CONSOLIDATED REPORT

2023-2024 SANTA BARBARA COUNTY GRAND JURY

2023-2024 Santa Barbara County Grand Jury

Consolidated Report

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2023-2024

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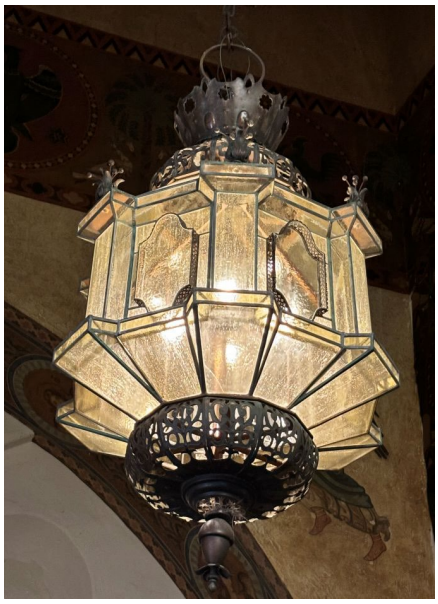
FOREWORD

GRAND JURY REPORTS

The lamps in this report adorn the Santa Barbara County Courthouse.



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Grand Jury
Santa Barbara County

July 1, 2024

The Honorable Pauline Maxwell
Santa Barbara County Superior Court
1100 Anacapa Street
Santa Barbara, California

Dear Presiding Judge Pauline Maxwell,

On behalf of the 2023-2024 Santa Barbara County Grand Jury, I am honored to present to you and the citizens of Santa Barbara County our Consolidated Report. We hope these reports will help inform the public and contribute to improved local government. Individual reports have been posted throughout the year on the Grand Jury website www.sbcgj.org, and are available to the public.

The members of this Jury represent a diverse group of dedicated individuals from the various supervisory districts of our county. The efforts extended by the Jurors in the investigation and report development process have allowed each report to represent a thorough evaluation of the inquiries. Each report represents hundreds of hours of work involving reviewing copious pages of documents and numerous interviews with personnel and managers of county agencies, as well as subject matter research.

On behalf of the Grand Jury, I extend our appreciation to you, Judge Maxwell, for your support of our Jury's efforts and to Michael Muñoz, Deputy County Counsel, for his guidance on legal matters. In addition, this Jury created a Proclamation and honored Rob Vlieger, Accountant Supervising, Finance AP for the Santa Barbara Superior Court. He has served this Jury and others for fifteen years of dedicated service which is much appreciated.

I acknowledge the engagement, diligence, and year-long commitment to fulfill the Jury's charge to investigate or inquire into county matters of civil concern in their service to the residents of Santa Barbara County. This Consolidated Report represents the culmination of this process for the 2023-2024 Santa Barbara County Grand Jury.

It has been an honor for me to serve with this outstanding Jury.

Best Regards,

Eva Macias

Eva Macias
Foreman
2023-2024 Santa Barbara County Grand Jury

2023-2024 SANTA BARBARA COUNTY

GRAND JURY MEMBERS

MICHAEL BABCOCK (NOT PICTURED)

MELISSA BRAUN

TREVA BOWMAN

SUZANNE BRAYTON

DARREN BROWN

JONATHAN COLMAN

MARILEE HAASE

BARBARA LANDON

EVA MACIAS

ROBERT MACLEOD

PAMELA PALERA

JOHN REED

JOHN RICHARDS

MARK RICK

GWEN RIGBY

IRENE SOLOVIJ

BARBETT TIGERT

BARBARA VALENTA

ANN WELLMAN

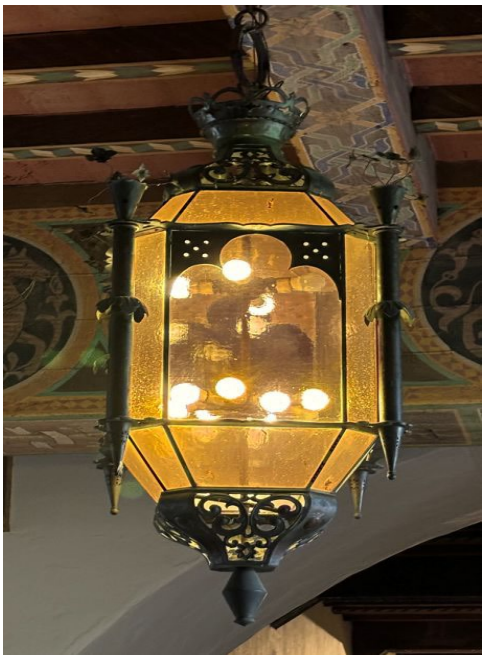
2023-2024

SANTA BARBARA COUNTY CIVIL GRAND JURY

WITH THE HONORABLE JUDGE PAULINE MAXWELL

LOMPOC TOURISM IMPROVEMENT DISTRICT

MANAGEMENT AGREEMENT 2019-2028



CITY OF LOMPOC AND VISIT LOMPOC, LLC

Lompoc Tourism Improvement District
Management Agreement 2019-2028

SUMMARY

Annual reporting by Visit Lompoc LLC shows hundreds of thousands of dollars in unaccounted-for funds. Over the first five years of the current agreement between Visit Lompoc LLC and the City of Lompoc, the cumulative amount of those under-reported funds is more than $500,000. This amount has been verified by the Santa Barbara County Grand Jury, Lompoc, and Visit Lompoc LLC's financial services firm. There has been a consistent lack of oversight by Lompoc. Additionally, Visit Lompoc LLC has failed to follow through on a commitment to submit to an independent financial audit. Currently, there is $800,000 that was previously transferred to Money Market accounts that, while earning a higher level of interest, are not accounted for in the required annual reports submitted to and approved by the Lompoc City Council. Per California's Property and Business Improvement District Law of 1994, this money can only be spent on tourism enhancement projects and cannot be used for general purposes. Additional oversight by Lompoc, in conjunction with Visit Lompoc LLC, is needed to optimize the intent of the Management Agreement between these entities.

INTRODUCTION

In 2018, the City of Lompoc (Lompoc) and Visit Lompoc LLC (VLI) established the Lompoc Tourism Improvement District (LTID) Management Agreement 2019-2028 (Agreement). This Agreement continues the intent of the original LTID agreement executed in 2013. The primary purpose of the Agreement is to promote tourism and business opportunities for Lompoc.

In addition to various responsibilities outlined for both parties, the Agreement documents the process wherein each of the hotels located in Lompoc will collect a fee equal to 3% of its revenue. That revenue is then passed on to Lompoc who, in turn, claims a 1% administrative fee of the total revenue and submits the balance of the funds to VLI. Per the Agreement, these fees shall only be used for purposes set forth in the Resolution and District Management Plan for the LTID.

The Jury also discovered prior Grand Jury reports outlining the failure of Lompoc to enact an auditing policy for non-profit organizations to which it provides funds:

"A Failure of Oversight"

The Grand Jury of 2011-12 issued a report that identified Lompoc's failure to monitor control of funds provided to the non-profit Lompoc Housing and Community Development Corporation.

That oversight led to an estimated loss of $1.8 million of taxpayer funds. The Jury's report recommended Lompoc formally adopt a non-profit audit policy. In their response to the report, the City Council of Lompoc expressed regret about their inaction and agreed to implement the recommendation. The recommendation was to establish a policy requiring annual audits prepared by an independent auditor.

"Lompoc's Failure to Adopt an Audit Policy for Non-Profit Organizations"
The Grand Jury of 2013-2014 followed up on the 2011-2012 report and determined that Lompoc had taken no steps to implement this policy. Multiple follow-ups were conducted over a year and various reasons were provided every time. During the 2013-2014 investigation, that Jury received no evidence that Lompoc had implemented or was even considering establishing such a policy.

METHODOLOGY

A Request for Investigation (RFI) received by the Grand Jury (Jury) highlighted potential financial irregularities and other possible violations of the contract between Lompoc and Visit Lompoc LLC (VLI). It should be noted that the Jury's investigation discovered a similar RFI had been submitted to the 2022-2023 Jury, but that group was not able to address it before completing their term. The Jury used the current RFI as the initial document associated with its investigation.

The Jury interviewed the complainant from the RFI which had been submitted to last year's Jury, members of the Lompoc City Council and Staff, representatives from VLI's Board, VLI's technical consultant, and some of VLI's affiliates. The Jury also reviewed multiple financial records, both in the public domain and those acquired directly from VLI.

OBSERVATIONS

Discrepancies in VLI's Annual Report
VLI is required to submit annual reports to Lompoc per the Property and Business Improvement District (PBID) Law of 1994. However, while the Agreement mandates the reports shall be provided to Lompoc within two months after the end of a calendar year, VLI has never been able to achieve that goal. The PBID law does not require such reports to be submitted in that time frame. The Jury acquired the annual reports from Lompoc for the calendar years (CY) 2018 through 2023 as submitted by VLI to Lompoc. An analysis of the financial data from those reports yielded the following information:

Annual Report Analysis

	Est. Budget	Carryover	Total Budget	Collections	Actual Spent	Balance	Carryover	Discrepancy
2018	$ 365,000.00	$ 152,012.60	$ 517,012.60	$ 424,986.60	$ 461,132.01	$ 115,867.19	$ 115,867.19	$ (0.00)
2019	$ 440,000.00	$ 115,867.19	$ 555,867.19	$ 296,449.32	$ 393,325.19	$ 18,991.32	$ 18,991.32	$ 0.00
2020	$ 136,426.85	$ 18,991.32	$ 155,418.17	$ 435,153.53	$ 170,562.04	$ 283,582.81	$ 264,591.49	$ 18,991.32
2021	$ 360,000.00	$ 264,591.49	$ 624,591.49	$ 526,509.12	$ 272,926.84	$ 518,173.77	$ 253,582.28	$ 264,591.49
2022	$ 480,972.00	$ 253,582.28	$ 734,554.28	$ 782,526.00	$ 479,898.00	$ 556,210.28	$ 302,628.00	$ 253,582.28
2023	$ 740,000.00	$ 302,628.00	$ 1,042,628.00			$ 302,628.00		
							Total Discrepancy	$ 537,165.09

The analysis took information directly from the reports and compared the calculated balance versus the carryover values. The balance for each year was determined by adding the prior year's carryover to the current collections and subtracting the actual expenses. The carryover value is the amount reported by VLI in their annual report. The discrepancy value results from the calculated balance less the carryover numbers published by VLI.

Starting in CY2020 there is a difference in the balance of funds as compared to the reported value of carryover. The rolling cumulative value of those annual discrepancies exceeds $500,000. There is no mention of these potential accounting discrepancies in the annual report for CY2020 or any subsequent reports.

At a meeting of the Lompoc City Council, a representative of the VLI Board volunteered to have an independent audit conducted of their financial records. The Jury was not able to find any evidence that such an audit had been requested or completed.

Review of VLI Financial Records

The Jury requested and received financial statements directly from VLI. Discrepancies similar to those indicated above were discovered in the Jury's analysis of these records. There are differences in some of these numbers when compared to those reflected in the annual reports. Most of those differences are relatively small in value and could potentially be related to earned interest.

The Jury's analysis of the financial data from those reports yielded the following information:

Grand Jury Financial Statement Analysis

	Carryover*	Income**	Expenses	Savings/Loss	P&L Savings/Loss	Reported Savings/Loss*	Discrepancy	Annual City Fee***
2019	$ 115,867	$ 296,664	$ 384,125	$ 28,406	$ (87,461)	$ 18,991	$ 9,415	$ 2,965
2020	$ 18,991	$ 435,728	$ 170,562	$ 284,157	$ 265,165	$ 264,591	$ 19,566	$ 4,352
2021	$ 264,591	$ 527,647	$ 252,219	$ 540,019	$ 275,428	$ 253,582	$ 286,437	$ 5,265
2022	$ 253,582	$ 782,527	$ 479,899	$ 556,210	$ 302,628	$ 302,628	$ 253,582	$ 13,265
2023YTD	$ 302,628	$ 462,191	$ 383,323	$ 381,496	$ 78,868		$ 381,496	$ 6,601
		$ 2,504,757						$ 32,448

* As reported in VLI Annual report

** Includes interest earned

*** 1% applied from 2019-2021, Increased to 1.5% in 2022

	Starting Balance	Ending Balance	
2019	$ 73,230	$ (23,683)	
2020	$ (23,683)	$ 241,482	
2021	$ 241,482	$ 516,909	
2022	$ 516,909	$ 118,811	$700,000 transferred to Money Market account in Nov/Dec 2022
2023YTD	$ 118,811	$ 133,161	$100,000 transferred to Money Market account in May/Jun 2023

The analysis shown in the above table reflects the differences in the calculated savings/loss amount as opposed to the reported values. The Jury calculated savings/loss as the sum of the carryover and income, less expenses. There are minor accounting differences between the profit and loss (P&L) savings from the financial records and the VLI annual reported savings. There is a significant difference between the Jury's calculated savings and the reported savings. This discrepancy appears to be directly related to the annual carryover values not being included in VLI's profit and loss record keeping. The starting and ending balances shown above reflect the beginning and ending cash balances for VLI's checking account. The Jury also discovered a total of $800,000 that VLI transferred out of their checking account and into a separate Money Market account. The Money Market account funds are not reported in the annual reports submitted to Lompoc.

Analysis of VLI Financial Records by Lompoc

The Jury provided Lompoc with the financial records submitted by VLI and the Jury's analysis of those financial statements. The Jury also provided the Lompoc administration with its analysis of the Annual Reports submitted to Lompoc for the years 2018-2022. Lompoc agreed to conduct a review of those financial records and provide the Jury with a summary of the results. Lompoc discovered an accounting anomaly due to the different accounting methods used (accrual vs. cash). That difference amounted to $9,450. Additionally, as a result of its analysis, Lompoc also discovered the >$500,000 cumulative difference in savings/loss versus reported carryover but only stated that VLI accounts for that value differently.

Summary of Lompoc's Financial Statement Analysis

Calendar Year 2021		Calendar Year 2022	
Carryover Reported	$ 253,582.28	Carryover Reported	$ 302,628.00
Carryover by Our Calc	$ 528,618.92	Carryover by Our Calc	$ 831,246.98
Difference	$ (275,036.64)	Difference	$(528,618.98)

Analysis of Records by VLI's Financial Services Firm

When members of VLI's board were interviewed by the Jury, they neither concurred nor disagreed with the Jury's findings of Lompoc's analysis. VLI did agree to have the firm that manages their accounts review the data reflecting the discrepancies. After conducting such a review, the analysis performed by VLI's financial services firm yielded similar numbers as those calculated by the Jury (see below). The primary difference is that the financial services firm did not include in its analysis the annual reports submitted to Lompoc, since the firm is not responsible for preparing them. The carryover from 2022 calculated by the firm is $555,575 higher than the estimated carryover reflected in VLI's 2023 annual report. While the calculations from the Jury, Lompoc, and VLI's financial services firm vary, the difference between the carryover value reported annually and the actual savings/loss amounts are all more than $500,000.

Financial Services Firm Financial Statement Analysis

	Est. Budget	Carryover	Total Budget	Collections	Actual Spent	Balance	Carryover	Discrepancy
2018	$ 365,000.00	$ 152,012.60	$ 517,012.60	$ 424,986.60	$ 461,132.01	$ 115,867.19	$ 115,867.19	$ (0.00)
2019	$ 440,000.00	$ 115,867.19	$ 555,867.19	$ 296,449.32	$ 393,325.19	$ 18,991.32	$ 18,991.32	$ 0.00
2020	$ 136,426.85 [1]	$ 18,991.32	$ 155,419.17 [2]	$ 435,153.53	$ 170,562.04	$ 283,582.81 [3]	$ 283,582.81	$ 0.00
2021	$ 360,000.00	$ 283,582.81	$ 643,582.81	$ 526,509.12	$ 252,218.90	$ 557,873.03 [4]	$ 557,873.03	$ (0.00)
2022	$ 480,972.00	$ 557,873.03	$ 1,038,845.03	$ 780,255.00 [5]	$ 479,898.00	$ 858,230.03 [6]	$ 858,230.03	$ -
2023	$ 740,000.00	$ 302,628.00	$ 1,042,628.00			$ 302,628.00		
							Total Discrepancy	$ (0.00)

Annual Reporting

VLI utilizes local financial services and accounting firms to manage its bookkeeping and tax reporting requirements. Additionally, VLI contracts with a third-party firm to prepare and submit the mandatory annual reports required for a Tourism Business Improvement District and by the Agreement. The financial services company provides its bookkeeping data to the accounting firm and they, in turn, provide data to the consulting firm for the annual report.

VLI works with Civitas Advisors, a consulting firm offering legal and technical assistance to non-profits, as that third link in the reporting chain. Civitas aided VLI in establishing its non-profit organization and has worked with them in preparing and submitting the required annual reports. VLI does not have a multi-year contract with Civitas to perform this service and has been contracting with them on an annual basis. Even though VLI's agreement with Lompoc requires the submittal of the annual report within 60 days after calendar year-end, VLI typically does not reach

out to Civitas for assistance until after that deadline has passed. Each year VLI contacts Civitas to request their services helping prepare an annual report. Civitas standardly commits to providing this report within 30 days of receiving all the required information from VLI. Specifically, in 2023 the financial information provided by VLI to Civitas had several issues that prevented Civitas from completing the financial section of the report. Due to those issues, Civitas did not complete the financial section of the report and told VLI they could not do so without that information. The Jury was unable to determine what the specific issues were. Each year Civitas submits the annual report directly to Lompoc, as requested by VLI. The Jury was not able to determine if anyone from VLI reviews or approves the report before that submittal.

$800,000 in Money Market Funds

As indicated in the financial analysis data above, VLI has recently transferred $800,000 out of its regular checking account into a Money Market account. At the end of 2022, $700,000 was transferred (VLI's total budget for 2022 was $734,000) and an additional $100,000 was transferred in May/June of 2023. The transfer of funds at the end of 2022 is not reflected in the annual report submitted by VLI in 2023. The 2023 contingency budget reported by VLI for unexpected expenses is only $54,000 and that amount currently resides in a Money Market account. Approximately $712,000 resides in a separate Certificate Account with no indication of any interest income. VLI is not required to provide Lompoc with its financial statements but Lompoc is allowed access to that information per the Agreement.

When a member of VLI's board was questioned by the Jury regarding the $800,000, the individual confirmed the transfer of funds and the value in the Money Market account. The same individual had no explanation as to why those funds were not declared in the annual reports submitted to Lompoc.

Potential conflict of interest

The Jury investigated whether there was any potential conflict of interest between member(s) of the Lompoc City Council and VLI. Based on the evidence presented to the Jury and the subsequent investigation, the Jury could not confirm whether a specific conflict exists. While it was evident that a perceived conflict may exist, Lompoc does account for this possibility by adjusting its consent calendar when necessary and ensuring applicable recusals are effected when appropriate.

CONCLUSION

The City of Lompoc does not have an adequate system of checks and balances to administer its Agreement with VLI. Transparency in the reporting of funds collected from Lompoc businesses for tourism enhancement should clearly show how these funds are being used to promote Lompoc. Accounting is not a disappearing act and neither cash nor accrual methods cause year-over-year

carryover discrepancies of this magnitude. The Jury advocates for a mutual agreement between the City of Lompoc and VLI that results in ongoing third-party audits of the 2018-2029 agreement. These recommendations will enable a transparent relationship benefitting all parties including the businesses, residents, and tourists of Lompoc.

FINDINGS AND RECOMMENDATIONS

Finding 1: Lompoc City Council has not directed Visit Lompoc to request, conduct, or complete an independent audit of its Annual Reports.

Recommendation 1a: Lompoc City Council shall instruct Visit Lompoc to have an independent audit performed of their Annual Reports and present the findings to the Council no later than mid-2024.
Recommendation 1b: Visit Lompoc shall use excess funds under its control to fund this audit.

Finding 2: Lompoc City Council has not directed Visit Lompoc to request, conduct, or complete an independent audit of its Financial Statements.

Recommendation 2a: Lompoc City Council shall instruct Visit Lompoc to have an independent audit performed of their financial records and present the findings to the Council no later than mid-2024.
Recommendation 2b: Visit Lompoc shall use excess funds under its control to fund this audit.

Finding 3: For the time period 2018 through 2022 the analysis conducted by Lompoc and Visit Lompoc's accountants of the Visit Lompoc's financial records confirmed the >$500,000 discrepancy in unspent funds versus reported carryover values.

Recommendation 3: Lompoc City Council shall address the accounting discrepancies by amending the Agreement and holding Visit Lompoc accountable for reporting all funds (including any excess) or mandating that all excess funds (less an approved contingency amount) be utilized for purposes related to enhancing tourism.

Finding 4: Lompoc does not have an adequate system of checks and balances to confirm that Visit Lompoc's accounting methods are accurate and complete.

Recommendation 4: Lompoc City Council shall formally establish a review process to ensure there is no inaccurate or incomplete reporting on behalf of Visit Lompoc before the submittal of the 2024 annual report.

Finding 5: Other than the reference in the Agreement to the Resolution and District Management Plan there are no specific guidelines concerning how Visit Lompoc LLC shall expend its funds.

Recommendation 5a: By the end of 2024, Lompoc City Council shall re-evaluate the terms of the Agreement to ascertain whether the 3% fee assessed on hotel customers is achieving its intended objectives.
Recommendation 5b: By the end of 2024, Lompoc City Council shall determine whether it should have a greater ability to direct unused funds for tourism enhancement projects.
Recommendation 5c: By the end of 2024, Lompoc City Council and Visit Lompoc shall create a joint ad hoc committee potentially including private citizens and other business owners within Lompoc to develop and implement projects utilizing excess funds to further enhance tourism in Lompoc.

Finding 6: The Annual Reports submitted by Visit Lompoc to the City of Lompoc did not include all amounts that should be publicly disclosed.

Recommendation 6: Lompoc City Council shall mandate Visit Lompoc to account for all Lompoc-provided funds under its control via its required annual reports beginning with the submittal of the 2024 annual report (i.e.; zero-based budgeting methodology).

