SANTA BARBARA COUNTY GRAND JURY

A Death in Custody | Lessons Learned

SUMMARY

> *"Prisoners are persons whom most of us would rather not think about. Banished from everyday sight, they exist in a shadow world that only dimly enters our awareness."*
>
> *Justice William J. Brennan, Jr.*[1]

JT died in a Santa Barbara County Main Jail safety-cell approximately 20 minutes after he was booked and engaged in a physical struggle with Santa Barbara Sheriff's Office custody staff. The 2022-23 Santa Barbara Grand Jury (Jury) examined the facts surrounding his arrest and incarceration for non-injury domestic violence, his death, and the Santa Barbara Sheriff-Coroner's investigation into the manner and cause of his death.

On the night of January 11-12, 2022, JT, who was morbidly obese, in poor overall health and had a history of drug abuse, suffered a severe mental health crisis. This included multiple suicide threats and ideation.

In Part 1 of this report, the Jury finds that the law enforcement and health care systems failed to provide JT with much needed urgent mental health care intervention. JT was known to be suffering from a mental health crisis by his arresting officers, by the Wellpath (the private provider of health services at the Jail) medical staff on duty at the Jail, and by the custody officers who led JT into a safety cell. Yet, at no time did any of these professionals attempt to provide effective crisis intervention that could have avoided the custody officers' use of force that night. Compounding the problem was that the County

[1] O'Lone v. Estate of Shabazz (1987) 482 U.S. 342, 354 [107 S.Ct. 2400, 2407, 96 L.Ed.2d 282, 293] (Justice Brennan, dissent)

of Santa Barbara does not provide on-site 24/7 mental health services in the Jails, although witnesses told the Jury it was badly needed. After nine months of working on this Report, the Jury wholeheartedly concurs.

In Part 1 the Jury makes findings and recommendations: a) to improve delivery of on-site, 24/7 professional mental health services in the Main and North County Jails; and b) to broadly improve law enforcement officer and jail medical service providers' mental health crisis prevention training and interagency communication skills.

In Part 2 of this report, the Jury finds that the Sheriff's Office conducted the investigation into the actions of its own personnel. The Santa Barbara County Sheriff-Coroner's Office had a duty to investigate all reasonably available evidence. JT was forced into an on-stomach prone restraint hold that he vigorously resisted. The autopsy showed that JT was obese, with a heart condition and had a history of substance abuse. The Coroner's Office found that JT's death was only indirectly caused by the custody staff's on-stomach restraint hold and JT's resistance to it.

The Jury examined all information it was provided by the Santa Barbara County Sheriff-Coroner's Office and found one critical question that was not answered: Whether the custody officers' on-stomach restraint hold and JT's resistance to it was, medically speaking, a direct cause of JT's cardiac arrest. The Jury interviewed two independent, out-of-county medical experts who told the Jury that a subject like JT, especially because of his obesity and other comorbidities, are known to suffer cardiac arrest from prone restraint holds and resistance. Neither the Coroner's Office nor the Santa Barbara County District Attorney's Office discussed or considered whether the on-stomach prone restraint was a direct cause of JT's cardiac arrest.

In Part 2 of this report, the Jury recommends that the County of Santa Barbara and the Santa Barbara Sheriff-Coroner's Office submit JT's case to the State Attorney General's Office for: a) reinvestigation as to whether, from a medical perspective, the custodial

officers' use of the prone restraint and JT's resistance was an indirect or direct cause of JT's death; and b) legal consequences that stem from the Attorney General's reinvestigation.

In making this recommendation for reinvestigation, the Jury expresses no opinion, and none should be inferred, on what factual conclusions should be made once all relevant facts are considered or what legal consequences, if any, should stem from such a reinvestigation of JT's death.

METHODOLOGY

The Jury requested the Santa Barbara County Sheriff's Office to provide all documents relevant to JT's death. Over eight months, the Jury received hundreds of pages of documents, including reports, notes, photographs, and audio and video recordings.

The Jury interviewed nearly 30 witnesses, including experts in physical and mental health, leaders in the Santa Barbara County criminal justice system, and others with knowledge of local programs and systems. In the medical field alone, the Jury interviewed a forensic psychiatrist, cardiologist, forensic psychiatric nurse, PhD psychologist, emergency room doctors, and two forensic pathologists.

Lastly, the Jury researched widely available online sources and professional papers published by experts in areas relevant to this Report.

DISCUSSION OF THE FACTS

PART 1

The 911 call and arrest

At approximately 9:53 p.m. on January 11, 2022, JT was arrested for domestic violence and kidnapping.[2] Two hours earlier, a female victim's 911 call relayed that JT was suicidal. This information was communicated to patrol officers employed by a municipal police department located in Santa Barbara County. JT was arrested and complained about a six-month-old wrist injury while being handcuffed. He was taken to a local private hospital emergency room offering mental and physical healthcare. The arresting officers informed the ER doctor about JT's physical condition but did not inform him about JT's suicide threats. JT stated he suffered from a severe mental illness, but hospital health records did not reflect such a diagnosis. The doctor examined only his physical health.

The municipal police department's policy is to take individuals arrested for domestic violence to Jail to protect the victim. JT's arresting officers believed his mental health issues would be evaluated at the Jail. They did not realize that the County had not contracted to provide mental health services at the Jail from 11 p.m. to 7 a.m. JT was arrested around 10 p.m. and delivered to the Jail just after 1 a.m. The Jury learned that had the hospital known about JT's suicidal ideation, it would have asked for a mental health evaluation before he left the hospital. Because the officers did not inform the hospital about the earlier victim's 911 call or their own observations regarding his behavior, the hospital did not provide JT with skilled mental health crisis intervention.

