Annual Report: 2025

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OIR GROUP

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Introduction

This is the second Annual Report issued by the Office of Inspector General for Santa Cruz County.[1] It is intended to provide a summary of the work done by the OIG throughout 2025 while also providing a window into the internal and primarily confidential accountability mechanisms at work in the Sheriff's Office. Our review of these issues resulted in 10 recommendations that are discussed in detail throughout the report. Since the time of our first Annual Report, in October 2024, we have issued two interim reports (in February and August, 2025[2]) to provide the public updates on our work.

The scope of the OIG's work falls into four main categories: review of complaints from members of the community, including incarcerated individuals; review of administrative investigations conducted by Internal Affairs into allegations of misconduct by Sheriff's Office personnel; review of deputy-involved shootings; and review of in-custody deaths. We are happy to report that these final two categories produced no work for us in 2025 – deputies did not engage in any shooting incidents, and no one died while in Sheriff's Office custody. We also regularly review and offer input on Sheriff's Office policies and procedures.[3] One additional area of review has developed over the time of our engagement, with the concurrence of the Sheriff's Office: regular review of use of force incidents and

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[1] In 2022, the County of Santa Cruz created an Office of Inspector General and, in 2023, selected OIR Group to fill the role. OIR Group of is a team of police practices experts that has worked exclusively in the field of independent oversight of law enforcement since 2001. OIR Group has worked in jurisdictions throughout California and in several other states, providing a range of services while serving in a variety of capacities.

[2] All of the OIG's reports can be found here: https://www.santacruzcountyca.gov/Departments/OfficeofInspectorGeneral.aspx

[3] For example, we recently reported to the Board on the development of a Sheriff's Office policy regarding the use of data from Automated License Plate Readers.

participation in the monthly Use of Force Review meetings conducted by Operations and Corrections personnel.

This report discusses these main areas of work, with the following findings and recommendations:

- Individuals submit complaints to the OIG regarding a variety of subjects and allegations involving the conduct of Operations Bureau deputies as well as ongoing grievances related to the County's jails. The Sheriff's Office's responses to these complaints have been objective and fair.

  Our key finding in this section relates to the timeliness of investigations into these complaints and recommends an internal target completion date to allow complaints to be fully resolved within 180 days.

- We acknowledge the tremendous improvement in the level of detail provided in notification letters to complainants at the conclusion of investigations. These more personalized close-out letters convey the seriousness with which the Sheriff's Office approaches its obligation to thoroughly investigate and fairly resolve these complaints.

- The Internal Affairs investigations we reviewed were thorough, objective, and complete, and each resulted in appropriate disciplinary findings. We appreciate the ongoing effort to involve us in these cases by sharing investigative reports with us and remaining open to our input.

- Sheriff's Office personnel use force judiciously and relatively infrequently. There were no uses of deadly force in 2025, and nothing beyond minor injuries to those on whom force was used. The Sheriff's Office takes seriously its responsibility to meaningfully review each use of force incident. Nonetheless, we recommend more formal documentation of use of force reviews that will bring the Sheriff's Office in greater alignment with modern best practices.

This report begins, though, by addressing a key area of concern for both the Sheriff's Office, the Santa Cruz community, and communities around the state and country: the ways in which law enforcement responds to

people in mental health crises. The frequency with which calls for service involve someone in crisis continues to grow, often placing law enforcement officers in untenable positions. This report discusses some alternative approaches to mental health calls, generally, and Santa Cruz County's response, specifically. We reviewed a sample of calls for service that involved a mental or behavioral health component and make findings and recommendations based on that review and our familiarity with approaches to these scenarios in numerous other jurisdictions. These include:

- Sheriff's Office personnel's overall response to mental health calls is exemplary in many ways, including the use of various de-escalation techniques, the exercise of discretion regarding their enforcement authority, engagement with family members when possible, disengagement in appropriate circumstances, and overall situational awareness.

- The Sheriff's Office's partnership with County mental health professionals, including a Mental Health Liaison who is assigned to the Sheriff's Office and the County's Mobile Emergency Response Teams plays a vital role in helping to de-escalate and assist individuals in mental health crisis. The longstanding opening for a second Mental Health Liaison position, though, limits these efforts, and we recommend the County move expeditiously to fill this vacancy.

  We also encourage the Sheriff's Office and the County to continue to think broadly about the most efficient and effective ways to respond to calls for assistance involving nonviolent individuals experiencing mental health crises, including the possibility for enhanced training for Sheriff's deputies as well as increased coordination and communication between all County stakeholders and advocates. The recently-initiated pilot program to divert mental health crisis calls away from law enforcement and directly to the County's Mobile Crisis Response Team is a promising development that we will continue to follow.

- Our review of incidents involving mental health calls also led to specific recommendations around handcuffing and transporting individuals who are suicidal or otherwise in need of mental health

services; strategies for infusing compassion into de-escalation tactics, and improved documentation of mental health-related calls.

- With respect to the challenges the Corrections Bureau confronts when addressing the mental health needs of individuals in custody in the County's jails, we recommend the Sheriff's Office and the County consider creating an Ombudsman's office to serve both as a liaison to family members of incarcerated persons and as an intermediary to address some of the most challenging concerns raised in the custody environment.

Throughout the year, we appreciated our continued ability to connect with various individuals and organizations who play important roles in the community, particularly with respect to criminal justice issues. Specifically, we reached out to organizations and individuals who expressed interest in our work, sending links to our first Annual Report and two interim reports, including the NAACP, NAMI (National Alliance on Mental Illness), MILPA (Motivating Individual Leadership for Public Advancement), Monarch Services, the Public Defender's Office, and the County's Justice and Gender Commission. We thanked them for their input to our work and reminded them we are available to discuss any questions, concerns, or issues they have.

We had periodic contact with an NAACP representative about law enforcement issues and had regular communications with a faith leader who worked frequently in the jail. In March 2025, we held a virtual community meeting to discuss an interim report and listen to community concerns. In October 2025 we attended an ACLU membership meeting where we listened to their concerns and answer questions about OIG activities. And we appeared on a local community radio show to discuss our work and answer questions from callers.

This ability to engage with members of the Santa Cruz community informed our work in important ways throughout 2025, and we are grateful to all those who gave their time to these essential meetings and contacts. With the release of this report, we plan to host another community meeting, this time in South County so that we can meet with and listen to the concerns of South County residents and organizations.

Also critical to our work is our regular contact with Sheriff's Office leadership. We noted in our first Annual Report the existence of a 2021 law that gives California counties the ability to establish Offices of Inspector General to play a role in the monitoring of local sheriff's offices. Since 2021, only a handful of the 58 Sheriff's Offices in California have adopted any form of oversight, and few have done so with the level of commitment as the Santa Cruz County Sheriff's Office. The Sheriff's Office remains fully transparent, communicative, and receptive to our questions, ideas, and requests for information. We have complete access to all Sheriff's Office records and the freedom to interact with any members of the command staff and others as needed, a degree of access that is essential to the transparency that the County prioritized in creating the OIG.

Since our first report, Sheriff Chris Clark has stepped to the helm of the organization, and his commitment to meaningful oversight matches that of his predecessor. We are grateful to him and his team for their cooperation and facilitation of our work. Our regular meetings with the Sheriff, Undersheriff, Chiefs, and key Lieutenants provide an important forum for sharing information and ideas of common interest.

We hope this report will add to the public's understanding not only of our role but also of Sheriff's Office operations. We remain committed to being available to members of the public and incarcerated persons who contact us about their specific complaints or broader concerns, and we look forward to a continued collaborative approach with Sheriff's Office leadership in addressing the recommendations made in this report, as well as ongoing issues as they arise.

Responding to Mental Health Crises

The frequent interaction between law enforcement officers and persons experiencing mental health crises represents one of the most significant challenges faced by our public safety and criminal justice systems. Counties, cities, and law enforcement agencies nationwide are increasingly responding to demands for alternative approaches to mental health calls and for more holistic responses to persons in crisis.[4] This dynamic prompted us to explore various aspects of the Sheriff's Office response to persons in crisis and the resources available in Santa Cruz County.

For our review, we met with representatives of the County's Behavioral Health Division as well as the Mental Health Liaison assigned to the Sheriff's Office. And we participated in a ride-along where we had the opportunity to observe and interact with the Mental Health Liaison in the field.

We also requested and reviewed a sample of calls for service that involved a behavioral health component. The Santa Cruz County Sheriff's Office, as with all agencies nationwide, responds to a high volume of these calls for service: in 2025, SCCSO responded to over 3,500 such calls. This represents around 5% of all calls for service that the Sheriff's Office responded to in that year. Our observations, findings, and recommendations follow.

