


# Office of the Sheriff



## SANTA BARBARA COUNTY

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July 31, 2024

**BILL BROWN**

Sheriff - Coroner

**CRAIG BONNER**

Undersheriff

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Foreman, SBC Grand Jury  
Santa Barbara County Courthouse  
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Re: Response to the Santa Barbara County Grand Jury Report Entitled "*Deaths in Custody in Santa Barbara County Jails: Our County Jails Meet Many Needs*"

Dear Foreperson Macias,

Enclosed is the Santa Barbara County Sheriff's Office response to the 2023 – 2024 Santa Barbara County Grand Jury Report entitled "*Deaths in Custody in Santa Barbara County Jails: Our County Jails Meet Many Needs.*"

As requested in the report, the Sheriff's Office responds to Findings 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14, and Recommendations 1, 2, 3a, 2b, 4, 5, 6a, 6b, 6c, 7a, 7b, 8a, 8b, 9, 10, 11a, 11b, 12, 13, and 14.

Should you have any additional questions, please feel free to contact me at (805) 681-4290.

Sincerely,



**BILL BROWN**  
Sheriff-Coroner

Enclosure: The Santa Barbara County Sheriff's Office response to the 2023 – 2024 Santa Barbara County Grand Jury Report entitled "*Deaths in Custody in Santa Barbara County Jails: Our County Jails Meet Many Needs.*"

**Santa Barbara County Sheriff's Office**  
**Response to the Santa Barbara County Grand Jury 2023-2024 Report**  
*"Deaths in Custody in Santa Barbara County Jails: Our County Jails Meet Many Needs"*

**Findings and Recommendations**

**Santa Barbara County Sheriff: 60 Days**

**Finding(s): 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, and 14**

**Recommendation(s): 1, 2, 3a, 2b, 4, 5, 6a, 6b, 6c, 7a, 7b, 8a, 8b, 9, 10, 11a, 11b, 12, 13, and 14**

The Santa Barbara County Sheriff's Office acknowledges the investigation conducted by the Santa Barbara County Grand Jury in their 2023-2024 report titled "Deaths in Custody in Santa Barbara County Jails: Our County Jails Meet Many Needs." The Sheriff's Office remains committed to the highest standards of custody and care for all individuals within our facilities. We appreciate the recommendations and findings provided by the Grand Jury and are dedicated to implementing necessary changes to enhance the safety and well-being of those in our custody.

We recognize the gravity of the incidents reviewed and the profound impact on the families and communities involved. Our responses reflect our ongoing efforts to uphold our responsibilities, ensure accountability, and strive for excellence in our operations. The following document details our responses to each finding and recommendation made by the Grand Jury. These responses include acknowledgments of areas needing improvement, explanations of current practices, and outlines of steps already taken or planned for implementation.

Through continued collaboration with healthcare providers, behavioral health experts, and other stakeholders, we aim to address the issues highlighted and ensure that our facilities operate in a manner that prioritizes safety, health, and human dignity. Our commitment is to learn from these incidents, evolve our practices, and maintain transparency with the public we serve.

**FINDING 1**

Being placed in a prone position while restrained contributed to JG's death.

**Sheriff's Office Response:**

*Disagree partially with an explanation*

The Sheriff's Office disagrees that the position JG was restrained in was a contributing factor in JG's death, but rather that it was the physical exertion that JG exerted against staff's efforts to restrain him that contributed to his death.

**Recommendation 1**

The Sheriff's Office should review and reevaluate the use of prone restraint position with obese individuals.

**Sheriff's Office Response:**

*Has been implemented, with a summary of the implementation actions taken*

The Sheriff's Office regularly evaluates its use-of-force tactics and options, and incorporates new developments, state and national standards, and best practices from across the country into its Basic Academy and in-service training curricula. Additionally, the Sheriff's Training Bureau staff continue to

investigate alternative restraint-related positioning of suspects who are obese or suffering from other physical disabilities. If other methods are determined to improve the suspects' safety without jeopardizing custody deputies' safety, these alternative techniques will be implemented into department training.