JT's decompensation after the hospital

When JT was discharged from the hospital, the doctor indicated that if JT decompensated, he should be brought back to the ER. The arresting officers interpreted decompensate to include physical health issues but not mental health issues, such as suicidal threats or ideation. From the hospital to the police station, JT jumped in the back seat, gagging himself on nothing and made multiple bizarre statements including expressing his desire

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[2] Battery is a "willful and unlawful use of force or violence upon the person of another." (Penal Code, § 242.) Section 243(e)(1) of the Penal Code specifies additional conditions for battery against one of the specified familial or intimate relationships. Penalties are enhanced if the victim suffers "inflicted serious bodily injury."

to harm himself. Commendably, the officers' de-escalated the situation. They put a protective helmet on JT, left him in the vehicle, and avoided the use of force. The officers were aware that JT's mental health had worsened, but rather than return to the hospital they delivered him to Jail because they believed he would get immediate mental health assistance.

The mental health challenge in Santa Barbara Jails

The Jury learned that law enforcement interacts with a growing number of subjects that suffer from mental health issues. The Santa Barbara Sheriff's Office webpage states: "Local Santa Barbara County Law Enforcement officials have estimated that anywhere from 15-60% of all calls for service involve some type of contact with a mentally ill subject."[3]

The Jury asked the Santa Barbara County Sheriff's Office for the source data of this statement and for data reflecting current inmate mental health status. The Santa Barbara County Sheriff's Office indicated that such data was not currently available, but hopefully it would be available in the future.[4]

The Jury conducted independent research about the possible scope of mental health issues in jails and prisons. An oft-cited study found that one in four people with a mental health condition has been arrested at some point in their lifetime, and approximately 1% of calls for service involve people with a mental disorder.[5] From the perspective of

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[3] Source: https://www.sbsheriff.org/behavioral-sciences-unit/ Last viewed May 19, 2023.

[4] In July 2022, the Sheriff's Office hired a data analyst who is working to produce such data.

[5] Source: James D. Livingston, "Contact Between Police and People with Mental Health Disorders: A Review of Rates," Psychiatric Services, V. 67, no. 8 (Aug. 2016) Source: https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201500312 Last reviewed May 19, 2023.

California prisons and jails, between 2009 and 2019, there was a 42% increase in the number of active mental health cases in custody. Likewise, over the same period, there was an 80% increase in the total number of inmates receiving psychotropic medication. Ventura County Sheriff's Office provided the Jury with data suggesting that over the period 2007-2020, the Ventura County jail population dropped by 28%, but the number of inmates with identified mental health conditions and diagnosed illnesses nearly tripled (See Appendix I).

The Jury learned from multiple sources that Santa Barbara County agencies suffer from inadequate data collection and interdepartmental data sharing. Even if individual agencies capture relevant data, it is not guaranteed that it will be shared even with those who would benefit from access. Each agency has its own data systems, which often cannot be shared easily with other agencies. The Jury identified a recent study from San Diego that might provide a useful roadmap for Santa Barbara County to use in solving this problem.[6]

The Jail intake process

During the ride from the hospital to the Jail, JT told the transporting officer that he wanted to commit suicide. At approximately 1:12 a.m. on January 12, 2022, a Wellpath Intake nurse[7] met the officer and JT at the intake trailer.

The intake nurse reviewed the paperwork provided by the transporting officer and took JT's vital signs. They were all within normal range. The transporting officer did inform the

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[6] SANDAG, *A Data-Driven Approach to Protecting Public Safety, Improving and Expanding Rehabilitative Treatment and Services, and Advancing Equity Through Alternatives to Incarceration.* Final Report. March 15, 2023. Source: https://www.sandag.org/-/media/SANDAG/Documents/PDF/data-and-research/criminal-justice-and-public-safety/evaluation-services/adults/ati-final-report-2023-04-24.pdf Last reviewed May 18, 2023.

[7] Under contract with the County of Santa Barbara, Wellpath provides comprehensive physical and mental healthcare for approximately 800 jail inmates in the two county jails, one in Santa Barbara and the other in Santa Maria.

nurse that JT was suicidal but did not relay the full extent of JT's decompensation that evening, as set forth above.

As part of the computerized check-in process, the intake nurse asked JT about his physical and mental health history. JT indicated he suffered from a wide range of severe mental illnesses, including extreme anxiety and stress. Also, JT related his present suicidal state of mind and gave specific details of a recent suicide attempt that was prevented by a friend. JT was cooperative, appropriately communicative, and not seemingly under the influence of a drug. However, when the intake RN indicated that JT was going to be placed in a safety cell,[8] JT became highly agitated and he threatened resistance and self-harm.

Lack of 24/7 mental health coverage

The Jury learned that JT was not immediately referred to a professional for mental health evaluation because the County's existing contract with Wellpath, the private provider of health services at the Jail, does not provide mental health professional services overnight.

The Jury interviewed numerous knowledgeable professionals about the need-for 24/7 mental health coverage in the Jails. The vast majority agreed that inmates need mental health services at all hours of the day and night. The Jury learned that 24/7 mental health coverage is not provided because it is considered a low priority. To provide 24/7 mental health coverage, the County would need to amend its contract with-Wellpath. The Ventura County Sheriff's Office, like the Santa Barbara County Sheriff's Office, contracts with Wellpath for physical health and mental health inmate care. The Jury was informed that Ventura County and Wellpath had recently negotiated a contract provision that includes inmate access to on-site 24/7 mental health professional care.

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[8] Santa Barbara County Sheriff's Office, *Custody Operations Policy & Procedures Manual* (Updated June 5, 2019), Policy 304. Source: https://www.sbsheriff.org/wp-content/uploads/2019/11/Custody-Operations-Policies-and-Procedures-Manual-072016.pdf Last reviewed May 19, 2023.

More than one witness indicated that mental health services might be provided by telehealth and/or tele-psychiatry. The Jury explored this but rejected recommending alternatives to 24/7 on-site care. The *Murray* case,[9] a federal class action lawsuit that sought to address the dangerous and unconstitutional conditions at the Santa Barbara Jail, was settled by a court ordered Remedial Plan.[10] Dr. Kahlil Johnson, board certified general and forensic psychiatrist, was appointed Mental Health Expert to make progress reports regarding Santa Barbara County's meeting Remedial Plan requirements. In his most recent report (Second Report, April 23, 2023), he states that currently most of the mental health care in the jails is provided by tele psychiatry services. He opines that while it is better than no care, telehealth services have drawbacks. "The standard of care remains in-person psychiatric care of inmates."[11] Dr. Johnson made the following recommendation:

> "Expand onsite psychiatric care as soon as possible with the goal being that tele psychiatry is supplemental to onsite psychiatric care."[12]

Murray Case: Mental health intake responsibilities

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[9] Murray et al. v. County of Santa Barbara et al. Case No. 2:17-cv-08805.
[10] Murray Case, Class Action Stipulated Judgment, Exhibit A (July 17,2020). PDF copy available at: https://www.disabilityrightsca.org/system/files/file-attachments/Stipulated%20Judgment%207-17-2020.pdf Last reviewed May 27, 2023.

