Office of the Sheriff

SANTA BARBARA COUNTY

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Sheriff - Coroner

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August 19, 2019

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The Honorable Michael J. Carrozzo
Superior Court of Santa Barbara County
Santa Barbara County Courthouse
1100 Anacapa Street
Santa Barbara, California 93101

RE: Response to the Santa Barbara County Grand Jury Report Entitled *"SUICIDE IN CUSTODY"*

Dear Presiding Judge Carrozzo:

Enclosed please find the Santa Barbara County Sheriff's Office response to the 2018-2019 Santa Barbara County Grand Jury Report entitled "*Suicide in Custody*".

Please do not hesitate to contact me if I can provide any additional information.

Sincerely,

BILL BROWN
Sheriff – Coroner

Enclosure

INTRODUCTION

I appreciate the opportunity to respond to the Grand Jury Report entitled, "Suicide in Custody," received on June 27, 2019 (hereafter the "Report"). I respect the Grand Jury and its role and responsibilities in investigating, evaluating and making recommendations to public agencies. I also recognize that the Grand Jury "shall inquire into the condition and management of the public prisons within the county." (Penal Code Section 919.) Internal quality assurance efforts sometimes miss or discount important factors that help an organization improve and grow. When critical or crisis situations occur, the Jury's objective and outside insight can often be an opportunity for reflection, consideration and change in our operations, procedures, and policies.

INACCURACIES

I will now respond to specific parts of the Jury's Report that are inaccurate or do not include pertinent facts, by page, in the order that they appear in the Report. In the following sections, quotations taken directly from the Report are italicized and are followed by the Sheriff's Office response.

Report, Page 1

"First, throughout the investigation, the Sheriff's Office impeded the Jury's ability to obtain what we believed to be highly relevant documents and information, by ignoring requests, making delayed or partial responses, or flatly refusing to honor requests. On more than one occasion, the Jury needed to make two or more follow-up requests before the documents were produced. Moreover, a specific request for the production of important internal investigative reports pertinent to our inquiry – Risk Assessment Unit (RAU) and Criminal Investigation Division (CID) reports in particular - at first was ignored, and ultimately rejected."

Response: First and foremost, we acknowledge that an initial communications breakdown within our organization caused a regrettable delay in our response to the Grand Jury's initial request for information. Upon realization of this, we designated a Sheriff's lieutenant to act as a direct point of contact for the Jury. This lieutenant was responsible for ensuring the Jury's requests for documents and other evidence were addressed in a thorough and timely manner. The reason for this was that many different sections or divisions of the Sheriff's Office were involved in this matter. The lieutenant in question, who was assigned to the Office of the Sheriff, had the authority and ability to request, access, copy, and deliver such materials from the entire agency. Instead of using this person as a resource, the Jury made repeated requests from witnesses throughout our agency to produce documents that they either did not personally possess or have access to, were not familiar with, or of which they had little or no knowledge. In efforts to satisfy these repeated requests, some of the witnesses located and released documents that were in draft form, or that were only partially complete. Although the release of these documents was well intended, this situation created confusion and fueled distrust with one juror in particular. Not making these requests in writing through the designated staff member ensured that delayed and partial responses were provided to the Jury. The Jury was also informed on several occasions that while they had broad access to numerous records, they would not be provided the Risk

Assessment Report as it is protected by the attorney-client privilege. All CID reports were provided to the Jury.

Report, Page 2

"The original 2015 contract between the County and WellPath's corporate predecessor, CFMG, required this accreditation to be obtained no later than April 30, 2017." (Emphasis added.)

Response: The contract between the County of Santa Barbara and California Forensic Medical Group (CFMG) was approved by the Board of Supervisors in February 2017 with an effective date of April 1, 2017. Up until that time, Corizon was the medical provider at the Jail. The contract required National Commission on Correctional Health Care (NCCHC) accreditation to be completed by April 30, 2019.

CFMG merged with another correctional healthcare company and may also be referred to as WellPath in this Response.

"The following are the essential facts surrounding AB's death in custody...In the meantime, the deputies, two of whom were still within their probationary period, continued their investigation inside and around the house."

Response: The Report selectively pointed out that two of the deputies who responded to the call for service were on their probationary periods and thus relatively inexperienced. The Report failed to acknowledge the fact that the on-duty supervisor (sergeant) and an additional deputy sheriff, both highly experienced, were also present and directly involved in the handling of the incident.

"Left alone in the rear of the vehicle, AB became increasingly agitated. Although he began loudly to complain that he was thirsty, no one brought him water. As observed on the dashboard camera video, AB then became even more agitated and began purposely to strike his head violently against the vehicle's interior."