REQUIREMENTS FOR RESPONSES

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

Responses to Findings shall be either:
- Agree
- Disagree with an explanation
- Disagree partially with an explanation

Responses to Recommendations shall be one of the following:
- Has been implemented, with a summary of the implementation actions taken
- Will be implemented, with an implementation schedule

- Requires further analysis, with an analysis completion date of fewer than 6 months after the issuance of the report
- It will not be implemented with an explanation of why

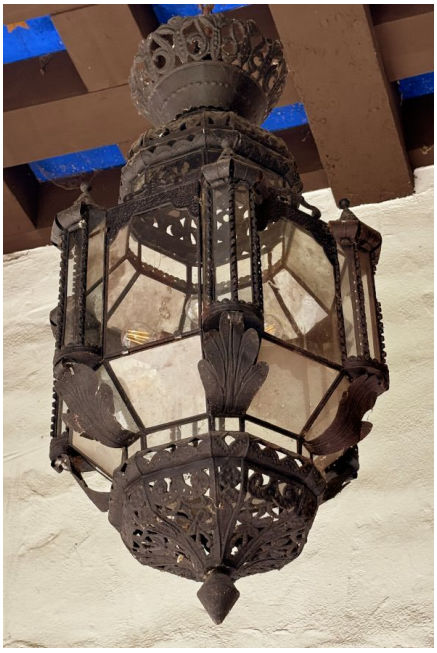
Lompoc City Council: 90 Days

Finding(s): All

Recommendation(s): All

2

POTENTIAL PERCEIVED CONFLICT OF INTEREST FOR DEATH IN CUSTODY INVESTIGATIONS



POTENTIAL PERCEIVED CONFLICT OF INTEREST

FOR DEATH IN CUSTODY INVESTIGATIONS

SUMMARY

The potential liability to Santa Barbara County for in-custody deaths is significant and is comparable to any law enforcement-involved death. Mandating the participation of independent criminal investigators and medical examination teams would aid greatly in mitigating this risk. Based on the 2023-24 Santa Barbara County Civil Grand Jury findings, the cost to achieve this recommendation would be minimal when compared to either the overall budget of the Sheriff's Office or possible liability caused by lack of transparency and potential conflict of interest.

INTRODUCTION

Santa Barbara County (SB) is one of 47 counties within the State of California with a Sheriff/Coroner system. Five counties have a Coroner system separate from the Sheriff and six have Medical Examiner departments. California (pop. >19 million) is one of three states by law that does not mandate the separation of the Sheriff and Coroner offices. The other states are Montana (pop. >800,000) and Nevada (pop. >400,000). The 2023-24 Santa Barbara County Civil Grand Jury (Jury) elected to compare and contrast two neighboring counties, Ventura and San Luis Obispo (SLO), to SB concerning how their Coroners' responsibilities are organized and executed.

SLO has the same type of Sheriff/Coroner organization as SB, but the pathology work is outsourced to a San Diego firm, NAAG Forensic. NAAG performs the required procedures in SLO at a county-provided facility. Since 1984, the Ventura's Medical Examiner Department (ME) has been separate from the Ventura County Sheriff. Ventura employs its own certified pathologists and forensic investigators within the ME Department.

The SB County Coroner Bureau is led by the Sheriff/Coroner. The Bureau is managed by a Sergeant and a staff of four Sheriff detectives along with a Forensic Pathologist, Pathology Technicians, and Administrative Support.

METHODOLOGY

The Jury interviewed the individual who submitted the Request for Investigation (RFI), a representative from the Medical Examiner office of Ventura County, and members of the Sheriff/Coroner departments of SB and SLO counties. The Jury also visited the SB Coroner facility as part of its investigation.

OBSERVATIONS

Deaths in Custody and Resultant Medical Examinations

Per the California Department of Justice, the total number of Deaths in Custody **(**DICs) in SB County from 2006-2020 was 24 (https://www.bsa.ca.gov/reports/2021-109/supplemental.html). The total number of DICs from the beginning of 2021 through the end of 2023 in SB County has been 10. The information for post-2020 was requested and received from the California State Attorney General's office and was current at the time of the request (December 2023). The table below highlights the DICs in SB, Ventura, and SLO for comparative purposes:

Deaths in Custody Pre and Post 2020

County Name	2006-2020	Post 2020
San Luis Obispo County	20	1
Santa Barbara County	24	10
Ventura County	47	7

One hundred percent of the DICs reported in those other counties resulted in autopsies being performed. The sole exception is when an inmate dies because of known natural causes (i.e.; pre-diagnosed terminal cancer). All of the DICs in SB had autopsies authorized by the Coroner's Bureau. In SB, a member of the Coroner's Detective Staff, in conjunction with the pathologist, decides whether to conduct an autopsy. It is not at the sole discretion of the pathologist. In each of the other counties, the medical staff decides whether to perform the autopsy or not.

Certification and Training of Staff

Ventura and SLO counties mandate their pathologists be certified per the American Board of Medicolegal Death Investigators (ABMDI) standards and their facilities and equipment meet the standards set by the National Association of Medical Examiners (NAME). Neither the medical staff nor the facilities of the SB County Coroner's Bureau are certified to these standards. It should be noted that these standards are recommended by the U.S. Department of Justice but are not mandatory.

The Jury discovered that in SB both Pathology Technicians are retired Law Enforcement Officers, and, while they have had the required training to perform their jobs, there is no succession plan to fill those positions when needed. The training required for Medical Laboratory Technicians (aka Pathology Technicians) is listed on the California Department of Public Health website (https://www.cdph.ca.gov/).

Cross County Cooperation

The Jury discovered that other counties collaborate on DIC investigations or request independent reviews/medical services for those cases. For example, Monterey County uses SLO's pathology group for DIC autopsies. However, SB does not seek the assistance of other counties. The Jury learned that SB does not request independent assistance with any DICs or other death investigations.

The company that provides forensic pathology services for SLO, NAAG Forensic, charges $2,200-$2,700/autopsy (not including toxicology), and they are willing to provide support to SB for DICs (see Exhibit A). Ventura also provides autopsy services to the public, and they charge $5,000/case. It is not yet known whether they would be willing to provide this service to SB for DICs and mitigate any potential or perceived conflict of interest.

In-Custody Death Investigations (California Senate Bill (SB) 519)

The SB County Sheriff/Coroner organization has a specific protocol that mandates a multiple discipline investigation for all DICs. Members of the Custody, Criminal, and Coroner investigator

departments must participate jointly in every DIC occurrence. In some cases, there has been reluctance on behalf of the Criminal Investigation Department to participate in these reviews. This was the case in December 2023 when an inmate committed suicide at the County Main Jail. As a result, the Sheriff has specifically ordered that all departments comply with this policy with no exceptions.

In 2023, Governor Newsom signed Senate Bill 519 which will be effective July 1, 2024. This measure: (1) requires public disclosure of records relating to investigations conducted into local in-custody deaths, as specified; and, (2) establishes within the Board of State and Community Corrections (BSCC) the position of Director of In-Custody Death Review. That new position will be responsible for reviewing investigations of any death incident occurring within a local detention facility. All Coroner facilities and staff will be facing additional scrutiny regarding these incidents. With an increasing level of DICs, SB County may alert the recently appointed Director for an in-depth process review.

Coroner's Budget

In the SB County Coroner Bureau budget for FY 2023-24, total expenditures are budgeted at $2,480,900, comprised of $1,979,600 in employee total compensation, $312,000 in services and supplies (e.g., primarily removal/disposal costs, communications, operating supplies), and $189,300 in other charges (liability insurance, motor pool charges, and utility costs). The Coroner Bureau is predominantly (95%+) funded by the SB County General Fund, as well as a small amount of fees for services.

Potential Perceived Conflict of Interest

There is a potential perceived conflict of interest for the Sheriff/Coroner to perform investigations and autopsies for DICs. Since Ventura's ME is a separate department, the perceived potential conflict of interest becomes a moot point. In SLO, while the investigative team remains under the direction of the Sheriff, any medical decisions associated with a DIC are made by the forensic pathologist. As previously mentioned, in SB the Coroner Detective Staff makes the medical

decisions as to when to conduct autopsies, in conjunction with the Forensic Pathologist. Furthermore, SLO assists its neighbor to the north, Monterey, by performing autopsies for most or all their DIC cases.

California Government Code §27491.55, specifies the conditions when an independent medical examination or, in the instance of a potential criminal case involving a DIC, an investigation could be performed:

§**27491.55.** In any case where a coroner is required to inquire into a death pursuant to Section 27491, the coroner may delegate his or her jurisdiction over the death to an agency of another county or the federal government when all of the following conditions have been met:

(a) The other agency has either requested the delegation of jurisdiction, or has agreed to take jurisdiction at the request of the coroner

(b) The other agency has the authority to perform the functions being delegated.

(c) When both the coroner and the other agency have a jurisdictional interest or involvement in the death.

The Jury was unable to uncover any instances where the Coroner staff had requested an independent investigative or medical exam from an outside source.

CONCLUSION

The inherent risk and potential liability to the County are significant when Deaths-in-Custody occur and those numbers are rising. These conditions are exacerbated when the Sheriff's own Criminal Investigation Department is sometimes reluctant to engage in DIC investigations. Utilization of existing independent resources is readily available and easily implemented. These low-cost resources are a viable means to eliminate or significantly mitigate these risks and liabilities.

FINDINGS AND RECOMMENDATIONS

Finding 1: There is a real or perceived conflict of interest in investigating and conducting pathological exams related to deaths in custody that can be avoided or mitigated by having a separate Medical Examiner's office (inclusive of a separate investigative detective unit) or outsourcing those specific cases to an independent agency.

Recommendation 1a: To avoid a potential conflict of interest in having the Sheriff/Coroner's office conduct deaths in custody investigations, the Sheriff/Coroner's office shall request another Santa Barbara County agency to conduct either an independent or parallel investigation for all deaths in custody events. This could be implemented immediately.

Recommendation 1b: All deaths in custody pathology investigations shall be conducted using an independent medical examination team. This policy shall be implemented no later than the end of December 2024.

Finding 2: The Sheriff/Coroner's office has no current succession plan to replace or train new staff if either or both are no longer available to provide the required support.

Recommendation 2: The Sheriff/Coroner shall develop and implement a succession plan for pathology technicians (including identification of potential candidates and ensuring training budget is available) following current California Department of Health standards, with a specific timeline by the end of September 2024.

Requirements for Responses:

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

Elected Official: - Santa Barbara County Sheriff/Coroner - 60 Days

Finding(s): 1, 2

Recommendation(s): 1a, 1b, 2

Responses to Findings shall be either:

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

Responses to Recommendations shall be one of the following:

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

EXHIBIT A

Potential Pricing for Independent Medical Examinations

2024 CALIFORNIA SHERIFF-CORONER ON DEMAND RATES

SERVICE	INCLUDES	FLAT RATE
Records review	All professional and paraprofessional time related to the review of investigative and medical records; offer opinion on COD and MOD	$600
External examination	All professional and paraprofessional time related to the review of investigative and medical records, examination of the external aspects of the decedent with or without specimen collection; offer opinion on COD and MOD; report NOTE – Does not include toxicology testing	$600
Standard autopsy	All professional and paraprofessional time related to the review of investigative and medical records, examination of the external and internal aspects of the decedent with specimen collection; offer opinion on COD and MOD; report NOTE – Does not include toxicology testing EXAMPLES – Sudden cardiac death, suicidal violence, drug overdose, etc.	$2200
Complex autopsy	All professional and paraprofessional time related to the review of investigative and medical records, examination of the external and internal aspects of the decedent with specimen collection; offer opinion on COD and MOD; report NOTE – Does not include toxicology testing; does include histology and tissue consultation services EXAMPLES – Delayed blunt head trauma, post-operative cardiac death, etc.	$2700
Pediatric autopsy	All professional and paraprofessional time related to the review of investigative and medical records, examination of the external and internal	$2750

	aspects of the decedent with specimen collection; offer opinion on COD and MOD; report NOTE – Does not include toxicology testing; does not include genetic studies, metabolic studies or molecular assays; does include histology and tissue consultation services	
Criminally suspicious pediatric death / homicide autopsy	All professional and paraprofessional time related to the review of investigative and medical records, examination of the external and internal aspects of the decedent with specimen collection; offer opinion on COD and MOD; report NOTE – Does not include toxicology testing; does not include genetic studies, metabolic studies or molecular assays; does include histology and tissue consultation services	**$7500**
Criminally suspicious death / homicide autopsy	All professional and paraprofessional time related to the review of investigative and medical records, examination of the external and internal aspects of the decedent with specimen collection; offer opinion on COD and MOD; report NOTE – Does not include toxicology testing; does not include professional time related to depositions or trial	**$2750**
Brain-only autopsy	All professional and paraprofessional time related to the review of investigative and medical records, examination of the external aspects of the decedent with specimen collection; formal neuropathology consultation; report NOTE – Our pathologists perform limited autopsies in very few circumstances, examples include dedicated evaluation for dementia, and suicidal gunshot wounds deaths where the projectile is remained in the head	**$1700**

3

WELLPATH CONTRACT SERVICES PROVIDED TO SANTA BARBARA COUNTY AND THE SHERIFF'S OFFICE

WELLPATH CONTRACT SERVICES PROVIDED TO SANTA BARBARA COUNTY AND THE SHERIFF'S OFFICE

Summary

The County of Santa Barbara with the Sheriff's Office has a contractual agreement with California Forensic Medical Group/Wellpath, a privately held corporate correctional healthcare provider. Along with positive qualities within the Wellpath organization, shortcomings exist. Contractual variances, lack of staff, and inadequate reporting systems call for corrective measures. Additionally, the lack of Sheriff's Office oversight allows contractual financial deficiencies to persist. Recognizing and correcting these shortcomings would facilitate the delivery of improved and more cost-effective healthcare in the Santa Barbara County jails.

Background

Prior to 2009, Santa Barbara County Public Health provided healthcare in the Main Jail. Budgetary concerns led the Sheriff's Office to cancel this contract and search for an independent healthcare provider. In 2009, the Sheriff contracted with Corizon Health. From 2009 through 2016, the healthcare provided for the adult jail faced unfavorable reviews and latency in meeting accredited standards, leading to scrutiny by the community and Board of Supervisors (BOS).

In 2017, the California Forensic Medical Group (CFMG), later renamed Wellpath, was selected jointly by the BOS and the Sheriff's Office (SO) to replace Corizon. A five-year contract was signed into effect April 1, 2017, ending in 2022, with a maximum of three one-year extensions. The Wellpath Agreement/Contract (Contract) was thoroughly reviewed by the 2023-2024 Santa Barbara County Grand Jury (Jury), including the four amendments. The First Amendment in May of 2020 expanded healthcare to the Sheriff's Office Northern Branch Jail and re-adjusted staffing for the Main Jail Facility. Subsequent amendments extended the Contract for three additional one-year periods. The most recent Amendment extends the term through March 31, 2024.

The initial 2017 Wellpath contract for services covered the Main Jail and the Juvenile Detention Centers. This report focuses solely on the adult jails.

In 2022, the average daily population of the Main Jail was 277 inmates and 491 in the Northern Branch Jail. In 2023, the Main Jail on average housed 335 inmates, while the Northern Branch Jail population was 422.

In 2020, three significant challenges occurred. One was the settlement of a lawsuit, Murray v. Santa Barbara County, resulting in the Remedial Plan. Requirements within the settlement mandated many health service-related enhancements, including structured mental health programs, continuity in the administration of prescribed medications, and improved transfer of written medical records to electronic records. To fulfill these requirements, seven Wellpath staff members were added. It took six months to fill these positions. These added positions included a mental health professional, a mental health supervisor, a Registered Nurse, a Compliance

Coordinator, a Continuous Quality Improvement Coordinator and additional hours for the Medical Director and a Psychiatric Nurse.

The second challenge was the outbreak of the Covid-19 pandemic which exerted overwhelming pressure on all aspects of healthcare systems. The incarcerated population was at high-risk due to close-quarter indoor confinement. Managing this risk involved the added workload of continuously testing inmates to prevent the spread of the virus as well as enforcing isolation protocols when inmates tested positive for Covid-19 or the emergent variants. Early in the pandemic there was scarcity of personal protective equipment, which greatly elevated the risk to the healthcare providers.

A third challenge occurred in 2022 when the Northern Branch Jail opened for inmate transfer from the Main Jail. A shorter timeline than the previously anticipated and agreed upon 60-day start-up period required Wellpath to expedite the hiring and training of staff to fill positions at this jail.

Despite these challenges, improvements were achieved in several aspects of health provisions for inmates in the adult jails. Wellpath provided extra services demanded by the Remedial Plan, Covid, and the staffing of the Northern Branch Jail. However, important contractual and staffing variances came to light during negotiations with the Board of Supervisors and prompted this investigation.

Methodology

The Jury interviewed multiple individuals in the Wellpath organization and County departments. Nineteen in-depth interviews were conducted, including:

- Wellpath administrative staff, legal counsel, nurses, and physicians
- Sheriff deputies at both adult jails
- Juvenile Probation personnel
- Board of Supervisors members
- Public Health administrative staff
- Behavioral Wellness administrative staff
- County Executive Office staff
- Sheriff's Office Executive staff

The Jury reviewed and analyzed the Sheriff's Office's adult jail transactions pertaining to Wellpath invoices and payments for services, medications, and electronic medical record keeping.

Discussion

The principal covenant for the Wellpath/Sheriff Agreement specifies that "Wellpath will provide on-site medical, behavioral, nursing, dental and prescription services to the adult jail and probation facilities." Further specified in the Statement for Work is a directive that "at least one Registered Nurse shall be working twenty-four hours per day/seven days per week." (Pursuant to Contract Section *Staffing Plan 15.3 Nursing. A)*

The Jury investigated four structural and compliance deficiencies that existed in the Wellpath/Sheriff contract. The clauses listed below offer more comprehensive descriptions and details of the principal covenant. The Jury's concerns are outlined following each specified clause.

First issue: Lack of accountability for staff vacancies

The Jury's investigation uncovered a lack of accountability for the Wellpath staff shortages over the last two years. This is in violation of the Wellpath contract, which reads:

> "The Contractor (Wellpath) will develop and maintain a pool of trained nursing staff available to serve on a per diem basis to cover vacancies, holidays, vacations, etc. Wellpath shall take immediate action to fill vacant positions." (*Staffing Requirements 14.0 I)*
> "Wellpath shall adhere to a staffing schedule agreed upon in this Agreement*." (Staff Maintenance 14.2 E)*
> "Wellpath shall implement staffing efficiencies where recruitment and retention challenges develop." *(14.2 A Part 4)*

The Jury's interviews revealed that Wellpath administration records the daily attendance of the various health providers, including Registered Nurses (RNs), Licensed Vocational Nurses (LVNs), Physician Assistants (PAs), Licensed Clinical Social Workers (LCSWs)/Licensed Marriage Family Therapists (LMFTs), dental assistants, and Psychology Nurses (Psych RNs).

When absences occur, efforts are made to fill these vacancies. The Wellpath health service administrator fills open positions with the option of using per diem nurses, locums or requesting current staff to work overtime. Despite these attempts, vacancies continued to persist. Increasing the number of per diem nurses would reduce unforeseen or protracted absences, but this is not yet in the contract.

Wellpath acknowledges that more recruiting efforts should be made, but there are mitigating factors for their efforts. Santa Barbara County and neighboring counties (San Luis Obispo and Ventura) have large hospitals that compete for staffing. Coupled with the high cost of living and lack of affordable housing, recruiting, and retaining qualified healthcare staff is challenging. Of the Wellpath staff interviewed, very few lived within Santa Barbara County or City limits. Incentives such as sign-on bonuses, additional pay for extra credentials/certificates, tenure of service, relocation and transportation reimbursement have had little effect on the hiring and retaining of qualified healthcare staff.

Wellpath nurses have assigned priorities during the day, evening, and night shifts. Receiving screening at intake is one priority that precedes all others, requiring nurse attendance at the time of detainee arrival and admittance to the jail. Medications and treatments are of paramount importance, necessitating precise adherence to the prescribed schedule within a one-hour window to ensure dosing efficacy. During the day shift, routine medical exams, follow-ups, non-urgent sick calls, psychiatric consultations, counseling appointments, and other health-related issues are managed by Wellpath providers and custody deputies. The nursing staff has responsibility for 760 inmates housed at the two jails, based on an average daily census. The Jury has been informed that as many as 60% of these inmates are on medications.

A significant underlying concern, especially during staff shortages or extended absences, is the impact on the quality of healthcare provided to the inmates. When there are vacancies, fulfilling medical services to all inmates becomes difficult. Emergent, urgent, and routine procedures rely on adequate qualified staffing for the provision of healthcare. Moreover, long duration vacancies of providers could strain staff, decrease their time allotted to patients, and potentiate turnover or burnout.

An additional concern, as noted in several interviews, is with the outmoded Main Jail. Due to infrastructure restrictions, most procedures require inmate escorts by custody officers. When the custody department is unable to transport inmates to their appointments due to lack of nursing availability, it can further result in decreased efficiency.

The annual Wellpath report references the Board of Supervisors' concern about "how significant achievements or shortfalls affected the overall health program." Staffing shortfalls negatively impact the services provided.

Second issue: Lack of 24/7 mental health coverage

During the hours of 11 p.m. through 7 a.m., there is no dedicated mental healthcare professional on site at either of the two jails. A concern has been raised that during these hours if a mental health crisis should arise, there is not a properly trained professional in the jail to deal with this emergency. The staff psychiatrist is only on site approximately once every two months and on call for telemedicine 24/7. There is a full-time psych nurse on site during the daytime five days per week. This schedule leaves hours when there is no psychiatrist or psych nurse present in the facilities.

The Wellpath nursing staff does receive mental health training and some crisis intervention instruction. The nurses do not have the in-depth training which the Officers have. Beginning in 2021 all custody staff graduates receive 40 hours of training in various areas related to mental health and crisis intervention included in their core academy curriculum. All current custody deputies are required to receive 24 hours of annual training, a part of which deals with de-escalation techniques and special considerations regarding the mental state of the subjects/inmates.

As stated in the initial 2017 Wellpath Agreement, "The county intends to engage Public Health (PHD) and Behavioral Wellness (BW) to serve as Agreement advisors, managers and community partners with the Sheriff and Probation and the Contractor in the design, delivery and evaluation of healthcare services." *(External Oversight 13.0 A).*

It was reported in the December 5, 2023, BOS meeting that PHD and BW have increased their monitoring roles. In addition, the BW Mobile Crisis Unit was scheduled to be located adjacent to the Main Jail beginning in February 2024. This move would provide emergency response to mental health-related issues in the jail and in the community at large. The final placement and timing of the BW unit and staff have been delayed due to several issues. These include employee concerns within BW, ongoing discussions to contract outside resources for after-hours mental healthcare, and exclusivity concerns with Wellpath.