[11] Murray Case, Dr. Khalil Johnson, Remedial Plan Mental Health Report (Second Round) April 24, 2023, p. 25. https://www.disabilityrightsca.org/system/files/file-attachments/2023-04-24%20Murray%20Second%20Round%20Mental%20Health-Suicide%20Prevention%20Report%20w%20Cover%20Letter%20FINAL.pdf

[12] Ibid. p. 26.

The *Murray* Case Remedial Plan specifically set standards for the Santa Barbara County Jail intake procedures. For example, the intake nurse must use a screening tool to identify individuals at risk of self-injury and the risk factors that need a mental health referral.[13]

The night of JT's booking the intake nurse fulfilled these duties:

1. To make a mental health computerized "referral" entry; and
2. To recommend that JT be placed in a safety cell.

If JT had been booked during the day shifts, the intake nurse would typically have asked a Wellpath mental health professional to see and evaluate JT. Because no such professional was available on-site during the night shift, the intake nurse provided no mental health intervention after JT said he would fight against being placed in a safety cell. The Jury learned that Wellpath medical nurses are not trained to provide advanced mental health crisis response. Yet, according to the Remedial Plan, when mental health staff is not available, the on-duty medical nurse "shall respond" to emergent and/or urgent mental health cases within four (4) hours or "sooner if clinically indicated."

The Jury learned that the duty of the on-duty medical nurse to "respond" in urgent or emergent situations requires the on-duty nurse to do more than put someone into a safety cell, especially when critical care cannot be provided for six or more hours. The Jury learned that-pursuant to the Remedial Plan,-the on-duty intake nurse was required "to perform an evaluation appropriate for the presenting problem." The intake nurse did not fulfill this responsibility primarily due to a lack of training from Wellpath. Because the nurse was not adequately trained, the Santa Barbara County Jail again did not provide JT with needed professional mental health crisis intervention.

The Jury learned the intake nurse had options to reach out for assistance. The intake nurse had an option to call Wellpath employed regional mental health supervisors, but

[13] See fn. 11. Exhibit A, Remedial Plan, Sec. III.B.1, p. 13/56.

the nurse's on-the-job training did not include this information. The intake nurse could have called a Santa Barbara County's Behavioral Wellness' (BeWell) Mobile Crisis Team. One was available and would have responded if asked.

Transfer to Custody Staff and booking

At approximately 1:15 a.m., the intake nurse transferred JT to the custody deputies, who admitted him into the Jail. The intake nurse told the custody deputies that JT threatened to resist being placed into an isolation cell. As a result, the senior custody officer summoned a five-member Santa Barbara County Sheriff's Office Special Operations Response Team (SORT)[14] to place JT into a safety cell.

Knowing JT would resist being placed into a safety cell, the officers were required to follow the Santa Barbara County Sheriff's Office's use-of-force policy. It provided that, when "feasible, deputies should consider utilizing de-escalation, crisis intervention tactics and other alternatives to force in order to slow down or mitigate situations that may otherwise lead to the use of force."[15] Additionally, in gauging the reasonableness of using force, one factor is "The availability of other options and their possible effectiveness."[16] The custody deputies told JT that the safety cell was for his protection. The Santa Barbara County Sheriff's Office policy also recognizes what numerous mental health professionals told the Jury: People with mental health disabilities often lack the "ability to understand or comply with commands from peace officers."[17]

Entry into the safety cell and the officers' use of force

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[14] Special Operations Response Team. SORT's mission: "provide safety, security, control and order for Custody Operations in incidents of critical or high-risk nature," including "high risk prisoner transportation." Source: https://www.sbsheriff.org/special-operations-response-team-sort/ Last reviewed May 16, 2023.
[15] Sheriff's Policy Manual, Sec. 300.2.1.
[16] Sheriff's Policy Manual, Sec. 300.2.1(h).
[17] Sheriff's Policy Manual, *Use of Force,* Sec. 300.2.1(e)(1), p. 48. Source: https://www.sbsheriff.org/wp-content/uploads/2021/03/Santa-Barbara-Sheriff-2021-Policy-Manual.pdf Last reviewed May 19, 2023.

The Jury was provided image-only, timestamped videos.[18] At 1:16 a.m., five officers escorted JT down the corridor to the safety cell. Despite his prior threats, JT offered no resistance in the hallway and exhibited no signs of distress.

At 1:21 a.m.[19], the officers and JT entered the safety cell. JT offered no resistance as he was led into the cell, handcuffed from behind. Santa Barbara County Sheriff's Office safety cell procedures require inmates to be stripped naked.[20] JT's first act of resistance was when he refused to help the officers take off his clothing. One officer pulled JT's shirt towards his shoulders while another lowered his pants. Three officers lowered JT to his knees and onto his stomach, his hands still cuffed behind him. JT's active resistance began once he was lowered onto his stomach where a different officer held each of his arms and one officer pushed JT's legs into a figure-four bent towards his buttocks. JT fiercely resisted this on-stomach prone restraint hold.

Officers' weight was put on JT's posterior

Until the officers retreated from the cell completely (1:27 a.m.), the officer who held JT's left arm had his right knee on top of JT's lower back, starting just above the buttocks and ranging up to and occasionally up the back towards the thoracic region. The officer who held JT's right arm had his right knee on JT's right shoulder close to his neck.

JT said he could not breathe

Approximately two minutes after entering the cell (1:21-1:23 a.m.), JT's cuffs were unlocked, and the last of his clothing was removed. A fourth officer handed these items to a fifth standing outside the safety cell. JT said he could not breathe and he made grunting and snorting sounds.