As part of our ongoing in-service training, sheriff deputies and custody deputies have received and continue to receive training on alternative positioning of suspects, including the use of supine vs. prone positioning, if feasible, that minimizes the potential for positional cardio-respiratory impacts on restrained persons. Specifically, deputies are trained to restrain individuals without placing weight on their upper torso to help eliminate the risk of causing respiratory issues for those in similar circumstances.

### **Finding 2**

The arresting officers failed to inform the intake staff that JG had complained of back and chest pain. This lack of communication was a missed opportunity to ascertain whether JG needed timely and appropriate medical care.

### **Sheriff's Office Response:**

*Agree*

### **Recommendation 2**

The Grand Jury recommends that the Sheriff's Office implement a mandatory communication protocol between arresting officers and jail medical intake staff. This protocol should ensure that arresting officers consistently relay all potentially relevant medical information to intake nurses, including any complaints of pain or existing medical conditions.

### **Sheriff's Office Response:**

*Has been implemented, with a summary of the implementation actions taken*

The Sheriff's Office Behavioral Sciences Unit (BSU), along with WellPath, developed a form, currently, entitled "Mental Health Evaluation Request Form," that provides a written record of passing on information to the medical staff of observations and/or concerns of the arresting officer concerning an arrestee's health and potential for self-harm. These forms are available at the booking areas at both facilities. In this instance, it was not utilized. Corrective actions have already been taken to train and reinforce compliance with those protocols by the Sheriff's Office immediately after the incident. Furthermore, a policy change will now make the sharing of information mandatory. We will integrate specific pertinent *medical* and mental health information into the Santa Barbara County Jail Booking Record Form. This update aims to ensure that arresting deputies or officers have a structured and comprehensive method to relay crucial medical and mental health information to healthcare and custody staff. The new booking form will be implemented by October 1, 2024. This effort underscores our commitment to enhancing communication and ensuring the safety and well-being of all individuals in our custody.

### **Finding 3**

Custody Deputies removed JG from the medical intake screening process before completion. The failure to prioritize JG's medical needs at intake raises serious concerns about the potential for harm to individuals in custody.

**Sheriff's Office Response:**

*Disagree partially with an explanation*

The Sheriff's Office agrees that JG was removed from the medical intake screening process. However, the custody staff involved were not only charged with ensuring that JG's medical needs were met, but also with maintaining the safety and security of everyone present, including incarcerated persons, other staff, visitors, and the public. In this instance, JG displayed behaviors that placed the safety of everyone present in jeopardy, and we determined that moving JG to another, more secure location would mitigate the safety risks. The decision was made based on the information available to them at the time. Their actions conformed to current policy, sound correctional practice, and California regulations and laws regarding the use of force and restraint.

The safety and security of the facility for everyone, including inmates, deputies, medical staff, and visitors, is paramount. Once the inmate is safe and the facility's security is not at risk, the medical screening process will be completed. In the meantime, the inmate would be checked on every 15 minutes to ensure their well-being.

**Recommendation 3a**

The Grand Jury recommends that custody and medical staff develop improved communication protocols. This collaboration should ensure that medical intake screenings are consistently completed before individuals are removed from the process.

**Sheriff's Office Response:**

*Will be implemented, with a summary of implementation actions taken*

The Sheriff's Office continually evaluates communication and cooperation between WellPath and Custody staff. In addition, every event with an adverse outcome is reviewed by a multidisciplinary team, including command and executive staff from the Sheriff's Office, WellPath management and practitioners, and BeWell and Public Health Department representatives. Aiming specific efforts and direction at completing medical intake screenings, as the Grand Jury recommends, implies a systemic problem in this area rather than an isolated incident, in JG's case, which was unfortunate. Nevertheless, we have identified a way to strengthen communication and the medical intake process.

Henceforth, we will integrate specific pertinent medical and mental health information into the booking form, rather than use a separate form. This update aims to ensure that arresting deputies or officers have a structured and comprehensive method to relay crucial medical and mental health information to healthcare personnel. The new booking form will be implemented by October 1, 2024. This effort underscores our commitment to improving communication and ensuring the safety and well-being of all individuals in our custody.

**Recommendation 3b**

The Grand Jury recommends revising the medical screening questionnaire to prioritize the most critical information. Specifically, a question like "Are you currently experiencing any pain or are you suffering from an acute condition?" should be placed as the first question on the questionnaire. This simple change could ensure that individuals with immediate medical needs are identified and addressed promptly.

