ANOTHER SUICIDE IN SANTA BARBARA COUNTY JAIL

Inmate's Death Should Have Been Prevented

SUMMARY

The 2024-2025 Santa Barbara County Grand Jury (Jury) investigated the in-custody death of a female inmate (CC) at Santa Barbara County's Main Jail (Main Jail). On the afternoon of November 13, 2024, CC hung herself by the neck using a wall-mounted telephone cord in a mental health observation cell.

Penal Code §919(b) requires the Grand Jury to examine the operation of the jails within the County. Based upon its investigation of CC's death, the Jury finds that several systemic problems within the Main Jail limited the staff's ability to safeguard CC's well-being, including insufficient numbers of properly equipped mental health observation cells. These issues resulted in a series of breakdowns leading to CC's placement in an observation cell with a telephone cord, which ultimately resulted in her death. The Grand Jury finds that her suicide could and should have been prevented.

The Jury finds that the County's jails need additional funding to solve the many deficiencies that limit or obstruct the humane treatment of the many mentally ill inmates who occupy that space. The Jury is pleased to report that on April 1, 2025, the Santa Barbara County Board of Supervisors approved funding for construction of an additional 348 beds at the Northern Branch Jail, including more mental health beds, and an additional 20 custody deputies. When the construction is completed in 2029, inmates in the Main Jail will be transferred to the Northern Branch Jail, and most of the Main Jail will be closed. This will be a major step toward addressing the issues outlined in this Report. However, improvements must be made before 2029.

INTRODUCTION

Inmate suicides have been a recurring problem at local jails and state and federal prisons throughout the country, including Santa Barbara County. Nationwide, from 2001 to 2019, the number of suicides increased 85% in state prisons, 61% in federal prisons, and 13% in local jails.[1] Between 2010 and 2019, suffocation, including hanging and self-strangulation, accounted for nearly 90% of suicide deaths in local jails.

[1] Bureau of Justice Statistics, Suicide in Local Jails and State and Federal Prisons, 2000–2019 Statistical Tables. See https://bjs.ojp.gov/library/publications/suicide-local-jails-and-state-and-federal-prisons-2000-2019-statistical-tables

CC was a 41-year-old mother who resided with her family in Santa Ynez, California. She had a history of significant mental disorders and suicide attempts. On November 8, 2024, CC was pulled over by a Santa Barbara County Deputy Sheriff for driving in a reckless manner. After attempting to evade law enforcement and using her car as a weapon, she was arrested. She was first taken to Santa Ynez Cottage Hospital and was then transferred to Santa Barbara Cottage Hospital for a psychiatric evaluation. While there, she was booked *in absentia* for felony evading police officers, assault with a deadly weapon (automobile), and driving under the influence. On November 9, 2024, CC was moved to the Main Jail while awaiting arraignment.

In the days preceding CC's death on November 13, 2024, she made several suicidal statements to mental health providers, who then assigned her to a safety cell on suicide watch.[2] Five days into her incarceration, CC was moved to a holding cell where she committed suicide by hanging. The County Coroner's pathologist later performed an autopsy, finding that the cause of death was a suicide.

During her incarceration, the mental health staff at the Main Jail did not know that CC had previously been diagnosed and treated for severe mental illnesses, including bipolar disorder and psychoses. Nor did they attempt to obtain such history from any of CC's private doctors and hospitals. Thus, she was not offered a level of care commensurate with her mental health needs.

When an inmate is deemed suicidal by a mental health provider (MHP), there are several protective housing options available.[3] Safety cells are the highest level of protective custody and typically reserved for inmates at high risk of self-harm. The Main Jail has four safety cells. Once MHPs determine an inmate no longer requires a safety cell, the individual is relocated to a holding cell (known as a "step-down"), a lower level of protective custody. There are seven holding cells (H-1, H-2, H-5, H-6, H-7, H-8 and H-9) in the IRC. By practice, H-1, H-2, and H-9 were the holding cells that SBSO would prioritize using for mental health observation purposes before utilizing other holding or housing cells. Based on need and physical plant logistics, cells H-6 and H-7 were used regularly for observation purposes. Inmates in an observation cell must be monitored by custody deputies every 15 minutes.

Because some observation cells are on occasion used to hold newly arrived inmates who are legally entitled to make phone calls, three of these observation cells contained wall-mounted telephones with cords at the time of CC's death.

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[2] Pursuant to applicable policies at the County's jails, safety cells are to be used to temporarily house inmates who pose a threat to themselves or others. Inmates placed in safety cells are stripped of their clothing and given a paper smock which cannot be used as a ligature. The policy requires the on-duty Shift Commander or designee to approve safety cell assignments prior to placement. Jail protocols require custody deputies to conduct and document direct visual observations of safety cell inmates twice every 30 minutes.

[3] For purposes of this Report, the MHPs are master's level mental health counselors employed by Wellpath.