[18] The videos offer only visual images without sound.
[19] Stated times in parenthesis are from the video.
[20] See fn. 8. Policy 304, sec. IV Procedures, no. 9. Page 116/292.

For a period of four minutes after he was uncuffed and stripped, three officers continued to hold JT down in the on-stomach prone restraint position. JT continued to struggle and resist. The Jury learned that the officers continued holding him for four more minutes in the prone restraint position, in part, to tire him out.

The last of the officers left the safety cell at 1:27 a.m. JT was still on his stomach, face down, and motionless.

The video did not record images for the next six (6) minutes because a motion sensor operates it. The officers noticed JT did not move. Some of them thought JT was playing possum. They shouted at him through a feeding slot in the door. To get a reaction from him, one officer pushed a button outside the cell to flush the safety cell toilet, which made a loud noise. JT did not react. The officers reentered at 1:33 a.m. and determined that JT had no pulse. The officers turned him over, and custodial officers traded off administering CPR. The intake nurse arrived, followed by emergency response personnel. No pulse was detected. JT was pronounced dead at 2:03 a.m.

Advanced mental health 40-hour training

Knowledgeable sources informed the Jury that all Santa Barbara County Sheriff's Office custody deputy staff would benefit from advanced mental health training consisting of at least 40 hours.[21]

Approximately four years ago, the Santa Barbara County Sheriff's Office hired an experienced clinical psychologist to establish a Santa Barbara County Sheriff's Office Behavioral Sciences Unit (BSU).[22] The BSU psychologist and BeWell created co-response teams whereby specially trained Santa Barbara County Sheriff's Office patrol officers are teamed in the field with BeWell's professional mental health staff. Currently, three such

[21] The Jury was unable to obtain course content for the 40-hour course developed by the Sheriff's Behavioral Science Unit's psychologist.
[22] https://www.sbsheriff.org/behavioral-sciences-unit/ Last reviewed May 15, 2023.

teams operate county-wide, with plans for a fourth to start during summer 2023. The Jury has learned from numerous sources that the co-response teams have worked well and produced measurable, positive results. Cases have been resolved in the field, with many subjects suffering from mental health issues referred to community-based programs instead of Jail. The municipal police agency that arrested JT has a similarly trained co-response crisis intervention team within its jurisdiction.[23]

The law enforcement officers participating on co-response teams have all received advanced 40-hour mental health training. While every sworn law enforcement officer, including custody deputies, receives approximately eight hours of mental health care training delivered by the basic training academy they attend before being hired, this represents less than 1% of over 800 hours of academy instruction. Recently hired custody officers must take the 40-hour advanced mental health course designed by the BSU psychologist. However, existing custody staff, many of whom have been employed for decades, must volunteer to obtain this training. The Jury was informed that the custody officers involved with JT that night of his death did not receive this advanced training.[24]

"Why?" The key question that was not asked

The Jury learned from experts that a mental health professional or custody deputy with advanced mental health crisis response training likely would have started by asking JT: "Why?... Why are you so afraid of being put into an isolation cell?" The purpose of crisis intervention training is "to provide law enforcement officers with the cognition, information, resources, and skills that allow effective problem-solving and promote positive outcomes when responding to incidents involving mental health

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[23] See generally, CALIFORNIA COMMISSION ON PEACE OFFICER STANDARDS AND TRAINING. *A FIRST RESPONDER'S GUIDE FOR PERSONS WITH MENTAL ILLNESS OR DEVELOPMENTAL DISABILITY*. February 2020. Source: https://post.ca.gov/Portals/0/post_docs/publications/mental-health/Mental_Health.pdf Last reviewed May 19, 2023.

[24] The Jury asked for all involved custody deputies' training records and training course content. These documents were not provided to the Jury.

consumers."[25] In other words, such training provides officers with tools that can help avoid and/or reduce the use of force. None of these tools was used to control JT without resorting to force.

PART 2

The Sheriff-Coroner death-in-custody investigation and autopsy

In Santa Barbara County, the Sheriff-Coroner[26] is an elected office held by a single person. In accordance with law and policy, the Sheriff-Coroner initiated an investigation into JT's death in custody.[27] An investigation of this nature consists of:

1. Preserving physical evidence, such as JT's body, clothing, all documents regarding JT's arrest and incarceration, and the 'real-time' image-only videos taken of JT being placed into the safety cell;
2. Preserving the scene where JT died for study and investigation, such as taking photographs of the deceased and his immediate surroundings;
3. Interviewing witnesses, such as the Santa Barbara County Sheriff's Office custodial deputies with knowledge of the events leading up to JT's death; and
4. Conducting an autopsy performed by a forensic pathologist.[28]

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[25] CA Peace Officers Standards and Training, "What does CIT training consist of?" Source: https://post.ca.gov/crisis-intervention-team#:~:text=The%20primary%20goals%20of%20a,consumers%20during%20law%20enforcement%20contacts. Last reviewed May 29, 2023.

[26] According to the Sheriff-Coroner's website, the offices of Sheriff and Coroner were combined into one elective office in 1947. Source: https://www.sbsheriff.org/command-and-divisions/office-of-the-sheriff/coroners-bureau/ Last reviewed May 16, 2023.

[27] "It shall be the duty of the coroner to inquire into and determine the circumstances, manner, and cause of all violent, sudden... deaths...[and] deaths in prison...." (Gov. Code, § 27491.)

[28] The forensic pathologist is an MD with a subspecialty in pathology whose area of special competence is the examination of persons who die suddenly, unexpectedly, or

The Sheriff-Coroner's forensic pathologist and the assigned Deputy Sheriff-Coroner, not a medical doctor, determined that JT died of sudden death due to the combination of five factors (Combined Factors):

1. morbid obesity[29]
2. dilated cardiomyopathy[30]
3. acute methamphetamine intoxication[31]
4. active resistance
5. restraint

Based the Combined Factors ruling, the Deputy Sheriff-Coroner found that JT's death was an accident,[32] which appears on JT's death certificate. Based on the Coroner's 'Combined Factors' ruling, the Santa Barbara County District Attorney's Office concluded that the on-

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violently. The forensic pathologist is a medical doctor with special expertise in determining cause and manner of death. Source: https://www.forensicscolleges.com/blog/htb/how-to-become-a-forensic-pathologist Last reviewed May 16, 2023.