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[4]The history of state psychiatric hospital closures, underfunded mental health services, and the resulting increase of individuals with mental illness in jails and prisons is widely acknowledged and well-documented.

Mental Health Response in Santa Cruz County: Coordination and Collaboration

Mental Health Liaison

Since as early as 2015,[5] the Sheriff's Office has partnered with a Mental Health (MH) Liaison, a County Behavioral Health clinician who responds on scene with deputies to mental health related calls. Currently, the MH Liaison works four days a week between 8 AM and 6 PM providing on-scene crisis intervention services, including assisting with de-escalation and assessment. The MH Liaison connects individuals to treatment and services and often provides follow-up with individuals after a crisis incident. Additionally, the MH Liaison participates in after-incident debriefing sessions with the Sheriff's Office, assists in law enforcement training on behavioral health crisis response and serves as a resource to deputies who have questions and concerns related to individuals in behavioral health crisis.

Focused Intervention Team (FIT)

In 2019, the Sheriff's Office created the Focused Intervention Team (FIT) to address repeat offenders who are resistant to assistance or treatment. Comprised of a sergeant and a deputy, FIT contacts individuals experiencing mental distress, both on the street and in jail and connects them to services, including drug and mental health treatment. The team's primary mission is to lessen the burden on local emergency services by identifying high frequency users of emergency services who often commit low-level crimes and connecting them with the resources they need.

Mobile Crisis Response Teams

Santa Cruz County Behavioral Health operates multiple Mobile Crisis Response Teams, including a Mobile Emergency Response Team

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[5] This program began on a trial basis in 2015, though at the time the working hours were more sporadic. It has only more recently been a full-time partnership with a MH Liaison permanently assigned to the Sheriff's Office.

(MERT) for adults, a Mobile Emergency Response Team for Youth (MERTY)[6] and Mental Health Liaisons who partner with the County's law enforcement agencies, including the Sheriff's Office as well as the Santa Cruz Police Department.[7]

CAREalert

Another collaborative County program we learned about is CAREalert,[8] which is intended to enhance the safety of individuals with various types of special needs by providing law enforcement officers with information that can guide their response in any interactions with those individuals. It is a County-wide program in collaboration with NAMI (National Alliance on Mental Illness) that creates the opportunity for community members to register their loved ones and provide specific information about limitations, communication preferences, and potential triggers. This information is then linked to any calls or interactions with those individuals so that law enforcement officers can provide appropriate care and support during those interactions.

Crisis Response Models Nationwide: Variety and Specialization

Nationwide, law enforcement agencies and the communities they serve have endeavored to address the increase and complexity of behavior health crisis calls in a variety of ways. These fit into a few different categories, including a first-level response by specially-trained officers; co-response by law enforcement and mental health clinicians; and community-based programs that feature response by non-law

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[6] Records from the Sheriff's Office often documented when a Mobile Crisis Response Team was on scene or had been contacted. Most often this documentation used the term "MERT" and did not distinguish between MERTY – the County's Mobile Crisis Response Team for Youth – and MERT – the County's Mobile Crisis Response Team.

[7] For reference, the County's Mobile Crisis Response Teams (including MERT, MERTY, and MH Liaisons) responded to a total of 1,463 incidents during FY24-25, for a combined average of 163 incidents per month. Around half of these involved MH Liaisons.

[8] https://carealert.santacruzcountyca.gov

enforcement personnel. We provide an overview of these models and their relevance to Santa Cruz County, for background and reference.

Specialized Training for Law Enforcement

Many law enforcement agencies, including the Sheriff's Office, provide their officers Crisis Intervention Training (CIT). Typically, either a 24- or 40-hour course, CIT provides officers with information about mental illness, development disabilities, addiction and other relevant topics and includes scenarios designed to teach officers communication and de-escalation skills to intervene safely with people in crisis. CIT training is often provided in partnership with community programs, particularly the National Alliance on Mental Illness.[9]

Some agencies select certain officers based on their skill and particularized interest to receive advanced or enhanced CIT training. These officers receive a specialized designation recognized by dispatchers, who will attempt to match them to mental health calls. Other officers also will request their response when needed to assist with crisis calls.

Sheriff's Office deputies typically receive 24 hours of CIT training. In the past, County Behavioral Health provided training, but the Sheriff's Office reported that deputies have not received CIT training locally from County Behavioral Health for several years. We recommend that the Sheriff's Office ensure that all deputies have received, at a minimum, the 24-hour CIT curriculum. We suggest that all new deputies, including Correctional Deputies, receive this training in their respective academies. In addition, the Sheriff's Office should consider sending some subset of officers to a more advanced CIT training.

In addition to CIT training, the Sheriff's Office has since 2018 trained deputies in Integrating, Communications, Assessment, and Tactics (ICAT) which emphasizes de-escalation and critical decision-making strategies, an approach particularly effective when interacting with individuals in

[9] https://www.nami.org/advocacy-at-nami/crisis-intervention/crisis-intervention-team-cit-programs/

mental health crisis. Since implementation of this training curriculum, the Sheriff's Office reports that use of force incidents have declined and it has not had any fatal uses of force.[10]

> RECOMMENDATION 1: The Sheriff's Office should ensure that all deputies receive the basic CIT training curriculum and should consider sending some subset of deputies to advanced CIT training that provides a specialized designation or certification.

Co-Response Models

Many agencies – including the Sheriff's Office – have partnered with mental health professionals to respond to crisis calls. These collaborations are based on the notion that a joint response is preferable because it combines both mental health and law enforcement expertise: police provide safety in potentially violent or injurious situations while mental health professionals bring different skills to communicate, assess and provide psychiatric care to those in crisis. In some cities, law enforcement agencies directly hire clinicians while other models rely on a partnership with the city's behavioral health department or other service providers. Some communities have also incorporated peer specialists or peer advocates into their co-responder team.

Such police-mental health collaborations take a variety of forms. Clinician-officer teams may ride together in the same police car (marked or unmarked) or (as in the case of the Sheriff's partnership with its assigned MH Liaison), they may arrive separately at the scene. Other law enforcement agencies have arrangements in which officers can obtain assistance from a mental health clinician via phone or telehealth support. Some of the police-mental health partnerships provide a primary response to crisis calls while other models rely on clinicians to follow up to ensure individuals are linked to services after an officer responds to the initial crisis call. Another type of co-responder model focuses on identifying

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[10] In April 2024, the Police Executive Research Forum highlighted the Santa Cruz County Sheriff's Office's early adoption of ICAT for both patrol deputies and correctional officers and its reduction in total use of force incidents. https://www.policeforum.org/assets/SpotlightSantaCruz.pdf

individuals considered high users of police and emergency services and provides these individuals comprehensive case management.

All of these various models share the goal of increased safety, reduced numbers of arrests and uses of force, and improved linkages to mental health services. The other commonality generally lies in resource challenges: availability of these teams often is limited due to staffing and costs.

Non-Law Enforcement Response Models

Finally, a growing number of communities have adopted non-law enforcement community-based alternatives, choosing to dispatch mental health clinicians or other civilian professionals to non-violent crisis calls and requesting police assistance only when needed. These models, again, take many different forms, depending on the needs and resources of a given community.

Teams dispatched to crisis calls may be a combination of mental health clinicians, nurses, EMTs, social workers, or peer specialists (individuals with lived experience who can empathetically relate to individuals in crisis). A growing number of communities are adopting some aspects of the Eugene, Oregon program that has gained recognition – Crisis Assistance Helping Out On The Streets (CAHOOTS)[11] – which pairs a civilian crisis intervention worker and a medic for dispatch to nonviolent crisis calls.

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[11] CAHOOTS reportedly responds to nearly 20 percent of the city's 911-dispatch calls, requesting police backup in fewer than 1 percent of those calls. By reducing the strain on police and local emergency departments, this community-based program with an annual budget of roughly $2 million saves the city an estimated $8.5 million in public safety costs and $14 million annually in ambulance trips and emergency room costs.

Review of Mental Health Calls for Service

We requested a sample of calls for service related to individuals experiencing some type of mental health crisis. We asked the Sheriff's Office for a list of all mental health-related calls during a three-month period in 2025. From this list of 375, we selected 14 incidents where officers generated a report. We intentionally selected some calls from days the Mental Health Liaison was working, and some that occurred on her scheduled days off.

We also reviewed records from use of force reviews during this time period and noted two cases with a mental health component where officers used force in the course of their response. We added those cases to our sample.