The Jury has found evidence that a 24/7 mental health nurse would not be optimal or cost effective. In general, the reason given was that Wellpath staff is in place to identify mental health patients and requests assistance if necessary. Custody staff has mental health training to handle emergencies. More specifically:

- Intake screening can identify high risk individuals who would then be properly housed and monitored when admitted.
- Intake screening can determine if the inmate can be medically maintained at the jail with guidelines on triage that could warrant sending an inmate to the hospital.
- When a night shift mental crisis/emergency does present itself, the nursing staff and custody officers respond immediately, assess the situation, and determine if the patient needs de-escalation, transport to the hospital emergency room, or involuntary admittance to the Psychiatric Health Facility (PHF).
- Being with the inmates daily, the correctional personnel are often the first to notice behavioral or emotional changes that could potentially have a bearing on their mental health status.
- Mental health related standard procedures cannot be performed in the off hours. Allowance for inmate sleep is mandatory. Hence a sole commissioned mental health provider would not be able to perform routine procedures or evaluations in the nighttime hours.
- The entire Wellpath staff is trained in emergency management of mental health crises.
- Cost effectiveness is a factor in the employee matrix, placing the proper amount of human resources in the locations where needed at the times they are the most productive. The greatest need for coverage is between 7 a.m. and 11 p.m.
- Recognition at intake of a mentally unstable inmate is key to mitigating negative mental health consequences, thereby lessening the need to have an underutilized mental health provider 24/7.

Some interviews did suggest that an "ideal" scenario would involve an expansion in staffing with mental health providers. The compliance standard from the National Commission on Correctional Health Care (NCCHC) requires at least 75% of staff present to be current in mental health training. It is unclear if this standard has been met and maintained. The overriding goal is to address any gaps in care while efficiently allocating professional resources based on need and cost considerations.

Third issue: Accounting shortfalls

Vacancies, according to the Wellpath contract, should initiate adjustments or credits in the invoice sent to the Sheriff's Office. Specific criteria are outlined below:

> Pursuant to Wellpath/Sheriff Contract, Exhibit A, "Wellpath shall not be compensated for un-staffed shifts for clinical positions. Monthly, Wellpath shall be allowed a 2% margin of missed hours to allow for exigent circumstances in staffing. When this 2% margin is

exceeded, Wellpath shall reduce the invoice by the amount equal to the hourly cost to County for the clinical position hours not covered.*" (Payment Provisions 17.2 A)*
"Wellpath shall invoice the Sheriff and Probation separately and payments will be remitted separately. Payments to Wellpath may be adjusted for staffing variances." (*Payment Provisions 17.0 B)*

The Wellpath/Sheriff's Office contract states that when staff shortages exceed 2% vacant hours, remuneration will be credited (reduction in invoice) to the Sheriff's Office. At end-of-month billing, Wellpath should clearly display deductions due to staff vacancies. It is a dual oversight system. Both Wellpath and the Sheriff's Office are responsible for monitoring staffing levels and account for any shortfalls. In the years 2021, 2022 and 2023, when reviewing and analyzing the billing statements and subsequent payments, with admitted known staff shortages, no adjustments were assessed as specified by the Contract.

It has been difficult to accurately determine how many times staff shortages triggered the 2% rule. Some positions went unfilled for extended periods of time (months). Similarly, the Sheriff's Office could not provide an approximation of how often and to what extent there were Wellpath staff shortages. There had been multiple vacancies in Wellpath staffing over the past two years. There have been ongoing discussions concerning this issue.

Having no record of the frequency of vacancies, the staff positions involved, or the hourly rate, invoices indicated no evidence of credits and/or deductions. These invoices were submitted to the Sheriff's Office and were approved for payment in full.

Several reasons were provided by the Sheriff's Office for not assessing Wellpath staff shortage credits or deductions.

First, the process of checks and balances may not have been properly overseen by the Sheriff's Office. Custody officers have not been trained in financial accounting. During the initial stages of the Wellpath tenure, Wellpath invoices were handled with a pass-through approval process with no oversight by the Sheriff's Office. Unlike the financial department in the Juvenile Probation Department, which has noted vacancies, the Sheriff's Office has not brought the missed hours that exceed the 2% rule to light. Without this oversight, no deductions or credits have been accounted for in Wellpath's invoices.

At the December 5, 2023, BOS meeting the County Executive Office recommended to the BOS that the Sheriff's Office add administrative staff in the jail to help bolster contract compliance. An additional recommendation was to require newly dedicated PHD resources to monitor and report on contract performance measures and service level agreement shortfalls. Currently, PHD has two BOS approved positions and is actively recruiting a part-time correctional health advisor/auditor and a full-time nursing level advisor.

Another reason stated to the Jury was that Wellpath was also providing extra services to assist with the Remedial Plan (Murray v. Santa Barbara County), which had not been specified in the original Wellpath contract. The Remedial Plan implementation began in 2020, three years after the original Wellpath Contract Agreement had been approved in 2017. The First Wellpath/Sheriff Amendment Agreement (2020) stated, "if expansion in services is needed, related to current litigation, the

Sheriff's Office and Wellpath will work together in good faith to negotiate an amendment to this contract." These extra services provided were not insignificant. In helping the Sheriff with implementation of the remedial requirements it was confirmed that Wellpath was deserving of considerations. The leniency in assessments for staff vacancies was apparently one such consideration.

The Wellpath staff faced an additional challenge with the outbreak of Covid-19, requiring intense medical monitoring and treatments for the inmates. Not only did this affect the health providers themselves, resulting in increased sick days, but heightened their role in infectious disease control within the jail.

Moreover, an expedited opening of the Northern Branch Jail (NBJ) required Wellpath to rapidly increase its staff, provide training, and relocate to this new facility. "The County shall notify Wellpath of the date of facility opening at least sixty (60) days prior to opening the facility to allow Contractor time to recruit, hire and train staff." *(Transition Hiring Plan 21.0)* Over 200 inmates were transferred from the Main Jail to the Northern Branch Jail on January 22, 2022, which was three months before the NBJ was officially opened for intake.

A further explanation offered was the difficulty Wellpath faced with staffing. There is county-wide competition for a limited pool of healthcare workers. In addition, several Wellpath nursing staff commented on the complexities of working within the confines of the jail as most nurses typically prefer positions in customary hospital settings. Wellpath's nursing staff were further affected by across-the-board post-Covid-19 burnout.

Without accurate accounting for the staffing vacancies, it is difficult to assign monetary value to this omission or to make an approximation of the monetary credits that were not assessed. The Jury's only barometer, albeit not directly comparable, was a $27,500 credit received during year six of the contract by the Probation Department for Wellpath staffing shortages at the juvenile facilities. Fiscal personnel in the Probation Department verified these payments. The monetary credits for the adult jails would be larger. One estimate provided to the Jury was that in 2023 the credits would have been approximately $135,000.

While non-compliance with any contract can carry implications, it is essential to consider legitimate adjustments. The reasons presented for the variances do have merit and are worthy of reasonable concessions. However, a lack of accurate accounting negatively impairs county taxpayers' expectations of transparency in local government as well as allows complacency in filling Wellpath vacancies. Transparency regarding unreported and unaccounted-for credits would be equitable for all parties involved: the County, the Sheriff and Wellpath.

Fourth Issue: Lack of timely annual reporting

Several important metrics were established within the Wellpath Agreement. One was that the "timely, accurate and actionable data to monitor the vendor" be included in the annual reports presented to the BOS.

> "Wellpath shall submit to the County an annual report based on the contract year, giving a comprehensive review of monthly statistical and program reports examining significant

trends and issues. The report is due no later than 60 days after the end of each contract year." (*Mandatory Reporting 15.11 C)*

This would allow the BOS to independently verify the fulfillment of certain pre-established criteria, ensure efficient overall operation of healthcare delivery, and assess how significant achievements or shortfalls affected the overall cost-effective health program commensurate with community standards. These reports were required to be filed and presented to the BOS within 60 days after the end of each contract year. Each contract year ends March 31; hence the reports should be presented no later than early June of each calendar year. The 2022 annual report was not presented to the BOS until December 2023, a delay of over seven months. Timely annual reporting is considered standard management practice by the National Commission on Correctional Health Care (NCCHC), which accredits the Santa Barbara County jails.

Sheriff deputies and Wellpath administration took responsibility for the tardiness of this report. Wellpath had submitted a portion of their annual report to the Sheriff's Office in August of 2023. When the full report was finally presented to the BOS in December of 2023 by multiple Wellpath staff members, it highlighted achievements and significant trends. These included: enhanced jail-based competency treatments, increased enrollments in Early Access Stabilization Services, and assistance with Remedial Plan compliance.

High numbers of sick calls, medications, medical treatments, increased Covid-19 testing protocols, and prioritized overtime demands were also cited as contributing to the delay. Despite Wellpath having three full-time medical records clerks dedicated to inputting all the medical data, and $15,000 in startup funds provided for Electronic Medical Records (EMR) at the initiation of the Wellpath Contract, the reporting process faced challenges.

In each subsequent year, approximately $21,000 in additional funds have been paid to Wellpath for cooperation in development, modernization, and implementation of the EMR system. With electronic medical record keeping and computer analytics, the report data should be readily accessible for presentation in a timely and chronological format. Withholding payment for delayed annual reports has been suggested by the BOS, but it has not been brought to a vote. When the delay in reporting continually extends beyond the 60-day end of contract year, the Board's evaluation of Wellpath's services inhibits accurate assessment for possible funding increases.

Conclusion

Ensuring access to timely and appropriate healthcare for all detainees and inmates in the County jails is a fundamental human right. Adherence to accepted standards within the framework of the correctional system can effectively deliver such care. Wellpath, the privately held corporate healthcare provider, and their staff work collaboratively with the Sheriff's Office staff. Both entities maintain a positive working relationship and jointly strive to meet or exceed established standards, but they sometimes fall short of achieving all contractual requirements. The Jury's recommendations are intended to assist in the formulation of and compliance with an improved contract among the chosen healthcare provider, the Sheriff, and the County Board of Supervisors.

Commendation

All Wellpath staff members exhibit integrity, compassion, and a willingness to be the very best healthcare providers they could be. The Sheriff custody deputies demonstrate dedication and sincerity in their mission of safeguarding the public while concurrently providing care to persons incarcerated.

Findings and Recommendations

Finding1: Wellpath/Sheriff staffing shortfalls at the Santa Barbara County jails occurred frequently, which could lead to delayed healthcare provision to the inmates.

Recommendations:
1A: The Sheriff's Office shall include more healthcare positions in the upcoming 2024 contract.
1B: The Sheriff's Office shall institute higher initial compensation to better assist recruitment of qualified healthcare staff in the upcoming 2024 contract.
1C: The Sheriff's Office shall negotiate for competitive incentive programs in the upcoming 2024 healthcare contract. These would include signing bonuses, retention bonuses, enhanced benefit packages, transportation allowances, or other housing assistance packages commensurate with the high housing costs in Santa Barbara County.

Finding 2: A lack of accounting within the Sheriff's Office did not acknowledge Wellpath staffing shortfalls which exceeded the agreed upon 2% vacancy level for which credits should have been applied.

Recommendations:
2A: For the balance of 2024, prior to end-of-month invoice submission from Wellpath, financially knowledgeable Sheriff custody staff shall work with the Wellpath Health Administrator to examine, concur, and record any staff vacancies that exceed the 2% limit.
2B: This agreed upon vacancy credit shall be clearly delineated in Wellpath's end-of-month billing invoice.
2C: The bookkeeping/accounting department in the Sheriff's Office shall provide accurate oversight to ensure proper entries of credits coupled with transparent deductions in payments.
2D: The Board of Supervisors shall require Public Health Department resources to carefully oversee and regularly report on performance measures and Contractual Agreement adherence.

Finding 3: There is an absence of Wellpath 24/7 mental health providers at both County Jail sites.

Recommendations:
3A: The Sheriff's Office shall instruct Wellpath to expand in-depth training for nursing staff to better recognize and address both potential and existing mental health issues and crises to be initiated by the end of December 2024.
3B: The Sheriff's Office shall expand in-depth training of all custody deputies to better identify potential and existing mental health issues and crises to be initiated by the end of December 2024.

3C: The Board of Supervisors shall ensure the presence of a Behavioral Wellness crisis team adjacent to the jail facility ensuring the presence of trained crisis response team members in the nighttime hours (11 p.m. – 7 a.m.) to be initiated by the end of December 2024.
3D: The Sheriff's Office shall instruct Wellpath to conduct a thorough assessment of the accessibility and benefits of telepsychiatry, focusing on optimization of this service in the nighttime hours (11 p.m. – 7 a.m.) to be initiated by the end of December 2024.

Finding 4: The annual Wellpath report to the Board of Supervisors has routinely been delayed.

Recommendations:
4A: The Board of Supervisors shall immediately insist on the timely generation and submission of annual reports.
4B: The Jury recommends that the Board of Supervisors impose penalties in payments when annual reporting extends beyond the 60-day end of the contract year.

Requirements for Responses:
Pursuant to California Penal Code §933 and §933.05, the Grand Jury requests each entity or individual named below to respond to the Findings and Recommendations within the specified statutory time limit.

**Santa Barbara County Sheriff: 60 Days **

Finding(s): 1, 2, 3

Recommendation(s): 1A, 1B, 1C; 2A, 2B, 2C, 2D; 3A, 3B, 3D

Santa Barbara County Board of Supervisors: 90 days

Finding(s): 1, 2, 3, 4

Recommendation(s): 1A, 1B, 1C; 2D; 3C; 4A, 4B

Responses to Findings shall be either:

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

Responses to Recommendations shall be one of the following:

- Has been implemented, with a summary of the implementation actions taken
- Will be implemented, with an implementation schedule

- Requires further analysis, with an analysis completion date of fewer than 6 months after the issuance of the report
- It will not be implemented with an explanation of why

4

2023-2024 Santa Barbara County

Grand Jury Response Report

2023-24 SANTA BARBARA COUNTY GRAND JURY
RESPONSE REPORT

INTRODUCTION

The Santa Barbara County Civil Grand Jury (Grand Jury) is empaneled annually to act on the public's behalf, conducting investigations and reporting to the community on areas of concern as requested.

This Status Report by the 2023-24 Grand Jury assesses the adequacy of the responses to the seven Investigative Reports issued by the 2022-23 Grand Jury. Each investigative report required responses from one or more government agencies. *California Penal Code sections 933 and 933.05,* specifies the response form and the statutory time limit to respond. All Grand Jury reports and the responses to each report are posted on the Grand Jury's website.

The Jury's objective is to increase transparency and operating efficiency. The 2023-2024 Grand Jury collected and reviewed the required responses to each report.

The 2022-2023 Grand Jury issued seven (7) reports that include 35 findings and 51 recommendations to local agencies on issues regarding Deaths in Custody (2 reports), Incarceration of the Mentally Ill, Cybersecurity in School Districts, Death on Electronically Monitored Home Release, and Santa Maria Valley Water Conservation District (2 reports).

RESPONSE REQUIREMENTS

Responses to Findings shall be either:	Responses to Recommendations shall be one of the following:
• Agree • Disagree wholly • Disagree partially with an explanation	• Has been implemented with a summary of the implementation actions taken • Will be implemented with an implementation schedule • Requires further analysis, with a time frame that shall not exceed six months from the report's publication date • Will not be implemented, with an explanation of why

SUMMARY OF RESPONSES

Total # of reports	Total # of Findings	Findings Agreed With	Findings Disagreed With	Findings Partially Agreed With
7	35	19	2	14

Total # of Recommendations	Already Implemented	Will Be Implemented	Requires Further Analysis	Will Not Be Implemented
51	11	12	6	22

SUMMARY OF SPECIFIC REPORTS

The seven reports requiring responses to the recommendations are discussed in the order in which they appear in the 2022-23 Grand Jury's final report. These reports, their findings, and responses to recommendations are summarized below. These summaries are not intended to alter, replace, add to, or subtract from the 2022-23 Grand Jury's report, findings and recommendations.

A Death in Custody – Lessons Learned

An inmate died in a Santa Barbara County Main Jail safety-cell approximately 20 minutes after he was booked and engaged in a physical struggle with Santa Barbara Sheriff's Office custody staff. The 2022-23 Grand Jury examined the facts surrounding his arrest and incarceration.

Responses to Findings

Responding Agency or Elected Official	Agree	Partially Agree	Disagree
SB County Board of Supervisors	2	1	-
SB County District Attorney	1	-	1
SB County Sheriff/Coroner	2	2	1

Responses to Recommendations

Responding Agency or Elected Official	Already Implemented	Will Be Implemented	Requires Further Analysis	Will Not Be Implemented
SB County Board of Supervisors	-	-	-	7
SB County District Attorney	-	-	-	1
SB County Sheriff/Coroner	-	1	3	3

The 2022-23 Grand Jury found the criminal justice and healthcare systems offered numerous opportunities to provide the decedent with effective mental health crisis intervention. Each of those opportunities was missed for preventable reasons, including lack of awareness, miscommunication, inadequate training, and lack of mental health professionals on duty 24/7 at the jail.

Every Death In Custody Is A Failure

The 2022-23 Grand Jury investigated the July 2021 suicide death of an in-custody inmate. The decedent hung himself one day after his cellmate's attempted suicide.

Responses to Findings

Responding Agency or Elected Official	Agree	Partially Agree	Disagree
SB County Board of Supervisors	1	1	-
SB County Sheriff/Coroner	-	2	-

Responses to Recommendations

Responding Agency or Elected Official	Already Implemented	Will Be Implemented	Requires Further Analysis	Will Not Be Implemented
SB County Board of Supervisors	2	-	-	1
SB County Sheriff/Coroner	2	-	1	-

A crucial question is how much medical information can be obtained by custody staff. The Sheriff maintains this is a critical problem and has asked for legal counsel on this issue. The Sheriff's Office has implemented a policy to help inmates who are exposed to traumatizing events

A Vicious Cycle – Incarceration of the Severely Mentally Ill

The 2022-23 Grand Jury examined two deaths in custody at the North Branch Jail. Both inmates had a history of mental illness and drug addiction. At different times, each was found to be incompetent to stand trial (IST).

Responses to Findings

Responding Agency or Elected Official	Agree	Partially Agree	Disagree
SB County Board of Supervisors	1	2	-
SB County Sheriff/Coroner	-	1	-

Responses to Recommendations

Responding Agency or Elected Official	Already Implemented	Will Be Implemented	Requires Further Analysis	Will Not Be Implemented
SB County Board of Supervisors	2	-	-	2
SB County Sheriff/Coroner	2	-	1	-

Santa Barbara County Sheriff's Office is working closely with the Superior Court and the criminal justice agenda to reduce IST orders. The Board of Supervisors states it is mandated to implement the Community Assistance, Recovery and Empowerment (CARE) Court. The Behavioral Wellness Department currently runs an Assisted Outpatient Treatment (AOT) program.

Cybersecurity for School Districts in Santa Barbara County

Santa Barbara County school districts are regularly targeted by cybersecurity threats placing students and teachers directly in harm's way. Serving over 20 public school districts with approximately 70,000 students, the Santa Barbara County public education sector is a highly decentralized entity.

Responses to Findings

Responding Agency or Elected Official	Agree	Partially Agree	Disagree
Santa Barbara County Education Office	-	5	-

Responses to Recommendations

Responding Agency or Elected Official	Already Implemented	Will Be Implemented	Requires Further Analysis	Will Not Be Implemented
Santa Barbara County Education Office	-	-	-	7

The 2022-23 Grand Jury found that Santa Barbara County Schools are at great risk. Cyber threats are targeting our education system, and increased cybersecurity demands add strain to school districts. Cybersecurity programs need resources and prioritization.

Death on Electronic Monitored Release

The 2022-23 Grand Jury investigated the circumstances surrounding the death of a 40-year-old inmate who was participating in the Alternative Sentencing Bureau Electronic Monitored Home Release Program. This program is designed to reduce jail overcrowding by allowing nonviolent offenders to serve their county jail and state prison sentences outside the jail facility.

Responses to Findings

Responding Agency or Elected Official	Agree	Partially Agree	Disagree
SB County Board of Supervisors	1	-	-
SB County Sheriff/Coroner	4	-	-

Responses to Recommendations

Responding Agency or Elected Official	Already Implemented	Will Be Implemented	Requires Further Analysis	Will Not Be Implemented
SB County Board of Supervisors	1	-	-	1
SB County Sheriff/Coroner	1	2	1	-

The 2022-23 Grand Jury found that the Santa Barbara County Sheriff's Office did not monitor whether the decedent had contacted or participated in any addiction programs. The Sheriff's Office has transferred the Electronic Monitored Home program to the County Probation Department.

Lack of Transparency and Due Diligence at the Santa Maria Valley Water Conservation District

The Santa Maria Valley Water Conservation District is charged with operating and maintaining the Twitchell Dam and Reservoir located in northern Santa Barbara County and a small portion in southern San Luis Obispo County. The 2022-23 Grand Jury found the District's transparency lacking in both timeliness and adequacy. The absence of disclosures by the District created a vacuum in the flow of public information.

Responses to Findings

Responding Agency or Elected Official	Agree	Partially Agree	Disagree
Santa Maria Water Conservation District	3	-	-

Responses to Recommendations

Responding Agency or Elected Official	Already Implemented	Will Be Implemented	Requires Further Analysis	Will Not Be Implemented
Santa Maria Water Conservation District	-	3	-	-

The 2022-23 Grand Jury noted that the District needs to operate in full public view, thereby supplying the District's constituents with timely and accurate information. The 2022-23 Grand

Jury also found that the District needs to thoroughly vet the financial capacity and capabilities of potential parties to all contracts.

Santa Maria Valley Water Conservation District – Aspects of Governance

The 2022-23 Grand Jury investigated actions that were alleged to have been occurring at the District over the past five years. The request for investigation alleged: (i) violations of the California Water Code; (ii) inappropriate hiring and personnel evaluation practices; (iii) refusal of one District Director to take required training; (iv) one District Director operating an illegal wood cutting business at Twitchell Reservoir; and, (v) said District Director's personal use of vehicles and equipment owned by the District.

Responses to Findings

Responding Agency or Elected Official	Agree	Partially Agree	Disagree
Santa Maria Water Conservation District	4	-	-

Responses to Recommendations

Responding Agency or Elected Official	Already Implemented	Will Be Implemented	Requires Further Analysis	Will Not Be Implemented
Santa Maria Water Conservation District	1	6	-	-

The 2022-23 Grand Jury found that the District Directors are challenged by the complexities of running a special district. The District needs improvement in its management, training, stewardship of public resources, and overall transparency.