[29] Class III obesity, formerly known as morbid obesity, is a complex chronic condition that can lead to several serious health issues. Source: https://my.clevelandclinic.org/health/diseases/21989-class-iii-obesity-formerly-known-as-morbid-obesity Last reviewed May 16, 2023.

[30]Penn Medicine. https://www.pennmedicine.org/for-patients-and-visitors/patient-information/conditions-treated-a-to-z/dilated-cardiomyopathy#:~:text=Dilated%20cardiomyopathy%20(DCM)%20is%20a,the%20rest%20of%20the%20body Last reviewed May 16, 2023.

[31]Eugene A. Kiyatkin, and Hari S. Sharma. *Acute Methamphetamine Intoxication: Brain Hyperthermia, Blood-Brain Barrier, and Brain Edema.* Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3145326/ Last reviewed May 16, 2023.

[32] On a death certificate, a Deputy Coroner is presented with the following choices for Manner of Death: Natural causes; Accident; Homicide; Suicide; Traffic related; Could not be determined. Source: https://www.sbsheriff.org/command-and-divisions/office-of-the-sheriff/coroners-bureau/ Last reviewed May 16, 2023.

stomach restraint hold and resistance to it was two of five factors that contributed to JT's death, stating explicitly that they were not the direct cause of JT's death.[33]

The Duty of the Sheriff-Coroner

The Coroner's staff has the "duty to inquire into and determine the circumstances, manner, and cause of all violent, sudden... deaths...[and] deaths in prison."[34] This requires a determination and establishment of an accurate cause of death, which includes an examination of all possible causes. According to the Sheriff-Coroner's webpage, the purpose in these "often emotional and difficult death investigations... [is] to provide answers to loved ones."[35] In the words of a California appellate court,

> "There has long been widespread recognition and acceptance of the importance of developing accurate and adequate information about the death of each and every human being, whenever possible."[36]

The Jury learned that within reasonable medical certainty, the custody staff applied on-stomach-prone restraint and JT's vigorous resistance to it was the direct cause of JT's cardiac arrest.

The Interviews conducted by the Coroner[37]

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[33] Office of the District Attorney, County of Santa Barbara, PUBLIC REPORT ON THE DEATH OF [JT] IN SANTA BARBARA COUNTY JAIL ON JANUARY 12, 2022 @ *p. 8.* October 6, 2022.
Source:https://da.countyofsb.org/documents/JonathanPaulThomasICDfinal.pdf https://da.countyofsb.org/documents/JonathanPaulThomasICDfinal.pdf Last reviewed May 30, 2023.

[34] Gov. Code, § 27491.
[35] Source: https://www.sbsheriff.org/command-and-divisions/office-of-the-sheriff/coroners-bureau/ Last reviewed May 19, 2023.
[36] People v. Roehler (1985) 167 Cal.App.3d 353, 374.
[37] The Jury learned that the interviews were monitored remotely from another room by a Santa Barbara Deputy District Attorney and one of its investigators.

All key witnesses to JT's death were Santa Barbara County Sheriff's Office employees, except three civilians. The Jury interviewed the Deputy Coroner who conducted the investigation and the forensic pathologist who conducted the autopsy. The Jury investigated the following questions:

1. Medically speaking, what does it mean that JT died from Combined Factors?
2. But for[38] the restraint hold and JT's resistance to it, would JT have died that day from his weak heart and acute methamphetamine intoxication?

These unanswered questions led the Jury to interview two independent medical doctors. Both practice outside of Santa Barbara County, and both have considerable experience in understanding the mechanism of death under the abovementioned circumstances. The independent forensic pathologist and the independent cardiologist explained that morbid obesity is widely known to contribute to what was discovered during JT's autopsy, including an enlarged heart, restricted lung capacity,[39] and exacerbated hypertension.[40] The autopsy toxicology report showed that JT exhibited acute methamphetamine intoxication.[41]

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[38] "'But-for the injury (or hostile environment), would the person have died when he/she did?' This logic is often cited as a simple way to determine whether a death should be classified as natural or non-natural (homicide, suicide, accident)." Randy Hanzlick, et al. *A Guide for Manner of Death Classification.* First Edition. National Association of Medical Examiners. (2002)Source: https://name.memberclicks.net/assets/docs/MANNEROFDEATH.pdf Last reviewed May 16, 2023.

[39] "There is a major epidemic of obesity, and many obese patients suffer with respiratory symptoms and disease. The overall impact of obesity on lung function is multifactorial, related to mechanical and inflammatory aspects of obesity." Dixon AE, Peters U. The effect of obesity on lung function. Expert Rev Respir Med. 2018 Sep;12(9):755-767. doi: 10.1080/17476348.2018.1506331. Epub 2018 Aug 14. PMID: 30056777; PMCID: PMC6311385 Last reviewed May 16, 2023.

[40] The Jury learned from the cardiologist that JT's respiratory capacity was compromised because of his obesity, i.e., the excessive fat surrounding the chest cavity constricted the pulmonary function and caused his heart to work harder, i.e., causing higher than normal blood pressure.

[41] Kiyatkin EA, Sharma HS. Acute methamphetamine intoxication: brain hyperthermia, blood-brain barrier, brain edema. Int Rev Neurobiol. 2009; 88:65-100. doi:

Since 1995, law enforcement agencies nationwide have been advised to avoid using prone restraint holds, especially on obese individuals.[42] The Jury learned from the independent cardiologist that on-stomach-prone restraint and JT's resistance created a dangerous situation for someone morbidly obese.[43] The more people strain and work their muscles, the more CO2 is created, which must be expelled from the lungs. When people have trouble breathing, such as for an obese person placed in an on-stomach prone restraint position, there's a decrease in breath ventilation and a corresponding decrease in cardiac output. The body takes in less oxygen and at the same time it purges less carbon dioxide. The acid levels in the blood rise, a condition termed metabolic acidosis. Further, the Jury learned that the higher the acidosis, the lower the pH, which increases the risk of cardiac complications. When the pH gets too low, the heart can stop.