At the time of CC's suicide, MHPs generally knew that step-down patients had sometimes been placed in holding cells with telephone cords when the three cordless cells were unavailable. MHPs recognized the risk of placing a potentially suicidal inmate into a cell with a cord but were limited in recommending other options to the Deputies due to the limited number of observation cells.

METHODOLOGY

This Jury reviewed reports, documents, and other evidence gathered from:

- The Santa Barbara County Sheriff's Office and Coroner's Bureau
- California Forensic Medical Group, Inc. (Wellpath), the contract healthcare provider for the County's jails
- Santa Barbara County Department of Behavioral Wellness
- County of Santa Barbara Health Department
- Santa Barbara Cottage Hospital
- Santa Ynez Valley Cottage Hospital
- Published studies analyzing the nature and extent of inmate suicides

On the legal front, the Jury considered the outcome of federal class action litigation entitled *Murray v. Santa Barbara County* regarding substandard conditions at the Main Jail. The Jury further consulted federal and state laws regarding topics such as involuntary psychiatric holds and the confidentiality of inmate health information.

The Jury conducted numerous interviews with MHPs, custody personnel, nurses, and doctors who provided evidence related to CC's mental illness and death. The Jury consulted a psychiatrist as an independent expert witness. The Jury reviewed videos of CC taken in the two safety cells and the hallways outside the holding cells. The Jury also visited the Main Jail's safety and holding cells.

OBSERVATIONS

The following section provides a chronology of the events leading up to and following CC's death in the Main Jail.

Related Incident Two Weeks Prior to Death

On October 28, 2024, approximately two weeks prior to her suicide, CC was visited at her home by a deputy sheriff for a welfare check, and an ambulance was called given her level of agitation. She was taken to the emergency department at Santa Ynez Valley Cottage Hospital evidencing a panic attack, anxiety, and depression. CC was angry, agitated and delusional during the evaluation. CC had a history of suicide attempts. She was diagnosed with psychosis, malingering, conversion,

and depression with psychotic features.[4] During the examination, CC's alter ego "Patricia" was manifesting. Patricia was typically more agitated and ruder to people than she was.

The Mobile Crisis Team, a unit within Behavioral Wellness tasked with performing psychiatric hold evaluations within the County, was called and found that she did not meet the criteria necessary to issue a Welfare and Institutions Code section 5150 (5150) 72-hour involuntary hold because she did not express suicidal ideations.[5] She was discharged from the hospital the same day.

November 8, 2024

On November 8, 2024, CC's car was pulled over by a Santa Barbara County Deputy Sheriff for driving her vehicle in a reckless manner. Although she initially stopped when the deputy's overhead lights were illuminated, she suddenly drove off despite being ordered to stop. She nearly collided with parked vehicles, ran through stop signs, and sped through an elementary school parking lot towards a nearby park. A patrol car performed a "PIT" maneuver causing CC's car to stop. She then reversed and collided with her vehicle into an occupied patrol car, rendering her unconscious. Deputies suspected that CC was overdosing and administered Narcan.

Following her arrest, she was then transferred to Santa Ynez Valley Cottage Hospital for further evaluation. She told hospital staff that she may have been diagnosed with bipolar disorder.[6] During her brief stay in the Emergency Department, medical staff found her to be at a high risk of suicide. She believed she was the devil and must kill herself to save and protect her children.

November 9, 2024

Still under arrest but not yet cleared for transfer to the jail, CC was next transported to Santa Barbara Cottage Hospital on the morning of November 9, 2024, for further psychiatric assessment of her suicidal ideations. While there, she was booked *in absentia* for evading police officers, assault with a deadly weapon (her car), and driving under the influence of drugs. She reported to staff at the hospital that she tried to choke herself when visiting deceased relatives at a cemetery

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[4] Malingering is the intentional production or display of false or exaggerated symptoms for a specific benefit or reward. Conversion disorder is a mental health condition that causes real, physical symptoms that a person cannot control. Psychosis is a term for symptoms that happen when a person has trouble telling the difference between what is real and what is not.

[5] Pursuant to Section 5150, subdivision (a), "When a person, as a result of a mental health disorder, is a danger to others, or to themselves, or gravely disabled, a peace officer, professional person in charge of a facility designated by the county for evaluation and treatment, member of the attending staff, as defined by regulation, of a facility designated by the county for evaluation and treatment, designated members of a mobile crisis team, or professional person designated by the county may, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention …."

[6] Bipolar disorder, formerly called manic depression, is a mental health condition that causes extreme mood swings. These include emotional highs, also known as mania or hypomania, and lows, also known as depression. See https://www.mayoclinic.org/diseases-conditions/bipolar-disorder/symptoms-causes/syc-20355955

that day. She stated that she was taking Xanax but had stopped taking her other medications, including medications for bipolar disorder. CC told hospital staff she was suicidal. A member of the hospital's mental health staff documented that CC needed psychiatric hospitalization.