5

GRAND JURY COMPENSATION

CIVIL GRAND JURY COMPENSATION

SUMMARY

The Civil Grand Jury is made up of volunteers who commit to serving for twelve months. The weekly time commitment is conservatively 25-30 hours. In the County of Santa Barbara, compensation for serving as a Grand Juror is paid as a taxable per diem of $25 (plus a nontaxable mileage reimbursement). This per diem has remained unchanged since before 2000.

For Santa Barbara County to remain in compliance with Section 23 of Article 1 of the California Constitution, a grand jury must "be drawn and summoned at least once a year in each county." A diverse pool of applicants is desirable as this would provide for a more representative body of jurors. To ensure the functional success of the jury, taking into consideration the high cost of living in Santa Barbara County, an increase in the per diem for Civil Grand Jurors is pivotal to achieving this goal.

INTRODUCTION

The Santa Barbara Civil Grand Jury (Jury) has faced an increasingly high turnover rate of qualified jurors. As new jurors become aware of the scope of duties and the time commitment needed to perform those duties, some are leaving the Jury before the completion of their term. In 2023, as the most recent example, it was necessary to utilize all ten of the available alternates in order to fulfill the required 19 juror positions. When the count still fell short of the required 19 persons, an appeal was made to former jurors to return and serve another term. Even so, only 18 of 19 available positions have been maintained as of December 2023. Santa Barbara County residents face a high cost of living, especially in housing. The Grand Jury meets during business hours; therefore, many working people will not apply. Additionally, time may be needed to care for family members or fulfill other obligations.

METHODOLOGY

For this inquiry, the Jury has researched public sources, reviewed County budgets, the history of Jury applications, and turnover of Jury rosters, and has considered the following items:

- Compliance with the California Constitution

- A civil monitoring body of high standards and diversity
- The time involved to investigate properly and report to the public
- The cost of living in Santa Barbara (SB) County
- The State's minimum wage
- Fair compensation in line with other California Grand Juries

OBSERVATIONS

Applicant Pool and Turnover of Jurors

Under the California Rules of Court, specifically Rule 10.625, the Court must develop and maintain a database containing information regarding prospective civil grand jurors. The database includes, but is not limited to, the following criteria: name, age range, occupation, gender, race or ethnicity, and the prior year(s) served on the Civil Grand Jury. It should be noted that the SB Superior Court utilizes a random drawing methodology to select both potential Jurors and Alternates. The only exception to this process is for those Jurors who carry over for a second term. The SB County Jury has 19 members and 10 alternates at the beginning of the term.

The Jury requested this information for the last three years from the SB Superior Court office. A summary of the data received is reflected in the following tables:

AGE RANGE OF JUROR APPLICANTS

Year	18-25	26-34	35-44	45-54	55-64	65-74	75+
2023-24			2	9	13	32	14
2022-23					4	13	12
2021*	3	1	2	1	7	19	10
Total	3	1	4	10	24	64	36

*Grand Jury term had a modified calendar due to the COVID-19 pandemic

GENDER OF JUROR APPLICANTS

Year	Male	Female
2023-24	32	38
2022-23	16	13
2021*	26	17
Total	74	68

RACE/ETHNICITY OF JUROR APPLICANTS

Year	American Indian or Alaska Native	Asian	Black or African American	Hispanic or Latino	Native Hawaiian or other Pacific Islander	White	Other Race or Ethnicity	Declined to Answer
2023-24		1	4	3		55	2	5
2022-23				2		25		2
2021*				2		29		12
Total		1	4	7		109	2	19

As indicated by the data received there is a relatively equal mix of males and females. However, there is a predominance of people who identify as "white" and are above the age of 54.

Per the latest complete U.S. Census Bureau information from 2020, (https://data.census.gov/profile/Santa_Barbara_County,_California?g=050XX00US06083) , the disparity between the number of White and Hispanic/Latino applicants versus the demographics of the County is significant. As of 2020, the Hispanic/Latino population of the County was approximately 47% of the total population compared to 5% of applicants. Also, the percentage of people 65 years or older was 16.6% versus 70% of applicants.

The 2023-24 Jury started its term on July 1st with a full contingent of Jurors and Alternates. However, by the end of August, the entire reserve of Alternates had been exhausted and two additional carry-over Jurors from the previous year were asked to rejoin. The Jury was not able to determine in every case why there was significant turnover but can attribute some resignations due to the greater than expected time commitment.

Impact of Inflation

The State of California mandates a minimum per diem for a Grand Jury of $15. SB County currently has a $25 per diem rate requiring a minimum of one hour's work. The Jury was unable to determine when this rate was established in the County, but that rate has been in existence since before the year 2000. The purchasing power of $25 in the year 2000 would require $46** in 2024.

**Source of data:www.usinflationcalculator.com

Rising Costs of Living

As evidenced by the impact of inflation on the cost of living, the SB Board of Supervisors has consistently voted to increase its salary and mileage reimbursement amounts. In 2021, the Board gave itself a 3% raise which, at the time, was the maximum it could implement by law. In 2023, the Board voted to raise the maximum annual increase amount to 5%, which is the most allowed for elected department heads. The County Human Resources (HR) Department tied the salary increases to the Consumer Price Index for the Los Angeles-Long Beach-Anaheim area, which is the most comparable area to SB. The Board also increased the auto allowance for its members to $262 from $220 every two weeks. SB County Jury members currently get mileage reimbursement at $0.67 per mile with no maximum allowance.

Based on the Board's actions and utilizing the Los Angeles-Long Beach-Anaheim area as the most comparable area to SB, the Jury collected the per diem information for the Grand Juries in those counties. The table below reflects what Grand Jurors earn in Santa Barbara, Los Angeles, and Orange Counties.

Grand Jury Per Diem Comparison

County Name	Current Juror Per Diem	Implementation Date
Santa Barbara	$25	Prior to 2000
Orange	$50	2001
Los Angeles	$60***	2007

***It should be noted that, in 2023, Los Angeles County agreed to an increase to $100 pending further analysis. The SB Grand Jury could not determine whether this analysis was initiated or completed.

Comparison to California Minimum Wage

The SB County Superior Court website (https://sbcgj.org/become-a-grand-juror/) states, "Persons selected for the Grand Jury must make a commitment for a full year, and be prepared to serve at least 20 hours a week." Based on the experience of the 2023-24 term's Jurors and those who carried over from the prior term, the 20-hour-a-week threshold is understated and misleading. In a March

2024 Noozhawk article, the Court recognized this and has restated the requirement as "Applicants should be prepared to commit 25-30 hours a week…." While California has steadily increased the minimum hourly wage rate (see below), the SB County Grand Jury per diem rate has remained stagnant.

California Minimum Wage Rate History

Year	2018	2021	2024
Wage Rate/Hour	$6.25	$11.00	$16.00

Grand Jury Workload

The expectations of the Civil Grand Jury include the following:

- Attending weekly plenary meetings and at least three committee meetings. Meetings are typically 1-3 hours in length
- Evaluating and researching all submitted Requests for Investigations, along with corresponding witness interviews
- Researching, reviewing, writing, and working independently
- Reviewing and investigating, as needed, all the deaths in custody that occur during the Grand Jury's term of service
- Completing a series of County facility tours to educate and inform Jury members on how they function
- Performing a series of facility inspections in Santa Barbara County
- Writing formal reports about the results of its investigations including findings and recommendations

Report writing is one of the Grand Jury's most essential and time-consuming duties. It asks Jurors to work independently and as a team. Jurors must also provide a variety of skills to bring an accurate report to successful completion. The jury is required to review, edit, and approve every report. Jurors share information in person, via email, and through video conferencing to prepare

reports for formal approval and publication. This preparation includes discussing all content, grammar/punctuation editing, and gaining consensus on impactful findings and recommendations.

Creating a More Diverse Jury

Available jurors include a broad spectrum of the population, particularly of race, national origin, and gender. While diversity comes in many forms, the historical demographic makeup of SB Grand Juries has not adequately reflected that of its residents. As a community "watchdog," the Jury should better represent a cross-section of the people it represents.

The Jury per diem rate has not been adjusted for inflation. Consequently, only County residents with sufficient savings or additional sources of income other than employment can afford to serve. Jury composition is predominately made up of retirees.

An increase in the per diem rate could enhance the attractiveness of the service and compensate members of the Jury closer to a level commensurate with the time, effort, and value they provide to the community.

Potential Budget Increase Mitigations

The second largest budgeted cost, after per diem, associated with the Grand Jury is mileage reimbursement. Fifty percent (50%) of this year's Jury is comprised of citizens from the North County area. This change in demographics has been an ongoing trend especially as the North County population outgrows that of the South County. The incorporation of online meetings has somewhat mitigated the cost of travel.

Additionally, jurors are encouraged to carpool whenever possible. The value of in-person meetings is significant as the Jury begins its term, during the investigation process, and subsequent report writing. Travel from the Santa Barbara County Courthouse to the court facility in Santa Maria is approximately 150.0 miles round trip. Facility inspections and meetings demand jurors travel within a geographical area ranging from Carpinteria to Cuyama. While this mileage is significant, it is unavoidable and must be compensated.

Because of the confidential nature of the work, all Jury meetings and interviews must be conducted in a closed session. Members of the Jury are sworn to secrecy to ensure that all investigations will be managed in a confidential manner. To ensure this confidentiality, the members of the Jury must meet in a space that affords them the ability to speak without being overheard and display sensitive documents. The Jury Room at 1100 Anacapa St. in Santa Barbara is secure and fully equipped to facilitate jury work. However, there is no comparable space in North County that is available to jury members on a weekly basis. Some commuting costs may be alleviated (150.0 miles round trip) if an adequate space were available to jury members in the North County.

CONCLUSION

The daily compensation (per diem) for members of the Civil Grand Jury of Santa Barbara County is currently set at $25 per day for any day that the Jury member works for at least one hour. Santa Barbara Superior Court has traditionally estimated that Jury members will work a minimum of 20 hours each week. This time frame is supposed to adequately cover the duties of the members of the Grand Jury during their one-year term of service.

The $25 stipend Jury members receive for their hour plus of daily work has not increased in at least 25 years. This report shows clearly how inflation has changed the value of the dollar and both the minimum wage and the cost of living.

This Jury's goal is to expand the number of Jury applicants and balance the demographics of Grand Jury membership to more fairly represent the population of Santa Barbara County. To reach this goal, Santa Barbara County should reconsider increasing the per diem pay in relation to the time commitment expected of the Grand Jury.

Santa Barbara County is required to support a Civil Grand Jury with 19 jurors. When the Jury loses so many members that it exhausts not only the pool of alternates but also must ask former members to return, Santa Barbara County has a problem. The recommended changes this Grand Jury proposes will help Santa Barbara County better reach its goal of maintaining a viable and diverse Civil Grand Jury to better represent the citizens of the County.

FINDINGS AND RECOMMENDATIONS

Finding 1: The Santa Barbara County Grand Jury per diem of $25 has not increased in more than 25 years.

Recommendation 1: The Board of Supervisors should increase the Santa Barbara County Grand Jury per diem to $50, effective January 1, 2025.

Finding 2: The second highest budgeted cost associated with the Grand Jury is mileage reimbursement. Most of this cost is associated with Jury members who commute from North County because dedicated space and equipment are only available in Santa Barbara.

Recommendation 2a: The Board of Supervisors in conjunction with the Superior Court will make available for the sole use of the Grand Jury for a minimum of one day per week a room in Santa Maria with the capacity to support 19 members of the Grand Jury with equivalent communication, printing, photocopy, kitchenette, restroom access, and parking capabilities as is available in the Santa Barbara County Courthouse facility.

Recommendation 2b: The Board of Supervisors in conjunction with the Superior Court will make available for three to four (3-4) days per week a room in Santa Maria with video conferencing capabilities, access to restrooms, adequate parking and the capacity to support up to 10 members of the Grand Jury for ad hoc use.

Requirements for Responses:

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

Elected Official: Santa Barbara County Board of Supervisors – 90 Days

Finding(s): 1, 2

Recommendation(s): 1, 2a, 2b

Responses to Findings shall be either:

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

Responses to Recommendations shall be one of the following:

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

6

SANTA BARBARA COUNTY CORONER

FACILITY AND EQUIPMENT

SANTA BARBARA COUNTY CORONER

FACILITY AND EQUIPMENT

A Hazardous Environment

SUMMARY

The existing, outdated, and deteriorating Coroner facility is a detriment to the profession and poses a significant health risk to the members of the Coroner's Bureau. The Sheriff's Office and General Services Department have been remiss in their oversight and willingness to provide upgrades to this property, even though alerted to the substandard conditions for more than a decade. Major upgrades and repairs are necessary to make this workplace environmentally safe and efficient. A total rebuild of the facility is essential to establish a safe workplace for the Sheriff's Coroner Bureau to avoid what has been a band-aid approach in the past.

INTRODUCTION

Prior Santa Barbara County Grand Jury (Jury) reports in 2013 and 2015 recommended multiple capital improvements. Almost none of the recommendations have been implemented. The 2020 Grand Jury report also highlights several of the ongoing facility and personnel needs of the Coroner Bureau.

The Coroner Bureau facility was constructed in the early 1970s by an inmate labor crew and has had minimal capital upgrades since then. The modular office structure was added at a later date. Other than a negative pressure ventilation system installed in 2016, no other Jury recommendations have been funded or implemented by the Sheriff or Board of Supervisors. Due to the limited space and a single autopsy room, some autopsies are being conducted in open-air conditions when necessary. New equipment is on order (rapid toxicology), but the Jury's inspection of the facility

indicated the building is still in need of significant additional upgrades, modernization, or replacement.

METHODOLOGY

The Jury visited the Santa Barbara (SB) Coroner facility as part of its investigation and reviewed the previous Jury reports submitted over the last decade. The Jury also interviewed representatives from the Medical Examiner offices of Ventura and San Luis Obispo counties (who are familiar with the SB facility), multiple members of the Sheriff/Coroner Bureau of Santa Barbara, and employees of the SB County General Services (GS) organization.

OBSERVATIONS

Coroner Facility

In 2020, the SB Coroner Bureau staff were doing an average of five (5) autopsies per month. In 2023, they were presented with approximately 8-10 deaths per day while conducting an average of 4-5 autopsies per month. All of these have been performed in a substandard physical plant.

The SB Pathology facility is housed in an old building and needs new equipment and other updates. There have been three Grand Jury reports in the last 10 years highlighting the age and substandard status of the facility and its related equipment. The Sheriff's Office has made minimal capital improvements over that time frame, and the ongoing deferred maintenance has now reached a critical level.

The prior Grand Jury reports highlighting the deficiencies with the Coroner Facility are as follows:

2012-13	"SHERIFF-CORONER'S BUREAU: The Manner of Death - A Final Diagnosis"
2014-15	"SANTA BARBARA SHERIFF-CORONER'S BUREAU: Still an Unhealthy Environment"
2019-20	"SANTA BARBARA COUNTY CORONER'S BUREAU: Still a Substandard Facility"

In its response to the 2014-15 Grand Jury report, the Board of Supervisors stated that after the air systems were upgraded, "General Services (GS) will work with the CEO and Sheriff's departments to develop a Capital Improvement Project (CIP) for the refurbishment of an existing facility or the construction of a new facility." The CIP would also address the Coroner's needs, recommend a location, and estimate the construction and ongoing maintenance costs. The Jury found no evidence supporting any follow-through on this.

The Jury conducted a tour and inspection of the Coroner's Facility as part of its investigation. Two buildings comprise the facility. The front building (Bldg. 1) houses the administrative staff, autopsy suite, cold storage facility, and relevant equipment. The rear building (Bldg. 2) houses the detective staff and the pathologist. There is an empty space between the two buildings which is, in effect, the second autopsy suite when needed.

Photo of Second Autopsy Suite

Empty Lot between Bldg. 1 and Bldg. 2

In cases when a severely decomposed body is delivered to the Coroner facility, a temporary, outdoor autopsy site must be set up behind the building to avoid cross-contamination and to manage the emanating odors (see photo above). An enclosed second autopsy suite has been requested by the Coroner's Bureau but has not been approved by the Sheriff or Board of Supervisors.

The Jury was informed the roof of the front building requires replacement; however, only the section above the bathroom was approved for repair after the inspector fell through an existing hole. The hole was repaired, but the job was only partially done and there remains a large opening in the ceiling. Multiple requests to replace the entire roof have been denied. In addition, there is visible evidence of termite damage in the eaves and roof line and probable wood rot.

Photos of Coroner Facility – Building 1

Termite damage and wood rot (Bldg. 1)

View of the bathroom ceiling in Bldg. 1

Another view of the bathroom in Bldg. 1

During the Jury's investigation, it also learned that the detective's office area in the Coroner's building is in deplorable condition. There is visible evidence of water intrusion, possible mold, and significant wood rot.

Photos of Coroner Facility – Building 2

Rotted handrail outside Bldg. 2

Evidence of water intrusion and possible mold in Bldg.2

More evidence of water intrusion and possible mold in Bldg.2

A History of Remission and Deferred Maintenance

The Facilities Maintenance Division of General Services is responsible for the maintenance, both preventative and repairs, of the Coroner Bureau's facility. GS has a significant backlog of deferred maintenance across the County, with an estimated cost of $200 million.

The Jury was provided with the GS deferred project list and discovered records of attempted repairs. There were multiple requests from the Coroner Bureau to repair gutter systems, roof leaks, and mold. Some of these requests were completed and others were denied. The Jury also discovered requests to replace the roof on both the main and modular buildings. The Jury learned this effort is out for bid a second time, but no date has been set for these projects.

While the Coroner Bureau has requested multiple repairs, very few have been completed by the Facilities Maintenance Division (including the rejection of the roof replacement stated above). This Division is directly responsible for the Coroner's facility and is also empowered to correct unsafe conditions. The Division is also aware of the possibility of mold/mildew/water intrusion and the deteriorated handrail outside Building 2. Instead of testing for mold or replacing the handrail, a rain gutter was installed on one side of the building.

GS does not have a Safety Officer or any specific safety inspection schedule. The Jury also learned that no independent safety inspections had been conducted. Even though GS employees are encouraged to look for and report safety concerns, GS is almost totally reliant on other County employees to notify them of issues and concerns.

Coroner's Equipment

The main cold storage located inside the building is the original unit installed 50 years ago and has had air conditioning failures requiring the use of the excess capacity trailer located in the front parking lot. This extra equipment was donated to the Coroner Bureau. The primary storage unit is frequently at capacity which requires constant coordination with various mortuaries and funeral homes to retrieve bodies and manage the available space. Another factor impacting the turnover time for Coroner investigations is the long lead time for toxicology. The Coroner's staff has addressed this complication with the order of new rapid toxicology equipment.

In addition to the existing rapid DNA capability, new rapid toxicology equipment is on order. The costs of sending samples for toxicology tests to an outside facility outweigh the price of the new equipment. The equipment will provide a return on investment (ROI) in approximately one (1) year once it is fully operational. The Jury was informed the Coroner staff conducted a benchmark comparison with Riverside County and has crafted a calibration schedule that requires a minimum of 6 months of parallel tests to ensure accuracy. Once the new equipment is set up and calibrated, it will provide the Coroner staff the ability to obtain results in approximately 17 minutes versus having to send out samples and wait weeks or months to get results.

There is a cold storage unit located outside the building that is used for after-hours deliveries of badly decomposed bodies. Due to the unit being outdoors, it is subjected to the elements and there is evidence of decay on the equipment. The scale utilized to measure the gross weight of incoming bodies was originally installed 50 years ago, is also located outdoors, and can no longer be calibrated with confidence. There is no lifting equipment available for the staff to move excessively large bodies, so that task must be performed manually at the potential cost of physical injury to personnel.

CONCLUSION

The County's Rapid DNA capability has already received state and national recognition. Kudos to the Coroner's Bureau for expanding its technology base by adding a rapid toxicology capability. Once fully calibrated, this new process will significantly improve the ability of the Coroner Bureau to support their customers (families of the deceased and those involved with investigations).

Nonetheless, the outdated and deteriorating Coroner's facility is a hazardous environment and poses a significant health risk to the nine staff members of the Coroner's Bureau. The Sheriff's Office and General Services Department have been remiss in their oversight and willingness to address safety and health issues and provide other upgrades to this property.

FINDINGS AND RECOMMENDATIONS

Finding 1: The buildings that the Coroner Bureau occupies are dangerous to the health and safety of the Coroner Bureau staff; they present an ongoing health hazard to everyone who works there.

Recommendation 1a: The Jury recommends the installation of new roofing, including the replacement of accompanying support beams as needed, by a licensed roofing contractor, and not by handyman employees or janitorial staff from the Sheriff's Office or General Services. Repairs shall be completed by the end of the third quarter of calendar year 2024 or sooner.

Recommendation 1b: The Jury recommends a licensed professional mold abatement contractor be hired to assess whether there is active mold and, as necessary, conduct all required eradication efforts. Repairs shall be completed by the end of the third quarter of calendar year 2024 or sooner.

R**ecommendation 1c:** The Jury recommends a licensed professional exterminator be hired to assess whether there is active termite infestation and, as necessary, tent both structures. Additionally, the exterminator must perform all required sectional work to repair or replace all the termite-damaged areas. Repairs shall be completed by the end of the third quarter of calendar year 2024 or sooner.

Recommendation 1d: The Jury recommends the installation of a state-of-the-art ventilation system in the front autopsy building. This shall be completed by the end of calendar year 2025.

Recommendation 1e: The Jury recommends the entire Coroner's facility shall be demolished and rebuilt. The Sheriff's Office shall request, and the Board of Supervisors shall allocate, funding to implement a design and a timeline to replace this antiquated facility with one that ensures the safety of its employees and visitors by the end of calendar year 2024.

Finding 2: There have been no independent safety or health inspections or audits conducted at the Coroner's facility.

Recommendation 2a: An inspection of the Coroner's facility by OSHA or Cal-OSHA, whoever is available first, shall be requested immediately.

Recommendation 2b: In the event that neither OSHA nor Cal-OSHA are available within 60 days, the SB County Public Health Department shall contract with an independent, accredited entity to conduct an inspection.

Finding 3: It will be beneficial to conduct parallel testing to confirm that the new rapid toxicology equipment on order is calibrated accurately and produces accurate results.

Recommendation 3: The Coroner Bureau shall conduct parallel toxicology testing for a minimum of 6 months based on the success of the model used by the Riverside County Coroner's office.

Finding 4: The Facilities Maintenance Division of General Services does not have a Safety Officer.

Recommendation 4a: General Services shall develop a job description for a General Services Safety Officer and identify or recruit an individual to function as the Safety Officer.