The Jury learned from the Coroner's pathologist, the independent pathologist and independent cardiologist that from a medical perspective JT was a high medical risk individual. The three concur that JT's physical exertion in opposition to the force used by the custodial deputies to control him was linked in some way to his sudden death. However, the Coroner's pathologist and the two independent doctors disagreed on whether, within reasonably medical certainty, there was a direct link between the custody staff's restraint hold and JT's resistance to that hold, on the one hand, and JT's sudden death, on the other.

10.1016/S0074-7742(09)88004-5. PMID: 19897075; PMCID: PMC3145326 Last reviewed May 16, 2023.

[42] See National Law Enforcement Technology Center, Positional Asphyxia—Sudden Death. June 1995. Source: https://www.ojp.gov/pdffiles/posasph.pdf Last viewed May30, 2023.

[43] Weedn V, Steinberg A, Speth P. Prone restraint cardiac arrest in in-custody and arrest-related deaths. J Forensic Sci. 2022 July; 67:1899-1914. doi: 10.1111/1556-4029.15101. Epub 2022 Jul 22. PMID: 35869602; PMCID: PMC9546229. Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9546229/pdf/JFO-67-1899.pdf Last viewed May 30, 2023.

Coroner's conclusion

From the perspective of the Coroner's pathologist who conducted the autopsy, the prone restraint hold and JT's resistance to it were only two of five factors contributing to JT's death. According to his view, JT's enlarged and weakened heart could have killed him at any time. He could have walked into a cell and sat down on his own without anyone touching him and suffered a cardiac arrest. Even without the restraint and resistance to it, JT may have died that night from his high-risk health problems. The Sheriff-Coroner's Office labeled JT's death an accident.

Independent doctors' opinion

The independent pathologist and an independent cardiologist said, within reasonable medical certainty, that JT died from cardiac arrest caused by the on-stomach-prone restraint hold, including knees on his back and shoulder near his neck, and JT's vigorous resistance to it. The cardiologist stated that some studies indicate that the weight of a single knee on the back of a struggling subject can be approximately 50 lbs. In addition, the video shows two officers each with a knee on JT for the entire time they had him on the ground.

These two independent experts agree[44] that the restraint applied by the custody officers and JT's resistance, within reasonable medical certainty, caused JT's cardiac arrest.[45] From this, JT's death would more accurately be labeled as a homicide on the death certificate. [46]

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[44] The Jury interviewed them at separate times.

[45] This is a medical opinion, not a legal one. Questions such as did the custody officers harbor criminal intent or commit criminal negligence are within the province of the District Attorney. Questions such as whether the force was excessive, whether the officers followed or did not follow their training--more broadly, were the officers negligent-- also were not considered by the Jury. The reader is cautioned not to draw any inference to the contrary.

[46] "...[T]he classification of Homicide for the purposes of death certification is a "'neutral'" term and neither indicates nor implies criminal intent, which remains a determination

Custody deputy prone restraint training

The Jury learned that Santa Barbara County Sheriff's Office's on-stomach restraint hold training includes warnings against use of carotid restraint, meaning holds in which pressure is applied to the sides of a person's neck that involves a risk of restricting blood flow.[47] The Jury learned from several sources that serious injuries, including death, can occur if a struggling subject is placed on their stomach in a prone restraint position, handcuffed from behind, and weight is placed on the subject. The Jury's investigation revealed awareness by custody deputies of prone restraint dangers. They emphasized that while JT was in the on-stomach-prone restraint position, they put as little weight as possible on JT.

Did the Sheriff-Coroner fulfill its duty?

The state forbids restraint holds that reduces the ability to sustain adequate breathing.[48]The autopsy report and Sheriff-Coroner's investigation did not explain what actions were taken by custody staff after JT said that he could not breathe. Nor did it examine JT's ability to breathe adequately given the weight of the officers' knees on his lower-to-middle back and on his shoulder close to his neck. The officers had achieved their objectives within two minutes: JT was uncuffed and stripped. Yet, they kept him in

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within the province of legal processes." Randy Hanzlick, et al. *A Guide for Manner of Death Classification.* First Edition. National Association of Medical Examiners. (2002) Source: https://name.memberclicks.net/assets/docs/MANNEROFDEATH.pdf Last reviewed May 16, 2023.

[47] Santa Barbara County Sheriff's Office, SO Policy Manual. (2021) Sec. 300.3.7.

[48] "A law enforcement agency shall not authorize techniques or transport methods that involve a substantial risk of positional asphyxia." Government Code section 7286.5, subdivision (a)(2), Positional asphyxia means situating a person in a manner that compresses their airway and reduces the ability to sustain adequate breathing. This includes, without limitation, the use of any physical restraint that causes a person's respiratory airway to be compressed or impairs the person's breathing or respiratory capacity, including any action in which pressure or body weight is unreasonably applied against a restrained person's neck, torso, or back, or positioning a restrained person without reasonable monitoring for signs of asphyxia. (Gov. Code, § 7286.5(b)(4).)

an on-stomach-prone restraint position for four additional minutes. The Sheriff-Coroner's Office investigation did not disclose whether holding JT in the prone restraint position for four minutes was within the Santa Barbara County Sheriff's Office custody staff's use of force policies.

Confirmation bias

The Jury had many questions about why the Coroner's Office failed to consider medical-physiologic facts about the relationship between cardiac arrest and restraint hold and resistance by morbidly obese individuals. Since the Sheriff-Coroner was investigating the conduct of its own personnel, confirmation bias is one plausible explanation.