However, a few hours later, during her interview with a hospital psychiatrist, CC denied suicidal ideations and did not meet the criteria for a 5150 hold. CC was diagnosed with adjustment disorder with mixed disturbance of emotions and conduct and was discharged to the Sheriff's Office's (SBSO) custody.[7] Later the same day, she was moved to the Main Jail.

When entering the Main Jail's Inmate Reception Center (IRC), there were no prior Jail medical records available to medical staff because she had not been recently incarcerated in a jail in the County. CC indicated that she suffered from bipolar disorder and depression, and mental health staff was notified accordingly. However, bipolar disorder was never diagnosed nor treated by any Jail mental health staff. During the intake interview, CC stated that she had attempted to choke herself the previous day but was no longer experiencing suicidal thoughts. At that time, she was assigned to a cell in the general population unit known as West 6. A psychiatric consultation was not sought.

November 10, 2024

On the morning of November 10th, a deputy in West 6 asked a Jail MHP to assess CC because she was having problems with other inmates in her unit. More specifically, those female inmates confronted CC because she was hovering over them and violating their personal space. During the MHP's discussion with CC, she appeared to have difficulty keeping her eyes open and was breathing very deeply as though she was about to hyperventilate. She then collapsed to the ground. Medical staff was called to the scene and reported that she was awake, shaking, and speaking nonsensical sentences. She stated that she deserved to die and made other suicidal statements. The MHP then ordered her transferred to Safety Cell 3 (on suicide watch) by wheelchair because she could not walk. In the safety cell, she stated that she needed a pregnancy test and that she loved her babies. She then attempted to choke herself.[8]

The Jury learned that some MHPs would routinely call the Mobile Crisis Team to assess all inmates placed in safety cells.[9] If asked, the Mobile Crisis Team would usually come to the Main Jail within the hour. The Mobile Crisis Team would typically assess safety cell inmates during their routine

[7] "Adjustment disorder with mixed disturbance of emotions and conduct" is defined as an extreme reaction to a stressful incident that impacts mental equilibrium and causes negative changes in behavior. See https://www.hopkinsmedicine.org/health/conditions-and-diseases/adjustment-disorders

[8] Wellpath's on-call psychiatrist was not called on November 10th because she did not work on weekends (November 10th was a Sunday).

[9] The Mobile Crisis Team is called to assess inmates who need an assessment for an involuntary 72-hour hold. It is staffed by at least one Marriage and Family Treatment Counselor.

daily visits to the Main Jail. Here, however, the Mobile Crisis Team inexplicably did not evaluate CC until the evening of November 12th.

November 11, 2024

During a safety cell round by medical staff on November 11th at 2:03 a.m., CC was very anxious and was having difficulty sleeping. CC was observably distressed and crying at the time. CC expressed delusional thoughts claiming the devil would harm her children. CC did not make any threats to herself or others. An antihistamine was prescribed to treat these behaviors.

At 8:09 a.m. on November 11th, an MHP visited CC in Safety Cell 3. The MHP offered to speak confidentially with CC in a private room, which CC declined. Thus, the MHP briefly spoke with CC through the food slot in the cell door. CC stated that she was not suicidal and would not engage in a Collaborative Safety Plan (CSP).[10] She appeared anxious, angry, and hostile and again noted she was concerned about being pregnant. The MHP concluded that CC no longer needed a safety cell and advised the Deputies to move her to an observation cell. Custody deputies then placed her in Holding Cell H-6, which had a wall-mounted telephone and 12-inch cord.[11]

November 12, 2014

On November 12th, while housed in cell H-6, CC stated that she wanted to kill herself by hanging. At approximately 8:00 a.m., CC told the MHP that prior to her arrest she had been seeing a psychiatrist at a health clinic, where she was prescribed Hydroxyzine and Xanax.[12] The MHP did not document CC's prior history of bipolar disease, nor her history of stopping her previously prescribed anti-psychotic medication. The MHP told CC that the Mobile Crisis Unit would assess her that evening and that she would again be placed in a safety cell in the interim. The MHP noted that CC had not yet been diagnosed but offered a provisional diagnosis of major depressive disorder. CC was then moved to Safety Cell 4.

CC was evaluated by the Mobile Crisis Team at 10:30 p.m. on November 12th, which found that she did not qualify for a 5150 hold. The evaluator from the Mobile Crisis Team was not a licensed mental health worker. The Mobile Crisis Team did not document its denial of a 5150 hold in writing. CC was characterized as not volatile, and she denied any suicidal ideations during that encounter. However, the Mobile Crisis Team felt that CC exhibited bizarre behavior that necessitated further evaluation and treatment. Because there was no documentation of this

[10] A CSP includes a series of questions used to determine warning signs, coping skills and the patient's "reasons for living," for example the extent of supportive family and friends.

[11] According to SBSO policy, "the Classification Unit will assign appropriate housing with consideration to those inmates with physical and/or mental disabilities and/or special needs."

[12] Hydroxyzine is an antihistamine used to treat anxiety, tension, and allergic conditions. Xanax is used to help control anxiety and tension caused by nervous and emotional conditions.

assessment, the Jury cannot determine whether the Mobile Crisis Team knew of CC's bipolar disorder or recommended a treatment plan.

