliance Matrix, 12/2/21,Section IV, "Suicide Prevention", pp. 103-123

CONCLUSION

While significant progress has been made, the 2021 Santa Barbara County Grand Jury believes that further changes and improvements are needed. The agreement between Wellpath and the County is due for renewal in April 2022, and that would be an appropriate time for assuring continuous process improvement. The Jury is hopeful that negotiations will include discussion of around-the-clock coverage by on-site mental health professionals, reduced lapse time between identifying and initiating medical and mental health protocols, improvement in communication processes between deputies and mental health professionals, and improved training in identification of substance abuse and suicide prevention. The monitor for the Intake Screening Implementation Plan reported in August 2021 that "the county has experienced serious suicide incidents and attempts in the last year and implementation of the suicide prevention policies should continue to be a targeted priority." The Jury agrees.

FINDINGS AND RECOMMENDATIONS

Finding 1

During this early 2021 incident there was a failure in communication between the observations of the Santa Barbara County Sheriff's Office transporting patrol deputy and the Wellpath intake Registered Nurse regarding Inmate A's behavior, substance abuse, and mental health issues, as required by the Intake Screening Implementation Plan, which prevented Inmate A from receiving appropriate and timely mental health care.

Recommendation 1a

That the Santa Barbara County Sheriff's Office initiate joint training with all deputies and Wellpath health professionals to foster more efficient sharing of medical information at all major points of contact with the arrestee, including arrest, transport, intake, booking, classification, housing, and follow-up processes.

Recommendation 1b

That the Santa Barbara County Sheriff's Office develop a real-time, commonly accessible database that includes all information at all major points of contact with the arrestee, including arrest, transport, intake, booking, classification, housing, and follow-up processes.

Finding 2

The initial intake screening process failed to identify and record observations of Inmate A's substance use, which prevented Inmate A from receiving appropriate and timely "urgent substance abuse/mental health care" as required by the Intake Screening Implementation Plan.

Recommendation 2

That the Santa Barbara County Sheriff work with the on-site Wellpath Health Services Administrator to develop, implement and train its health professional staff in the application of "urgent care" for inmates with substance abuse and/or mental health issues.

Finding 3

The contract between the County of Santa Barbara and Wellpath allows a significant time lag between the identification of potential medical or mental issues and the initiation of treatment protocols, delaying the initiation of necessary care.

Recommendation 3

That the Santa Barbara County Board of Supervisors propose shorter required response times to initiate medical and mental health protocols during the upcoming contract negotiation process.

Finding 4

There is no on-site coverage by a Wellpath mental health professional from 11:00 PM to 7:00 AM daily, which can allow for urgent medical needs to go untreated in a timely manner.

Recommendation 4

That the Santa Barbara County Board of Supervisors propose that on-site mental health professionals be employed at County jails from 11:00 PM to 7:00 AM daily during the upcoming contract negotiation process.

Disclaimer: This report was prepared by the Santa Barbara County Grand Jury except for a Grand Juror who wanted to avoid the perception of a conflict of interest. That Grand Juror was excluded from all parts of this investigation, including interviews, deliberations, writing, and approval of this report.

REQUEST FOR RESPONSE

Pursuant to *California Penal Code Section 933 and 933.05*, the Santa Barbara County Grand Jury requests each entity or individual named below to respond to the enumerated findings and recommendations within the specified statutory time limit:

Responses to Findings shall be either:

- Agree
- Disagree wholly
- Disagree partially with an explanation

Responses to Recommendations shall be one of the following:

- Has been implemented, with brief summary of implementation actions taken
- Will be implemented, with an implementation schedule
- Requires further analysis, with analysis completion date of no more than six months after the issuance of the report
- Will not be implemented, with an explanation of why

Santa Barbara County Board of Supervisors – 90 days

Findings 3, 4

Recommendations 3, 4

Santa Barbara County Sheriff's Office – 60 days

Findings 1, 2

Recommendations 1a, 1b, 2