We reviewed all relevant evidence related to these calls, including body worn camera footage and police reports. Overall, we found the Sheriff's Office's performance to be in compliance with policy and exemplary in many ways. In particular:

- Deputies used various de-escalation techniques, such as positive communication, establishing rapport by citing previous encounters, and presenting an authoritative, yet compassionate presence. The involved officers all showed the involved individuals considerable respect.
- Deputies gathered available relevant evidence prior to responding to the calls, including information about individuals' diagnoses and prior justice system and/or behavioral health system involvement.
- Deputies generally chose to resolve situations without using enforcement authority, even when they could have made arrests.
- In cases where it was appropriate, deputies spoke with family members and social workers to inform their decisions.
- When deputies determined that a mental health hold was necessary, officers provided a full advisement to the subject and fully articulated the rationale for the hold in their related report.

- Deputies disengaged where appropriate, when the subject did not pose a risk to others, did not meet criteria for an involuntary hold, and/or deputies had no legal standing for detention.
- We observed deputies provide the appropriate documentation and verbal debrief during the hand-off to medical staff.
- Officers maintained situational awareness, clearly keeping everyone's safety in mind throughout the incidents we observed.

Mental Health Calls: Incident Summaries

We provide the following brief summaries of the cases we reviewed to illustrate the types of situations the Sheriff's Office responds to on a regular basis and to frame the discussion of our recommendations for potential improvement that follows.

Case 1

Deputies were dispatched to a domestic disturbance involving a man and his adult son, who had a history of mental health diagnoses. The MH Liaison also responded. She assessed the son, who was behaving erratically, and determined he should be placed on an involuntary hold. Deputies handcuffed him without incident and transported him to Telecare[12].

The father reported the son had struck him but did not want to press charges. Deputies did not pursue any criminal action.

Case 2

A deputy responded to a report of an assaultive and emotionally distressed juvenile. Before arriving on scene, the deputy learned that the juvenile had autism and a history of aggressive behaviors, mental health detentions, and juvenile court involvement. When the deputy arrived, he observed the parents and younger children inside a vehicle and the juvenile banging on the car window. The juvenile told the deputy he had kicked his mom and hit his stepfather out of frustration. The MH Liaison

[12] Telecare is a crisis stabilization facility in Santa Cruz County.

interviewed the juvenile and determined that he did not meet 5150 criteria. Although the juvenile's actions constituted a battery, the parents did not seek prosecution. With the arrival of an in-home support aide and a Mobile Emergency Response Team member who knew the juvenile, the deputy and MH Liaison created a safety plan that involved the aide taking the juvenile to a nearby café.

Several aspects of this case stood out as exemplary. Before his arrival, the deputy obtained important information about the juvenile's diagnoses and history. On scene, the deputy established a good rapport with the juvenile and gained his cooperation. The on-scene presence of the MH Liaison enabled the deputy to interview the parents while the Liaison continued to engage and assess the juvenile. The arrival of the aide and MERT provided further support and options for diffusing the family dynamics. This case exemplified effective de-escalation and a creative safety plan that resulted from the deputy's and MH Liaison's collaboration with additional behavioral health players.

Case 3

A woman called to report her juvenile foster child was possibly suicidal and had attempted to jump out of her moving car into traffic earlier that day. Deputies located the juvenile and the lead deputy spoke with her at length. He established a rapport with her, referencing prior contacts he'd had with her. The deputy also spoke with the juvenile's case worker to learn more about her background and foster family.

The deputy determined she met the criteria for an involuntary mental health hold based on statements she made about possible suicidal intent. As with other cases, there is no documentation to suggest whether deputies considered calling a mental team to respond to this call.

Deputies transported the juvenile to the hospital.

Case 4

In another case involving a juvenile, deputies responded with lights and sirens to a reported suicide attempt. They discovered the juvenile had cut relatively superficial wounds on her wrist. One deputy spoke with the juvenile about her troubles and concerns with compassion and sensitivity while other deputies spoke with the parents to learn more about their

daughter's background and history. Deputies ultimately decided to write a mental health hold. There is no documentation to suggest that the deputies considered calling MERTY or whether any mental health teams were available to respond.

The juvenile was transported to the hospital by the paramedics who had arrived on scene.

Case 5

Deputies and the MH Liaison located a mother and son inside their car in a hospital parking lot after she called 911 to report her son was threatening suicide. The son hid his face and refused to talk with the deputies or the MH Liaison. The mother explained that during school drop off, her son said he wanted to hang himself and began tying a strap around his neck. She was able to get him to release the strap and drove him to the hospital for an evaluation but he refused to leave the car.

The MH Liaison determined the juvenile met the criterial for a 5150 hold. For about an hour, Deputies, the MH Liaison and the Mobile Emergency Response Team encouraged the juvenile to exit the car without success. Finally, the juvenile exited the car and walked on his own into the hospital.

Here, the juvenile who was suicidal had no weapon and posed no safety risk to others. The passage of additional time and encouragement resulted in his eventual voluntary cooperation to enter the hospital.

Case 6

A woman with various mental health diagnoses drove herself to a Sheriff's Office service center, reported that she was thinking about killing herself, and asked for help. A deputy spoke with her for a short time – again, with compassion and respect – and then drove her to Telecare, where the MH Liaison met them to offer her assistance and smooth the transition.

Case 7

The Sobering Center[13] staff called a deputy for assistance when a woman entered the Center and said she was feeling suicidal and threatened to stab herself. The deputy spoke with her at the Sobering Center and learned that she was off her prescribed medications. He initiated a 5150 hold and transported her to Telecare but learned that she needed hospital clearance before being admitted. He then transported her to and from the hospital where she ultimately was cleared for admission on the 5150 hold to Telecare.

Two aspects of this case stood out. Similar to other nonviolent crisis calls, as we discuss further below, we questioned the need for and efficiency of a law enforcement response. Here the deputy was taken out of service for 2 hours and 42 minutes to conduct a mental health hold on a compliant individual who was seeking psychiatric help. Though the deputy was empathetic and thoughtful throughout his interactions, a clinician would have been better suited to address her needs. Second, although the individual was cooperative and voluntarily sought psychiatric help, the deputy relied on law enforcement protocols to place her in handcuffs as she was transported in the deputy's patrol vehicle to and from Telecare and the hospital. As detailed below, we recommend that in collaboration with the County's Behavioral Health partners, the Sheriff's Office explore alternative transportation protocols that do not require handcuffing of nonviolent individuals seeking mental health services.

Case 8

Several law enforcement agencies and first responders were dispatched to a call of a woman threatening to jump off a bridge. When they arrived on scene, the woman had retreated down a steep ravine. She was distraught but also extremely hostile toward law enforcement, shouting that they had killed her brother. Sitting on a narrow platform with a steep drop off to a wooded creek, the woman threatened to jump and also told

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[13] The County's Sobering Center was opened in February 2024, as an alternative to the County Jail for people who have been detained by law enforcement for DUI or public inebriation. A person can remain at the sobering center for up to 24 hours, and receive a citation and a notice to appear in court rather than being booked into the jail.

officers to shoot her. A deputy and another officer grabbed her arms and placed her in handcuffs and continued holding her to prevent her from jumping. A deputy brought Fire Department personnel to the woman's location to gain her cooperation. She accepted the Fire Department's help up the embankment which required her use of a safety rope harness. Once she was brought up to the road, a MH Liaison assessed her and initiated a 5150 hold. She remained in handcuffs and was transported by deputies to Telecare. Throughout her interactions with law enforcement – including when the deputies walked her into Telecare – she was agitated and belligerent. In contrast, she was consistently calm and cooperative with Fire Department personnel.

Several aspects of this case merit further discussion.

First, this was a complex call for service involving coordination among several law enforcement officers in dangerously steep terrain. A deputy and another officer who grabbed hold of the woman's arms to handcuff her acted swiftly and with minimal force to prevent her from jumping. Their continued holding of her arms was reasonable in light of how distraught she was and her continued threats to jump. Second, recognizing that the presence of law enforcement exacerbated the woman's distress, deputies astutely requested that Fire Department personnel come to the woman's location to gain her cooperation and to have Fire Department personnel – rather than law enforcement – lead the rescue effort up the embankment. The involved deputies demonstrated an important insight into the woman's agitation. By proactively engaging Fire Department personnel to take over the communication and rescue efforts, the deputies effectively de-escalated a tense and dangerous situation.

Unfortunately, the leadership and proactive planning appeared to falter once the woman was brought up to the road. After a MH Liaison determined she met 5150 criteria, instead of behavior health staff continuing to assist her and transport her to Telecare, she was placed in a deputy's marked vehicle in handcuffs and transported to Telecare. She became increasingly agitated and belligerent to the deputies throughout the encounter. Because she had not committed a crime and did not pose a danger to others, we question the need for continued law enforcement engagement at this point, particularly here, where it was clear that the woman reacted negatively to the presence of law enforcement and had

been cooperative with other personnel.[14] There was no documentation or video footage to suggest on-scene personnel considered other options.

We also noted that early on when Fire Department personnel asked the woman when she'd last eaten, she replied that it had been three days. And yet none of the involved personnel offered her anything to eat. This was a missed opportunity we discuss more fully below.