> One psychological process by which investigators reach the wrong conclusion is confirmation bias. Confirmation bias is the tendency to bolster a hypothesis by seeking consistent evidence while disregarding inconsistent evidence (Nickerson, 1998). In criminal investigations, a preference for hypothesis-consistent information undermines accuracy by leading investigators to overlook potentially relevant evidence that challenges their theory.[49]

Independent review of deaths-in-custody

California law mandates that the Santa Barbara County Sheriff's Office report all deaths in custody to the Attorney General.[50] Additionally, the Santa Barbara County Sheriff's

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[49]://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fdx.doi.org%2F10.2139%2Fssrn.913357&data=05%7C01%7Cmbabcock%40sbcourts.org%7C78b73d3f3b444c3ed04808db71bea7c7%7C4a1d091552d847db8133b686194f77c7%7C0%7C0%7C638228835902824345%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=NMhp%2BjcPWK%2F4cMtTg9nROmAuicxh9eHM%2FiobuLezzIQ%3D&reserved=0" \t "_blank" \o "Original URL: https://dx.doi.org/10.2139/ssrn.913357. Click or tap if you trust this link."http://dx.doi.org/10.2139/ssrn.913357 Last reviewed May 19, 2023.

[50] "... [T]he law enforcement agency or the agency in charge of the correctional facility shall report in writing to the Attorney General, within 10 days after the death, all facts in the possession of the law enforcement agency or agency in charge of the correctional facility concerning the death." (Gov. Code, § 12525.)

Office must report monthly to the state Department of Justice whether any "incident in which the use of force by a peace officer against a civilian results in serious bodily injury or death," including whether the civilian suffered from a "mental disability."[51] The Legislative history states that these laws were inspired by the *Presidential Task Force on 21st Century Policing* (May 2015) (Task Force)[52]. The Task Force Report intends to "strengthen community policing and trust among law enforcement officers and the communities they serve - especially in light of recent events around the county that have underscored the need for and importance of lasting collaborative relationships between local police and the public." Specifically, the Task Force adopted:

> *2.2.2 Action Item:* These policies should also mandate external and independent criminal investigation in cases of police use of force resulting in death, officer-involved shooting resulting in injury or death, or in-custody deaths.

District Attorney's decision not to prosecute

In Santa Barbara County, the Sheriff-Coroner and Santa Barbara County District Attorney have an arrangement whereby the District Attorney's Office reviews all officer-involved shootings or deaths. The District Attorney's policy states that control of such investigations is per the employing agency's protocol,[53] meaning that regarding the death of JT, the method and manner of the investigation is to be conducted in accordance with

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[51] Gov. Code, § 12525.2, subd. (a)(3) and (d)(2).

[52] President's Task Force on 21st Century Policing. May 2015. *Final Report of the President's Task Force on 21st Century Policing.* Washington, DC: Office of Community Oriented Policing Services. Published 2015. Source: https://cops.usdoj.gov/pdf/taskforce/taskforce_finalreport.pdf Last reviewed May 19, 2023.

[53] Officer-involved shootings and deaths Source: https://da.countyofsb.org/documents/DA_OIS_Protocol.pdf Last reviewed May 19, 2023.

the Sheriff-Coroner's procedures. The District Attorney also investigates law enforcement officer-involved deaths, use of deadly force incidents and restraints.[54]

Once the Sheriff-Coroner completed its investigation of JT's death in custody, the reports and videos were submitted to the District Attorney for review.–It considered two legal questions:

1. Did the custody deputies apply reasonable and lawful force to JT's body while they were inside the safety cell?
2. Does any involved custody deputy bear state criminal law liability?

On October 6, 2022, the District Attorney's Office posted a public report announcing it was declining to file charges against anyone, stating that the custodial deputies did not harbor criminal intent, i.e., "...there is no credible evidence that any of the custody deputies intentionally tried to harm [JT], [and thus] no criminal liability for murder or manslaughter is present." The District Attorney's Office analysis starts by stating that it accepted the Sheriff-Coroner conclusion that JT's death was "accidental" and that multiple combined factors caused his death. The restraint used was only one factor and not the direct cause of JT's death.[55]

The District Attorney's Office appears to have found that JT's death was not caused by positional asphyxia, carotid restraint or choke hold.[56] Nowhere in its report does the

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[54] Santa Barbara County District Attorney Policy Manual, sections 300-304. https://da.countyofsb.org/documents/1-31-23%20SBDA%20Investigations%20policy%20for%20webpage.pdf Last viewed June 16, 2023.

[55] Office of the District Attorney, County of Santa Barbara, PUBLIC REPORT ON THE DEATH OF [JT] IN SANTA BARBARA COUNTY JAIL ON JANUARY 12, 2022 @ *p. 8.* October 6, 2022.
Source:https://da.countyofsb.org/documents/JonathanPaulThomasICDfinal.pdf https://da.countyofsb.org/documents/JonathanPaulThomasICDfinal.pdf Last reviewed May 30, 2023.

[56] District Attorney Report, p. 10, n 9. See also, Gov. Code, § 7286.5

District Attorney's Office consider whether the custody staff's use of its on-stomach prone restraint hold and JT's resistance to it caused metabolic acidosis and cardiac arrest, as opined to the Jury by the independent cardiologist and independent forensic pathologist.[57]

CONCLUSION

JT died in a jail cell while suffering from a mental health crisis. The criminal justice and heath care systems offered numerous opportunities to provide JT with effective mental health crisis intervention. Each of those opportunities was missed for preventable reasons, including lack of awareness, miscommunication, inadequate training, and lack of mental health professionals on duty 24/7 at the Jail.

Additionally, the Coroner's and later District Attorney's Office investigation of the manner and cause of JT's death failed to address whether the custody officers' restraint hold and JT's resistance to it caused high metabolic acidosis and cardiac arrest. The Jury recommends that the Santa Barbara County Sheriff's Office ask the State Attorney General to independently review the facts surrounding and legal conclusions that stem from JT's death-in-custody.

FINDINGS AND RECOMMENDATIONS

Finding 1

Under the existing agreement between the County and Wellpath, Santa Barbara County does not provide mental health professional care onsite in the Jails from 11 p.m. to 7 a.m.

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[57] See n 465.

Recommendation 1

That by the end of the second quarter of FY 2023-24, Santa Barbara County amend the existing agreement between the County and Wellpath to provide Jail inmates, in both the north and south facilities, with overnight (24/7) mental health professional onsite services.