November 13, 2024 – Day of Suicide

On November 13th, at approximately 8:46 a.m., an MHP spoke with CC in Safety Cell 4 for about five minutes. At the time, CC was not in any acute mental distress and stated she did not want to kill herself. She mentioned that her children provided her with a reason for living. CC was scheduled to be seen by a Jail psychiatrist later that morning.

The MHP notified custody staff to step down CC from the safety cell to an observation cell. A custody deputy placed CC into cell H-6.[13] That cell contained a wall-mounted telephone with a 12-inch cord. All three of the cordless mental health observation cells were occupied when CC was stepped down from the safety cell on November 13th.

CC was never evaluated or diagnosed by a psychiatrist during her time in jail. For the first time, on November 13th at approximately 1:39 p.m., a Jail psychiatrist was scheduled to evaluate CC from a remote location via telehealth, but CC refused. She was never assessed by the psychiatrist. Instead, the psychiatrist merely prescribed Hydroxyzine and scheduled a follow up visit for a week later. The psychiatrist took no further actions to address CC's refusal of that evaluation, made no inquiries of Jail MHPs, did not review any of CC's prior mental history, did not know CC had been in safety cells for suicidal ideations twice in the previous three days, did not know she had been diagnosed with bipolar disorder, and did not prescribe antipsychotic medication.

Jail staff conducted safety checks of CC throughout the day, including at 4:04 p.m., 4:19 p.m., and 4:31 p.m., all of which demonstrated no unusual circumstances. However, while performing rounds at approximately 4:48 p.m., a custody deputy observed CC hanging from a 12-inch telephone cord wrapped around her neck. The deputy radioed a request for additional Deputies to respond to H-6 due to a hanging. The Shift Commander called for an ambulance. Deputies and Jail medical staff continued to administer medical aid until paramedics arrived at approximately 4:57 p.m.

At approximately 5:31 p.m., paramedics terminated resuscitation efforts, and CC was pronounced dead. An autopsy was later conducted by the Coroner's Bureau, which concluded that the cause of death was suicide by hanging.

After Death Events

As noted above, two holding cells that contained telephones with 12-inch cords were regularly used as observation cells when other options without telephones were not available. Several days after CC's death, Jail staff removed the telephone cords from cells H-6 and H-7. Since then, all

[13] The custody records contain conflicting data regarding which observation cell CC was assigned to.

holding cells that contained a telephone with a 12-inch cord have had the phone cord removed. There are now seven holding cells that do not have any phone cords.

Photos taken of cell H-6 after CC's death revealed a wall-mounted telephone with a 12-inch cord emanating from the bottom of the telephone. Based upon the Jury's research, several options on the market could have been installed to prevent inmate suicides using telephone cords, including telephones with six-inch cords, wireless speaker telephones, and a telephone cord that comes out of the top of the telephone housing, making it more difficult to use as a ligature.

Board of Supervisors Hearing Regarding Jail Health Monitoring

On March 11, 2025, a hearing was conducted by the Board of Supervisors to provide an update on Jail Health Monitoring activities. According to performance audits conducted by the County's Health Department and Behavioral Wellness, of 29 combined quality assurance measures reflecting the adequacy of health coverage, the Main Jail was rated "noncompliant" in nine measures, and "persistently noncompliant" in five of the nine. For the Northern Branch Jail there were eight measures of noncompliance, five of which demonstrated "persistent noncompliance."

The measure that generated the most alarm from the County Supervisors was the extent to which Wellpath failed to meet its contractual obligation to medically assess inmates placed in safety cells every four hours, properly doing so as required only 13 percent of the time at the Northern Branch Jail and 73 percent of the time at the Main Jail. Likewise, MHPs failed to timely check on such inmates inside safety cells within 12 hours, as the contract requires, doing so properly only 67 percent of the time at the Northern Branch Jail and 80 percent of the time at the Main Jail.

On April 1, 2025, the Board of Supervisors approved a new two-year contract with Wellpath.

DISCUSSION

Jail suicides are a serious and tragic problem throughout the country. According to published reports, some factors contributing to these suicides often include: an inmate's mental health issues, substance abuse, and stressful conditions within the jails. Inmate hangings in California, including Santa Barbara County, have been a significant issue in recent years. These incidents often highlight the challenges faced by the jail system in ensuring the safety and mental well-being of inmates. As discussed below, these and other systemic deficiencies were addressed in an inmate class action lawsuit filed in Federal District Court in the 2020 case of *Murray v. Santa Barbara County*.[14]

[14] *Murray v. County of Santa Barbara*, Case Number 2:17-cv-08805-GW-JPR, U.S. District Court (C.D. Cal. 2017).