Case 9

Deputies and the MH Liaison were dispatched to a call regarding a man with a diagnosed mental illness who had been off his medications and may have been drinking. He was shouting inside his home, and when the Sheriff's Office staff approached his door, he yelled to deputies that he did not want to speak with them and he did not want them to come into the house.

Outside the home, deputies interacted with the man's son and a woman who had been staying in the home. Deputies ensured their safety, confirmed there were no other residents in the home, and decided to disengage from the residence while giving the son instructions in the event the situation escalated.

Case 10

Deputies responded with lights and sirens to a call of a man threatening to jump off a cliff into the ocean. The first deputy to arrive began speaking to the man, with kindness and genuine concern, and quickly got him to agree to come with him to get help. While the Sheriff's Office MH Liaison was not working that day, the deputy initially requested the MH Liaison assigned to Santa Cruz PD to respond. After a brief wait, however, he decided to write the mental health hold and cancel the request. The deputy transported the man to Telecare.

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[14] It was learned later that the woman's brother had been killed in an encounter with police officers, offering some explanation for her strong reaction to deputies' presence.

Case 11

An ex-girlfriend called 911 several times on a Saturday night to request a well-being check on her 20-year-old ex-boyfriend who had texted her with a threat to commit suicide. A deputy called the ex-boyfriend who denied having any recent contact with his ex-girlfriend and denied being suicidal and having a gun (something he had implied in his texts to the ex-girlfriend). He said he no longer wanted to talk with the deputy and suggested he talk with his mom, with whom he lived. Two hours later the ex-girlfriend called 911 again, this time to report that she had a received a video from the ex-boyfriend of him taking pills and saying, "I wish you cared a little for me." A different deputy spoke by phone with the ex-boyfriend's mother. She confirmed that she was with her son, he was resting in bed and although sad about the breakup, he was not suicidal. The deputy also talked by phone with the ex-boyfriend who said he was not suicidal, was under the care of a psychiatrist and had taken five of what he described as a normal eight-pill dose. Deputies documented all of their calls but did not respond to the residence or engage their mental health partners in the call.

Case 12

A deputy documented his phone discussion with a school administrator who had called to report that a student at the school (a minor) threatened suicide in response to a situation in which he was being extorted for money in circumstances that involved the texting of nude photos. MERT responded to the school and created a safety plan for the student. The deputy spoke by phone with the student's mother who had responded to the school. The deputy documented the incident and forwarded the information to the Sheriff's investigative team.

We noted that while the deputy documented the content of his calls to the school administrator and the student's mother in his incident report, he did not preserve any recording of these calls. Best investigative practices require deputies to record and preserve all witness calls during a criminal investigation. When we questioned the Sheriff's Office about why this was not done in this case, we learned this deputy is no longer with the department and that he likely simply neglected to activate his body-worn camera for the call.

Case 13

Deputies responded to a request for a welfare check after an individual called a family member to report that he had killed his dog. The family member was concerned for the individual's well-being in addition to the safety of his girlfriend. Deputies located both the individual and his girlfriend and confirmed that the dog had died under suspicious circumstances. Before questioning the individual about the dog's death, the MH Liaison spoke with the individual to assess his well-being and suicide risk. After further investigation, the deputies arrested the individual for felony animal cruelty charges and took him into custody without incident.

Case 14

A deputy was dispatched to a residence after a mother called 911 to report that her 14-year-old daughter had locked her out of the house, broken into a locked cabinet, and taken an unknown amount of medication. When the deputy arrived, the mother had been able to get back inside the house. The deputy learned that the daughter had a history of previous mental health holds and had threatened to kill herself when the mother picked the daughter up from school. The deputy talked with the daughter, determined she met 5150 criteria and arranged that the daughter be transported to the hospital via ambulance. When the daughter became upset and refused to move from her bed, the deputies and ambulance personnel lifted her off of the bed and carried her to a gurney outside without incident. She was then transported to the hospital.

Observations and Considerations Going Forward

As discussed above, while we were impressed overall with the Sheriff's Office responses to these calls for service, we also identified areas for consideration going forward.

Partnerships with Mental Health Professionals

The MH Liaison who is assigned to the Sheriff's Office brings significant knowledge and skill to crisis calls, effectively works with deputies, and plays a vital role in helping to de-escalate and assist individuals in behavioral health crisis. However, this important partnership occurs

during only four 10-hour shifts. The Sheriff's Office is budgeted to have a second MH Liaison, but this position has been vacant for over a year. Behavioral Health representatives informed us that they are in the process of hiring another MH Liaison to partner with the Sheriff's Office and explained that the hiring and training process can be lengthy.[15] We recommend the County expedite hiring a second MH Liaison to give the Sheriff's Office additional access to this valuable, needed resource.

> RECOMMENDATION 2: The County should expedite the hiring of a second Mental Health Liaison to partner with the Sheriff's Office in their response to mental health related calls, and should prioritize filling any future vacancies in this critical position.

Beyond fully staffing its MH Liaison positions, we recommend that the Sheriff's Office and the County think more broadly about the efficiency and effectiveness of law enforcement responding to calls for assistance involving nonviolent individuals threatening suicide or experiencing other mental health crises. Over half of the 14 cases we reviewed are in this category (cases 3, 4, 5, 6, 7, 10, 11, and 14), with individuals voluntarily seeking psychiatric help or calls for service that were not criminal in nature.

For calls for service such as these, civilian professionals – behavioral health clinicians, peer specialists, nurses, or EMTs – may provide a more effective response than Sheriff's deputies. We don't take issue with the quality of the deputies' response, but clinicians trained and experienced in assessing mental health needs are better suited to evaluate these individuals and connect them with the services they need.

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[15] For more information about MH Liaison staff vacancies and staff recruitment and retention challenges including rising cost of living, competitive out of county salaries and high burnout levels of crisis care providers, see Santa Cruz County Behavioral Health's Mental Health Services Act Innovation Crisis Now Project | FY 24-25 Annual Report, https://www.santacruzhealth.org/Portals/7/Pdfs/BH/Mobile%20Crisis%20Response%20Team/SCC%20Crisis%20Now_FY24245%20Report_FINAL_20250627_STC.pdf.

Likewise, individuals in crisis may respond to law enforcement officers with a greater degree of fear, anxiety, anger, or distrust than they would to a mental health clinician. For example, in case 11, the young man seemed to be annoyed by the call from the deputy, responding to the deputy's questions in a defensive tone that indicated he believed he was being accused of wrongdoing. That led the deputy to take a more confrontational approach than we would expect from a mental health responder.

In addition, these calls often involve a deputy being taken out of service, sometimes for hours, for cases that are wholly behavioral in nature and do not require any law enforcement response. For example, in case 7, above, the deputy was unavailable to handle other calls for nearly three hours to complete a mental health hold on a compliant individual who was seeking psychiatric help.

We understand there are sometimes other complicating factors at work, particularly related to the County's geography. Case 6, for example, originated in the northern part of the County. A deputy could arrive relatively quickly, but the MH Liaison would have had to respond from a much greater distance. It made sense in that case for the deputy to respond quickly to the suicidal individual's needs, with the MH Liaison meeting them at Telecare to assist.

Similar situations arose in other cases as well. We repeatedly heard and observed in our case review that while the Sheriff's response to the call for service was generally rapid, when deputies called for mobile crisis emergency response team assistance, they often were not available or estimated a significant delay in their arrival.

We recommend that the Sheriff's Office and the County continue to work to explore alternatives for more efficiently and effectively responding to calls for service related to mental health care, including consideration of other co-response or community-based response models that we describe above.[16] We understand that budgets are tight, but beginning a

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[16] In May 2026, as we were preparing this report, we learned that the County has initiated a "Mental Health Crisis Calls for Service Diversion Pilot Program" involving all the law enforcement agencies within the County, the County's Behavioral Health division, the Family Service Agency (a non-governmental community-based organization), and 9-1-1 dispatchers. The program establishes a procedure for

discussion around these issues is largely cost-neutral and may lead to more innovative responses. We have seen other jurisdictions convene a roundtable of stakeholders, including law enforcement, Fire department personnel, and mental health providers, to brainstorm ways for improving responses to various types of service calls.

> RECOMMENDATION 3: In partnership with other County stakeholders and advocates, the Sheriff's Office should convene a roundtable discussion to address ways to provide more efficient and effective service using existing resources, but also to think more broadly about alternative approaches for responding to non-violent crisis calls.