Finding 2

Wellpath medical staff do not receive advanced training on mental health crisis intervention, which can be critical in circumstances when mental health staff are not on duty or not otherwise available and is required under a federal court order.

Recommendation 2a

That by the end of the first quarter of 2023-24, Santa Barbara County amend the existing agreement between the County and Wellpath (or its successor) to provide all medical staff with advanced 40-hour mental health crisis response training.

Recommendation 2b

That by the end of the first quarter of 2023-24, Santa Barbara County amend the existing agreement between the County and Wellpath (or its successors) that requires Wellpath medical staff, when faced with an emergent or urgent mental health case when Wellpath mental health staff is not on duty or available, to be trained on how to obtain outside assistance from a) senior regional Wellpath mental health staff and/or b) an available County Behavioral Wellness Crisis Management Team.

Finding 3

The majority of the Santa Barbara County Sheriff's Office custody staff hired pre-2021 have not been provided 40-hour mental health crisis response training. Although the Santa Barbara County Sheriff's Office offers an advanced mental health 40-hour training course for members of its patrol co-response teams and for Santa Barbara County

Sheriff's Office custody staff recent hires, it does not mandate this for custodial staff hired before 2021.

Recommendation 3

That by the end of the first quarter of FY 2023-24, Santa Barbara County and Santa Barbara County Sheriff's Office provide funding so that the Sheriff's Office implement effective advanced mental health crisis response training consisting of at least 40 hours of instruction and annual refresher training consisting of at least eight-hours for its custody staff.

Finding 4a

JT's mental health crisis was not adequately evaluated at the local hospital because municipal law enforcement patrol officers did not share with hospital staff available vital information of JT's suicidal threats and ideation.

Finding 4b

All cities in Santa Barbara County with their own police departments, i.e., cities of Guadalupe, Lompoc, Santa Barbara, and Santa Maria, and the Santa Barbara County Sheriff's Office patrol officers and supervisory personnel would benefit from advanced mental health crisis response training consisting of at least 40 hours of instruction and annual refresher training consisting of at least eight-hours.

Recommendation 4a

That by the end of the first quarter of 2023-2024 all cities in Santa Barbara County with their own police departments, i.e., cities of Guadalupe, Lompoc, Santa Barbara, and Santa Maria, provide funding for advanced mental health crisis response training for patrol officers and supervisory personnel consisting of at least 40 hours of instruction and annual refresher training consisting of at least eight hours.

Recommendation 4b

That by the end of the first quarter of 2023-24, Santa Barbara County provide funding to the Santa Barbara County Sheriff's Office and the Sheriff's Office implement for its patrol staff and supervisors effective advanced mental health crisis response training consisting of at least 40 hours of instruction and annual refresher training consisting of at least eight hours.

Finding 5

Lawfully shared data collection and analysis among multiple Santa Barbara County law enforcement agencies (Santa Barbara County Sheriff's Office, Santa Barbara County District Attorney's Office, Santa Barbara County Public Defender, Santa Barbara County Probation Department), the municipal police departments in Santa Barbara County (Guadalupe, Lompoc, Santa Barbara, and Santa Maria), mental health (County Behavioral Wellness) and public health (County Public Health) agencies would provide relevant county personnel with better tools to effectively serve community members with mental health illness.

Recommendation 5

That by the end of the first quarter of 2024 Santa Barbara County, the Santa Barbara Sheriff's Office, Santa Barbara County District Attorney's Office, Santa Barbara County Public Defender, Santa Barbara County Probation Department, and all local municipal city councils with police agencies (Guadalupe, Lompoc, Santa Barbara, and Santa Maria), mental health (County Behavioral Wellness), and public health (County Public Health) agencies adopt relevant recommendations for more effective data sharing in the referenced San Diego Association of Governments (SANDAG) study.[58]

Finding 6

The Santa Barbara County Sheriff-Coroner investigation and the District Attorney's Office review of the medical cause and manner of JT's death that left the Jury with questions:

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[58] See fn 6.

a) whether within reasonable medical certainty, the custody staff's use of on-stomach prone restraint and JT's vigorous resistance to it was the direct cause of JT's cardiac arrest; and b) whether the custody staff followed Santa Barbara County Sheriff's Office training policies when they employed the on-stomach prone restraint hold on JT.

Recommendation 6

That the County of Santa Barbara and the Sheriff-Coroner's Office request an independent review from the State Attorney General of all facts and circumstances leading up to the death-in-custody of JT, and any legal consequences that result from that review to include the following questions:

1. Whether within reasonable medical certainty, the custody staff's use of on-stomach prone restraint and JT's vigorous resistance to it was the direct cause of JT's cardiac arrest;
2. Whether the custody staff followed Santa Barbara County Sheriff's Office training policies when they employed the on-stomach prone restraint hold on JT.

REQUEST FOR RESPONSE

Pursuant to California Penal Code Section 933 and 933.05, the Santa Barbara County 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; or
- 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; or
- Will not be implemented, with an explanation of why.

Santa Barbara County Board of Supervisors – 90 days

Findings 1 and 2

Recommendations 1, 2a, 2b, 3, 4b, 5, and 6

Santa Barbara County Sheriff's Office – 60 days

Findings 3, 4b, 5, and 6

Recommendations 3, 4b, 5, and 6

Santa Barbara County District Attorney's Office – 60 days

Findings 5 and 6

Recommendation 5

City of Guadalupe – 90 days

Findings 4a, 4b, and 5

Recommendation 4a and 5

City of Lompoc – 90 days

Findings 4a, 4b, and 5

Recommendation 4a and 5

City of Santa Barbara – 90 days

Findings 4a, 4b, and 5

Recommendations 4a and 5

City of Santa Maria – 90 days

Findings 4a, 4b, and 5

Recommendations 4a and 5

The Jury respectfully invites a response from the Santa Barbara County Public Defender – 60 days

Finding 5

Recommendation 5

The Jury respectfully invites a response from the Santa Barbara County Probation Department – 60 days

Finding 5

Recommendation 5

Appendix I

Ventura County Sheriff's Office Data - Mental illness increase in the jail