The County Has Not Fully Complied with the Court-Approved Remedial Plan in *Murray*

The *Murray* lawsuit alleged, in part, that Santa Barbara County and its Sheriff's Office housed inmates in facilities that were overcrowded, understaffed, and unsanitary, and which failed to provide minimally adequate medical and mental health care to its inmates. The parties agreed upon a process for the retention of experts to improve conditions at the Main Jail, which ultimately resulted in a Remedial Plan (Plan).

The Plan requires Jail MHPs to provide clinical input regarding appropriate housing placement upon discharge from suicide precautions. Classification Deputies should consider such clinical input in determining post-discharge placement and conditions of confinement and document the reasons when clinical input is not followed. Once clinically discharged from suicide precautions, the inmate must be promptly transferred to appropriate housing. The Plan also requires the County to designate specialized mental health units, with provision of appropriate levels of programming and treatment for each mental health care service level. The County must provide enough beds at all necessary levels of clinical care and levels of security to meet the needs of inmates with serious mental illnesses.

In May 2025, Wellpath presented its "2024 Annual Report of Wellpath Medical and Mental Health Services." It reported that 5 suicides were attempted in the Northern Branch Jail during 2024, all of which were unsuccessful. In the Main Jail, 12 suicides were attempted, and one was successful, that being CC's case. Wellpath concluded that despite updating its inmate monitoring tools, there still existed "recurring non-compliance issues," such as the "failure to reassess patients in safety cells within the specified timeframe, delays in responding to sick calls, and incomplete post-suicide watch assessments."

In CC's case, an MHP removed her from a safety cell and advised custody officers to transfer her to an observation cell for further monitoring. MHPs had little to no control over cell placement. Hence, CC was assigned to a cell that contained a danger to potentially suicidal inmates—a telephone cord—because the Main Jail lacked enough cordless mental health observation cells to house recently suicidal inmates. Three such cells were not sufficient to accommodate the needs of the most vulnerable inmates, those demonstrating suicidal ideations.

There Was a Considerable Risk in Placing CC in an Observation Cell with a Telephone Cord

In the past seven years, six inmates, including CC, have committed suicide in the County's jails. In July 2018 an inmate hung himself by tying his T-shirt to the upper portion of his cell bars. In October 2019, an inmate with mental health issues committed suicide in a cell by wrapping a telephone cord around his neck. In early 2021, an inmate hung himself using a bed sheet. Two inmates committed suicide in 2023, one by hanging and another by jumping off a second-story tier.

There are haunting similarities between the circumstances in CC's suicide and the October 2019 suicide case. An inmate identified as D1 in a previous Grand Jury report had a history of suicide risk according to jail records. D1 was placed in a holding cell that contained a telephone and committed suicide there by hanging himself with the phone cord, exactly as CC did.

The 2019-2020 Santa Barbara County Grand Jury's investigation concluded with a Finding that "The inmate was housed in a cell that was not intended for mental health or medical observation." That Grand Jury recommended "the Santa Barbara County Sheriff Custody Staff house inmates displaying symptoms of mental illness in cells intended for mental health or medical observation" and that the Sheriff "not house inmates in cells with corded telephones."

In his formal response to the Grand Jury report, the Sheriff refused to implement the corded telephone recommendation, arguing that it was inconvenient for other inmates and unnecessary because all phone cords had been reduced from 18 inches to 12 inches following D1's suicide. More specifically, the Sheriff asserted that the 12-inch cord "does not allow for the ligature point and still provides inmates with a normalized telephone." In that same response, the Sheriff claimed that the recommendation to house inmates with mental health problems in cells designed to meet their needs "has been implemented."

Unfortunately for CC, the SBSO's failure to provide a suitable holding cell resulted in her untimely death.

Other Options Could Have Been Pursued Instead of CC's Transfer to H-6

CC was a suicide risk given her repeated suicidal statements and self-strangulation attempts in the week leading up to her suicide. Even if there were no cordless observation cells available on the day CC committed suicide, the staff could have tried several options other than the one chosen:

1. CC could have been moved to the County's psychiatric holding facility (PHF) or the Crisis Stabilization Unit if a bed was available.
2. The Mobile Crisis Team could have been called to perform an emergency 5150 assessment potentially resulting in a 72-hour hold in the appropriate psychiatric facility.
3. CC could have been moved to a local hospital's emergency department for further evaluation.
4. CC could have been moved to the Northern Branch Jail if a mental health observation bed was available.
5. CC could have been moved to another county's psychiatric facilities.
6. CC could have been assigned a "sitter," an individual that provides constant observation for inmates at risk.

The Jury has seen no evidence that any of these options were considered or sought. It should be noted that many of the above options may have, if tried, been unavailable due to overcrowding in

those facilities. We may never know if that was true because none of those options were tested in this case.

The Main Jail's infrastructure is antiquated and has a limited number of observation cells available. This problem has been identified several times over the past years, by the Grand Juries, the SBSO, Behavioral Wellness, and the Board of Supervisors. Indeed, Sheriff Brown has argued in favor of jail expansion, citing concerns over overcrowding and deteriorating conditions in the Main Jail. In this investigation, insufficient staffing and housing were the root causes that allowed CC's suicide. Efforts have been underway for at least the last two years to increase the number of beds available in the Northern Branch Jail such that inmates at the Main Jail can be moved there. The Northern Branch Jail is better equipped to handle mental health patients.