Response: The Report fails to acknowledge that the same video footage from the patrol car documents that the deputies provided AB with the requested water from a water bottle at approximately 6:20 P.M. On the video, one can clearly hear the deputies provide AB with the water he requested, and AB responded by verbally thanking them.

Report, Page 3

"In Santa Barbara County, unlike all other counties in California, it is the Sheriff's Office policy that the arresting officer cannot make that preliminary judgement himself or herself and a mental health professional must first determine if the predicate exists."

Response: This statement is incorrect. While it is true that Santa Barbara County law enforcement officers do not place persons under holds pursuant to California Welfare and Institutions Code § 5150, this is not a Sheriff's Office policy. This is a county-wide policy

applying to all local law enforcement agencies that has been in existence for more than 30 years, it reflects a long history of having mental health evaluations conducted in the field by mobile teams of behavioral health specialists.

"The patrol vehicle's dashboard camera video revealed that, while in transit from his home to the Jail, AB kept calling out to God for help and continued to strike his head forcefully against the vehicle's interior, causing contusions to his forehead."

Response: The patrol car video clearly documents that AB did not, "Call out to God for help," at any point during the drive to the jail. When the evidence is viewed objectively, it is clear that AB was expressing anger at being arrested and was headbutting the plexiglass divider and cursing in an attempt to get the deputy's attention and convince the deputy to either roll down the car window or turn on the air conditioning (which he had already turned on). Furthermore, the Report makes no mention of the fact that the video documents AB stating, "I'm not combative. I was upset because you didn't have your window rolled down."

"Yet, to this point, contrary to the medical provider's policy, it does not appear that anyone made any effort to review computerized or any other records of AB's mental health or arrest history or gave any consideration to whether a "5150" might be indicated. Even a quick review of available records would have revealed that AB was arrested in December 2015, at which time it was noted that AB engaged in "suicidal talk," which triggered a "5150" hold and his transport to the Cottage Hospital Emergency Department." (Emphasis in original.)

Response: The records available to Custody and WellPath staff members at the time of AB's booking did not include the type of previous law enforcement contact information that the Jury contends was "*available*" to them. The record of AB's placement on a 5150 WIC hold in December of 2015 does not reside in the same database as his booking record or medical record, which only records admissions to the Jail.

Report, Page 4

"The video also appeared to show a deputy removing a piece of evidence from the cell. The deputy told the Jury that the item was a towel; however, the Jury believes the item shown in the video was the T-shirt ligature, a potentially important piece of evidence. The T-shirt later reappeared inside a paper bag at the autopsy, as shown by autopsy photographs. However, the Sheriff's Department told the Jury the T-shirt was then "thrown away" and not preserved as evidence."

Response: This alleged mishandling of evidence is false and not upheld by a preponderance of facts that were presented and explained to the Jury. The T-shirt ligature was photographed and packaged by a forensic technician who processed the scene in the jail. The handling of the ligature was documented clearly in the technician's report, which was provided to the Grand Jury. A Coroner's detective received the ligature and placed it with the decedent in a numbered and sealed evidence bag. Those actions were clearly outlined in the Coroner's detective's report, which was also provided to the Jury. Later, at the autopsy, the sealed evidence bag was opened,

and the ligature was removed and photographed by a second forensic technician. Once again, these actions were documented in yet another report, which was provided to the Grand Jury. The evidence is clear that the T-shirt ligature was recorded appropriately, was present at the autopsy for comparison purposes, and was handled in accordance with standard procedure. The item appearing in the video was a soiled towel that was used during resuscitation efforts and subsequently discarded. Despite video, written and testimonial evidence to the contrary, the Report states otherwise.

"The Sheriff's Department told the Jury that the malfunctioning resuscitation equipment had not been retained as evidence, and more importantly, that there was no log or other documentation showing that required inspections of the Jail's life-saving equipment had occurred."

Response: The piece of equipment in question was a suction device that is not contained in the Emergency Response Kit put together for these situations. It was requested after nurses observed vomitus around AB's mouth during resuscitation efforts. While it is true that the suction device malfunctioned, that piece of equipment had been inspected, as required, the week prior to the incident and was found to be in working order. The log for that piece of equipment was offered by WellPath employees to the Jury, however the Jury indicated that it was not required. The faulty suction device and others like it have been discarded and replaced by new cordless models that are more portable and easier to maintain.