**Sheriff's Office Response:**

*It will not be implemented with an explanation of why*

The Sheriff's Office contracted healthcare provider, WellPath, utilizes an evidence-based intake questionnaire that is reviewed at the corporate level annually. It is not reasonable, prudent, or feasible to alter this instrument based on a single, isolated incident. However, to ensure better communication, we are adding specific questions to the Santa Barbara Jail Booking Record Form. This update aims to provide arresting deputies or officers with a structured and comprehensive method to relay and immediately alert healthcare personnel of crucial medical and mental health information. The revised booking form will be implemented by October 1, 2024.

#### **Finding 4**

LR's physical injuries and cognitive abilities worsened during his three days of incarceration at the Main Jail, an admitted alcoholic, he was not treated for alcohol withdrawal symptoms when examined by mental health or medical personnel.

#### **Sheriff's Office Response:**

*Agree*

#### **Recommendation 4**

Any incarcerated person who has admitted to prolonged and excessive alcohol consumption and begins exhibiting symptoms consistent with alcohol withdrawal must immediately be treated in a manner to reduce symptoms and monitored for continued physical and/or cognitive degradation.

#### **Sheriff's Office Response:**

*Has been implemented, with a summary of the implementation actions taken*

The Sheriff's Office's contracted healthcare provider, WellPath, has policies and protocols in place that address this. In this instance, the protocol was not followed. Corrective actions have already been taken by WellPath management to train and reinforce compliance with those protocols immediately after the incident.

#### **Finding 5**

When the Public Health Medical Advisor position has been filled, this medical professional will be working with Wellpath staff at the jails.

#### **Sheriff's Office Response:**

*Agree*

#### **Recommendation 5**

The Public Health Medical Advisor shall help oversee and advise treatment for medically compromised individuals entering the jails, especially during the critical first week of incarceration.

#### **Sheriff's Office Response:**

*Will be implemented, with an implementation schedule*

Santa Barbara County Public Health Department, in conjunction with the Sheriff's Office, is currently recruiting eligible candidates for the position of Chief Correctional Health Medical Advisor (follow this link for the job opportunity announcement: [Chief Correctional Health Medical Advisor](#)). This is a "Continuous" recruitment and will remain open until the position is filled. We anticipate the selection and onboarding processes will be completed sometime during the first two quarters of this fiscal year.

The duties of this position will include *monitoring* and *advising* the provision of services by WellPath, as well as providing guidance to the Sheriff's Office, Santa Barbara County Public Health Department, and WellPath.

#### **Finding 6**

RU and DL suffered from drug addiction and died within two days of entering the jails.

#### **Sheriff's Office Response:**

*Agree*

#### **Recommendation 6a**

The Sheriff's Office should contract with Behavioral Wellness for a number of beds in the recently reopened Crisis Stabilization Unit next to the Main Jail, where arrestees can be consistently monitored.

#### **Sheriff's Office Response:**

*It will not be implemented with an explanation of why*

The Crisis Stabilization Unit will only be appropriate for a handful of newly arrested defendants. All felony arrests require a court order to release a defendant. Qualifying for pre-arraignment release from the Sheriff's Office custody includes analysis of criminal sophistication, severity of charges, previous criminal justice involvement, risk of reoffending, and risk to public safety, among other factors. There is no limited mechanisms for the Sheriff's Office to release persons from custody based solely on their need for observation or monitoring. To follow the Grand Jury's recommendation, the Sheriff, in all but a few instances, would be forced to post a guard at the facility at all times while the defendant is there, causing an undue burden on the Custody Branch's already scarce and stretched resources, as the Grand Jury acknowledges throughout their report.

We must balance public safety with the need to observe and monitor defendants. The current protocols ensure that decisions about release and supervision are made carefully considering the potential risks to the community, thereby upholding our commitment to maintaining public safety.

#### **Recommendation 6b**

The Sheriff's Office shall direct medical staff at the Northern Branch Jail to hold a number of beds in the medical unit for those arrestees entering the jail who exhibit withdrawal symptoms.

