"EVERY DEATH IN CUSTODY IS A FAILURE"

--a Senior Santa Barbara Sheriff's Officer

SUMMARY

Pursuant to Penal Code section 919(b), the 2022-2023 Santa Barbara County Grand Jury (Jury) investigated the July 2021 suicide death in custody of KP. He hung himself in his cell just one day after his cellmate's attempted suicide. KP had been incarcerated on several prior occasions. Each time, his medical files recorded his disorders and suicidal ideations. Wellpath, the jail medical care provider, did not share this mental health history with the Sheriff Office's custody staff. Wellpath believed that such sharing was barred by law. Thus, highly relevant, critical data was not shared with the very officials who were to decide where KP should be housed. These officers more than any others had a need to know KP's mental health fragility.

After his cellmate's attempted suicide, it was determined by persons unknown to rehouse KP, alone, in the very cell where he was traumatized from witnessing his cellmate's attempted suicide. All of the custody staff and independent mental health professionals interviewed by the Jury agreed that had KP's mental history been known, KP would not have been placed back into the same cell, especially alone, and without constant observation.

The Jury therefore has recommended that Santa Barbara County and the Sheriff's Office request Santa Barbara County Counsel to undertake a legal review of the present coordination and communication processes between Wellpath (or its successors) and the Santa Barbara Sheriff's Office custody staff to allow inmates' serious medical and mental health issues to be revealed on a need to know basis to the custody staff responsible for making housing and program decisions.

METHODOLOGY

Pursuant to California Penal Code section 919(b), the Jury interviewed a number of Sheriff's Office custody staff and their supervisors, the intake nurse who interviewed KP following his arrest, the psychiatric social worker who saw him shortly thereafter, a senior head psychiatric nurse at a private hospital, and a psychologist-administrator for a mental health public agency. The Jury examined a substantial number of documents, including KP's extensive electronic medical and mental health records, statements of persons interviewed during the internal investigation of his suicide, relevant Sheriff's Office and Wellpath policies and procedures, the terms and conditions of the existing contract between Wellpath and the County, and the *Murray* case[1] Remedial Plan's annual monitor reports.

[1] *Murray v. County of Santa Barbara*, Case No. 2:17-cv-08805-GW-JPR, U.S.D.C. (C.D. Cal). Source: https://www.disabilityrightsca.org/cases/murray-v-county-of-santa-barbara. Last reviewed June 6, 2023.

DISCUSSION

KP's arrest and key events leading up to his death

On July 12, 2021, KP, age 35, was arrested for burglary and probation violation. On July 17, KP was alone in his cell when he hung himself with his bed sheet. The night before KP committed suicide, JC, his cellmate, attempted suicide using a bed sheet as a ligature. Awakened by the noise, KP saw what was happening and alerted custody deputies. They responded promptly, cut his cellmate down, removed the ligature from around his neck and revived him.[2]

Custody staff removed KP from the cell and took him to a secure area.[3] KP was rehoused alone, back into the same cell. The Jury learned that custody staff should have conducted routine walk-by observations, every 45-50 minutes, and failed to do so, as reflected in the observation logs.

The Jury learned that KP engaged in a recorded telephone call on the morning of the day he died where he stated he was going to commit suicide.[4]

---

[2]His cellmate was transported to a local hospital, treated, and returned to the Jail. The Jury does not know if KP was told that his cellmate survived.

[3] See extensive discussion below regarding the conflicting information leading to some unknown person's decision to rehouse KP alone in the same cell where his cellmate attempted suicide.

[4] Sheriff's Office custody staff do not monitor phone calls in real-time. Sheriff's Office personnel did not hear that recorded conversation until the day after KP died during its internal investigation of KP's death.

KP's extensive mental health history

When he was admitted to the Jail, a registered nurse (RN) interviewed KP. The RN was employed by California Forensic Medical Group, Inc. (a.k.a. Wellpath[5]), the County's private for-profit health provider. Since 2017, Santa Barbara County has contracted with Wellpath to deliver medical and mental health services to its jails. The Jury learned that the RN had been employed there for only a few months and that the training the RN received consisted of watching some videos and on the job training by shadowing more senior healthcare workers.

During his intake interview, KP denied that he had any mental health history. The Jury learned that to the contrary, KP had a well-documented, extensive, and serious mental health history.

The custody staff's decision to house KP in a 2-man cell

The Jail custody classification staff determined that KP did not pose a significant security risk to himself or others. These staff personnel did not know about KP's extensive prior mental health history. Wellpath does not share its medical file information with the custody staff, even though they have an appropriate need to know this information. Wellpath's position is based on its interpretation of federal[6] and state[7] medical records privacy law. From what the Jury could learn, the custody staffs' sole criterion for placing KP with his cellmate was based on "Covid-19" considerations and not on his extensive mental illness history.

---

[5] Wellpath is a for-profit corporation that provides medical and mental healthcare in jails, prisons, and inpatient and residential treatment facilities.

[6] HIPAA is the federal Health Insurance Portability and Accountability Act, Public Law 104-191 (1996). Source: https://www.cdc.gov/phlp/publications/topic/hipaa.html#:~:text=The%20Health%20Insurance%20Portability%20and,the%20patient%27s%20consent%20or%20knowledge Last viewed June 5, 2023.