Report, Page 5

"The Jury regrets that, for the most part, the Sheriff's Office seemed more interested in obstructing than working cooperatively with the Jury toward that goal." *(Emphasis in original.)*

Response: The allegation that the Sheriff's Office "*seemed more interested in obstructing*" than in working cooperatively with the Grand Jury is false. Despite opinions to the contrary that are included in the Jury's Report, this case demonstrates that the Sheriff's Office takes all matters of the Grand Jury seriously and cooperates with it in all ways practicable. In staff time alone, members from the Custody Operations Branch, Criminal Records Bureau, County Counsel, WellPath, and the Sheriff's Adjutant logged hundreds of hours testifying, researching, reproducing, evaluating, and delivering documentary and other evidence requests made by the Jury. We opened our doors and provided the Jury with escorts to access the scene of the event and other areas of the Jail. We reviewed hours of video on site with members of the Jury, as well as providing recordings of those videos so that they could be reviewed again. The only documentation specifically mentioned by the Jury that was withheld was due to the attorney-client privilege: the Risk Assessment Unit report. As stated above, the Criminal Investigation Division reports were provided to the Jury.

FINDINGS AND RECOMMENDATIONS

Again, let me state that my staff and I take the recommendations of the Grand Jury seriously. Regardless of the tone and portions of the content of the Jury's Report, we have taken an

objective look at their findings and recommendations. It is my hope that in doing so, we might find ways to prevent future suicides.
Pursuant to California Penal Code §§ 933 and 933.05, I submit to you the Sheriff's Office's formal response to the Report's Findings and Recommendations.

Finding 1
One witness who was at the scene of AB's arrest disclosed to the Jury information about AB that the Jury believes might have helped avoid AB's death if Sheriff deputies or medical personnel had obtained it; however, Sheriff's deputies did not interview this witness.

Response: The Sheriff's Office is unable to reasonably respond to this finding, because it has not been provided with the specific information the Grand Jury used as the basis of the finding. What we can state is that several Sheriff's deputies were present at and around AB's residence for approximately 1 ½ hours to investigate the incident. During this time, none of the family members or neighbors present informed the deputies of information that would indicate that AB was suicidal or otherwise at risk of committing suicide.

Recommendation 1
That the Sheriff review and improve training for patrol deputies in responding to calls involving persons who appear to be under the influence of drugs or alcohol, or exhibiting symptoms of mental illness, including questioning persons at the scene who may have relevant information about the subject's condition.

Response: This Recommendation has been implemented. The Sheriff's Office and the County of Santa Barbara recognize the importance of improving our collective capability to safely navigate the intersection between the law enforcement function and the prevalence of mental illness within our local communities. This commitment is evidenced by our collaboration with other agencies and individuals in implementing policy development and changes at the state and local level, and in our implementation of programs and training in how to interact with, and help, mentally ill persons who are encountered in the field or who are in our custody. Some examples of this include:

- Creation of the Sheriff's Behavioral Sciences Unit in 2016.
- Funding and staffing of a dedicated, full time manager, who is a clinical psychologist, for the Sheriff's Behavioral Sciences Unit in 2018.
- Providing Crisis Intervention Training for all sworn and dispatch personnel from our agency and other local law enforcement agencies, and many other professional staff members, in 8 hour and 40 hour courses. To date, 580 Sheriff's Office personnel have successfully completed the 8-hour CIT course, which was certified by the California Commission on Peace Officer Standards and Training (POST). Additionally, 56 Sheriff's Office personnel have completed the 40 hour CIT course.
- In collaboration with the Behavioral Wellness Department (BWD), we developed a pilot in-field Co-Response Team pairing a deputy sheriff with a BWD mental health professional to respond to in-progress calls involving mentally ill people in crisis. The

County recently obtained a collaborative grant, of which SBSO is a part, which funds this team for a period of at least 3 years.

- The Sheriff's Office took the lead in establishing our county's Stepping Up initiative to bring stakeholders from throughout the county together to find ways to reduce criminal justice involvement for the mentally ill.
- Since 2010 the Sheriff has served as a gubernatorially-appointed commissioner on the State of California's Mental Health Services Oversight and Accountability Commission.

The Sheriff's Office will continue to review and improve its many efforts to develop policy and train its personnel in the proper handling of calls involving mentally ill persons.

Finding 2

The transporting deputy radioed ahead to the Jail that AB was 'combative," without disclosing that AB had engaged in self-harming behavior in the patrol vehicle, which the Jury believes was relevant information for Jail personnel to have in determining whether to arrange an immediate psychiatric evaluation.