#### **Sheriff's Office Response:**

*It will not be implemented with an explanation of why*

The Sheriff's Office directs the Grand Jury to their own report, specifically on page 3, which shows that a snapshot population report indicated 49 incarcerated persons on Drug Withdrawal protocols and 29 on Alcohol Withdrawal protocols, totaling 78 individuals systemwide. The large number of individuals does not allow for specific housing locations for all of them. Moreover, the majority of these patients do not display symptoms that require more observation or monitoring than current protocols provide. If a patient shows symptoms of serious illness, they are transferred to a hospital for further evaluation and treatment. The Sheriff's Office asserts that no increased observation or monitoring, short of continuous one-to-one supervision, could have prevented these unfortunate events.

Our staffing levels do not allow us to operate a full medical facility within either of our custody facilities. We believe that if a person requires specialized medical care, the best place for them to receive that care is at a hospital, to which they will be transferred as needed.

**Recommendation 6c**

The Sheriff's Office shall work with Public Health and Behavioral Wellness to increase staffing of the Medically Assisted Treatment program at both jails.

**Sheriff's Office Response:**

*Has been implemented, with a summary of the implementation actions taken*

The Sheriff's Office has implemented the recommendation. We recently negotiated a contract extension with WellPath, which includes additional staffing for Alcohol and Drug Counselor positions dedicated to the Medically Assisted Treatment Program. The board of Supervisors ratified this extension on June 25, 2024. WellPath is actively recruiting for these positions and will select and onboard qualified candidates by August 2024.

**Finding 7**

SP spent over 12 hours confined in a safety cell without a mental health evaluation being conducted by a C.A.R.E.S. Mobile Crisis Unit during that time.

**Sheriff's Office Response:**

*Agree*

**Recommendation 7a**

To comply with its current policy, the Sheriff's Office should review and revise its protocols to ensure that timely mental health evaluations are conducted by a C.A.R.E.S. Mobile Crisis Unit for individuals retained in safety cells over the initial 12-hour limit.

**Sheriff's Office Response:**

*Has been implemented, with a summary of the implementation actions taken*

The Sheriff's Office's contracted healthcare provider, WellPath, has policies and protocols addressing Recommendation 7a. In this instance, the protocol was not followed. WellPath management immediately after the incident took corrective actions to train and reinforce compliance with those protocols.

**Recommendation 7b**

The Jury recommends that all procedures mandated by policy to be performed prior to the removal of an occupant from a safety or observation cell be incorporated as a checklist into the posted observation logs. A custody supervisor shall review the observation logs together with the checklist to ensure that each required step has been completed, and upon such verification, the custody supervisor's signature releases the occupant.

**Sheriff's Office Response:**

*Will be implemented, with an implementation schedule*

The Sheriff's Office has begun the process of modifying the existing form, developing the process, and issuing an interim directive with a projected implementation date of September 1, 2024.

**Finding 8**

There was a failure to initiate a collaborative safety plan with SP prior to his release from the mental health observation cell which is intended to provide support and decrease the chance of self-harm during a critical period of time.

**Sheriff's Office Response:** Agree.

**Recommendation 8a**

The Sheriff's Office shall ensure that the procedures outlined within its policy and its contract with Wellpath be completed prior to the removal of an occupant from a safety or observation cell.

**Sheriff's Office Response:**

*Has been implemented, with a summary of the implementation actions taken*

The Sheriff's Office's contracted healthcare provider, WellPath, has policies and protocols addressing this. In this instance, the protocol was not followed. WellPath management took corrective actions immediately after the incident to train and reinforce compliance with those protocols.

**Recommendation 8b**

The Jury recommends that all procedures that are mandated by policy to be performed prior to the removal of an occupant from a safety or observation cell be incorporated as a checklist into the posted observation logs. A custody supervisor shall review the observation logs together with the checklist to ensure that each required step has been completed and upon such verification, the custody supervisor's signature releases the occupant.

**Sheriff's Office Response:**

*Has been implemented, with a summary of the implementation actions taken*

The Sheriff's Office has begun the process of modifying the existing form, developing the process, and issuing an interim directive with a projected implementation date of September 1, 2024.

**Finding 9**

Ongoing renovations and upgrades within the IRC 300 housing unit had resulted in the in-cell intercom system, certain video surveillance systems, and the electronic locking mechanisms being non-operational at the time of SP's death, causing delayed response times by custody and medical staff.