As noted above, on April 1, 2025, the Board of Supervisors agreed to fund further construction to add additional mental health beds and staff hiring at the Northern Branch Jail, which, in this Report, the Jury observes has been desperately needed.

Wellpath Staff Did Not Comply with Its Policies in CC's Case

Wellpath staff failed to comply with applicable Wellpath policies and procedures in securing CC's safety, as discussed below.

The Main Jail was not equipped with a sufficient number of observation cells or mental health staff in the IRC. According to Wellpath policy, when the facility is not equipped with housing capacity and/or mental health staff to maintain the patient's safety, transfer must be arranged to the closest facility that can offer adequate protection for the patient. According to the applicable policies, the decision to pursue a transfer may include, but is not limited to:

1. Considering involuntary treatment
2. Requesting assistance from the court liaison in obtaining a community hospital bed
3. Requesting assistance from the facility's legal counsel in obtaining a community hospital bed
4. Ensuring awareness and request assistance from Wellpath's Regional Directors of Mental Health, Vice-President of Mental Health, and Regional or Chief of Psychiatry
5. Increasing clinical contact with the inmate

Other than the one 5150 assessment performed by a Mobile Crisis Team, the Jury has seen no evidence that any of these options were considered or implemented during CC's incarceration.

SBSO and Wellpath policies state that after an inmate has remained in a safety cell for more than 12 hours, the Mobile Crisis Team must be called to conduct an evaluation. CC was housed in Safety Cell 3 for 23 hours and 52 minutes between November 10th and 11th, but the Mobile Crisis Team did not assess her until November 12th at approximately 10:00 p.m. The policy also requires

MHPs to follow up regularly with the Mobile Crisis Team to inquire about the inmate's pending evaluation and placement. MHPs did not adhere to these policies.

According to Wellpath policy, an inmate must not remain in a safety cell beyond 24 hours unless there are "exceptional circumstances" documented by MHPs and custody staff. CC remained in Safety Cell 4 for 24 hours and 39 minutes between November 12th and 13th, but there was no documentation describing such exceptions. MHPs did not comply with this policy.

Wellpath policy states that prior to placing an inmate in a safety or mental health observation cell, custody staff shall inspect the cell to ensure no items are available for potential self-harm. When placing CC into H-6, custody staff knew that the cell had a telephone cord which, in the Jury's view, was available for potential self-harm.

According to Wellpath policy, cells housing suicidal patients should be as suicide-resistant as possible. Clearly, cell H-6 was not adequately suicide-resistant.

Wellpath policies state that inmates showing "no improvement or continuing deterioration" such as escalating, inappropriate, and/or bizarre behaviors or for whom, after six hours of placement in a safety cell, it is impossible to complete a hands-on nursing assessment (including vital signs), must be transferred to the hospital for further medical and diagnostic evaluation. This did not occur, even though CC continued to decompensate during her days in jail.

A Jail Psychiatrist Failed to Evaluate, Diagnose, and Treat CC

CC's self-reported history of bipolar disease was noted during the Jail health receiving screening, and CC stated she had not taken anti-psychotic medication in a year and a half. However, the Jail psychiatrist was not notified of the diagnosis.

Further, the MHPs who repeatedly evaluated CC during her incarceration did not document her history of bipolar disease, and did not consider this in their evaluation of her suicidal ideation. The MHPs are not licensed to prescribe medication and are required by their licensure to consult a psychiatrist to treat patients who require medication.

Furthermore, a psychiatric evaluation should have been conducted when CC was placed in the two safety cells. The SBSO's policy on the use of safety cells dictates that "the psychiatrist will examine inmates in safety cells." Wellpath's policies dictate that a psychiatrist must assess all inmates after being housed in a safety cell for 24 hours. CC was housed in Safety Cell 4 for more than 24 hours between November 12th and 13th, yet the psychiatric assessment never occurred because CC refused to participate.

The psychiatrist did not review CC's history between November 8th and 13th because CC declined to attend the November 13th visit, which was then cancelled. Nor did the psychiatrist contact the MHPs to follow up about CC's condition, simply scheduling an assessment for a week later.

The Jury learned that the goal in treating suicidal patients is to stabilize them and return them to the jail's general population at the earliest possible time. Specifically, the Jury learned that such patients should be prescribed anti-psychotic medications to control delusional and bipolar conditions. Prescribing anti-psychotic medications to individuals with bipolar disorder can greatly reduce their risk of suicide. CC was never prescribed anti-psychotic medications during her stay in the jail.

Despite the ongoing deterioration of CC's mental status in the days leading to her demise, a psychiatrist at the jail failed to take steps to ensure CC's safety given that she was at risk of suicide.