Transportation and Security Options

Even where a law enforcement response was necessary, we questioned the need in some cases for transporting individuals to a mental health care provider in marked patrol vehicles. We understand that sometimes no other options currently exist. But, for example, in case 8, Fire Department personnel were on scene and communicating well with the subject. The reports and BWC footage we reviewed did not address why the woman remained in Sheriff's Office custody or whether any deputies or supervisors considered other transportation options. Particularly in that case, where the subject was belligerent with deputies but compliant with Fire personnel, continued care and transportation to Telecare by non-law enforcement personnel may have been preferable.

The unsatisfactory nature of transport by deputies becomes more evident in light of law enforcement protocols that generally require or encourage deputies to handcuff people who are being transported in patrol vehicles. For example, in case 7, the deputy followed protocol and placed the entirely cooperative subject in handcuffs as he transported her to and from Telecare and the hospital.

We saw one instance where this was not the case – case 4, where a suicidal individual walked into a Sheriff's substation asking for help –

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routing non-emergent mental health crisis calls directly to specialized mental health professionals rather than law enforcement officers. The program was established as a 90-day trial. We look forward to learning about and reporting on its outcomes.

where the deputy told the woman he would not handcuff her because she was being so cooperative. We appreciated this deputy's exercise of judgment, but suggest that this should be more the norm than the exception. In fact, the Sheriff's Office's policy on handcuffing (Policy 301.9) encourages deputies to use discretion in deciding whether to handcuff individuals:

> *Although recommended for most arrest situations, handcuffing is discretionary and not an absolute requirement of the Office. Deputies should consider handcuffing any person they reasonably believe warrants that degree of restraint. However, deputies should not conclude that in order to avoid risk every person should be handcuffed, regardless of the circumstances.*

We recommend that the Sheriff reinforce through training that deputies may exercise independent judgment in deciding whether to handcuff cooperative individuals when they transport them to the hospital or psychiatric care facilities, balancing safety risks against the need for compassion.

We also recommend that the Sheriff's Office collaborate with its non-law enforcement partners, to explore alternatives for monitoring and transporting nonviolent suicidal individuals seeking mental health services.

> RECOMMENDATION 4: The Sheriff's Office should reinforce through training deputies' ability to exercise independent judgment and balance safety risks against the need for compassion when deciding whether to handcuff cooperative individuals during transport to medical or mental health facilities.

> RECOMMENDATION 5: In collaboration with County Behavioral Health and other non-law enforcement partners, the Sheriff's Office should explore alternative options for transporting nonviolent, cooperative individuals who have been placed on mental health holds.

In addition to the transport and handcuffing concerns, we also noted in Case No. 7 above, a missed opportunity perhaps created by the challenge of a multiple-agency response. When numerous first responders and Sheriff's deputies were in the steep ravine assisting the woman who had

threatened suicide, she told them she had not eaten for several days. Yet, none of the involved personnel offered her anything to eat and a significant amount of time lapsed between when they first encountered her in the ravine and when she finally arrived at Telecare.

The ability to acknowledge an individual's dire situation and offer something, however small, can make an important difference in the response team's overall effectiveness. We have seen law enforcement officers make small gestures during a crisis – offering a snack, a tissue, or a cigarette – that can humanize the interaction and help gain the individual's trust and cooperation. We recommend that the Sheriff's Office explore options to incorporate such gestures when appropriate into their de-escalation and crisis response strategies, training, and written protocols.

> RECOMMENDATION 6: The Sheriff's Office should explore options to incorporate strategies such as offering food or water or other comforting gestures when appropriate into their de-escalation and crisis response tactics, training and written protocols.

Documentation and Data Tracking

Our review of cases identified a couple of concerns around documentation and data tracking. First, the Incident Reports we reviewed have a box under "Additional Information" that deputies can check that says simply, "Mental Health." Although all of the incidents we reviewed clearly were mental health-related, this box was not checked in over half of them. This creates a gap in the Sheriff's Office ability to effectively track and account for the ways in which its deputies are being called on to address mental health concerns.

We also noted that deputies did not often document their interactions with or decision making regarding the County's mobile crisis response teams (MERT or MERTY). When reviewing our sample of cases, we often questioned whether deputies had requested a MERT response or, if not, their reasons for not making the request. If MERT was requested, it would be helpful to document its response time.

We suspected that sometimes deputies declined to request mental health resources because they expected there would be an extended response

time, often because of the County's geography. For example, the call in case 14 was in the northern part of the County, in a location more difficult for the County's mobile crisis response teams to reach. The deputies did not request MERT to respond and did not document any rationale for this decision, though it was clearly a call for which a clinician response would have been helpful (juvenile with previous mental health holds threatening suicide). In terms of resource allocation, it would be useful to track situations where a mobile crisis response would have been valuable, but was unavailable or infeasible for some reason. The Sheriff's Office should consider ways to more fully document and track deputies' decision making in these scenarios.

> RECOMMENDATION 7: The Sheriff's Office should require deputies to accurately log their mental health-related calls, and should explore ways for deputies to fully document reasons for their decision making about whether or not to engage the County's mobile crisis response teams.

Mental Health Concerns in Custody

Our focus in this section was to evaluate the response to calls with a mental health component by personnel working in the Operations Bureau of the Sheriff's Office. It is impossible, though, not to acknowledge the profound challenges faced by the Corrections Bureau in addressing the mental health needs of those individuals in custody in the County's jails.

Since the OIG's inception, we have seen these challenges in a number of contexts: repeated contacts with people in custody with significant mental health diagnoses, the review of incidents where officers used force on an individual in mental health crisis (which we discuss in greater detail in the section addressing Use of Force Review, below), conversations with Sheriff's Office executives about the challenges of providing mental health treatment in the current custody environment, and numerous discussions with family members whose loved ones are struggling with mental health challenges while incarcerated in the County's jails.

This report does not purport to tackle all of these challenges, but we do offer some overall observations, particularly with respect to those conversations with family members. The most prevalent takeaway is the

anguish that their loved ones are in jail – an environment not conducive to fostering improved well-being – rather than receiving care at a psychiatric hospital. This is especially true for those who are held in some type of isolation, most often because the behaviors associated with their mental illness makes it difficult for them to interact safely with many other incarcerated persons. This feels to family members and those in custody like a form of unjustified punishment. When we raise those concerns with Corrections leadership, we learn about their frustration with the lack of suitable housing for the most severely mentally ill and their efforts to move individuals in and out of various units in an attempt to find a place where they can safely interact with others. The nature of the jail's demographics, coupled with a relatively small populations and antiquated facilities, often leaves custody managers with few options for housing mentally ill inmates in more beneficial group settings, despite the acknowledgement that isolation jeopardizes the likelihood of successful mental health recovery.

Another frequently communicated sentiment is frustration around the lack of information which family members have access. Intended to protect the privacy rights of those incarcerated, it nonetheless can impede successful treatment and recovery. Individuals in mental health crisis can be incarcerated without their family members knowing their location or how to reach them, their mental illness inhibiting them from taking the necessary steps to call family or friends. Family members may attempt to speak with mental health staff at the jail, but if the incarcerated individual has not signed a release, personnel often cite state and federal privacy regulations as a barrier to those conversations. Parents and loved ones have difficulty learning anything about the individual's condition and sometimes are not even able to provide information about their medical and psychiatric history which could assist in improving their loved one's treatment.

For example, one parent described to us a significant period of time during her son's incarceration where she did not hear from him and could not learn anything about his condition. It took significant time and diligence on her part to finally reach a lieutenant who was able to report on her son's condition, locate and deliver to the son the books she had sent him and let him know that he had money on his account to pay for commissary goods.

One possible avenue for addressing these concerns about communication would be the creation of an Ombudsman's office that could serve as a

liaison between incarcerated individuals, their families, and the jail personnel to address inquiries and concerns. Its role would include improving communication to and from family members about incarcerated individual's mental and physical health concerns to the appropriate jail staff.

An Ombudsman's role could extend beyond this family liaison function and address many other issues we've seen come up frequently – complaints about jail conditions, housing issues, and concerns about medical care. The goal of an Ombudsman's office would be to facilitate solutions to some of these challenging circumstances by unlocking channels of communication, identifying barriers, and developing strategies to reconcile differences. We recommend that the Sheriff's Office work with its County partners to explore possibilities for creating an Ombudsman's position.

> RECOMMENDATION 8: The Sheriff's Office and the County should consider possibilities for creating an Ombudsman's office that could serve as a liaison to family members of incarcerated persons, particularly those in mental health crises, as well as an intermediary to address some of the most challenging concerns raised by incarcerated persons.

Community Complaints and Allegations of Misconduct

A law enforcement agency's ability to fairly investigate allegations that its personnel engaged in misconduct or violated policy is a key measure of the organization's effectiveness and public legitimacy. Assessing these investigations, then, has been a central part of the OIG's role over the past year.