**Sheriff's Office Response:**

*Agree*

**Recommendation 9**

The Sheriff's Office should develop and implement more effective alternatives for visually monitoring incarcerated individuals and enabling emergency communication when the electronic surveillance and intercom systems are not functioning properly, including relocating incarcerated persons to other holding locations within the County jail system, increasing the frequency and duration of in-person safety checks and cell inspections by custody staff when electronic monitoring is unavailable, and stationing custody personnel within the housing unit to enhance direct supervision.



**Sheriff's Office Response:**

*It will not be implemented with an explanation of why*

In this instance, the system was being replaced, something that does not occur on a regular basis. The project is still underway. However, security controls and other surveillance and communications systems in the housing areas are fully functional. The Sheriff's Office has initiated protocols that increase the frequency and duration of in-person safety checks during times when the security system is malfunctioning or otherwise inoperable. Rehousing large numbers of incarcerated persons and stationing staff in affected housing areas might be considered in extreme cases, but is not reasonable or feasible in all but a very few potential scenarios.

**Finding 10**

There were only 11 Custody Deputies on shift at the time of SPs' death. The level of safety inside jail facilities is directly affected by the number of Custody Deputies on duty. If more than one critical incident were to occur at the same time, it could be extremely difficult to manage.

**Sheriff's Office Response:** Agree.

**Recommendation 10**

The Sheriff's Office shall review its minimum staffing levels in the jail facilities.

**Sheriff's Office Response:**

*Has been implemented, with a summary of the implementation actions taken*

The Sheriff's Office continually reviews the minimum staffing plan for both jail facilities, with the most recent review formalized and endorsed through labor-management discussions with the Deputy Sheriff's Association (DSA), which represents Custody Deputies and Custody Sergeants. While minimum staffing levels are prescribed, various factors can impact the number of available staff, including authorized leave, sick calls, off-site supervision (e.g., hospital, Santa Barbara County Psychiatric Health Facility), and other details requiring on-duty staff reassignment. Chronic vacancies and lost time due to work-related injuries, FMLA, Military Leave, etc., can further exacerbate staffing shortages.

When faced with staffing shortages, our supervisors and managers prioritize the safety and security of the facility. This includes temporary adjustments to programs and strategically distributing personnel resources to ensure that the safety of both inmates and staff is maintained. The Sheriff's Office is actively recruiting qualified candidates and using all available resources to address existing vacancies and retain current staff.

**Finding 11**

SP, who had clearly expressed an intention to harm himself in any way that he could, was nonetheless placed in a cell located in a two-level housing unit, which provided SP with easy access and the means to jump to his death from the second level of the unit.

**Sheriff's Office Response:**

*Agree*

**Recommendation 11a**

The Grand Jury recommends that the Santa Barbara County Sheriff's Office immediately review and revise its incarcerated housing and classification placement protocols. Going forward, the Sheriff's

Office must ensure that individuals who have made suicidal statements or exhibit a desire to harm themselves are never assigned to cells or housing units that offer ready access to methods of self-harm such as elevated areas from which an incarcerated individual could jump.

**Sheriff's Office Response:**

*Has been implemented, with a summary of the implementation actions taken*

Custody Branch Classification staff have been directed to consult with WellPath Mental Health staff when rehousing incarcerated persons from safety and observation cells. All efforts will be made to ensure those who are at risk for self-harm are housed on the lower tier in housing areas where upper tiers exist.

**Recommendation 11b**

To help mitigate the risk of incarcerated persons jumping or falling from elevated housing areas, the Grand Jury recommends that the Sheriff's Office explore the feasibility of installing physical barriers, such as safety netting or higher railings, in those locations.

**Sheriff's Office Response:**

*Has been implemented, with a summary of the implementation actions taken*

The Sheriff's Office has requested that General Services explore the installation of a correctional-grade non-climbable fencing system on the upper tier levels of the Inmate Receiving Center (IRC). That request has been included in the ongoing development of a larger renovation project that is in the design bridging phase and is currently being incorporated into the overall design by the architects assigned to the project. The project is tentatively scheduled to begin in the last quarter of FY2024/25.