Recommendation 4b: The Safety Officer will conduct annual, at a minimum, safety inspections of the Coroner Bureau's facility.

Recommendation 4c: The Safety Officer shall generate reports of their findings to the Board of Supervisors.

Requirements for Responses:

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

Elected Official: Santa Barbara County Sheriff/Coroner - 60 Days

Finding(s): 1,2, 3

Recommendation(s): 1a, 1b, 1c, 1d, 1e, 2a, 2b, 3

Public Agency: Santa Barbara County Board of Supervisors – 90 Days

Finding(s): 1,2, 4

Recommendation(s): 1a, 1b, 1c, 1d, 1e, 2a, 2b, 4a, 4b, 4c

Responses to Findings shall be either:

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

Responses to Recommendations shall be one of the following:

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

7

DETENTION FACILITIES IN SANTA BARBARA COUNTY

DETENTION FACILITIES IN SANTA BARBARA COUNTY

2023-24 Grand Jury Inspections

SUMMARY

Under California Penal Code Section 919, subdivision (b), the Civil Grand Jury is required to "inquire into the condition and management of the public prisons within the county." The 2023-24 Santa Barbara County Civil Grand Jury visited all the detention facilities in the County. This report contains results of physical inspections of jails and detention facilities within Santa Barbara County which have the capability of detaining individuals who have allegedly violated the law. The Grand Jury also inspected the Coroner's Bureau facility.

The facilities visited are identified below by their respective jurisdictions:

Santa Barbara County Sheriff's Office

- Santa Barbara Sheriff/Coroner's Bureau
- Isla Vista Foot Patrol Substation - **holding cell closed**
- Lompoc Sheriff's Substation
- Lompoc Holding Facility
- New Cuyama Substation/Holding Facility - **new holding facility**
- Santa Barbara Court Holding Facility
- Main Jail
- Northern Branch Jail
- Santa Maria Court Holding Facility
- Santa Maria Substation - **holding cell closed**
- Solvang Substation - **holding cell closed**

Santa Barbara County Probation Department

- Los Prietos Boys Camp - **closed**
- Susan J. Gionfriddo Juvenile Justice Center

Municipal Police Jails and Holding Facilities

- Lompoc Police Department
- Santa Maria Police Department

- Santa Barbara Police Department
- Guadalupe "Secure Bench" - **closed**

METHODOLOGY

The facilities listed above were visited by the 2023-2024 Santa Barbara County Civil Grand Jury (Jury) one or more times. Teams comprised of not fewer than two jurors conducted these inspections. Law enforcement and staff members who were on duty were interviewed. As applicable, inquiries were made with custody staff members relevant to detainee operations, the conditions of the facility, and staff professionalism. A standard checklist was utilized as a guideline while conducting these inspections and interviews.

OBSERVATIONS

The following facility reports are in the same order as listed above:

Santa Barbara Sheriff/Coroner's Bureau

A separate investigation was conducted regarding the Coroner's Bureau facility. That report has been issued and can be found here: Santa Barbara County Coroner Facility and Equipment

Isla Vista Foot Patrol Substation - holding cell closed

Lompoc Sheriff's Substation

The holding cell at this location is a small interview room located just inside the building entrance from the secured parking area. The room is used by deputies to interview subjects who have been detained or to interview subjects who have reported to the substation at the request of law enforcement. A detainee is seldom in the room for more than 30 minutes and is always in the company of a deputy. When a detainee is arrested subsequent to being interviewed, the detainee is either immediately cited and released or transported to the Northern Branch Jail (NBJ) for booking and incarceration.

Lompoc Court Holding Facility

The court holding facility serves a single Superior Court Department with a criminal calendar. The facility is used only two days per week, all day on Wednesday and one-half day on Thursday. Incarcerated persons are transported to the facility by bus from the NBJ arriving between 8:30 and 9:00 a.m. Between 23 and 37 incarcerated persons are processed each day. Incarcerated persons are at the facility no more than seven hours on Wednesday and no more than four hours on Thursday. Incarcerated persons who have completed their court proceedings are returned to jail. No more than 10 incarcerated persons remain at the court at the end of the day. These incarcerated persons are transported back to the NBJ by bus.

The court holding facility is staffed by two or three deputies who accompany incarcerated persons to the facility on the bus. Additionally, an on-site Deputy Sheriff reports directly to the holding cells before incarcerated persons arrive and leaves when the last inmate has left the facility.

The facility has an observation office with multiple cameras recording all activity in the hallways, offices, and cell areas within the facility. The cameras also cover the bus sally port, and all entrances and exits from the facility. The observation office is continually staffed when incarcerated persons are present.

Cuyama Sheriff Substation/Holding Cell - new

The Cuyama Sheriff's Substation/Holding Facility is located in New Cuyama. The population of Cuyama at the time of this inspection is less than 600. The on-site deputies provide law enforcement for the Cuyama Valley, which includes numerous remote farms, schools, businesses, and homes. The substation has two full-time deputies who rotate shifts and receive support when needed from the California Highway Patrol or deputies from Santa Maria. In addition, the Sheriff deputies in residence in Cuyama will assist other law enforcement agencies as well as Fire and Rescue Services. This substation and holding facility share the same building with Santa Barbara County Fire.

The new facility was completed in June 2023. It has a main office with communication equipment, files, and computers. Additionally, there is a separate conference room with teleconferencing

capabilities. The deputies also have a small kitchen area, a shower, and an armory. All areas of the facility appear to be well-kept with plenty of space.

The holding cell, which is adjacent to the main office area, is currently not used for holding suspects because it has not received final state approval. The holding cell door opens into the cell rather than outward. This format is counter to the accepted standards for holding detainees. The interior of the cell includes an approximate 15” wide by 60” long concrete bench and a stainless-steel ensemble of toilet and basin (see photo below). If an arrest is made by the deputies, they either hold the suspect in their patrol vehicle or drive them immediately to the NBJ for booking. No suspects are kept overnight at this substation.

New Cuyama Holding Cell

Santa Barbara Court Holding Facility

The Superior Court Figueroa Building was constructed in 1954 and underwent renovation in 1990 and again in 2006. The Court Holding facility occupies the basement of the Superior Court building. The number of incarcerated persons held during any given weekday is no more than 42. The day the Jury visited, 33 incarcerated persons were or had been in holding cells awaiting their court appearance. No incarcerated persons are ever held there overnight. They are only detained there for their court appearance, and then as soon as possible they are returned to either the Main Jail or NBJ.

The Jury entered the holding location on the driveway to the east side of the Superior Court Figueroa building. The entrance leads into the basement of the building, and the driveway adjacent to the entrance serves as the most direct point of entry and exit for incarcerated persons. The entry structure is a painted metal enclosure (sally port). Even though there is a drainage system in the sally port as well as the corridor, during a severe rainstorm this year the sally port and the corridor were flooded. The drains were subsequently cleaned out.

Along the length of the entry corridor are nine sturdy single person cells that are now only used if there is an overflow of incarcerated persons or if certain incarcerated persons must be held separately from the others. The cells are about 7 feet tall by 32 inches square and are equipped with a very small, attached metal corner seat.

To the left of the single cells, there are holding cells of different sizes, some hold one inmate, some two or three. There are larger cells that hold up to 12 incarcerated persons. At the end of the corridor is the operational center. The hallway continued down a very narrow passageway where there are more holding cells.

The operation/observation center is located at the corner of the two hallways. There is an area outside the center where deputies can sit while they wait to escort incarcerated persons. The center is a cramped room with an alcove where the cell videos are monitored. Files, desks, and counters take up a good deal of the limited space.

Although it serves its purpose, the general condition of the Superior Court holding area is outdated, small, and crowded. Furthermore, the air in the basement was warm and muggy. The staff is, to some extent, inured to the air quality condition although there have been some maintenance repairs to correct the problem. But not enough has been done due to old equipment and outdated structural systems.

There needs to be a major overhaul of the facility, preferably an expansion in every aspect of the operation. Everything needs to be upgraded. But first and foremost, the air circulation must be improved. The State of California has budgeted for a new facility, which is currently earmarked to be initiated in fiscal year 2026-27.

Main Jail

With the opening of the NBJ, there are now only three areas currently in use at the Main Jail. The original section of the Main Jail was opened in 1971; the Northwest Wing was built in 1987-88; the Inmate Reception Center (IRC) was added in 1992. There are three types of populations: general, protected, and restricted.

Prior to the opening of the NBJ, the Main Jail was often cited for overcrowding. Floor sleeping was common. It was rated for 819 incarcerated persons and often the population exceeded that. Now there are half that number of incarcerated persons at the Main Jail. With over 200 incarcerated persons transferred to the NBJ, this has allowed the closure of several wings at the Main Jail.

There are two safety cells in use in the main area. Each safety cell is a cement box lined with impact absorbing material. There is a hole in the floor instead of a toilet, and there is no water available. The safety cells are for those who are actively combative or suicidal. The incarcerated persons inside are checked every 15 minutes. Their stay is normally scheduled for 12 hours maximum. There are also two holding cells for medical or mental health incarcerated persons. These have a concrete bed, toilet, and mirror. The staff makes rounds every 15 minutes and maintains an observation log based on what is seen through the glass window in the door.

The American with Disabilities Act (ADA) dormitory had 17 incarcerated persons on the day of the Jury's inspection. This room is a large space filled with beds and a few tables with benches. There was one wall of opaque glass for natural light. The bathrooms have recently been remodeled to accommodate incarcerated persons with disabilities.

The older group cells in the Main Jail have a compact front space filled with tables and benches, plus a TV. Sleeping bunks occupy a back room.

There are four housing units in the Northwest module. These units previously separated different gang members. They are now used for behavioral health incarcerated persons and inmate workers. A deputy is assigned to each Behavioral Health Unit (BHU).

The BHUs have been remodeled. They are considered step-up units compared to the former restrictive single cell units. These units have cells on two floors and a central day room. Depending on their level of behavior, the number of incarcerated persons allowed in the central dayroom may vary. This area has tables and benches, a rug, couches, a TV, and a phone. Incarcerated persons tend to respond better when in these units with more open space.

Incarcerated persons with behavioral health issues are housed in one unit and are considered incompetent to stand trial (IST). They take a class for jail-based competency to stand trial. Usually these individuals stay for six (6) months to be restored to competency so that they can participate in the court process; this used to take years. Before this program, they were in restrictive housing, which is harsher and less conducive to developing competency. This jail program restored 130 people last year.

The daily per capita cost for an inmate is $344 at the Main Jail and $280 at the NBJ. Based on the design of the NBJ, a lower number of custody officers is required.

The three housing areas of the Main Jail should be staffed by a minimum of 19 custody officers. Because of staff shortages, there are generally 10-14 officers working. They are scheduled for 12-

hour shifts and mandatory overtime is common. The overtime requirement is cited as the major reason custody officers stop working at the Santa Barbara County jails, Main and NBJ.

Because of the high cost of living in Santa Barbara County, most custody officers assigned to the Main Jail live in other parts of the County and even out of the County. Some custody officers who have a long commute use the former Medium Security Facility, on the Main Jail campus, to sleep between shifts. This part of the jail, which once held about 200 incarcerated persons, has been closed and is no longer used.

Cameras throughout the jail are being upgraded. They will offer a wider and clearer view of the residential areas. Monitoring the cameras will be consolidated in one room with two officers for greater efficiency.

Other infrastructure systems can be harder to renovate. The Northwest and the IRC wings have their own heating system; the original Main Jail has an older system that is harder to regulate. The jail's remedy has been to issue sweaters to incarcerated persons.

There are several outside areas. In the general population area, one large outdoor yard can hold up to 25 incarcerated persons at one time. The incarcerated persons must be escorted there, different groups at a time. The Jail is in the process of purchasing more correctional-grade recreation equipment. The other housing units in the Northwest branch have smaller open areas. All the outdoor yards are concrete with meshing over the top.

Besides the TV and the scheduled time in the outside yard, all incarcerated persons are issued an Android tablet to help occupy their time. The incarcerated persons are able to access emails, photos, legal research, music, games, and programs on the tablets.

Santa Barbara City College classes are available. The jail now has a full-time person who works with the community programs. By participating in these programs, the incarcerated persons will earn milestone credits toward release.

There are six Wellpath nurses' offices in the building. While the nursing positions are fully staffed at the moment, it is not always easy to get incarcerated persons to medical appointments because a custody officer must accompany the inmate to the office. This takes an officer away from other duties. Visits from family, friends, and lawyers also demand that a custody officer accompany the inmate to the visitation booths.

The jail is working on additional safety measures for the incarcerated persons. They have begun removing structural elements that could aid suicide attempts. This includes any prominent feature that could be used in hangings. Since a recent suicide by jumping from the second story of a housing unit, there have been discussions for the installation of mesh or some sort of fall protection.

Meals are prepared on site. There is a dietician to assist with special requirements and restrictions. All incarcerated persons are provided basic necessities. There is also a commissary, from which incarcerated persons can get a variety of food items, including coffee. Incarcerated persons can use a type of personal payment system to obtain more items from the commissary. This can be viewed as a reward by the incarcerated persons.

Although there have been modifications to the Main Jail, the future of the facility remains static. When asked if the building can be remodeled, answers from administration and custody staff have stated that for this building there is no current plan or funding to make this happen. In the meantime, staff continue to make any possible improvements.

Northern Branch Jail

The Santa Barbara County Northern Branch Jail (NBJ) is a Type II facility (typically referred to as County Jails) and has a Board of State and Community Corrections (BSCC) rating of 344 beds and an operating capacity of 376 beds. At the time of the inspection, the jail had a population of 300 male and 40 female incarcerated individuals.

The NBJ was opened for occupancy in January of 2022. This well-designed facility is a model for new jail construction. It sits on over 50 acres and includes housing for incarcerated persons, administrative offices, and medical and mental health beds in a specialized and well-equipped unit.

The jail is comprised of interconnected housing pods with small outdoor recreation yards. This correctional facility was designed as a predominantly direct-supervision facility. Custody Deputies supervise incarcerated persons while working within the housing unit twenty-four hours a day. Additionally, centralized electronic monitoring stations are staffed by custody deputies and sheriff's service technicians.

Incarcerated persons may access classrooms for continued education, behavioral counseling, or yoga instruction. There is an on-site warehouse and a central plant for maintenance, including painting and groundskeeping. An outdoor area is also designated for occupational training facilities. There is a fully functioning, professional-style kitchen where volunteer incarcerated persons help prepare meals. A laundry facility, also staffed by volunteer incarcerated persons, cleans jail clothing and bedding.

Medical, dental, and psychological care is administered by Wellpath, a contracted provider. The Jail has an area designated for restrictive housing and two Behavioral Health Units, one serving males and one serving females.

This Jury found the NBJ to be clean, bright, and quiet with a well-maintained physical plant. The staff was professional and engaging to the Jury members and to those who were incarcerated. While the NBJ faces chronic short staffing, the Jury recognizes this as emblematic of the crisis in law enforcement staffing across the nation. It should be noted that the administration at the Northern Branch Jail, in conjunction with the Sheriff's Human Resources Bureau, works diligently to attract qualified custody deputies.

Santa Maria Court Holding Facility

The Santa Maria Court Compound (SMCC) has 12 holding cells. Each cell can accommodate 4-28 incarcerated persons. The facility capacity is 113. The staff is comprised of 50 officers who work 10-hour shifts. The incarcerated persons are held as long as court/trial is in session.

The facility has not exceeded capacity since its last inspection. There have been no suicides, no attempted suicides, no deaths from other causes, nor have there been any escapes since last inspected.

There is no medical team on staff. If there is a medical emergency, American Medical Response (AMR) is called immediately. The staff is well aware of the medical conditions of the incarcerated persons, including any allergies. Cold meals are prepared including special diets and packed by NBJ staff daily. The meals are transported to the compound for the incarcerated persons and refrigerated in the small, clean kitchen area.

The facility is in compliance with the Americans with Disabilities Act. In case of fire or other emergency there is an escape route/plan in place. The control room is located in the middle of the holding cells with multiple cameras present and well-staffed.

Santa Maria Substation- holding cell closed

Solvang Substation – holding cell closed

Los Prietos Boys Camp - closed

Susan J. Gionfriddo Juvenile Justice Center, Santa Maria

The Juvenile Justice Center (JJC) is managed by the Santa Barbara County Probation Department and is the only 24-hour maximum security facility for juvenile offenders in Santa Barbara County. The JJC is adjacent to the Juvenile Court building, making it efficient for the youth to attend court. Juveniles (aka "wards") housed at the JJC include both males and females. They are directed to the facility from the juvenile justice system and may be serving a sentence or awaiting transportation to placement.

The JJC has a total capacity of 120. At the time of the Jury's inspection, the population included 34 males and three (3) females. Of these incarcerated youths, six (6) were considered "high risk." The number of wards has been declining because of changes in California State laws. Fewer youths

are sentenced to incarceration but instead may be part of the home detention program alternatives. These alternatives include but are not limited to electronic monitoring, house arrest, or home supervision.

The JJC offers incarcerated juveniles many services. Juveniles who have not earned a high school diploma must attend classes while in the JJC. College credits can be earned through local junior college courses available in the facility's classroom setting. All juveniles are medically cared for and undergo a Behavioral Wellness Health screening. Substance abuse rehabilitation is offered through the Council on Alcoholism and Drug Abuse (CADA) program. Counseling and support are offered to wards who may have suffered sexual exploitation. All wards are offered coaching through Courage to Change. This is a program designed to help offenders recognize areas that present risk and how to make better choices for long-term success.

The staff administers an effective performance program based on rewards for good behavior. The establishment of the Trust Unit gives wards an opportunity to be housed in a more relaxed environment with more daily choices. Housing in the Trust Unit is dependent upon ongoing good behavior. Both physical and mental health care continue throughout their stay.

The onsite mental health staff consists of licensed professionals provided by Wellpath. These professionals describe their team as cohesive, long-term, and committed to helping the population they serve. A mental health care professional is available Monday through Friday and holidays from 8:00 a.m. to 6:00 p.m. This staff deals in crisis management, ongoing mental health support, and "warm hand-off" care for those who are being released.

Surveillance cameras are placed throughout the JJC, although they do not face the cells. A staff member watches the videos from the central monitoring room.

The outdoor exercise facilities are available and are being developed. At the time of the Grand Jury visit the large open yard was being updated.

There are limited recidivism statistics due to the confidential nature of juvenile files and information. Evidence of the effectiveness of the JJC in reducing recidivism is lacking because juvenile records are sealed after the probation period terminates.

One area of concern for the Jury was food services. The current contract with a food catering service seems to be universally disliked by all the residents. It not only provides less food than adolescents need and want but also the food is sometimes found to be unpalatable to adolescent tastebuds. Staff reports that it is difficult to find companies willing to bid on the food contracts because of the 7 days a week / 52 weeks a year meal requirement the facility must meet. There are no commercial kitchen facilities available in the building, so in-house preparation is not an option.

Overall, the Grand Jury found the JJC clean and well-maintained. Those currently in charge of the facility work to not only meet but surpass California state operational requirements. The staff was extremely courteous and professional and demonstrated a high level of dedication toward the juveniles.

Lompoc Police Department

The facility has seven cells in total. Three general population male cells hold four incarcerated persons each for a total of 12; one general population female cell holds four, one protective custody cell can hold three (but usually is limited to one), one male sobering cell holds four, and one female sobering cell holds four. There are seven total cells with a maximum capacity of 27. It is staffed by the Jail Supervisor and three sworn jail employees. The control center, which has cameras covering the entire facility, is staffed whenever incarcerated persons are present. The Jury felt that the facility was old but adequate, well-maintained, and staffed appropriately.

Santa Maria Police Department

The facility is utilized for the initial processing of detainees and interviewing prior to the subject being cited and released or transported to the NBJ. Subjects are under the supervision of a Police Officer at all times. A video observation office observes and records activity in the area at all times. Ordinarily, subjects are in the facility for no more than thirty minutes.

Santa Barbara Police Department Holding Cell

The Santa Barbara Police has two holding cells in its facility. The cells appear to be in good condition, and the area adjacent to the cells is organized and clean. Directly across the hall from the holding cell room is an interrogation room.

No one is ever left in the cells overnight. Most arrestees are taken directly to the Main Jail for immediate booking. The only exception for holding an arrestee at the Santa Barbara Police Department would be when a capital crime has occurred that would necessitate immediate interrogations requiring the arrested individual to remain at the Police Department for an extended period.

The Police Department building on East Figueroa constructed in 1959 is outdated and in need of many infrastructure upgrades. In 2022, the decision was finalized to build a new Police Department Structure at the corner of Cota and Santa Barbara Streets. The new three-story, 65,000 square-foot headquarters with 236 parking spaces is estimated to cost approximately $95 million and is projected to be completed in 2026.

A rendering of the proposed new Santa Barbara police station at the corner of Santa Barbara and Cota streets downtown. (Courtesy Rendering / Cearnal Collective)

Guadalupe Police Department "Secured Bench"

The Secured Bench is no longer being used. Both adults and juveniles are now held at the Guadalupe Police Department for 45 minutes or less. The adults are cited and released or transferred to NBJ. The juveniles are cited and then immediately released to their parents.

CONCLUSION

The 2023-2024 Santa Barbara County Grand Jury would like to express its appreciation to the law enforcement officers and support personnel who helped facilitate the inspections. The jail and holding facilities within Santa Barbara County are staffed by professional and dedicated personnel. The findings and recommendations mostly stem from a lack of funding to upgrade outdated or poorly constructed buildings.

The Northern Branch Jail has been operating since 2022. This jail has allowed several holding facilities in Santa Barbara County to no longer be used.

FINDINGS AND RECOMMENDATIONS

Finding 1: The new Cuyama Sheriff's Substation / Holding Facility cell is unable to get certified due to an incorrect installation of the cell door.

Recommendation 1: The Sheriff's Office should request the repair of the cell door so it will meet the certification standard.

Finding 2: The Santa Barbara Superior Court Figueroa Building holding facility's metal cells in the entrance hallway are used only when overflow conditions require it.

Recommendation 2: The Sheriff's Office should remove the metal cells.

Finding 3: The Santa Barbara Superior Court Figueroa Building holding facility's air quality in the basement facility is poor.

Recommendation 3: The Sheriff's Office should request a complete overhaul of the air circulation system in the basement facility.