There Was Poor Communication Between the Mobile Crisis Team, Outside Mental Health Professionals, and Jail Mental Health Staff

The MHPs had little to no communications with Cottage Hospital regarding their treatment of CC just prior to her transfer to the Main Jail. CC was evaluated by a Cottage Hospital psychiatrist on November 9th who diagnosed her with adjustment disorder and gave her psychotropic medication while in the hospital. However, the MHPs were not provided with that psychiatrist's report or medication orders. In addition, the Jury has seen no evidence that the MHPs made any effort to obtain CC's prior mental health information or records from any outside provider, including Cottage Hospital and a health clinic where she had been seen.

MHPs would have to contact outside providers to request an inmate's prior medical and mental health records, which often takes days or weeks, thus delaying the information necessary for the mental and medical staff to properly treat inmates. An inmate's prior mental diagnoses, treatment, and treatment plans should be obtained by the MHPs as soon as possible to provide consistent ongoing care in jail. To expedite this process, mental and medical staff can request signed authorizations from all inmates upon entry for the release of information necessary for the protection of inmates' health. The Jury has learned that since CC's death, a new authorization form has been created, but the Jury does not know whether it is being used at intake in the IRC.

MHPs are not prohibited from obtaining an inmate's mental health records from outside providers pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA permits jail healthcare providers to obtain an inmate's mental and medical records from outside providers in certain circumstances without inmate consent. For example, 45 C.F.R., § 164.512 (k)(5)(i) states that a healthcare provider may disclose to a correctional institution an inmate's protected health information if the correctional institution represents that such information is necessary for the health and safety of such inmate. However, there was a misconception among

MHPs at the jail that they could not obtain mental health records from outside providers due to HIPAA confidentiality concerns.

Jail mental health and medical staff should be retrained on the applicability of HIPAA to the jail environment. The SBSO and other County mental health agencies are reassessing these issues in hopes of improving communication between outside providers and the County's jails. The Jury is hopeful that this can be resolved at the earliest opportunity.

The Jail's Electronic Health Record System Could Not Concisely Summarize CC's Prior Mental Health History from Outside Healthcare Providers

When any inmate enters the County's jails, the only medical records usually available at intake are from prior County jail stays. Even though CC was evaluated by Behavioral Wellness' Mobile Crisis Team just two weeks prior and a psychiatrist at Santa Barbara Cottage Hospital shortly before her intake, that and any other outside medical information was not available to Wellpath staff. It is up to the individual initiative of the medical staff at the County's jails if they make any effort to obtain past health records from outside providers or hospitals. In contrast to electronic health record systems utilized by other Santa Barbara hospitals, clinics, and doctors, the electronic health record system currently employed at the County's jails cannot receive information shared from outside sources. While there has been recognition of the need to upgrade the current health record information system to better obtain essential health history, this has yet to be done.

At the Board of Supervisors meeting on April 1, 2025, County officials stated that the SBSO may participate in the use of a new electronic health database that, at the very least, can access a patient's mental health record from Behavioral Wellness. The Jury hopes these efforts are forthcoming in the near future.

CONCLUSION

It is the Jury's view that the MHPs exhibited integrity and compassion in treating CC given the inherent deficiencies discussed in this Report. Likewise, custody staff demonstrated dedication and sincerity in their mission of safeguarding inmates. But that should not end the discussion. The systems and infrastructure used to evaluate and treat inmates with severe mental health concerns have failed inmates and staff. They must be given the necessary resources to ensure the health and safety of inmates, especially those with mental health conditions, or more individuals will die.

If you're having thoughts of suicide, please call the National Suicide Prevention Lifeline at 1-800-273-8255, or call or text 988 (Crisis and Suicide Lifeline). They have caring people available 24/7 to provide free and confidential support.

FINDINGS AND RECOMMENDATIONS

Finding 1: CC should not have been transferred to an observation cell with a telephone cord.

Recommendation 1a: The Grand Jury recommends that the Sheriff's Office will not place an inmate deemed by mental health staff to have been recently suicidal in an observation cell that contains a telephone cord. To be implemented no later than January 1, 2026.

Recommendation 1b: The Grand Jury recommends to the Sheriff's Office that if no cordless mental health observation cells are available when stepping down a potentially suicidal inmate from a safety cell, a Jail mental health provider should seek to transfer that inmate to the closest facility that can offer adequate protection. To be implemented no later than January 1, 2026.

Recommendation 1c: The Grand Jury recommends to the Sheriff's Office that if no cordless mental health observation cells are available when stepping down a potentially suicidal inmate from a safety cell in the Main Jail, a Jail mental health provider must contact the County's psychiatric holding facility, the Crisis Stabilization Unit, a local hospital, and the Northern Branch Jail to determine if a bed offering an appropriate level of care is available. To be implemented no later than January 1, 2026.

Recommendation 1d: The Grand Jury recommends that the Board of Supervisors negotiate a memorandum of understanding with San Luis Obispo County, Ventura County, Los Angeles County, and other neighboring counties in California setting procedures for transferring and accepting inmates with severe mental health disease when no other safe housing options are available. To be implemented no later than January 1, 2026.