**Finding 12**

The Public Defender's Office currently conducts an entry interview to establish a connection with newly incarcerated persons booked into the Northern Branch Jail, which continues until the incarcerated persons are discharged.

**Sheriff's Office Response:**

*Agree*

**Recommendation 12**

The Sheriff's Office shall work with the Public Defender's Office to initiate a similar program at the Main Jail.

**Sheriff's Office Response:**

*Will be implemented, with an implementation schedule*

The Sheriff's Office is working with the Public Defender's Office to initiate Early Representation Services at the Main Jail. The service is anticipated to begin within the first two quarters of FY 2024/25.

**Finding 13**

The Grand Jury investigations of deaths in custody rely heavily on information provided by the Santa Barbara County Sheriff's Office. Completion of the investigations was impeded greatly by a lack of timely cooperation by the Sheriff's Office.

**Sheriff's Office Response:** *Disagree*

The Grand Jury's assertion that "Completion of the investigations was greatly impeded by a lack of timely cooperation by the Sheriff's Office" is incorrect. Any delays that may have occurred were related to staffing or information availability. This generalization prevents the Sheriff's Office from addressing particular processes and does not accurately reflect the significant efforts made by the Sheriff's Office in support of the Grand Jury and its mission.

Upon the empanelment of the 2023-2024 Grand Jury, the Sheriff's Office promptly provided the contact information of the Sheriff's Adjutant, who was designated as the liaison for the Grand Jury. The Adjutant's role is to streamline communication between the Grand Jury and the appropriate personnel within the Sheriff's Office, thereby facilitating efficient and timely responses. The Adjutant works closely with Grand Jury members to determine what documentation they need and to provide that documentation as soon as possible. In fact, in an effort to make this process as smooth as possible, a secure, cloud-based document sharing portal was specifically established for the Grand Jury.

Furthermore, many of the requests for information made by the Grand Jury required clarification and/or were for data not currently at our disposal. The Adjutant's role is to assist the Grand Jury in determining what documents are available and helping refine their search efforts, thereby ensuring a more efficient process.

To enhance cooperation and ensure timely responses, the 2023-2024 Grand Jury was introduced to the Deputy Sheriff's Association (DSA) Counsel. It was agreed that all subpoenas for DSA members whom the Grand Jury wished to interview should be channeled through the DSA Counsel and the Sheriff's Adjutant. This procedure ensured proper and timely responses from the Sheriff's Office, during the 2022-2023 Grand Jury term. The 2023-2024 Grand Jury did not utilize this procedure; the Sheriff's Office recommends that future Grand Jurys use this procedure in order to enhance the efficiency and timeliness of their request.

The Sheriff's Office is committed to cooperate with the Grand Jury. By adhering to the established procedures and leveraging the role of the Sheriff's Adjutant, we will continue to provide the Grand Jury with the necessary resources and information.

**Recommendation 13**

The Sheriff's Office shall promptly provide information to the Grand Jury.

**Sheriff's Office Response:**

*Has been implemented, with a summary of the implementation actions taken*

As explained above, the Sheriff's Adjutant has been designated as the point of contact for all requests and inquiries made by the Grand Jury, and the Sheriff's Office has taken steps to streamline and enhance the exchange of requested documents and information.

**Finding 14**

Five of the six deaths in this report occurred within the first three days of entering the jail. The main factors for jail deaths involved issues of inconsistent and inadequate observation.

**Sheriff's Office Response:**

*Disagree with an explanation*

The Sheriff's Office asserts that the only event that involved potential observation issues was that of SP. The others were either under direct observation (JG), had secreted illicit drugs obtained from someone in their housing area or prior to their arrests (RU and DL), or were not observed because the inmate denied being in alcohol withdrawal, having a history it or displaying objective symptoms of withdrawal (LR).

**Recommendation 14**

The Sheriff's Office, working in conjunction with Wellpath, Behavioral Wellness and Public Health, shall have procedures in place to more closely monitor at-risk incarcerated persons when they enter the jails.

**Sheriff's Office Response:**

*Has been implemented, with a summary of the implementation actions taken*

The Sheriff's Office continues to collaborate with WellPath, BeWell, and Public Health in more closely monitoring at-risk incarcerated persons.