Elected Official: Santa Barbara County Sheriff - 60 Days

Findings: 1, 2, 3

Recommendations: 1, 2, 3

Requirements for Responses:

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

Responses to Findings shall be either:

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

Responses to Recommendations shall be one of the following:

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

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SANTA BARBARA COUNTY GRAND JURY COMMITMENT REPORT

2023-24 SANTA BARBARA COUNTY GRAND JURY
COMMITMENT REPORT

INTRODUCTION

Pursuant to the Penal Code, the Santa Barbara County Civil Grand Jury is empaneled annually to investigate city and county government organizations, special districts, and other agencies within the County. Findings and recommendations developed from these investigations are contained in the reports approved by the Civil Grand Jury and the Santa Barbara County Superior Court Presiding Judge.

The 2023-2024 Grand Jury reviewed seven (7) reports from the 2022-2023 Grand Jury. Recipient entities are to respond to the reports within certain time constraints and in accordance with specific formats pursuant to sections 933 and 933.05 of the California Penal Code. The responses to the recommendations must include one of the following legally permitted options:

- The recommendation has been implemented with a summary regarding the implemented action
- The recommendation has not been implemented but will be implemented in the future with a time frame for implementation
- The recommendation requires further analysis with an explanation, parameters of an analysis or study, and a time frame (which shall not exceed 6 months from the date of report publication)
- The recommendation will not be implemented because it is not warranted or not reasonable with an explanation thereof

The Grand Jury believes it is important for future Grand Juries to continue to review these responses and to be vigilant in seeing that recommendations are implemented. Special attention should be paid to those responses providing implementation within specified time frames. In this manner, the commitment and hard work of past and future Grand Juries will result in positive changes for the citizens of Santa Barbara County.

The Responses to the 2022-2023 Grand Jury reports are posted on the Grand Jury Website in their entirety and can be viewed at:

https://sbcgj.org/general-information/final-reports-responses-2022/

COMMITMENT REVIEW

Report title: A Death in Custody – Lessons Learned

The Santa Barbara County Sheriff responded to the Grand Jury that three (3) recommendations associated with this report required further analysis and one (1) recommendation would be implemented by January 2024.

The Jury found that, after further analysis, the Sheriff's Office will be partially implementing one of the Grand Jury's recommendations and will not be implementing the other three.

The entirety of the Sheriff's response can be found at the following link:

Santa Barbara County Sheriff's Office response

Report title: Every Death In Custody Is A Failure

The Santa Barbara County Sheriff responded to the Grand Jury that one (1) recommendation associated with this report required further analysis.

The Jury found that, after further analysis, the Sheriff's Office will not be implementing the recommendation of the Grand Jury.

The entirety of the Sheriff's response can be found at the following link:

Santa Barbara County Sheriff's Office response

Report title: A Vicious Cycle – Incarceration of the Severely Mentally Ill

The Santa Barbara County Sheriff responded to the Grand Jury that one (1) recommendation associated with this report required further analysis.

The Jury found that, after further analysis, the Sheriff's Office has partially implemented the recommendation of the Grand Jury.

The entirety of the Sheriff's response can be found at the following link:

Santa Barbara County Sheriff's Office response

Report title: Death on Electronic Monitored Release

The Santa Barbara County Sheriff responded to the Grand Jury that three (3) recommendations associated with this report would be implemented pending negotiations with Wellpath and a subsequent implementation plan. This initial negotiation activity was to be completed by January 9, 2024.

The Jury found that the Sheriff's Office has implemented two of the Grand Jury's recommendations and, after further analysis, will not be implementing the third recommendation.

The entirety of the Sheriff's response can be found at the following link:

Santa Barbara County Sheriff's Office response

Report title: Lack of Transparency and Due Diligence at the Santa Maria Valley Water Conservation District

The Santa Maria Valley Water Conservation District (District) responded to the Grand Jury that three (3) recommendations associated with this report would be implemented. There was not a timeline provided for two of them, and the third was scheduled to be completed by the end of December 2023.

The Jury found that the District has implemented all three (3) of the recommendations.

The entirety of the District's response can be found at the following link:

Santa Maria Valley Water Conservation District Response

Report title: Santa Maria Valley Water Conservation District – Aspects of Governance

The Santa Maria Valley Water Conservation District responded to the Grand Jury that five (5) recommendations associated with this report would be implemented. Three recommendations would be implemented by the end of December 2024, and the remaining two did not have a specified timeline.

The Jury found that the District has either implemented the recommendations or is actively in the process of implementing them.

The entirety of the District's response can be found at the following link:

Santa Maria Valley Water Conservation District Response

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Individuals in Crisis: The Right Care at the Right Time

INDIVIDUALS IN CRISIS

The Right Care at the Right Time

SUMMARY

The 2023-24 Santa Barbara County Grand Jury determined that there have been several previous attempts to improve the Co-Response Team effort with Behavioral Wellness, local police departments, and the Sheriff's Office regarding mental health crises throughout the county. Law enforcement officers have and will continue to benefit from enhanced training in assessing individuals with mental issues, especially in determining appropriate use of the Welfare Institutions Code 5150 involuntary holds. Furthermore, if the County would clarify the guidelines under which peace officers are expected to initiate 5150 holds, currently under the sole authority of Behavioral Wellness, it would enable them to promptly and effectively use probable cause for involuntary detention of individuals with mental disorders. As a result, these individuals would be better served, and the community would be safer.

BACKGROUND

The California State Welfare and Institutions Code (WIC), Division 5, Mental Health Services, Article 1 is commonly referred to as "5150 holds," also known as the Lanterman-Petris-Short Act (LPS Act). Specifically, a 5150 hold describes criteria for detention of mentally disordered individuals, defined as "a danger to others, or to themselves, or gravely disabled." This Code further specifies that "qualified peace officers or designated mental health experts can, upon probable cause, take, or cause to be taken, a person into custody for a period of up to 72-hours for evaluation and crisis intervention or be placed into a treatment facility designated by the County."

Despite having full legal authority to issue 5150 holds, Santa Barbara County (County) law enforcement agencies have been constrained by an obscure historical limitation. This indirect or implied limitation originated in July of 1978 following passage of State Proposition 13, a property tax limitation initiative. As a result of budgetary restraints caused by the passage of Proposition 13, the Santa Barbara County General Hospital was shuttered. This event prompted the County to formally request that Mental Health Services, the precursor to Behavioral Wellness, assess individuals with mental disorders, determine their status and, when necessary, issue a 5150 hold. Consolidating and streamlining services, lessening the burden on law enforcement, and controlling costs were the reasons behind this decision.

Several years later the County contracted with a private mental health care provider (Baldridge) to assume a similar role. This arrangement continued for eight years. In 1989, the County began utilizing Mobile Life Support, a paramedic provider. Similar reasoning encouraged the County's use of their service, which included cost containment, preserving good relationships with the private hospitals, shorter processing times for the patient and family, and avoiding overuse of State Hospital beds if the local Psychiatric Health Facility (PHF, often referred to as the "Puff") was full. In the early 2000s County Behavioral Wellness (BWell) assumed the lead role in dealing with the complex issues surrounding mental health related requests.

This timeline demonstrates that over the past 46 years there has been an inferred but unwritten agreement between County, law enforcement, and various mental health agencies to allow the current mental health agency (BWell) to assume sole responsibility and authority to issue 5150 involuntary holds.

Santa Barbara is the only California county where law enforcement officers do not initiate WIC 5150 holds.

METHODOLOGY

The 2023-2024 Santa Barbara County Grand Jury (Jury) conducted ten interviews including:

- Sheriff's Office staff
- Santa Barbara Police Department
- Lompoc Police Department
- Santa Maria Police Department
- Public Defender's Office staff
- Behavior Wellness staff
- Board of Supervisors staff
- County Executive Office staff

OBSERVATIONS

Behavioral Wellness

BWell has mobile crisis teams which are trained, designated, and empowered to issue the 5150 holds in Santa Barbara County. In most instances BWell endeavors to rapidly respond, de-escalate and stabilize individuals with mental disorders that pose serious risks. Their intervention often reduces the danger to the person and the community, avoids unnecessary emergency department care, and lessens or circumvents law enforcement involvement. In many responses, the individual of concern is stabilized on site, sometimes agreeing to a voluntary admission into a mental health facility, and therefore no involuntary hold is required.

Beginning January 2024, BWell no longer relies exclusively on a phone assessment in requests for their mobile crisis response services. Staff must respond in person within 60 minutes. The usual response time is now 20-40 minutes.

BWell is currently faced with a shortage of qualified personnel to fully staff their mobile crisis services and the Co-Response Teams, which often leads to delays in attending each mental health related request 24/7/365. Weekends and nights are of particular concern especially when absences occur due to staff vacations and sick leaves.

In the fiscal year 2022-2023 there were 425 involuntary 5150 holds written by BWell in Santa Barbara County.

Police Departments

There are eight incorporated cities within Santa Barbara County. Santa Barbara, Santa Maria, and Lompoc have independent police departments; the others contract with the Santa Barbara County Sheriff's Office for law enforcement. Santa Barbara and Santa Maria City Police Departments and the Sheriff's Office have Co-Response Teams.

The LPS Act allows for a law enforcement officer to respond to an undetermined 911 call to determine whether to issue a 5150 involuntary hold. The Co-Response Team model includes a qualified BWell clinician responding with law enforcement when dispatched to a suspected or clearly defined mental health crisis. In times of urgency, if a BWell clinician is not available, peace officers should not hesitate to issue a 5150. Law enforcement officers are often the first on the scene for most, if not all, crisis concerns reported to 911. Data suggests that 7-10% of law enforcement calls are in response to individuals displaying moderate to severe mental illness behaviors.

All California police academies have a 40-hour course in Crisis Intervention Training (CIT) which is included in their basic Police Officer Standards and Training curriculum. Furthermore, the Sheriff's Office currently has a clinician who instructs law enforcement officers in CIT and the proper procedures for 5150 issuances. This is in direct response to the need for some officers to receive supplemental training to ensure competency when responding to individuals in mental health crises. The Santa Barbara County Sheriff's Office launched a pilot program allowing its officers, under highly specific circumstances, to issue 5150 holds. In 2023 only one such 5150 hold had been issued. This low number has been cited to rebut widespread concerns among emergency department doctors and mental health care administrators that their facilities would be overrun by enabling law enforcement to issue 5150 holds.

The intent has never been to issue more 5150 holds, but rather to have law enforcement officers fully trained to evaluate, stabilize or refer mentally ill persons to a Crisis Stabilization Unit (CSU), PHF, emergency department, or available alternative and social services. This change would help guarantee future protection of individual civil rights and assist in providing the right treatment at the right time to those in need. The County Sheriff deputies, along with the Santa Barbara and Santa Maria City police officers, participated in CIT training and were authorized to make 5150 holds. It was stated to the Jury that the Sheriff's Office has issued only two 5150 referrals through February 2024.

Holding Facility Capacity

A critical concern in the discussion of which agency or department is authorized to issue 5150s focuses on the number of available beds in the PHF run by BWell. Under federal and state medical guidelines, to be eligible for Medi-Cal and Medicare reimbursements, the County is permitted one PHF with a 16-bed maximum. There are preliminary plans, based on updated State allowances, for the PHF to be expanded to 19 beds by 2026. It has been estimated that for Santa Barbara County's population the number of beds should be closer to 40, and even that number is considered a low estimate when compared to the guidelines established by the State.

The 16-bed limitation often begs the following question: Who is the gatekeeper for patients that require the services provided in the 72-hour hold in the PHF? The answer to this question is subject to some dispute. Community-based mental health advocates and social watchdog groups

state that simply claiming a lack of available beds does not properly address the urgent needs of those in their time of crisis. Mentally distraught patients who are a danger to themselves or others are entitled to the same medical services as for any other emergency. When the local PHF is at capacity, new patients who require an involuntary detention can be sent to an out of county psychiatric facility.

The experience at the Marian Medical Center's Crisis Stabilization Unit (CSU) in Santa Maria, opened in 2022, has demonstrated that 70% of the admitted patients stabilize within the 24-hour timeframe. By receiving de-escalation, social services, and medications, patients are often released to family members, caregivers, or into the general population. An added benefit is that the CSU diverts these patients from entering the emergency department, which can be overburdened, sometimes chaotic, and therefore not an altogether safe environment for someone with serious mental issues. In July of 2024, a Crisis Stabilization Unit is slated to open in Santa Barbara with an eight-bed locked facility admitting patients for detentions of up to 24-hours.

Santa Barbara Cottage Hospital has a locked psychiatric ward. The Emergency Department Physician can place an individual on a California Health and Safety Code 1799.111 hold to detain the person for 24 hours until a designated professional is able to evaluate the patient for a 5150 hold. All patients presented to the Emergency Department (ED) for psychiatric assessment will be registered as an ED patient and seen per ED protocol. Because Cottage Hospital is not an LPS Act designated holding facility, efforts to secure placement for each patient placed on a 5150 hold will begin immediately upon admission.

CONCLUSION

Previously unresolved barriers are slowly being recognized and lessened, thereby advancing the methodical process of training and empowering County and City law enforcement to issue 5150 involuntary detentions.

Full implementation of the LPS Act-5150 hold, with complete cooperation of the Santa Barbara County Sheriff, independent City Police Departments, and Behavioral Wellness will hopefully prevent negative outcomes of persons acting in an endangering manner, threatening harm to themselves or others.

FINDINGS AND RECOMMENDATIONS

Finding 1: The Jury finds that increased implementation of the 5150 holds by trained law enforcement officers and more Behavioral Wellness clinicians would benefit all citizens of Santa Barbara County.

Recommendation 1a: The Jury recommends that the Board of Supervisors direct Behavioral Wellness to increase the number of clinicians available for Co-Response Teams.

Recommendation 1b: The Jury recommends that all County and City law enforcement officers who are trained in crisis intervention, in accordance with State guidelines, be encouraged to fully exercise the issuance of 5150 holds in appropriate circumstances.

REQUEST FOR RESPONSE

Santa Barbara County Board of Supervisors – 90 days

Finding 1

Recommendation 1a

City of Santa Barbara – 90 days

Finding 1

Recommendation 1b

City of Santa Maria – 90 days

Finding 1

Recommendation 1b

City of Lompoc – 90 days

Finding 1

Recommendation 1b

Santa Barbara County Sheriff's Office – 60 days

Finding 1

Recommendation 1b

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

Responses to Findings shall be either:

- Agree
- Disagree wholly
- Disagree with partial explanation

Response to Recommendations shall be one of the following:

- Has been implemented, with brief summary of implementation actions taken
- Will be implemented, with implementation schedule
- Requires further analysis, with analysis completion date of no more than six months after the issuance of the report
- Will not be implemented, with an explanation of why

10

Homeless Encampments in Santa Barbara County:

Becoming Part of the Community Again

HOMELESS ENCAMPMENTS IN SANTA BARBARA COUNTY

Becoming Part of the Community Again

SUMMARY

In 2021 the Santa Barbara County Board of Supervisors approved the Homeless Encampment Resolution Strategy, a three-year plan to transition persons from encampments to housing. The 2023-24 Santa Barbara County Grand Jury studied the issues surrounding encampments and the progress made as the Strategy approaches the end of its first phase in mid-2024.

The Jury found that the Encampment Resolution Strategy energized several departments and agencies to address homelessness in new ways, generating collaboration among them, which has led to positive and helpful contact with unhoused people in the encampments. Many placements in housing were made and encampments were "resolved," or removed. Yet, many encampments continue to have negative impacts on neighborhoods. Heightened health, safety, mental health issues, substance abuse, along with environmental harm, remain concerns for everyone. Our local agencies are still handicapped by lack of affordable housing availability, impeding movement from encampments. Local economic challenges detract from the success of the Encampment Resolution Strategy, as more people are becoming unhoused than those being housed.

These multiple social problems would require unparalleled resources were it not for the enhanced collaboration among government and community agencies fostered by the Homeless Encampment Resolution Strategy. Ideally, the next phase of the Strategy will find more ways to ensure that collaboration is thoroughly planned, enacted, and funded.

Commendation

Stereotyping individuals without housing by labeling them as “the homeless” or “the mentally ill” can lead to misconceptions about unhoused persons as somehow different. The Grand Jury commends our community leaders, service agencies, and news media for using appropriate language when referring to our unhoused citizens. This fosters greater compassion and empathy, empowering society to better address the needs of those without housing.

BACKGROUND

Homelessness used to be dealt with by getting the person back to their family. Then local communities and their respective churches made efforts to feed, house, and care for them. America's early exposure to this phenomenon occurred after the Civil War. Wounded or shell-shocked veterans (today known as Post Traumatic Stress Disorder) were put on trains headed to their last known hometown. A note was pinned on their jackets with the shorthand version of "Homeward Bound," or the "hobo." Many of them never made it home. Santa Barbara was known for its encampment of people labeled as hobos on the famed Child’s Estate.

Since 2005 Santa Barbara County has actively sought long-term solutions to homelessness. Its first attempt to bring together partners to address chronic homeless issues resulted in a 10-year plan, *Bringing Our Community Together*, in 2006. Lack of sustainable funding impeded the plan’s progress.

The County revived its effort to tackle homelessness after the U.S. Department of Housing and Urban Development (HUD) in December 2015 required communities to create regional planning bodies in order to receive federal funding and develop a database to match unhoused individuals with services. The County responded with a Community Action Plan to Address Homelessness Phase I, which began in 2019, and Phase II, which started in 2021. The County Community Services Department began to create networks of agencies and data banks of individuals needing housing and services. A Continuum of Care (CoC) was established to create partnerships among

local government bodies and community agencies. It funneled federal and state monies to its member agencies.

The five overarching goals of the two Community Action Plans were:

- Increase access to safe, affordable housing
- Deliver supportive services for individual needs
- Build a database and improve data sharing
- Strengthen available support systems
- Build provider capacity to address the needs of specific populations

Although access to housing did not guarantee housing itself, just over 1,100 individuals were placed in housing, both transitional and permanent, during 2019 – 2021.

During the continued drought in 2019-21, numerous fires around homeless encampments in the Santa Barbara area placed scrutiny on those sites. These fires alarmed residents who feared the fires would spread beyond the encampments. In May 2021 the City of Santa Barbara declared a State of Emergency in fire-prone areas. These fires also prompted the County to focus its attention on homeless encampments, devising an Encampment Resolution Strategy (Strategy), which the Board of Supervisors adopted on August 31, 2021.

An encampment has been defined as any location where one person or more stays unsheltered every night in areas not meant for human habitation. Often included in the definition of a homeless encampment is that a person has more personal property than can be carried in one trip and is stored at the site. The County estimates at the beginning of 2024, about 750 people live in encampments.

Part of the 2021 funding for the Strategy went to new mapping software that pinpoints encampment locations. Each encampment site is counted rather than just the larger clusters. By August 2022, there were 961 encampments mapped in the County, making this problem more conspicuous. At the time that this report was written, 721 sites are identified on the encampment map, with an estimate of more than a thousand total. There are potentially many more because some encampments can be difficult to locate or reach, even by mapping drones.

Also in 2021, the State made emergency funding available to resolve encampment issues, especially along waterways and traffic corridors. The major hubs for encampments in Santa Barbara County were the Lompoc riverbed, the Santa Maria riverbed, and creeks throughout South Santa Barbara County.

In contrast to the Community Action Plans, the goals of the Strategy emphasized the safety and cleanliness of streets and open spaces, medical and behavioral health, service needs, and information sharing. For this, the Strategy promoted person-to-person connection. Outreach to unsheltered individuals was the primary directive. In its proposal to the Board of Supervisors, the Community Services Department noted:

> A key best practice in encampment response is *consistent* outreach and engagement that includes individual case management and housing navigation…. Successful street outreach requires collaboration among multiple stakeholders and strong coordination among teams. Approaches by teams should: permit ample time for engagement and rapport-building; allow for individualized case management; be client-centered, trauma-informed, and voluntary; be paired with availability of housing resources; and be transparent and consistent at every point of contact.

While the natural environment is not part of the County's homeless plan – nor a beneficiary of state grants – the Strategy directs attention to the unsafe conditions presented by encampments: the "risk of fire, impacts on public recreation areas and the environment, safety of the greater community and visitors, and concern for the health and safety of those experiencing homelessness."

An Encampment Response Coordinator was hired in 2021 to convene focus groups, including persons who had experienced homelessness, and forge a Response Team from many sources. The Encampment Response Team includes almost every department in the County and some outside

agencies: Community Services, Public Health and Environmental Health, Public Works, General Services, Code Enforcement, Parks, the Agricultural Commissioner, Behavioral Wellness, Social Services, as well as the Public Defender's Office. Notably, the Strategy team members participate with the County Fire Department, the Sheriff's Office, as well as many non-profit organizations in the efforts to resolve encampments.

The inclusiveness of the Encampment Response Team helps in approaching the totality of the homeless encampment dilemma.

Navigating Legal Issues of the Unhoused

Historically, interaction between the unhoused population and law enforcement has included writing citations for loitering, vagrancy, panhandling, or disturbance of the peace. Occasionally, the unhoused would be asked to remove themselves from public property, which might escalate to an arrest, resulting in jail time and fines.

As the unhoused population grew, keeping unhoused individuals incarcerated became an unsustainable solution. Jails became overcrowded, and the unhoused, once released with nowhere to shelter safely or resources for change, drifted back into the community, cycling back into custody. A recent survey of the Santa Barbara County jail population showed that 242 of the 767 (32%) incarcerated people were inmates without homes.

McKinney–Vento Homeless Assistance Act

The McKinney–Vento Homeless Assistance Act of 1987 provided states with funding for homeless shelter programs. This first step, though ambitious, did not address the diversity of the needs for services from basic housing to medical/mental health services among the unhoused population. Shelters were built but soon became overcrowded. Many unhoused remained without shelter, with communities' only resource to address this problem too often leading to incarceration without consideration of the civil and human rights of the unhoused.

Martin v. Boise

In 2009, six unhoused people sued the city of Boise, Idaho, stating that incarcerating the unhoused violated their constitutional rights when the city had nowhere else to house them. The group won

the lawsuit, which wound its way through the appeals courts, with a final upholding decision by the U.S. Court of Appeals for the Ninth Circuit in 2019 (*Martin v. City of Boise*, 920 F.3d 584 (9th Cir. 2019). The Ninth Circuit ruled that criminalizing a person for sleeping in public when no sleeping space is available in a shelter is prohibited by the Eighth Amendment's Cruel and Unusual Punishment Clause.