These administrative investigations fall into two broad categories, based on the source of the allegations: (1) external complaints that come from a community member and focus either on a deputy in the Operations Bureau or stem from an incident in the jail;[17] and (2) internal complaints that are based on information the Sheriff's Office receives in a variety of ways.

In our first annual report, we found the Sheriff's Office's handling of outside complaints met many of the foundational markers of an effective complaint investigation system. Complaints were taken seriously, investigated objectively, and assessed fairly when the evidence-gathering was complete. We also noted the opportunity for improvement in some specific aspects of the process and recommended efforts to improve the scope and format of administrative investigative reports to ensure they are consistently detailed and inclusive and thoroughly address all performance issues that emerge.

The Sheriff's Office accepted our recommendations and worked constructively through the year to make notable improvements to its

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[17] Corrections has a separate process for processing and investigating grievances from incarcerated persons. These generally are resolved within Corrections, but serious allegations of misconduct by an officer in the jail would get referred to Internal Affairs.

process for administrative investigations. We reported on some of these investigations in two interim reports we published in 2025.[18] We recap those here, and report on complaints received and investigations reviewed in the remainder of 2025. Overall, we found that these complaints were resolved appropriately, with outcomes that align with general standards and best practices.

External Complaints Received or Reviewed by OIG

Operations Bureau Complaints

Our interim reports in February and August 2025 detailed 20 complaints we reviewed in the first half of the year. We received an additional 10 complaints or requests for help in the rest of 2025, five of which have investigations pending. These complaints include:

- An individual who had been pulled over for a tinted window violation alleged that Sheriff's deputies engaged in a pattern of pulling him over to harass him based on his prior criminal history. He and his family members were detained while deputies did an extensive search of his vehicle, causing discomfort for the family members and a critical missed appointment, before they were all let go after no illegal substances or weapons were found. The complainant alleged that this happens to him frequently. A full Internal Affairs investigation is still pending.
- One of the involved family members also contacted us to complain about the same incident. That related investigation is also pending.
- An individual complained that her neighbor had vandalized her property and was harassing her in various ways, and that the Sheriff's

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[18] https://www.santacruzcountyca.gov/Portals/0/County/OIG/Santa%20Cruz%20County%20OIG%20Quarterly%20Report%20-%20Feb%2027%202025.pdf; and https://www.santacruzcountyca.gov/Portals/0/County/OIG/Santa_Cruz_County_OIG_Interim_Report.08082025.pdf

Office was not responding appropriately to these events. An IA investigation is pending.

- Other allegations with pending Internal Affairs investigations include:
  - Concerns about the way a deputy questioned a minor during an incident that arose at a local high school
  - Excessive force and rudeness by a deputy during a traffic stop
  - Unlawful stop and detention that was the product of harassment and unlawful profiling
- A complainant said she had been the victim of a scam following her son's arrest that was possibly connected to her son's phone being seized when he was arrested and not returned to him. The Sheriff's Office had initiated a criminal investigation into the theft tied to this scam, and determined that the individual's phone was not booked with his property by the arresting agency. The case did not involve allegations of wrongdoing by deputy personnel.
- Three other contacts with our office did not lead to administrative investigations:
  - A complainant said Sheriff's Office personnel misrepresented facts surrounding an alleged crime in their reports to the District Attorney's Office. When we reached out for further details, the complainant did not respond.
  - An individual was demanding that the Sheriff's Office intervene in a civil matter involving County Health personnel. The Sheriff's Office's Community Policing Team Sergeant made contact with the complainant and attempted to assist with the civil enforcement action.
  - Another complainant who alleged a series of harassing contacts with law enforcement did not respond to our requests for details regarding the allegation.
  - Throughout the year, we had frequent communication with a parent who lodged complaints against numerous agencies, including the Sheriff's Office, concerning the parent's adult daughter. We spoke with the Sheriff's Office and other agencies about these complaints,

attempted to engage services when appropriate and remained in contact with this individual about these matters.

We reviewed one completed investigation that was initiated following complaints made by members of the public.

- In one, an individual claimed that a deputy arrested him based on an inadequate investigation and had been untruthful with the complainant about his intent to arrest him in an effort to get the complainant to surrender at the Sheriff's station. The complaint also included a long list of additional allegations regarding the deputy's treatment of the complainant.

  The IA investigator did a complete, thorough, and objective investigation. He interviewed the complainant and the deputy, reviewed all reports and body-worn camera video from the arrest, as well as the deputy's original contact with the victim. The investigator also communicated with the District Attorney's Office regarding their review of the criminal case that initiated this complaint. The investigator concluded that the deputy's actions were all within policy.

  We reviewed the investigative materials, including all video associated with the case, and concluded the Sheriff's Office finding were appropriate.

- Another investigation into allegations of harassment and wrongful detention was closed after the complainant did not reply to the Sheriff's Office's request for additional information regarding the complaint.

Investigations into several other complaints that we received in 2025 remained pending at the time we prepared this report. We have discussed the timeliness of these investigations with Sheriff's Office officials, who acknowledged a growing backlog of investigations and cited various reasons for it, mainly an influx of complaints and a tremendous increase in the number of California Public Records Act (CPRA) requests that the Professional Standards and Conduct unit also is charged with handling.

A handful of complaint investigations were resolved just within the one-year statute of limitations that governs allegations of misconduct by sworn

personnel.[19] Resolving cases under this statutory deadline pressure is less than ideal for a number of reasons. First, investigations are best conducted when the memories of involved parties are fresh and documentary, video, and other forensic evidence are readily retrievable. Moreover, the ability to pursue additional information or conduct investigative follow-up can be constrained by a pressing deadline.

Beyond these investigative reasons, prompt resolution of misconduct allegations strengthens the remedial and deterrent effect of the accountability system and minimizes the chance that poor performance or bad behavior is repeated. Timely resolution of allegations is also important to complainants to demonstrate that the agency takes their concerns seriously. And the subject employees also have an interest in the timely resolution of investigations to limit the stress and uncertainty that unresolved allegations generate.

We are sensitive to the Sheriff's Office's staffing and workload concerns and appreciate the openness and transparency around these issues. Nonetheless, the one-year statute of limitations deadline should be seen only as an outside limit. Better practice is to complete investigations within 120 days and the review process and disposition within 180 days.[20] We understand additional personnel have joined the Professional Standards and Conduct unit, including an analyst who will assume some responsibility for responding to CPRA requests, freeing up time for sworn staff to work on investigations. We will continue to track this issue and work with the Sheriff's Office on strategies to address community complaints in an effective, timely way.

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[19] There are a few notable exceptions, but the California's Public Safety Officers Procedural Bill of Rights Act generally requires that notice of any discipline for a law enforcement officer's misconduct be provided "within one year of the public agency's discovery by a person authorized to initiate an investigation of the allegation." California Government Code Section 3304(d).

[20] We recognize that there may be times when an investigation may need to extend beyond these internal limits such as when a subject employee is not available to be interviewed.

RECOMMENDATION 9: The Professional Standards and Conduct unit should set an internal target completion date to ensure that investigations and the subsequent review process and disposition can be completed within 180 days.

Complaint Disposition

One important aspect of our assessment of investigations has been the review of letters written to complainants notifying them of the disposition of their complaints. One of our first recommendations to the Sheriff's Office was to prepare letters that go beyond the boilerplate language required by law and instead convey to complainants that their concerns were taken seriously and handled fairly. The Sheriff's Office embraced that recommendation and we are gratified to report that the notification letters associated with the investigations we reviewed met a high standard for their level of detail and sincerity.

While the complainants we interacted with did not generally agree with the investigation's outcome, the more personalized close-out letter helped the Sheriff's Office convey an understanding of the individual's concerns and the fact that the complaint was given serious consideration and thoroughly investigated.

Corrections Bureau Complaints

We continue to have regular correspondence with individuals in the County's jails as well as family members who reach out to us with inquiries or complaints. Many of these are repeated contacts with the same few individuals who reach out to us regularly to complain about various issues.[21] Some of these relate to conditions in the jail: cleanliness and plumbing issues, for example. Others relate to issues with classification and housing decisions, or complaints about the types of programming offered on the tablet system.[22] We

[21] Over the past year, we have received over 100 messages via the tablet system from just seven individuals.

[22] Tablets provided to incarcerated persons are designed to provide some controlled access to communication, education, entertainment, and legal resources. They are provided by a third-party vendor through a contract with the County and are tailored

received a small number of complaints about access to appropriate medical care.