[7] California Confidentiality of Medical Information Act (CMIA) [Civ. Code, § 56 et seq.] Source: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=56.10.&lawCode=CIV Last viewed June 5, 2023.

The Jury interviewed numerous custody staff and administrators and numerous Wellpath current and former staff members. All agreed that sharing such vital information, especially if there is a substantial mental health history where there is a legally appropriate need to know, would enable custody staff to make more effective classification and program decisions.

The Jury cannot and does not offer an independent legal opinion on medical privacy laws. Legal opinions are within the province of the Santa Barbara County Counsel. However, the Jury is concerned whether state or federal law does prohibit Wellpath (or its successors) from sharing an inmate's mental health data with the Sheriff's Office custody staff on an appropriate need to know basis. The Jury will recommend that Santa Barbara County and the Sheriff's Office obtain a definitive legal opinion. It will be recommended that the parties work together to reach a mutually acceptable agreement consistent with applicable state and federal law that considers the interests and needs of all concerned parties. It is critically important that inmates' personal medical or mental health information be shared on an appropriate need to know basis with law enforcement officials who are legally responsible for their safety and general well-being.

The decision to put KP in a cell by himself without evaluation and treatment

For over four months, the Jury asked Wellpath administrators and existing and former employees and Sheriff's custody staff the following questions: Who made the decision to put KP back in the same cell where his cellmate had tried to hang himself, and why? The Jury learned that Wellpath and the Sheriff's custody staff provided inconsistent and contradictory answers to these questions. The Jury interviewed multiple mental health professionals who opined that standard institutional practice would be to ensure that KP was not returned to and then left in the cell by himself.

A hospital psychiatric head nurse with over 20 years of experience opined KP would have been severely traumatized watching his cellmate try to kill himself. Another psychologist with expertise in crisis stabilization confirmed that KP would have been severely traumatized, as did a forensic psychiatrist whom the Jury interviewed. According to them, it would be standard mental health practice in such a case for professional staff to thoroughly debrief him, especially given his mental health history of suicide ideation, and to document his demeanor and reactions. If he were placed into housing with someone else, he would be less likely to attempt suicide with a roommate present.

Based on the experts' information provided and under the *Murray* Plan, Wellpath and/or the Sheriff's Office custody staff were required to provide KP with immediate mental health evaluation and treatment when it's clear that traumatizing events are sufficiently severe that it's reasonable that the patient's situation could deteriorate.[8] KP did not receive these services.

CONCLUSION

KP had a long history of arrests and documented severe mental health issues, including suicidal ideation. The Sheriff's Office custody staff did not have access to this substantial mental health history when it decided how to house him. KP committed suicide by hanging himself with his own bedding in the same cell where the day before

---

8 Murray case Plan, definition of "urgent." p. 3 of Plan. Source: https://www.disabilityrightsca.org/system/files/file-attachments/Stipulated%20Judgment%207-17-2020.pdf Last viewed June 6, 2023.

he witnessed his cellmate try to hang himself. Someone made the decision to rehouse KP alone and back into the same cell.

KP should have been thoroughly debriefed by a mental health professional and should not have been put back into the same cell. In fact, KP should never have been left alone in any cell without constant monitoring. Although a federal court order required the Jail to keep accurate records of inmate health care contacts and treatment intervention information, no such record was created in KP's case. Thus, the Jury was never able to evaluate the basis for the decision to rehouse KP back into the same cell.

FINDINGS AND RECOMMENDATIONS

Finding 1

Wellpath electronic medical records established that KP had a long history of substance abuse and severe mental health illness. When the Sheriff's Office custody staff decided to house KP with a cellmate, it did not have access to the full extent of KP's well-established severe mental illness history. Inmates' safety and overall health would be better protected if those making classification decisions had access to inmates' vital medical and mental health information.

Recommendation 1a

That Santa Barbara County and the Santa Barbara County Sheriff's Office promptly request that Santa Barbara County Counsel prepare a legal opinion as to whether, consistent with Federal and California law, Wellpath (or its successors) may provide

critical inmate mental health information to Sheriff's custody staff that have an appropriate need to know that information for inmate housing and programming.

Recommendation 1b

That if County Counsel determines that Wellpath (or its successors) has any legal authority to provide inmate mental health information, then Santa Barbara County shall amend the agreement between Wellpath and the Santa Barbara Sheriff's Office to provide inmate mental health and substance abuse information sharing on an appropriate need to know basis.

Finding 2

KP was severely mentally ill, was traumatized by witnessing his cellmate's attempted suicide, and should not have been rehoused alone, back into the same cell.

Recommendation 2

That Santa Barbara County and the Santa Barbara Sheriff's Office ensure that inmates with severe mental illness and suicidal ideation histories receive immediate mental health professional care after they are exposed to traumatizing events, including, but not limited to, the suicide attempt of a cellmate.

REQUEST FOR RESPONSE

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

Responses to Findings shall be either:

- Agree;
- Disagree wholly; or
- Disagree partially with an explanation.

Responses to Recommendations shall be one of the following:

- Has been implemented, with a 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 1a, 1b and 2

Santa Barbara County Sheriff's Office – 60 days

- Findings 1 and 2
- Recommendations 1a, 1b and 2