Johnson v. City of Grants Pass

A similar lawsuit originating from Grants Pass Oregon, included statements that the anti-camping ordinance exclude items needed for keeping safe and warm such as blankets, tents, pillows, sleeping bags, backpacks by those unhoused who must sleep in public places when no acceptable alternative forms of shelters are available. The U.S. Court of Appeals for the Ninth Circuit upheld the lawsuit reiterating that not allowing such items by the unhoused is a violation of the Eighth Amendment as cited in the *Martin v Boise* case in 2022.These Court rulings stated that cities' anti-camping ordinances cannot be enforced if cities do not have sufficient shelter beds available for their unhoused population. However, the rulings reiterated that a city or jurisdiction could enforce other types of restrictions of camping on public property specific to its community. This ruling applies to all nine western states over which the US Court of Appeals for the Ninth Circuit has jurisdiction, including California, Nevada, Idaho, Oregon, Alaska, Arizona, Hawaii, Montana, and Washington.

This ruling allows local jurisdictions to decide what to enforce or restrict in terms of where, when, and how the unhoused can camp. In the past year, there have been several challenges to the 9th Circuit Court's rulings of 2019 and 2023. Though pending review by the Ninth Circuit, the most recent filing of the *City of Grants Pass, Oregon v Gloria Johnson, et al*, was heard by the United States Supreme Court on April 22, 2024.The issue once again is whether state, county, and city anti-camping ordinances violate an individual's Eighth Amendment rights. As of the writing of this report, the Supreme Court is set to rule sometime in June 2024.

The Ninth Circuit Court of Appeals' decisions notwithstanding, cities across the country have put in place ordinances/laws to "curtail" the unhoused population and skirt around the ruling. Most are considered nuisance laws:

- Panhandling (Multiple Cities). It is a crime or a citable offense if visibly panhandling on streets, in front of businesses, and by on/off ramps.
- Camping Ban (Solvang). Bans can be loosely interpreted as prohibiting camping in parks and requiring the removal of tents, sleeping bags, and personal property from encampments. In November 2023, Solvang passed an ordinance defining the time and location where the unhoused can set up encampments or park their vehicles. Encampments or parked vehicles can only occur on city-owned property for 24 hours. After the 24 hours, they must be moved.
- Sit/Lie Ban (Santa Barbara). Individuals cannot sit or lie on the streets directly or on their backpack on the streets from 7 a.m. to 11 p.m. Recently, a federal judge ruled the sit/lie ban for State and Milpas streets was constitutionally insupportable. The ordinance did not distinguish sit/lie from those eating outside, sitting for a parade or other street event, or just resting for a period of time. This ruling, at the time of this report, is being reviewed for further discussion or action.
- Food Sharing Limits (Multiple Cities). It is a violation if either an unhoused person shares food or an individual attempts to provide or share food with a person without housing.
- RV Ban (Goleta). One cannot park between set hours in designated areas, which may result in fines, citations, or loss of the RV for non-compliance. The City of Goleta imposed a code for large vehicles in early 2024. It states that no person(s) may park or leave any large vehicle on any residential or commercial areas between the hours of 7:30 a.m. and 4:00 p.m. Goleta does offer safe overnight parking areas that can be accessed after applying for a permit.
- Bench Removal (Multiple Cities). Benches in public parks have been removed to discourage congregation, vagrancy, sleeping, or panhandling.

These ordinances and more have appeared in the cities of Santa Barbara County. Some have since been retracted.

Other laws are often used against unhoused individuals, such as those involving public intoxication, trespassing, public urination/defecation, disruptive behavior, aggressive panhandling,

blocking sidewalks, and littering. Ordinances against camping in public parks have been passed locally. City governments in Santa Barbara County have enlarged the scope of code enforcement for cases such as these, notifying police departments where codes are being broken. Law enforcement officers informed the Jury that citations are complaint driven mostly by private citizens or businesses. Homeless advocates say citations or arrests in these cases are harassment and that law officers treat everyone as criminals. Civic leaders, as well as law enforcement officers, are caught between the two points of view.

METHODOLOGY

The 2023-24 Santa Barbara County Grand Jury (Jury) encompassed a variety of resources in researching encampment issues. Jury members reviewed County documents, watched Board of Supervisors meetings, and read numerous news articles on local encampments and research papers on the effects of homelessness.

Committee members interviewed 22 individuals representing:

- Santa Barbara County Community Services Department
- Santa Barbara County Department of Behavioral Wellness
- Santa Barbara County Public Defender's Office
- Santa Barbara County Supervisors
- The Santa Barbara County Fire Department
- The Continuum of Care, Santa Barbara County
- Mayors of Cities in Santa Barbara County
- Homeless Services Coordinators and Shelter Managers
- Local non-profit organizations with outreach workers
- Municipal Police Chiefs in Santa Barbara County

• Santa Barbara Sheriff's Office

• Goleta Neighborhood Services Division

Committee members toured encampments in the Santa Maria area, accompanied by members of the Santa Maria Police Department and Rangers from the Parks and Recreation Department. The committee also interviewed a former resident of encampments.


Santa Maria Riverbed encampments

DISCUSSION

Homeless programs have always incorporated various agencies. The unhoused represent a microcosm of economic and social shortcomings, which they likely suffer from more than other segments of the population. The Community Services Department, in devising the Encampment Resolution Strategy, created working partnerships with many County and city departments and non-profit organizations to provide services more directly and effectively. This report will briefly analyze each area and its challenges and successes.

Public Safety

Fire Department

In the time span of 2020 – 2023, the Santa Barbara County Fire Department responded to 1392 fires, of which 113 (8%) were identified as transient-related. Separately, in 2023, transient-related fires accounted for 18 (5.5%) of the 329 total county fire responses. The figures for 2024 are not yet available.

In this time frame, five encampments were destroyed by fire, and two were abandoned due to significant fire hazards. Similar to rules in public campgrounds, any illegal fire that generates an incident response can lead to citations or arrests. There have been rare arrests made for fires originating in or adjacent to encampments where arson was suspected. The persons in encampments don't wish to draw attention to themselves, so they are careful to conceal flames and limit smoke plumes for their cooking and warming fires as much as possible.

Particularly in the dry season, serious damage could result with rapid fire spread ─endangering vegetation, structures, roadways, and even lives. The local fire departments do not actively patrol encampments, but they keep a vigilant eye on them.

When smoke or fires are reported at encampment sites, the Fire Department responds with fire abatement procedures. They can request backup with patrol officers if they perceive any threat, but generally they respond to the fire alone. If law enforcement is called in or is requested by the fire responders, confiscations of hazardous materials may occur to prevent recurrence.

The Fire Department realizes that warmth is a seasonal prerequisite for coping in encampments. Firemen offer alternative sources for staying warm (blankets, clothing) and encourage inhabitants to take advantage of temporary warming shelters offered throughout the community.

Because encampment residents are more receptive to firefighters than police officers, the Behavioral Wellness Department has approached the County Fire Department about forming co-response teams in 2024. At the time of this report, it is not known if Behavioral Wellness will be

ready to staff these new co-response teams. The Community Services Department will continue to partner with County Fire for encampment clearing.

Law Enforcement

Law enforcement plays a pivotal role in monitoring encampments. Santa Maria, Lompoc, and Santa Barbara have dedicated patrol divisions with assigned officers in charge of the nearby encampments. In Santa Maria, the Parks and Recreation Department City Rangers are also involved in monitoring encampments within city limits, and this now amounts to 70% of their workload. In South County, Santa Barbara has five police officers in a Community Action Team who regularly check on encampment areas.

The illegality of encampment locations can bring the presence of law enforcement officers due to encroachment on public lands, thoroughfares, private lands, and private corridors (railways). Complaints from residents and businesses affected by the unsheltered can also initiate visits and corrective actions, if indicated, for violations of city codes or criminal acts such as theft, property damage, littering, aggressive panhandling, blocking entrances, cutting fences for access routes, excessive open alcohol and drug use and abuse, prostitution, and environmental damage. Even nearby public walking trails might be impacted. A local high school in Santa Maria has worked out a time schedule with the City Rangers to lessen concerns about the danger of students walking along the levees where encampments are located.

Drug dealers regularly visit encampments, the Jury was told, to sell illegal substances, sometimes resulting in arrests. Law enforcement can make arrests for drug paraphernalia and evidence of drug use inside the encampment, but these only result in misdemeanors. There can be felony arrests for drug sales.

One Police Chief told the Jury that you do not solve homelessness by sending the unhoused people to jail. In fact, homeless advocates say that those living in encampments are more often victims of crime, not the perpetrators.

The Jury learned of concerns by encampment residents over aggressive police patrols and a negative undertone, if not open disregard, for the plight of those without housing. When law

enforcement is called to an encampment, they often are met with resistance due to fear of evictions, citations, and possible arrests. Social service personnel and non-profit volunteers often co-respond with law enforcement to provide non-threatening explanations, protections, and referrals to ensure the rights of unhoused persons are fully protected. However, when accompanied by law officers, distrust, even resentment, is often the reaction among the unsheltered.

Sweeps

Many consider the encampments visually displeasing with tarps, tents, shopping carts, bikes, pets, personal belongings, and pallets. There are many encampments sequestered underneath road overpasses and bridges, railway corridors, along riverbeds, creeks, and in the hills behind thick vegetation. When close to transportation corridors, those who pass by and those who occupy the encampment are at risk of injury. Caltrans has determined that encampments next to the highway are a danger to the public. This concern often leads to clearing encampments or "sweeps." The County, in conjunction with cities, Caltrans, and Union Pacific, has cleared 700 encampments since 2021.

Inhabitants from encampments can also negatively affect tourism and businesses if there is excessive loitering, use of private restrooms or trash bins, and aggressive panhandling. Farmers too have legitimate concerns about possible contamination due to human waste and unsanitary conditions near crops raised for human consumption. Farmers and business owners have been known to file complaints and initiate evictions.

Cities can enforce illegal camping rules, but currently they can only be applied if there is shelter for them, and the people in encampments refuse shelter. Then local jurisdictions can evict the residents and initiate a sweep. Jury members heard how some encampment residents will say they want shelter, knowing that none is available, so they cannot be cited for illegal camping or trespassing.

A number of people living in encampments have more than one place of settlement. If their current camp is swept, they transfer to their other location. Eventually, many return to the first site. Community frustrations rise when an encampment re-establishes at the same location. The large Santa Ynez River encampment near Lompoc is one key example. The City of Lompoc spent nearly

a half million dollars cleaning up 472 tons of trash from 60-70 encampments with over 100 residents in 2019, only to do a similar clean up two years later.

When a sweep is performed and the proper notifications and requirements are met, a police presence can be assured at that time. Multiple agencies are also involved. These include Social Services, Behavioral Wellness, housing representatives such as Good Samaritan, Santa Barbara Alliance for Community Transformation (SB|ACT), City Net, and People Helping People, mental health practitioners, substance abuse disorder specialists, medical coordinators, and other community support program managers and volunteers. These participants focus on housing provisions and wraparound social services for those being displaced. No matter how much time a posted notification is given ahead of a sweep, the displaced occupants can still be upset and complain of inadequate notice. Anger can be directed at all parties, especially law enforcement. For this reason, when all participating agencies coordinate, they are prepared to present a balanced front and carry through with empathy and consideration.

For example, in January 2024 an encampment on private property had been notified of a sweep along a Santa Ynez River tributary. The owner had been cited by the Central Coast Water Authority to remove the encampment material. In spite of the one-week notification of the upcoming sweep, no one left the encampment. Good Samaritan had contacted the residents about housing alternatives, but there were no takers for housing. On the morning of the sweep, People Helping People appeared with trucks and convinced people to sign up for services, including food stamps, storage of belongings, and housing with Good Samaritan.

Flooding

A large concern along the riverbed corridors is the threat of seasonal flooding. The past two years have seen significant rainfall totals in the upper Santa Ynez and Santa Maria watersheds, causing both rivers to experience substantial flow. Small creeks can also be very dangerous, with sudden rises in water levels after heavy rainfall in the surrounding mountains. In the spring of 2024, a transient woman drowned in Santa Barbara's Mission Creek.

When large county reservoirs fill (Lake Cachuma and Twitchell Reservoir), either the gates are opened to release excess water or overflow spillage occurs, resulting in increased river volume.

Inflow from multiple downstream tributaries coupled with dam overflow or release markedly escalates the risk for loss of personal property and endangers lives in the riverbed encampments.

Since 2019, riverbed encampments have been mapped by overhead drones equipped with GPS and cameras with the help of Heal the Ocean. However, drones cannot reach all sites because of their limited range. Warnings are then issued via foot patrols and loudspeaker announcements from the Sheriff's Office helicopters. After the heavy rains of 2023, the warning protocols were strengthened.

HOUSING

Point in Time Count

The Santa Barbara County Community Services Department and the CoC do a yearly Point in Time count in January. Volunteers visit shelters and also makeshift dwellings such as vehicles, abandoned buildings, bus or train stations, airports, parks, camping grounds, and known encampments. Many encampments are too isolated for the volunteers to reach and thus are not included in the Point in Time Count. Although the Count did not reach all people without housing or all encampments, the Count for 2024 found 232 more people than the Count for 2023. In 2024, the Count for Santa Barbara County was 2,119 individuals, of which 1,332 (63%) were unsheltered and 787 (37%) were sheltered. Of the people without shelter, 46% were outside and 53% in vehicles.

Due to more housing available recently, there had been a 3.7 % decrease in the number of people experiencing homelessness countywide between the 2022 and 2023 Point in Time Counts. But there was a 12% increase from 2023 to 2024. Both the number of persons living in shelters or transitional housing and those living unsheltered increased, the greatest increase being in individuals sleeping in cars and families with children. The Community Services Department attributes the increase to the rise in rents, the cessation of COVID-related eviction moratoriums and emergency housing vouchers, and continuing inflation. There was no count of those specifically living in encampments, although the County Community Services Department estimated that 750 unhoused people were living in encampments at the beginning of 2024.

Housing Inventory

The biggest challenge to encampment resolution is the lack of affordable housing. Homelessness is a housing issue.

Santa Barbara County has the sixth highest rental housing costs in the U.S. These costs are contributing to the rise in homelessness. There is very limited affordable housing built in this area without large amounts of government funding or foundation grants. During the pandemic, the State provided billions of dollars to convert motels into permanent housing. One such project in Goleta will open mid-2024, and it will be the last to open with Homekey funding, a part of the Coronavirus State Fiscal Recovery Fund.

Several permanent and interim housing projects have been added to the CoC inventory since 2020, resulting in an increase of 787 beds dedicated to persons who are or were experiencing homelessness. There are several established interim housing programs in the County: PATH Santa Barbara, Willbridge of Santa Barbara, Bridge House of Lompoc, Good Samaritan Santa Maria, Partners in Housing, Transition House Santa Barbara, the Rescue Mission and the Salvation Army. Since the Strategy began, 143 people from encampments have moved into permanent housing and 146 into interim housing or shelters.

Dignity Moves, a non-profit, offers lockable and secure 8'x8' units. It first opened a tiny home center in Santa Barbara in August 2023 with 34 units. In March 2024, 94 similar units opened in Hope Village in Santa Maria. Ten of these homes were dedicated to those living in encampments in the Santa Maria area. In May 2024, Dignity Moves opened La Posada with 80 units located between Santa Barbara and Goleta, of which half are meant to house 40 individuals living in the established encampments nearby. Those in encampments have been more willing to move into these homes than to relocate to shelters because of the privacy and safety afforded by locked doors.

Housing Resistance

Many encampment residents would prefer housing where they can maintain their independence, such as in transitional housing. Over the past two years, the acceptance rate for moving into a congregate (shared space) shelter has been only 20%, and for those who do accept, approximately 35% elect to re-camp after they have been in a congregate shelter.

Many unhoused individuals, especially those in encampments, have difficulty transitioning to housing programs. Some choose not to accept shelter and prefer the freedom of encampments, along with the ability to make their own decisions. Reasons given by the encamped residents for declining housing and services include curfews, unwillingness to pare down belongings, wishing to remain with their pets, not wanting to sacrifice their independence, distance from work or medical services, and lack of privacy in some congregate shelter settings. In Santa Maria, for example, of the approximately 120 people in encampments near the strawberry fields, only two or three accepted housing. Encampment Strategy Plan staff acknowledge that without provisions for partners, property, and pets ("the three Ps"), inhabitants of encampments often return to the encampment from interim housing.

Housing Services

Dignity Moves has restrictions for entering and staying at their centers, differing from federal and state-funded projects where Housing First is practiced. This federal protocol places people in housing first, with wraparound services available, letting the formerly unhoused work out their issues at their own pace. Santa Barbara County has a good track record – 90% stay when treatment is coupled with housing. Other agencies also have positive results. At the Good Samaritan shelter, the unhoused receive services on many levels, resulting in a 96% retention rate. However, services come at a high cost to the County.

The recent increase in units for the residents in encampments has been assisted by utilizing County-owned property. The County has 18 County-owned sites with a potential for nearly 6,000 new housing units. For the newly opened Hope Village in Santa Maria, Santa Barbara County provided $1 million toward the $7.5 million in capital costs and pledged $8.5 million more in services for five years. No further housing projects on County property are being discussed for the near future because of these high operational costs.

These low-cost move-in units helped house over 1,400 formerly unhoused people and resolved 700 encampments in the first two years of the Encampment Strategy. But more housing is needed. The County stated in its Year 1 Progress Report that "[t]he biggest challenge to encampment

resolution has been the lack of shelter (congregate and non-congregate).” Some individuals have moved into transitional units, only to be asked to leave when there are no units available at the next level. This setback can lead to being homeless again. Moving the unhoused into affordable housing, a limited commodity in Santa Barbara County, depends on high turnover up the housing chain. When forced to move out of provisional housing, former encampment residents are at great risk of leaving one unsheltered location for another.

MENTAL HEALTH

Living on the streets or in encampments is a challenging experience for those who have lost the means to support themselves and cannot afford to live in a traditional residence. For people who suffer from mental illness and are forced by circumstances to live in encampments, it is devastating. Statistics show that a significant proportion of individuals experiencing homelessness struggle with severe mental illness. The 2024 Point in Time Count estimated that 34% suffered from severe mental illness and 27% had a substance abuse disorder. The County Community Services Department estimates that drug addiction and mental health issues are even higher in encampments than in the general homeless population: 50-60% with mental health issues and 40-50% with addictions and/or substance abuse issues.

People in encampments are often victims of crime according to encampment residents and law enforcement. It is well-documented that trauma can be the result of repeated domestic abuse, sexual abuse, and other forms of violence. Compounding the problem is that unhoused individuals with mental illness may self-medicate just as other members of encampments do, and the illicit use of drugs can exacerbate their mental disorders. Individuals with mental illness may have difficulty performing regular daily tasks, caring for their hygiene, or making lasting relationships. Anti-social tendencies may cause dissension and misunderstandings, which may lead to more trauma.

Housing People with Mental Illness

There is considerable agreement in the professional community that one of the most important elements in assisting unhoused people with mental illness is to find stable housing. It must be subsidized and include wraparound services, as in Housing First. Arranging for housing involves incremental steps, beginning with a tiny home as a first haven and then segueing to more stable and permanent living arrangements. The ideal goal is to find long-term suitable housing whether it is the type of model such as Sanctuary Centers has developed where the goal is to house and attend to the needs of people with life-long mental illness, or other supportive housing solutions suitable to the nature of a person's mental illness. The bridge housing to be developed by Behavioral Wellness will also offer some units for those leaving homelessness.

Outreach is an integral step in ending homelessness. Mentally unstable individuals are less likely to contact agencies that will help them. A major roadblock occurs when assistance is offered to a mentally troubled person and the offer is refused. A nuanced introduction to the programs available is required.

Housing is a positive step because it ostensibly is meant to help stabilize individuals with mental illness feel safer, making it easier for them to receive medication and counseling. In this stable environment, symptoms could become less extreme, and they could begin to process traumatic experiences that they may have had prior to or when in encampments.

Educating the Public

Perception is everything. Residents of Santa Barbara County are impacted by the incursion of homeless encampments on or near their property. There are inherent difficulties in communicating with mentally ill members of the homeless settlements. While many residents of Santa Barbara County are empathetic and understand the circumstances that cause part of the population to be homeless, some citizens do not fully grasp the dire situations of people living apart from housed society.

Finding ways to create understanding in the public forum is necessary to decrease public misconceptions about the behaviors of people with mental illness. This becomes a critical step when county or community agencies are proposing housing for the people with mental illness in neighborhoods. In South County, public objections have stopped several supportive housing plans. However, an early meeting for the project at La Posada turned from negative to positive when one person stood up to tell her story of how supportive housing helped her find her way again. Citizens of North County, the Jury heard, are more willing to listen. Still, incidents such as those at Housing on Depot Street in Santa Maria, where too many complaints caused formerly homeless residents to lose housing, could damage a fragile acceptance.

Resources for Services

Behavioral Wellness extended its street outreach, which included:

- Consistent outreach by trained personnel
- Easily accessible assistance for those seeking or in need of help
- Crisis intervention availability – crisis centers such as the Crisis Stabilization Unit and co-response teams
- Collaboration between or integration of the mental health agencies and outreach workers
- Intensive training for those giving direct services

One large stumbling block for building a mental health network is the lack of qualified workers. With few outreach workers and not enough clinicians for co-response teams, Behavioral Wellness cannot fully service unhoused people with mental illness in encampments.

Good Samaritan and Behavioral Wellness work side by side with a mental health contract. These shelters have their own clinicians who are trained by Behavioral Wellness. They are then able to provide services and drug and alcohol treatment at their sites.

California Advancing and Innovation Medi-Cal (CalAIM) has a five-year plan that includes a comprehensive approach addressing the needs of the unhoused and people with mental illness. The timeline for the first CalAIM reforms began in January 2022, and additional reforms will be phased in through 2027. The 2023 Benioff Homelessness and Housing Initiative from the University of California, San Francisco, found that *just* expanding health coverage and adding social services is not serving all those in need. The Initiative found that 83% of unhoused people surveyed said they had health insurance, mostly through Medi-Cal, California's Medicaid program for low-income people. Yet more than half relied on the emergency room for care, and nearly a quarter said they couldn't access the care they needed. A majority who said they were experiencing mental health problems weren't being treated or did not receive care through emergency visits.

HEALTH

The Encampment Strategy prioritizes the health and safety of those living in encampments. In Santa Barbara County the unhoused population has faced various health challenges due to living in encampments, especially during the COVID-19 pandemic.

The COVID-19 pandemic illuminated limitations within the healthcare system. Its impact on unhoused individuals in Santa Barbara County was particularly pronounced. During the pandemic, there was concern that breaking up homeless encampments would create unnecessary risks for both the displaced individuals and the broader community. In 2020, the Centers for Disease Control (CDC) advised cities and counties to leave encampments in place. CDC's directive took effect, and people in encampments were removed only to safe bed situations, such as with Project Roomkey. Sweeps stopped. Ignoring the CDC's recommendation, a Pershing Park sweep in Santa Barbara in March 2021 forced campers back onto the streets, potentially exposing them and others to COVID-19.