We reached out to the Sheriff's Office to gain additional information on each of these and, where appropriate, request follow up investigation or responses from appropriate parties (including medical care providers). Some specific contacts include:

- An individual concerned his son was not receiving enough food in jail. With further inquiry, we learned that delivery of commissary items had been delayed due to a change in ordering systems. Because many incarcerated individuals supplement their meals with food they buy from the commissary, the complaint related to this temporary delay.
- Another parent reached out about concerns with the process for getting commissary items to her son and some irregularities in both deliveries of items and the accounting system for putting money into accounts that incarcerated persons use to purchase commissary. These issues were resolved by the Sheriff's Office.
- An individual reached out with concerns about the available treatment for her loved one's opiate withdrawals. We were able to provide information about the jail's practices around medical screening and treatment of substance use disorder that we hope alleviated these concerns. The individual did not respond to our request for additional details regarding any further specific complaints or concerns.

In the section of this report concerning mental health responses, we recommended that the Sheriff's Office work with the County to explore the possibility of creating an Ombudsman position that could serve as a liaison between incarcerated individuals, their families, and the jail personnel to address inquiries and concerns. We note that many of the contacts we have with people in Sheriff's Office custody might be appropriately resolved by an effective ombuds office.

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to maintain security while also providing a valuable means of communication and connection.

Internal Allegations of Misconduct and Administrative Investigations

As we reported in our 2025 interim reports, we have continued to review completed administrative investigations into cases involving serious allegations of misconduct by Sheriff's Office employees.[23] In each, the Sheriff's Office reached out to discuss the case, often before the investigation was complete, shared the complete case file with us, and welcomed our input into whether the cases had been fully and fairly investigated and resolved.

We appreciate the Sheriff's Office's ongoing effort to answer any public concerns about the objectivity of its investigations and the legitimacy of outcomes by sharing their investigative reports with us and remaining open to our input. The cases we reviewed in the second half of 2025 included:

- A deputy was involved in two separate "road rage" incidents in which he was detained by law enforcement while off duty. In one, an individual called 911 to report aggressive driving behavior while her husband was driving their car on a local highway. The 911 call described that the other car was cutting them off, brake-checking, and gesturing to them while they slowed their speed in the hopes of getting away from the car. The couple was fearful for their safety. California Highway Patrol responded and stopped the deputy's car. Because he did not observe any of the aggressive driving, the CHP officer released the deputy with a warning. The deputy reported this contact and received non-disciplinary counseling regarding expectations for off-duty conduct.

  Several months later, a different Sheriff's deputy, while on duty, observed the subject deputy, while off duty, engaging in similar

[23] When a Sheriff's Office deputy or other employee has potentially violated department or County policy, the Sheriff's Office initiates an administrative investigation into the alleged conduct. If that alleged conduct also potentially violates State law, a separate criminal investigation may be conducted concurrently with the administrative investigation. The two investigations move on parallel paths and the outcome of one is not necessarily determinative of the other.

aggressive driving, including swerving and brake-checking another motorist. The deputy pulled both cars over and issued warnings. The other motorist acknowledged his participation in the road rage incident and apologized for his recklessness. The subject deputy denied any aggressive driving.

Following this second incident, the Sheriff's Office opened an IA investigation into both incidents. Sheriff's Office investigators concluded that the deputy had been dishonest in several different ways during his administrative interview. The investigation was thorough and complete and resulted in an appropriate disciplinary finding.

- A correctional officer was cited for driving under the influence after witnesses reported observing reckless driving and multiple collisions. Sheriff's Office investigators had significant concerns about her honesty during the course of the administrative investigation. A final disciplinary decision is pending.

- Jail supervisors learned that a Correctional Officer was asking his co-workers to lend him substantial amounts of money. They met with the CO, who reported he had fallen into debt because of a failed business. Concerned about the implications for someone in financial difficulties working in the jail environment – where bribery, coercion, and manipulation by incarcerated persons is a recognized threat – the Sheriff's Office expedited an IA investigation to more fully understand the CO's circumstances and mitigate any risks.

  The investigation uncovered a wide-ranging financial scheme in which the CO was receiving money from many other COs under false pretenses. The case was referred for a criminal investigation.

  The administrative investigation was thorough and complete, with a comprehensive, well-written investigative report that concluded with multiple sustained findings of numerous policy violations. The CO resigned before a decision on discipline was reached.

Use of Force Review

Participating in the monthly Use of Force Review meetings convened by both Corrections and Operations Bureau staff has become a regular part of the OIG's responsibilities. These meetings – in which command staff discusses each use of force from the prior month – provide us the opportunity to get a summary of each incident and ask follow-up questions about tactics, policy, and training issues. When we have concerns about the circumstances of a particular incident, we request and review all the materials associated with the incident following the meeting. Where our review leads to additional questions or concerns, we address those with Sheriff's Office leadership in a subsequent meeting. We appreciate this complete and ongoing access to Sheriff's Office information, systems, and personnel.

Sheriff's Office deputies use force relatively infrequently and rarely use a level of force significant enough to cause injury. In 2025, patrol deputies in the Operations Bureau reported 351 uses of force in 255 separate incidents; Correctional Officers reported 267 uses of force in 170 incidents.[24] These numbers are generally higher than 2024 – when Operations deputies used force in 244 incidents and Corrections in 118 incidents – but lower than 2023 – when the numbers were 336 incidents for Operations and 181 for Corrections. We view these as within the range of normal year-to-year fluctuations.

None of the incidents we reviewed involved the use of deadly force, and none resulted in anything more than minor injury to the subject. In fact, the Sheriff's Office receives few complaints regarding use of force by its

[24] In a single incident, deputies often use multiple types of force, each of which is reported and counted separately.

personnel; just one of the complaints the OIG received from members of the public in 2025 related to the use of force.[25]

To break down the types of force used within the Operations Bureau:

- 197 (56%) of the uses of force were control holds
- 72 (20%) were takedowns
- 5 were Conducted Energy Device (Taser) deployments
- 77 (22%) involved the display of some type of weapon: 48 uses were the display of a handgun; 12 were a Taser; 11 involved a rifle; 6 were the display of a less-lethal shotgun.

In Corrections:

- 142 of the 267 uses of force (53%) were control holds
- 49 (18%) were takedowns
- 36 of the uses of force (13%) involved placements in a safety chair[26]
- Chemical agents (OC spray[27]) were used in 18 incidents (7%)

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[25] This investigation is pending.

[26] A safety chair is a form of restraint intended to be used when an individual is disruptive, assaultive, and/or self-injurious as a result of a medical issue or mental illness. The individual's hands and feet are secured to a chair that resembles a wheelchair. It is often used to facilitate movement and to allow medical or mental health providers to safely approach and treat the individual. To its credit, Sheriff's Office policy contains detailed guidelines for monitoring and documenting placement of individuals in safety chairs.

[27] "OC" is short for oleoresin capsicum, the active ingredient in pepper spray and derived from the naturally occurring compound in chili peppers. OC is an inflammatory agent, which results in near-instant inflammation to the body's mucus membranes, often causing a runny nose, watery eyes, the need to close the eyes, difficulty breathing, upper respiratory pain and inflammation, and coughing.

- Officers deployed a Pepperball Launcher[28] twice and a Taser once
- 19 incidents (7%) involved the display of force without deployment: 14 incidents where use of OC spray was threatened; four where the Taser was displayed; and one where officers threatened the use of Pepperball but did not deploy it

All of these incidents were discussed during a Use of Force Review meeting. As we said in our interim reports during 2025, we have been impressed with the scope of these reviews as well as the time and effort Sheriff's Office personnel devote to their review of each incident. Every month, lieutenants from Operations and Corrections prepare a spreadsheet listing each use of force, with a brief summary and a breakdown of various data points, including the type of force used, injuries, reason for force, and any recommendations. These worksheets are useful and allow for easy identification of trends and any gaps in documentation.

Nonetheless, one issue we continue to raise with the Sheriff's Office is the need for a greater degree of documentation related to the use of force reviews. None of the incidents we reviewed involved force that was unreasonable or found to be out of policy. Nonetheless, there are often areas of potential improvement that require attention or remediation of some type. These are often identified during the supervisory review process, but are not consistently documented in a way that allows for clear follow-up actions.

We have discussed this issue with the Sheriff's Office and provided some examples of Use of Force Review forms used by other agencies with which we are familiar. The Sheriff's Office has expressed its concurrence, and we will continue to collaborate with the executive team as it works toward finalizing protocols to establish a mechanism to achieve this objective. We formalize the recommendation here to allow for easy tracking and follow up.

[28] The Pepperball Launcher fires small plastic balls filled with a derivative of OC powder at sufficient velocity to cause the projectile to burst upon impact and disperse the chemical agent.

RECOMMENDATION 10: The Sheriff's Office should develop and employ Use of Force Review Forms that will allow for more formal documentation of use of force reviews in alignment with modern best practices.

Behavioral Health Crises and Uses of Force in Corrections

One observation we made throughout the year was the frequency with which use of force involved IPs in some type of behavioral health crisis. For example, during one fairly typical month in 2025, Correctional Officers were involved in 15 use of force incidents. Eleven of these initiated as responses to a mental health concern. There were no injuries resulting from any of these 15 incidents.