Response: The Sheriff's Office partially disagrees with Finding 2. As mentioned earlier within this response to the Grand Jury Report, the author of this Report has asserted their subjective opinion that AB had engaged in "self-harming behavior" while in the patrol car. However, AB's aggressive and antagonistic behaviors and verbalizations while in the patrol car were an attempt to get the deputies' attention and express his displeasure with being arrested and/ or with the temperature within the car. The comments were not reflective of an attempt to harm himself. As objective evidence of this, the patrol car video documents AB stating, "*I'm not combative. I was upset because you didn't have your window rolled down.*" (Emphasis added.)

Whenever a suspect is unusually aggressive or self-harming, deputies should certainly notify dispatch and dispatch should notify custody personnel that such a suspect is enroute to the jail. Having additional custody staff present to control the suspect can prevent injury to both the suspect and Sheriff's personnel. That was done in this case. However, what is most important is that the arresting deputy or officer communicate any observations or communications with the suspect or witnesses regarding the suspect's mental condition with custody staff, and that custody and medical staff properly screen the suspect for a history of mental illness to determine proper housing.

Recommendation 2

That the Sheriff review and improve training for all deputies in recognizing and accurately communicating to Jail staff any self-harming behavior by detainees.

Response: The Sheriff's Office implemented this recommendation prior to the Grand Jury Report. Please see response to Recommendation 2. Furthermore, in December 2018, the Sheriff's Behavioral Sciences Unit worked with WellPath to create a form that assists arresting officers in communicating the need for mental health evaluations with Custody staff, including jail medical personnel.

The Sheriff's Office and the County of Santa Barbara recognize the importance of improving our collective capability to respond to and serve mentally ill people within our local communities.

The Sheriff's Office is committed to regularly reviewing and improving training in this area.

Finding 3
The WellPath RN failed to follow established procedure requiring that a medical/mental health evaluation be conducted in a private interview room where the arrestee's computerized records are available for immediate reference.

Response: The Sheriff's Office partially agrees with the Finding. While we agree that the WellPath RN failed to follow the evaluation procedure, whenever an inmate is unusually aggressive the evaluation should not be conducted in a private interview room. Instead, it should be completed in an area where enough custody staff can be present to ensure everyone's safety.

Recommendation 3
That the Sheriff require the current contract health care provider, WellPath, to assure that its staff adhere to all policies, procedures, and contractual obligations regarding the assessment of the medical/mental health status of arrestees upon their arrival at the jail.

Response: The Recommendation was previously implemented. WellPath issued a training bulletin immediately after the incident reinforcing the proper procedure for handling newly admitted detainees who refuse to answer medical/mental health intake screening questions. The Sheriff's Office also issued a directive that included a procedure for identifying newly admitted arrestees that had not been medically screened and the proper procedure for assigning them to temporary housing.

Finding 4
Custody deputies at booking failed to closely examine AB's prior arrest records, which contained information that might have helped avoid AB's death.

Response: The Sheriff's Office disagrees wholly with this finding. The information that the Jury contends was available was not available at the time, since it was not contained in databases that were accessible to custody deputies at the time of booking. They were in fact sealed because of the nature of the call for service.

Recommendation 4
That the Sheriff require custody staff to adhere to its booking policies and procedures, specifically informing themselves as to an arrestee's prior arrest records at booking.

Response: This Recommendation will be implemented. The Sheriff's Office has been thoroughly engaged in projects that are aimed at integrating data across all the disciplines of County government. One such project is the Accurint Virtual Crime Center (VCC), a dashboard

interface that will give Sheriff's Office staff the ability to access records from law enforcement agencies across the State. Custody deputies will be given the appropriate training and access on how to gather information about previous law enforcement contacts that did not result in admission to the Jail, some of which will be records of calls involving mentally ill persons. This will be accomplished when the VCC goes live in Santa Barbara County in the Fall of 2019.

Finding 5
AB was placed in an observation cell monitored by a video camera that failed to show the portion of the cell where AB committed suicide.

Response: The Sheriff's Office agrees with the finding.

Recommendation 5
That the Sheriff either discontinue using Cell C-9 or improve the video equipment there to allow a complete view of the cell.

Response: This Recommendation has been implemented. A directive has been issued restricting the use of the holding cells in Front Central (the area that includes the location where AB committed suicide) to staging for medical appointments, transportation, and other movements. Furthermore, it was directed that henceforth no inmate is to be left alone in any of the cells in that area.

Finding 6
Sheriff's custody staff and WellPath staff failed to follow "man down" procedures regarding management and control of responding personnel.