Finding 2: Wellpath staff failed to comply with existing policy requiring a psychiatric assessment while housed in a safety cell.

Recommendation 2: The Grand Jury recommends that while an inmate is housed in a safety cell, the Sheriff's Office require a Wellpath psychiatrist conduct an evaluation of that inmate. Given that the recommendation is to follow existing policy, to be implemented immediately.

Finding 3: A Jail psychiatrist failed to evaluate, diagnose, or treat CC's severe psychiatric illnesses, which were serious shortcomings.

Recommendation 3a: The Grand Jury recommends that if the on-duty psychiatrist is not available to conduct what Jail medical and mental health staff deem to be an urgent evaluation of an inmate, the Sheriff's Office require Wellpath to designate another backup on-call psychiatrist to conduct such an evaluation. To be implemented no later than January 1, 2026.

Recommendation 3b: The Grand Jury recommends to the Sheriff's Office that if a stepdown inmate refuses to participate in a psychiatric evaluation, the on-duty Jail psychiatrist be required to obtain and review the inmate's mental health history. To be implemented no later than January 1, 2026.

Finding 4: During CC's first approximately 23-hour stay in Safey Cell 3, the Sheriff's Office failed to ensure that Wellpath staff comply with policy requiring that the Mobile Crisis Unit be called after 12 hours in a safety cell.

Recommendation 4: The Grand Jury recommends that after an inmate spends more than 12 hours in a safety cell, the Sheriff's Office require that Wellpath staff always call the Mobile Crisis Unit to conduct an evaluation and document the call and its outcome in the Jail electronic health record. Given that the recommendation is to follow existing policy, to be implemented immediately.

Finding 5: There was poor communication regarding CC's mental health history between Jail mental health staff, Mobile Crisis Teams, and outside healthcare providers who treated her.

Recommendation 5a: The Grand Jury recommends that the Sheriff's Office require additional training for Wellpath mental health providers regarding HIPAA regulations concerning inmates, including defining under what circumstances a mental health provider may legally contact outside mental health providers about an inmate's mental health history**.** To be implemented no later than January 1, 2026.

Recommendation 5b: The Grand Jury recommends that the Sheriff's Office require the on-duty registered nurses at the County's jails to request every newly arriving inmate at the time of intake to sign a written authorization to release their medical and mental health records and information. To be implemented no later than January 1, 2026.

Finding 6: Wellpath staff did not obtain critical health-related documentation from Cottage Hospital or Behavioral Wellness and therefore CC did not receive proper treatment in jail.

Recommendation 6a: The Grand Jury recommends that the Sheriff's Office require Wellpath staff to contact outside healthcare providers, such as hospitals, physicians, and clinics, to obtain inmates' health records in a timely manner following intake. To be implemented by January 1, 2026.

Recommendation 6b: The Grand Jury recommends that the Sheriff's Office upgrade its electronic health record system to allow it to receive patient health information from outside providers via an industry-standard means of internet transmission. To be implemented by March 31, 2027.

Finding 7: The Sheriff's Office did not comply with the Remedial Plan outlined in *Murray v. Santa Barbara County* because it did not provide enough beds at all necessary levels of clinical care and security to meet the needs of inmates with serious mental illnesses, as in CC's case.

Recommendation 7a: The Grand Jury recommends that the Sheriff's Office provide and maintain safety and observation cells sufficient in number to meet ongoing demands.

Recommendation 7b: The Grand Jury recommends that the Sheriff Office require custody staff to consider mental health staff's clinical input when determining placement upon discharge from a safety cell and document the reasons when clinical input is not followed.

This report was issued by the Grand Jury with the exception of a Grand Juror who wanted to avoid the perception of a conflict of interest. That Grand Juror was excluded from all parts of the investigation, including interviews, deliberations, and the writing and approval of this report.

REQUIREMENTS FOR RESPONSES

Pursuant to California Penal Code §933 and §933.05, the Grand Jury requests each entity or individual named below to respond to the findings and recommendations within the specified statutory time limit.

Responses to Findings shall be either:

- Agree
- Disagree with an explanation
- Disagree partially with an explanation

Responses to Recommendations shall be one of the following:

- Has been implemented, with a summary of the implementation actions taken
- Will be implemented, with an implementation schedule
- Requires further analysis, with an analysis completion date of fewer than 6 months after the issuance of the report
- It will not be implemented with an explanation of why

Santa Barbara County Board of Supervisors – 90 days

Findings 1, 2, 3, 4, 5, 6, 7
Recommendations 1a, 1b, 1c, 1d, 2, 3a, 3b, 4, 5a, 5b, 6a, 6b, 7a, 7b

Santa Barbara County Sheriff's Office – 60 days

Findings 1, 2, 3, 4, 5, 6, 7
Recommendations 1a, 1b, 1c, 1d, 2, 3a, 3b, 4, 5a, 5b, 6a, 6b, 7a, 7b