We offer the following summaries to provide a snapshot of the types of encounters between correctional officers and incarcerated persons that result in uses of force. We noted that officers used restraint in the amount of force used and, when feasible, attempted to talk to individuals first to gain compliance.

Four of the 15 incidents that month involved potentially suicidal incarcerated persons (IPs):

- One IP was escorted to a safety cell[29] after making suicidal statements. When officers attempted to remove his handcuffs, he resisted and grabbed an officer. The IP was taken to the ground and his handcuffs removed.
- Another IP refused to be handcuffed and removed from a cell after making suicidal statements. A team of officers entered the cell and

[29] A safety cell is designed to eliminate the possibility of self-injury for those who are intoxicated, under the influence of a controlled substance, or in mental health crisis. It has no furniture or plumbing fixtures and is constructed with indestructible padding and anti-ligature architecture to prevent hanging or attachment points.

used control holds to gain her compliance in leaving that cell for placement in a high observation unit.

- An IP was removed from his cell after officers found a noose in the cell. He became agitated and tried to get away from officers, who grabbed him and pulled him to the ground, secured him, and escorted him to a high observation unit.

- One IP refused to answer any intake questions related to suicidality. She appeared intoxicated, was resistant to all directives, and threatened to bite anyone who touched her. The mental health clinician advised officers to place her in a safety cell as a precaution. Officers used control holds to gain compliance and she was placed into a safety vest[30] while waiting for a safety cell to become available.

In three other incidents that month, Correctional Officers used force to prevent IPs from harming themselves:

- An IP was transported to Telecare for mental health treatment. During the intake process, she began hitting her own face and head with force. Officers intervened by grabbing her hands, and she responded by spitting on one officer. Another officer secured her head with her hands to prevent more spitting.

- One IP was brought into booking in an aggressive and non-compliant state. He began hitting his head on the concrete floor. Officers used control holds and secured the IP in a safety chair.

- An IP was in a holding room in intake when he began hitting his head against the window. The IP, who was under the influence of drugs, refused to comply directives, so officers used control holds to handcuff them, then moved him to a safety chair and eventually into a safety cell.

In four incidents, officers were moving IPs out of their cells for legitimate safety or mental health concerns:

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[30] A safety vest, or suicide gown, is a a tear-resistant single-piece garment that is generally used to prevent individuals from using the material to form a noose.

- In one, an IP had repeatedly refused to leave her cell to attend court. A team entered her cell, secured her with the use of a shield, and placed her in restraints. She was released from custody but was found to meet criteria for a mental health hold and was transported to Telecare.

- One IP was repeatedly kicking his cell door and striking the light fixture with his hands, causing an injury to his finger. He refused officers' commands to stop, so they entered the cell and used control holds to secure him in a safety chair. This same individual had been involved in a use of force 12 days earlier, after making suicidal statements and becoming combative when moved to a safety cell.

- An IP flooded his cell with water from his toilet and then refused to allow officers to secure him and remove him from the unit. An officer removed his OC spray from his holster and the IP complied. No force beyond the display of OC was used.

- An IP who was in a safety cell because of concerns about self-harm was transferred to a shower. Following the shower, she became resistive and combative with officers who were trying to return her to the safety cell. Officers used control holds to move her to a safety chair until she could be re-assessed by a clinician.

  This incident led to a discussion about the circumstances in which officers should remove someone from a safety cell to shower, with a conclusion about the need to evaluate each situation based on the unique circumstances presented in each case, with an emphasis on respecting individuals' dignity and humanity.

The remaining four incidents reviewed that month involved situations where IPs either assaulted another IP or became combative with staff.

- During the intake process, an intoxicated IP became combative with staff. An officer took him to the ground and then officers secured him in a safety cell.

- Also during intake, an IP under the influence of drugs lunged at an officer and appeared to be reaching for his Taser. A different

officer took the IP to the ground, where officers secured him in handcuffs.

- In another incident in the booking area during intake, an IP in a holding room attacked another IP who was sleeping. The responding officer gave very clear commands to stop fighting and warned that OC may be used. The assailant ignored these, and an officer deployed OC to gain compliance.

- Two IPs got into an argument in a day room. Other IPs held them back and prevented a physical fight while officers responded. IPs did not initially respond to commands to separate, so one officer displayed his OC and threatened to deploy it. The IPs complied and officers used control holds to secure them.

Use of force issues are one piece of a broader concern about the challenges of managing a large population of individuals with mental illness in the custody environment. In reviewing these incidents, we noted the sometimes complex interactions involving different components of the behavioral health system and the importance of effective communications between mental health professionals and Corrections personnel.

The challenges are profound: often people in crisis are unable to understand or comply with commands due to their condition, and an aggressive response from officers can exacerbate the current crisis and trigger further aggression or resistance. Correctional staff must balance their own safety against the health and welfare of those incarcerated. In the incidents we reviewed, we found Sheriff's officers struck an appropriate balance – favoring control holds and restraint devices over the use of chemical agents or other weapons.

Nonetheless, the jail remains an inappropriate setting for many of the individuals held there. Many of the individuals involved in use of force incidents we reviewed would benefit from a more therapeutic setting where they are as likely to encounter mental health clinicians as correctional officers. And, as we noted above, another component of any solution to this widespread challenge is working proactively to address mental health concerns at the front end – diverting calls for service to mental health professionals and employing a dual response with clinicians and deputies in the hopes of effectively handling crisis situations in a way that does not end with incarceration.

Moving Forward

As we move through another year of work as the OIG for Santa Cruz County, we continue to set priorities for our ongoing engagement. We will, of course, continue to perform our core functions – reviewing and responding to complaints, evaluating administrative investigations, and weighing in on issues that arise regarding uses of force or any critical incidents that may occur – and will continue to report on our findings.

We also look forward to a continued relationship with engaged members of the community, and to further collaboration with the Sheriff's Office. We hope that publication of this report will serve as a vehicle for further engagement, both with the Board of Supervisors and with the public, with an eye toward hearing their priorities for our future work.

From our perspective, some of these priorities surround the significant challenges the Sheriff's Office confronts with respect to meeting the public's expectations for the quality of care for incarcerated individuals. Many of these challenges are beyond the immediate and direct control of the Sheriff's Office, including facilities issues and the number and types of individuals it is charged with caring for and keeping safe in its jails. For example, beyond the significant challenges of housing individuals with severe mental illness which this report discusses, the County's jails currently house over 50 individuals[31] who are awaiting trial but have been in custody for more than a year. Many of these have been in custody for three or more years; six have been in the jail since 2020 and earlier. While recognizing that the Sheriff's Office is only one component of a multi-faceted criminal justice system that impacts this issue, we look forward to finding ways for the OIG to contribute to finding solutions to these significant concerns.

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[31] For perspective, the average daily population of the jails is generally around 325 individuals.

Recommendations

1: The Sheriff's Office should ensure that all deputies receive the basic CIT training curriculum and should consider sending some subset of deputies to advanced CIT training that provides a specialized designation or certification.

2: The County should expedite the hiring of a second Mental Health Liaison to partner with the Sheriff's Office in their response to mental health related calls, and should prioritize filling any future vacancies in this critical position.

3: In partnership with other County stakeholders and advocates, the Sheriff's Office should convene a roundtable discussion to address ways to provide more efficient and effective service using existing resources, but also to think more broadly about alternative approaches for responding to non-violent crisis calls.

4: The Sheriff's Office should reinforce through training deputies' ability to exercise independent judgment and balance safety risks against the need for compassion when deciding whether to handcuff cooperative individuals during transport to medical or mental health facilities.

5: In collaboration with County Behavioral Health and other non-law enforcement partners, the Sheriff's Office should explore alternative options for transporting nonviolent, cooperative individuals who have been placed on mental health holds.

6: The Sheriff's Office should explore options to incorporate strategies such as offering food or water or other comforting gestures when appropriate into their de-escalation and crisis response tactics, training and written protocols.

7: The Sheriff's Office should require deputies to accurately log their mental health-related calls, and should explore ways for deputies to fully document reasons for their decision making about whether or not to engage the County's mobile crisis response teams.

8: The Sheriff's Office and the County should consider possibilities for creating an Ombudsman's office that could serve as a liaison to family members of incarcerated persons, particularly those in mental health crises, as well as an intermediary to address some of the most challenging concerns raised by incarcerated persons.

9: The Professional Standards and Conduct unit should set an internal target completion date to ensure that investigations and the subsequent review process and disposition can be completed within 180 days.

10: The Sheriff's Office should develop and employ Use of Force Review Forms that will allow for more formal documentation of use of force reviews in alignment with modern best practices.