Response: The Sheriff's Office disagrees partially with the finding. The fact that a large number of staff members responded, arrived and remained on scene during the incident is irrelevant. It does not indicate that those staff members were not properly tasked or managed. The Jury made that determination without the benefit of an audio record, which is not included in the video of the incident. While the appearance of the involvement of a large number of staff members during this incident did not result in a positive outcome during this emergency, there is no evidence that their presence had any adverse effects on the outcome.

Recommendation 6
That the Sheriff require custody staff to receive continued training regarding policies and procedures to be followed in a "man down" situation, particularly to assure proper management and control of the scene and to release personnel no longer needed there.

Response: This Recommendation has been implemented. WellPath and Custody staff conduct a debriefing after every "man down" event. In just the first five months this year (Jan – May 2019), there have been 88 "man down" events. Resource management and scene preservation have been covered in many of those debriefings.

Finding 7
Custody staff failed to properly handle and retain evidence for possible need in the event of further investigation and potential litigation.

Response: The Sheriff's Office disagrees wholly. The Jury, in its own words, "[...] *believes* (emphasis added) the item shown in the video was the T-shirt ligature, a potentially important piece of evidence." This "belief" was not substantiated by any fact. To the contrary, eyewitness testimony was obtained by the Jury that refuted that "belief." Absent any additional evidence that would call into question the veracity of the witnesses, there is no substantive reason to come to that conclusion.

Recommendation 7
That the Sheriff require custody staff to properly handle and preserve evidence connected to incidents occurring at the Jail which later may be needed.

Response: This Recommendation has been implemented.
Custody Deputies are trained in the proper handling of evidence during the Basic Academy. The Sheriff also requires Custody Deputies to periodically be given refresher courses on the proper handling of evidence.

Finding 8
WellPath medical staff and Sheriff custody staff responding to the "man down" announcement was (sic) *unaware of the location of life-saving resuscitation equipment and that it was not functional.*

Response: The Sheriff's Office partially agrees with the finding. Medical and custody staff were aware of the location of the equipment, but once obtained, the suction machine was inoperable.

Recommendation 8
That the Sheriff require WellPath to inspect, repair and replace emergency life-saving equipment on a regular schedule; maintain a service log; and train custody staff regarding the location of life-saving equipment.

Response: This Recommendation has been implemented. The resuscitation equipment in question is inspected, repaired, and replaced on a regular schedule. Records are kept of those inspections. In addition, "man down" debriefings are frequently conducted, as previously discussed under Recommendation 6.

Finding 9
The Jail is operating without National Commission on Correctional Health Care (NCCHC) accreditation, contrary to the contract requirement.

Response: The Sheriff's Office agrees with the finding.

Recommendation 9
That the Board of Supervisors closely examine the provisions of the existing medical provider contract and enforce all of the current provider's obligations, especially with regard to the continuing failure to obtain National Commission on Correctional Health Care (NCCHC) accreditation for the Jail.

Response: This Recommendation has been implemented. The Sheriff, along with representatives from WellPath, are docketed to provide the Board of Supervisors with an annual report of their provision of health care at the Jail, which will include a report of their progress in securing NCCHC Accreditation, on September 17, 2019.

CLOSING
Any time someone takes their own life, whether inside the jail or elsewhere in our community, it is a tragedy. People take their lives because they believe the only way to end the unbearable pain they feel is to end their lives. They die because they don't have the words to express the deep psychological and biological turmoil they are experiencing, and often their burdens go unnoticed and untreated by others in the community. Although we will never be able to stop all those who are determined to commit suicide from doing so, we in the Sheriff's Office are committed to studying cases such as this one to seek ways that might result in successful preventative measures, more effective future interventions, and positive outcomes. We are determined to do what we can to insure that people in crisis receive proper mental health care and treatment. The Sheriff's Office has reviewed this case and we are committed to making improvements in our procedures, in our policies, in our training and in our equipment, and to do what we can, whenever we can, to safeguard life whenever possible, particularly with those who are in our custody. We understand and respect the Jury's authority and responsibility to conduct its investigations. We view the Grand Jury as a catalyst for quality assurance and improvement, and we are committed to fully cooperating with the sitting and future Grand Juries in their investigations.

Lastly, our hearts go out to the family of AB. Mental illness is a pervasive and insidious disease for which relief is, sadly, sometimes elusive. It has a profound effect on others, especially loved ones. On behalf of the men and women of the Sheriff's Office, I extend to them our collective sympathies and condolences.

BILL BROWN
Sheriff
Santa Barbara County

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