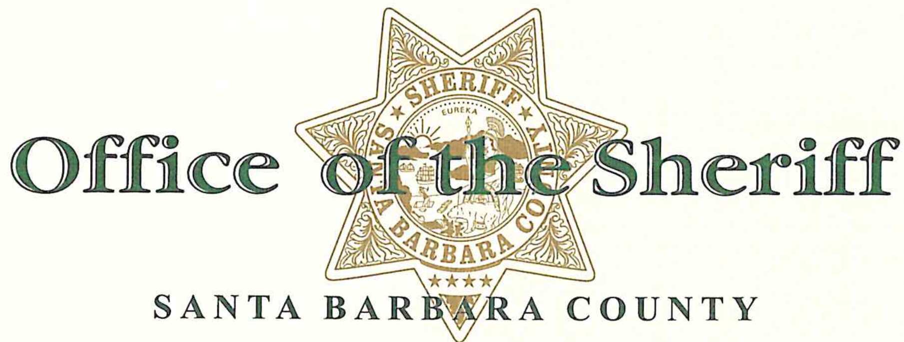

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BILL BROWN
Sheriff - Coroner

SOL LINVER
Undersheriff

February 22, 2022

Pamela Olsen
Foreperson
2021-2022 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 *"Suicide in Santa Barbara County Main Jail".*

Dear Foreperson Olsen:

Enclosed please find the Santa Barbara County Sheriff's Office response to the 2021-2022 Santa Barbara County Grand Jury Report entitled *"Suicide in Santa Barbara County Main Jail".*

As requested in the report, the Sheriff's Office is responding to findings 1, 2 and recommendations 1a, 1b and 2. 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 2021-2022 Report
"Suicide in Santa Barbara County Main Jail."

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.

Response: Disagree partially with an explanation.

The Sheriff's Office disagrees with the contention that there was a failure in communication between the transporting patrol deputy and the WellPath intake Registered Nurse ("RN"). There is clearly a difference in the recollections of the two. The Sheriff's Office asserts that the transporting patrol deputy verbally relayed his observations to the WellPath intake Registered Nurse, who then failed to document those observations. In any event, the facts prove that Inmate A received appropriate and timely mental health care. The referral made by the Classification Deputy triggered a mental health evaluation the following morning by a Licensed Marriage and Family Therapist LMFT who "did not observe any indication of suicidal ideation." Given these facts, an emergent referral was not clinically indicated.

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.

Response: Has been implemented, with a brief summary of implementation actions taken.

At the time of the incident, Wellpath had the referral forms (titled "Referral for Mental Health Services") located in the intake room for arresting agencies to use to notify medical and mental health of any mental health concerns. This form is also used to report any concerning behavior that the arresting agency noticed during the arrest. The completed form is turned into the RN during the intake process. This form has since been moved to outside of the intake room to make it more accessible to the officers. An email has been sent out to all agencies to remind them how to use this form. Wellpath has committed to assist with any necessary training to help the deputies and arresting agencies more efficiently share pertinent medical and mental information.

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.

Response: Will not be implemented, with an explanation of why.

Although the Sheriff's Office and Wellpath are willing to assist in any way legally permissible to increase efficiency in sharing necessary information, the sharing of information of a medical or mental health nature must be consistent with state and federal privacy laws. Over the years, many efforts have been made to attain as much transparency as possible, and those efforts will continue. However, a timeline and implementation plan that shares medical and/or mental health information so broadly cannot be implemented.

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.

Response: Disagree partially with an explanation.

During the intake process, Inmate A did not have a clinical presentation consistent with intoxication or substance use. Inmate A -reported a history of insomnia, PTSD, and bipolar, but denied taking any mental health medications and denied any suicidal ideations. As discussed previously, the intake RN denies being made aware of the transporting patrol deputy's concerns at the time of intake. Patient A was scheduled to see a LMFT the next day. Patient A's intake was completed at 2228 on 2/8/2021 and the patient was seen by a mental health professional at 0959 on 2/9/2021. Based on the patient's presentation at intake and the responses to the mental health and suicide screening intake form, an emergent referral was not clinically indicated.

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.

Response: Has been implemented, with a brief summary of implementation actions taken.

On-going training is required of all WellPath providers and Mental Health training for nursing staff was completed on 06/16/2021. The training was focused on Mental Health referrals during intake screening.