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September 13, 2023

Christian McGrath
Foreperson
2022-2023 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 *"Every Death in Custody is a Failure"*

Dear Foreperson McGrath:

I am sharing with you the Santa Barbara County Sheriff's Office response to the 2022-2023 Santa Barbara County Grand Jury Report entitled *"Every Death in Custody is a Failure."*

As requested in the report, the Sheriff's Office is responding to findings and recommendations 1 and 2. Should you have any additional 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 2022-2023 Report
"Every Death in Custody is a Failure"

FINDINGS AND RECOMMENDATIONS

In the Grand Jury Report for the year 2022-2023, the title "*Every Death in Custody is a Failure*" appears to be a stark representation of shortcomings that can unfold within the criminal justice system. However, it is important to recognize that the assertion made in the title does not accurately reflect the complexity surrounding this death. While every death in custody undeniably represents a *tragedy*, not all of them are attributable to systemic, institutional, or individual failure.

The Grand Jury report seeks to delve deeper into the intricacies of such distressing events, using the case of KP as an illustrative example. It should be noted, however, that during his time in custody, KP *denied* having any prior mental health history, and did not actively seek out mental health services that are available to inmates in custody. It is a fundamental principle of personal freedom that, absent indications that a person is a danger to himself or others, or gravely disabled, the decision to access mental health services rests with the person in question. In this context, KP elected not to seek such services.

While systemic or individual issues could play a role in certain cases, not every death in custody is a criminal justice system failure. Rather, these tragic events often serve as a poignant reminder of the many stresses and challenges faced by people in all walks of life, irrespective of whether they are in or out of custody, underscoring the pressing need for a comprehensive and empathetic approach to addressing mental health and well-being in all aspects of our community.

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.

Sheriff's Office Response: Disagree partially with an explanation.

The Sheriff's Office agrees that inmate would be better served if custody staff had access to their medical records. Although, in hindsight, it was determined that there were indications in KP's health records, these were not available to custody staff contemporaneous to his death. There was also nothing within the records to establish that KP had been diagnosed with "severe mental illness."

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.

Sheriff's Office Response: This has been implemented.

County Counsel has provided its opinion concerning whether WellPath (or its successor) may disclose mental health and substance abuse information.

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.

Sheriff's Office Response: Requires further analysis.

To the extent such information can be legally shared, additional research would be needed to ascertain if a WellPath contract amendment would be required due to an expanded scope of work. If so, negotiations would then be needed, as well as Board

approval and additional funding, once that process was completed. Even with an aggressive schedule, the full implementation of such an information-sharing procedure will likely take 8 to 10 months.

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.

Sheriff's Office Response: Disagree partially with an explanation.

At the time he was in custody, there was no indication that KP, who denied mental health issues, was "severely mentally ill," or was "traumatized" by witnessing his cellmate's attempted suicide. KP was not "re-housed," rather he was returned to his assigned cell once the emergency had resolved. It was KP's cellmate who was rehoused. Due to COVID-19 intake quarantine protocols, it would have been inappropriate to rehouse KP with another inmate at that time. Furthermore, KP denied any previous attempts or considerations of suicide during his classification interview, upon which his housing assignment was based. The above notwithstanding, the Sheriff's Office agrees in hindsight that KP should have been evaluated and monitored by mental health staff following his cellmate's attempted suicide.

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.

Sheriff's Office Response: This has been implemented.

Immediately following the multi-disciplinary death review, which was conducted within 30 days of KP's suicide, WellPath issued a written directive and conducted training to ensure that inmates are provided with immediate mental health professional care after exposure to traumatizing events, including, but not limited to, the suicide or attempted suicide of a cellmate. Sheriff's custody staff participated in that training, and a recently issued a critical incident follow-up communication directing custody staff to provide

inmates so exposed with enhanced observation, access to mental health services, and access to religious services.

Conclusion

It is important to understand that our custody facilities house a cross-section of members of our society, reflecting the diversity and complexity of the people within our care. It is also important to recognize that the provision of medical and mental health services within custodial settings is a formidable challenge. Many of those who enter our custody arrive with significant pre-existing physical and mental health challenges, and, regrettably, some choose not to seek, or they reject, medical and/or mental health services during their time in our facilities. Considering the complexities involved, it is essential to underscore a crucial point: the healthcare services provided within our custody facilities often exceed the level of care that many people receive in the community while outside of our custody. While we acknowledge that the health care services provided in our jail system are not perfect, we do believe they are excellent. Nevertheless, our commitment to continual improvement remains unwavering. We understand that the well-being of those in our custody is not solely a matter of institutional responsibility, but rather a reflection of our community's collective commitment to humanity.

While we acknowledge that deaths in custody are tragedies, just as they are anywhere else in our community, we hope this response to the Grandy Jury's report illuminates the multifaceted nature of the challenges we and our healthcare providers face. We remain steadfast in our dedication to improving conditions and services within our custody facilities, and to ensuring, to the best extent possible, that those under our care receive the best possible medical and psychological care and support. Our aspiration is that through our ongoing efforts, we can contribute to a broader dialogue on mental health, medical care, and the criminal justice system, ultimately fostering a community in which people receive the type of care and support they need, both within and beyond our custody facilities.