Unhoused individuals in Santa Barbara County face continual significant healthcare challenges, especially within encampments. These include:

- **Lack of Access to Basic Amenities**: Many encampments lack running water and sanitary facilities like bathrooms/porta-potties.
- **Infectious Diseases**: Close living quarters, inadequate hygiene, and limited access to medical care increase the risk of infectious diseases such as tuberculosis, hepatitis, and skin infections.
- **Substance Abuse**: Encampments often become hubs for drug use, which can lead to overdose, infections, and other health complications.

The Benioff Homelessness and Housing Initiative showed that involuntary displacement of people experiencing homelessness who inject drugs could lead to significant spikes in overdoses, hospitalizations, and mortality, possibly contributing to 15-25% of deaths among the unsheltered population over ten (10) years.

The Santa Barbara County Public Health Department last reported on deaths among the unsheltered in June 2023. During the period from 2019 to 2022, there were 143 deaths of people without housing in Santa Barbara County. According to the Public Health report to the Board of Supervisors, the leading causes of death were overdoses of drugs and alcohol, cardiovascular disease, and suicide. The underlying causes were predominantly substance abuse and mental health afflictions. The 2023 report from the County noted that the average age of death of those experiencing homelessness is 54, as opposed to 76 in the general population.

In health matters, the County has turned to its Multi-Disciplinary Team, which includes Behavioral Wellness, Public Health, and the Public Defender, counting on their field experience to reach those living in encampments. Outreach workers began by handing out hygiene kits and providing safe needle drops, COVID-19 testing, and vaccinations as “temporary health and safety measures.” The protocol for Public Health was to identify communicable diseases and treat the affected person to prevent the spread of disease. Health measures now also include clean-up of trash, human waste, and vector hazards.

Partnerships with community service agencies have provided many health services at various sites where people living in encampments can access health care. In 2020, SB|ACT began organizing representatives and nurses from various organizations in Santa Barbara to address health and psychological needs. Doctors Without Walls is one such organization. Good Samaritan in Santa Maria has a Public Health office on its site, where medications can be obtained. Its shelter has recuperative beds after hospitalization. Both organizations offer meals and showers to help attract homeless individuals and then connect them with health services. There are two other Health Care Centers located in homeless shelters and about a dozen Health Care Nurses stationed in shelters or transitional living centers. At these sites, the unsheltered can be entered into the County's databases for further health assistance and follow-up.

The health field is changing. CenCal, Medi-Cal, and CalAIM will focus on services for unhoused residents. In the year leading up to spring of 2024, over 900 individuals in the county's Homeless Management Information System had fully enrolled in Medi-Cal and over 1000 had applied for this coverage.

FUNDING

Traditionally, organizations like the Red Cross and the Salvation Army solicited donations from individuals to fund their efforts in helping unhoused individuals. Local churches took similar donations to fund their food and shelter programs, but these were limited in scope and effectiveness. These efforts basically intended to ease hunger and provide shelter during severe weather conditions or individual economic decline and were not long-term solutions for the individual suffering from homelessness. Now, the involvement of many members from different organizations in the County has become an ever more important resource in the solution for encampments.

The Encampment Strategy began during the pandemic when rapid encampment proliferation occurred. In October 2021, the Community Services Department requested funding for the initial Encampment Strategy and Response Protocol, a three-year project. At that time, the American Rescue Plan Act (ARPA) offered federal stimulus funds to local communities, and applications for helping the unsheltered community were encouraged. ARPA funds allowed for hiring an

Encampment Response Coordinator to direct the Multi-Disciplinary Team primarily made up of Behavioral Wellness, Public Health, the Public Defender, and Good Samaritan outreach workers. The County also allocated increased funding for shelter beds and housing from the general fund. Additional monies from ARPA funds went to software, debris removal, and some outreach.

In 2021, the State announced competitive grant funding to resolve encampments. Santa Barbara County's Encampment Strategy was successful in acquiring $2,520,000 for encampment resolution along transit corridors (highways and railroad tracks). This resolved 95 encampments. In 2022, more state funding became available to assist with encampments along waterways, and the Encampment Strategy was awarded $6,000,000. In 2024, the County won a third grant along with the City of Santa Barbara to clear 21 vehicle encampments, with the goal of housing 300 people. The award of three state grants is testimony to the efficiency of the Encampment Strategy programs and the dedication of those working tirelessly to resolve the encampments and house those living there.

The state grants are one-time allocations. The County is facing what they refer to as "funding cliffs" when the funds expire. New state funding for encampments cannot be assured. Response to reduced funding at the state level has encouraged the forging of new partnerships with other entities such as Community Correction Partnerships, Behavioral Wellness (Mental Health Services Act), CenCal Health, foundations, and non-profit organizations.

The California Encampment Resolution Fund Round 1 (CERF 1) was established in 2006 to increase collaboration between the California Interagency Council on Homelessness (Cal ICH), local jurisdictions, and the County's CoC. These funds address the safety and wellness of encamped individuals, transitioning them into interim and permanent housing. CERF 2 released funding in December 2022 and contributed to the three state grants awarded to the Encampment Strategy's staff. CERF 3 funds, available in 2023, will continue to focus on the resolution of encampments.

As the County's CoC is the designated receiver of various state and federal funds, it distributes most of its funding directly to non-profits that operate within the cities and the County. In the past, this has led to competition among the various agencies and has created a wedge in cohesive and collaborative relationships. Another drawback to funding being concentrated in the hands of the County's CoC is that cities do not usually receive similar grants. Thus, local cities do not have enough funding to be able to invest in housing.

Building teams outside the sphere of CoC has fostered coordination and cooperation among partners for specific projects. Such direct proactive cooperation among County agencies can greatly reduce redundancy for specific projects and produce tangible results. The first example of the team approach at the County level was Project Homekey in 2021. In just over five months an office building was converted into homeless housing. In 2024, the County collaborated with the City of Santa Barbara, and they were awarded a grant for the New Beginnings Safe Parking program which allows RV's and private vehicles to park overnight.

More robust state funding for health services began in 2022. Organizations will now be reimbursed for health and mental health expenditures for people experiencing homelessness. Medi-Cal, CalAIM, and CenCal will pay for wraparound services, which may free up more money for outreach and housing. Good Samaritan has been the first recipient of funding from CalAIM, which will help to provide intensive support services such as substance abuse prevention and case management.

Funding for unhoused people who have mental illness is available from California state-wide taxes, as well as Federal funds. State funding for mental illness amounts to $10-13 billion per year. About a third of the money counties receive to provide mental health services comes from the Mental Health Services Act passed in 2004, known as the "Millionaire's Tax Law" because of the taxation of 1 percentage point tax on incomes above $1 million per year. The recently passed

California Proposition 1 will take 30% of this tax to help the chronically unsheltered and those living in encampments by creating housing. The implementation will begin in July 2024.

In April 2024, for the third-year review of the three-year Encampment Strategy program, the Community Services Department requested $500,000 from the remaining ARPA funds for sanitation services. These funds would pay for the removal of debris and biohazards from encampments for two years. The department had previously asked for a funding allocation to support the position of the Encampment Response Coordinator for an additional two years. The Board of Supervisors extended the life of the Homeless Encampment Resolution Strategy by allocating these funding requests. The County has approximately $8 million left in ARPA funds for future homeless projects in the next two years.

Environment

The impacts of encampments on the environment are most noticeable in riverbeds and open spaces near transit corridors. Encampments next to freeways and railways endanger the landscape as well as the unsheltered themselves. Encampments in riverbeds can have further negative effects on the environment such as damage to vegetation and water pollution, whether to groundwater, local creeks, or the ocean.

The Encampment Resolution Strategy of 2021 had “impacting sensitive environment/water quality” as one of its five criteria for cleaning up encampments. The Response Protocol of the Strategy included $375,000 per year for sanitation services and $100,000 per year for storage of personal property during the three-year plan. Since state funding did not allow paying for clean-up, the County allocated ARPA funds for this, and the money is primarily dedicated to removing debris from abandoned encampments.

In 2019, the first year of the Strategy, no clean-up took place. In January 2022, the County hired a privately owned company for sanitation purposes, removing debris and human waste. During that second year, the County reported that the company removed 70 tons of trash, 145 pounds of bio-hazard waste, 4.75 pounds of needles, and 73 propane cylinders. Finding contractors for this purpose is problematic because of the biowaste left at the site. The City of Santa Maria hired a

private contractor willing to do the job. Heal the Ocean also has hired a small company, composed of trained homeless volunteers, to clean up after an encampment is removed.

Pollution is a serious threat to the environment. Garbage, propane and oil, biowaste, toxic trash such as needles, and chemical spills – all find their way into the ground. If near a water source, this contamination can enter the groundwater or be carried downstream. For those living near waterways and depending on groundwater for safe drinking water, encampments pose a threat to public health. Communities that rely on groundwater have no recourse from contaminating encampments at this time.

Complete resolution of an encampment would include restoration of the vegetation and the cleanliness of the water. Such work is long and costly. To date, only a few sites have been restored. The environment often remains endangered, as 35% of the cleared encampments reappear in the same location within a year's time according to the Community Services Department.

The first round of State funding granted $150,000 for environmental rehabilitation, but there has been no additional public funding for restoring the original state of the environment. Non-profit agencies have partnered with local government agencies to help monitor and clean out encampments voluntarily. Heal the Ocean has created a task force in conjunction with the Fire Department and the Sheriff's Office to coordinate clean-ups. Volunteers with the Santa Barbara Urban Creeks Council and Channel Islands Restoration have worked to restore creek beds after an encampment removal.

CONCLUSION

Encampments are a barometer of our efforts to help our unhoused individuals. If we do nothing, the encampments only grow. Dangerous conditions such as fire, illnesses, and crime increase. If we work collaboratively, we can assist the citizens living in encampments to reintegrate back into the communities.

Solutions to homeless encampments are no longer a local issue with limited resources. There are a multitude of resources available. There can be a collective impact when there is a true team approach. The success of multi-disciplinary teams lies in coordination of all agencies, government

and private, to work together to resolve the social and economic issues that encampments make visible.

The Homeless Encampment Resolution Strategy has demonstrated the clear vision of the Community Services Department. This Strategy evolved into a network committed to helping individuals who live in encampments and keeping our public lands safe and protected. In so doing, our County departments and our cities have learned to support each other for the good of everyone in the County.

Findings and Recommendations

Finding 1

Use of a team approach has made engagement with community services more acceptable to those who live in encampments.

Finding 2

The negative effects of encampment sweeps can be mitigated when a variety of community resources are present at the time of the clean-up.

Recommendation 2

The County and the cities shall ensure that all sweeps occur utilizing a multi-disciplinary approach.

Finding 3

Encampments lack basic sanitation services.

Recommendation 3

The County and the cities shall make trash cans, porta-potties, resources for handwashing, and sharps containers for safe disposal of needles and other hazardous waste available near encampment sites.

Finding 4

Encampment residents are reluctant to transition to housing with strict rules of conduct.

Recommendation 4

The County shall encourage the creation of more units that continue the Housing First model, providing a home first, and offering supportive services as the individual learns to cope in socially accepted ways.

Finding 5

State funding for helping people without housing is becoming less available.

Recommendation 5

The Board of Supervisors shall instruct the County Community Services Department to work with community partners in addition to Continuum of Care members to pursue funding opportunities beyond those coming from the State or the encampment resolution.

Finding 6

Most state encampment funding cannot be applied to environmental restoration.

Recommendation 6

The Board of Supervisors shall instruct the Community Services Department to invite environmental non-profits into its multi-disciplinary teams.

Finding 7

When heavy rain is forecast and materializes, the persons in encampments along creeks and riverbeds are at high risk for loss of life, personal property, and living quarters.

Recommendation 7a

The Santa Barbara County Sheriff's Office and the Office of Emergency Management, using mapping technology, shall continue to refine and share comprehensive locations of encampment sites among all concerned agencies.

Recommendation 7b

The Santa Barbara County Sheriff's Office and the Office of Emergency Management shall develop and formalize a multi-modal warning system to relocate persons when there are looming credible threats.

REQUEST FOR RESPONSE

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

Responses to Findings shall be either:

- Agree
- Disagree wholly
- Disagree partially with an explanation

Responses to Recommendations shall be one of the following:

- Has been implemented, with brief summary of implementation actions taken
- Will be implemented, with an implementation schedule
- Requires further analysis, with analysis completion date of no more than six months after the issuance of the report
- Will not be implemented, with an explanation of why

Santa Barbara County Board of Supervisors - 90 days

Findings 1, 2, 3, 4, 5, 6, 7

Recommendations 2, 3, 4, 5, 6, 7a, 7b

City of Santa Barbara - 90 days

Findings 2, 3

Recommendations 2, 3

City of Goleta - 90 days

Findings 2, 3

Recommendations 2, 3

City of Carpinteria - 90 days

Findings 2, 3

Recommendations 2, 3

City of Solvang - 90 days

Findings 2, 3

Recommendations 2, 3

City of Buellton - 90 days

Findings 2, 3

Recommendations 2, 3

City of Lompoc - 90 days

Findings 2, 3

Recommendations 2, 3

City of Guadalupe - 90 days

Findings 2, 3

Recommendations 2, 3

City of Santa Maria - 90 days

Findings 2, 3
Recommendations 2, 3

Santa Barbara County Sheriff's Office – 60 days

Finding 7

Recommendation 7a, 7b

APPENDIX

Homeless Management Information System (HMIS) partner agencies:

• 211
• Americorps Partnership United Way of Santa Barbara County
• CenCal Health
• Channel Islands YMCA
• City of Goleta
• City of Santa Barbara
• City Net
• CommUnify
• Community Action Commission
• Cottage Health
• Dignity Health
• Family Services Agency
• Fighting Back Santa Maria Valley
• Freedom Warming Centers- Unitarian Society of Santa Barbara
• Good Samaritan Shelter
• Housing Authority for the City of Santa Barbara
• Housing Authority for the County of Santa Barbara
• Independent Living Resource Center
• Jodi House Brain Injury Support Center
• LAGS Recovery Centers, Inc.
• Legal Aid Foundation of Santa Barbara County
• Outreach Grid • Mental Wellness Center
• New Beginnings Counseling Center
• Partners in Housing Solutions
• PATH Santa Barbara
• People's Self-Help Housing
• Sanctuary Psychiatric Centers of Santa Barbara
• Santa Barbara Alliance for Community Transformation (SB|ACT)

- Santa Barbara Community Housing Corporation
- Santa Barbara County Dept. of Behavioral Wellness
- Santa Barbara County Dept. of Community Services
- Santa Barbara County Office of Public Defender
- Santa Barbara County Dept. of Public Health
- Santa Barbara County Dept. of Social Services
- Santa Barbara Rescue Mission
- Santa Ynez Valley People Helping People
- Sarah House Santa Barbara
- Social Venture Partners
- St. Vincent's Santa Barbara State of California
- The Salvation Army
- United Way of Northern Santa Barbara County/Home for Good Santa Barbara County
- University of California at Santa Barbara Student Services
- Veteran's Administration
- WillBridge of Santa Barbara

11

Deaths in Custody in Santa Barbara County Jails:

Our County Jails Meet Many Needs

DEATHS IN CUSTODY IN SANTA BARBARA COUNTY JAILS

Our County Jails Meet Many Needs

SUMMARY

The Santa Barbara County Grand Jury investigates all deaths in custody within the geographical boundaries of Santa Barbara County. The 2023-2024 Santa Barbara County Grand Jury conducted a comprehensive review of six deaths of incarcerated individuals that took place while under the supervision of the Santa Barbara County Sheriff's Office. Among these deaths, three occurred during the tenure of the 2022-2023 Grand Jury. The remaining three deaths occurred during the current Jury's term. Of the six deaths, two were classified as suicides, two were classified as drug overdoses, and two were classified as multiple causes.

The Sheriff's Office is committed to implementing and maintaining current best practices in preventing deaths of anyone held in its facilities. Yet deaths continue to occur. In reviewing the six deaths for this report, the Grand Jury found that circumstances can be overwhelmingly difficult to manage. Illegal drugs enter the jails, incarcerated individuals are determined to commit suicide, and some inmates can have medical and mental health conditions that complicate desperate situations.

The Santa Barbara County Jails have become the main mental health institution, the main drug treatment center, and even at times the primary provider of health care for incarcerated individuals. In a jail system that is chronically understaffed, attention to acute details is compromised. To succeed in these roles, the jails need more resources, which may be provided by collaboration among County departments.

The Grand Jury investigations rely heavily on information provided by the Santa Barbara County Sheriff's Office. Completion of the investigations was greatly impeded by a lack of timely cooperation by the Sheriff's Office. What follows is a thorough report based on the information the Jury was able to obtain. The Grand Jury believes the Sheriff is and remains committed to remedying these difficulties going forward.

METHODOLOGY

Pursuant to California Penal Code section 919(b), this Jury reviewed reports, documents, and other evidence provided to us by the:

- Sheriff's Office
- Wellpath (the County jails' contract medical provider)
- Public Defender's Office
- Probation Department
- County Executive Office
- District Attorney's Office
- Superior Court
- Coroner's Bureau

Interviews were conducted with individuals who provided evidence related to the deaths in custody, including nurses, mental health staff, and custody staff. Additionally, past Santa Barbara County Grand Jury reports were reviewed, as well as similar reports from other counties. Site visits to both jails were conducted, going twice to the Main Jail and twice to the Northern Branch Jail (NBJ).

BACKGROUND

The diversity of incarcerated individuals at the jails complicates the demands on custody staff. In order to understand the complex nature of needed care and attention in the jail, the Jury obtained a categorical list of incarcerated individuals on one day in May 2024 as an example. On this day, both jails combined held 776 individuals.

- General population 340
- Protective custody 397
- Restrictive housing 12
- Behavioral Health Units 27

Some of the needs and concerns of the above incarcerated persons include:

- Psychiatric/mental health 262
- Serious mental illness 46
- Incompetent to stand trial 7
- Suicide 4
- Drug withdrawals 49
- Alcohol withdrawals 29
- Medically assisted drug treatment 77
- Move with 2 deputies 1
- Strip search/body scan 14
- ADA 98
- Wheelchair/cane/walker 20
- Medical Equipment 54
- Gang 97
- Sex crimes 29

- Sex offender 26
- Pedophilia 16
- Arsonists 10
- Alternative lifestyle 11
- Transgender 2
- Dementia 1
- Homeless 242

Routinely, the jails host a number of individuals with chronic medical conditions. For the above date in May, the following were counted: hypertension (59), seizures (30), diabetes (27), asthma (13), heart condition (12), infectious disease (11), blind (1), sleep apnea (3), and amputation/prosthesis (2).

Of all these justice-involved people, 28.2% have been sentenced and 71.8% were awaiting trial at the local courts.

Of the six deaths in custody, five of these deaths occurred within three days after intake.

DISCUSSION OF INDIVIDUAL CASE REVIEWS

MULTIPLE CAUSES

Arrestees who are experiencing medical issues may be taken to a hospital for clearance before entering the jail. Usually, they are taken to the jail once cleared from the hospital. Arrestees can also be taken directly to the jail. This decision is made in the field by the arresting officers.

The reception process at the jails begins with a medical intake screening exam. According to Santa Barbara Sheriff's Office policy, all newly arrested inmates are subject to a medical questionnaire and vital signs check conducted by a registered nurse. Most arrestees comply, but some are unwilling or unable to answer all questions. The questionnaire primarily focuses on physical health, with a minor emphasis on mental conditions. If an incarcerated individual's responses indicate a need for further mental health evaluation, a mental health practitioner (MHP) may be called in.

Those who arrive at the jail are often not in good medical condition. The purpose of intake screening is to determine if the arrestee is in a genuine medical crisis. The two cases in this section of the report demonstrate how the mental state can conceal the physical condition to a dangerous degree. Both the NBJ and the Main Jail have physicians, although the doctor at the Main Jail is only on-site four days a week. While incarcerated individuals have prompt access to a nurse, if they want to see a doctor, they fill out a request. They can be seen in two or three days, at most a week later. If an emergency arises, the incarcerated individual would be sent to a hospital.

The jail's medical provider, Wellpath, provides basic healthcare. Staffing is always a concern. The Public Health Department has begun to help monitor nursing care at the jails and work side by side with Wellpath. The intention is to have a Public Health Chief Correctional Health Medical Advisor, a Program/Business Leader-Physician, and a Correctional Health Quality Care Improvement Coordinator at the jails to oversee services, linking staff and administrators from Public Health and Wellpath. The duties of the Medical Advisor will include analyzing the root causes of in-custody deaths. The goal is to have quality care assessment that will begin with the initial screening. This partnership should lead to better evaluations before an incarcerated individual's condition leads to death.

JG died on December 28, 2022, age 34.

JG was on parole in a community sober living placement in Santa Maria on December 28, 2022, the day he died. JG called 911 early that morning stating that some of the residents at the sober living home were threatening him. JG was waiting outside when Law Enforcement Officers arrived. As he appeared to be under the influence of drugs or alcohol, his Parole Officer was notified. The Parole Officer then ordered JG to be taken into custody for a parole violation.

During his arrest, JG made several complaints of feeling unsafe. He was in a state of mental agitation. He was patted down, and the officer found that he had no weapons on his person. After being informed that he was under arrest, JG became more agitated and began to complain of pain. JG complained of chest and back pain multiple times, and said that he was afraid of being sexually assaulted in jail. The arresting officer considered taking JG to the hospital but made the decision not to do that.

He was transported to the NBJ before 9:00 a.m. to be processed. He appeared to become more confused, uncooperative, and angry as the process continued. He refused to leave the police car when they arrived at the jail, and three Custody Deputies cuffed him and placed him in a chair inside the intake portion of the jail.

JG's chest pain was not mentioned to the intake Registered Nurse (RN) upon his arrival at the jail. Medical personnel attempted to complete his intake forms, but his agitated behavior further deteriorated. His vital signs were taken and only a few questions were completed before it was decided to put him in a mental health observation cell. Before that was accomplished, he began to spit, kick, and lash out. The decision was then made to take him to a safety cell to protect himself and others.

Custody Deputies transported him to a safety cell, and almost immediately after laying him on his stomach with his hands cuffed behind him, he became non-responsive. Jail and medical staff

immediately rolled him over to give him Narcan, and he quickly regained consciousness. He then asked for water but started kicking and screaming when they tried to sit him up so he could drink. As soon as they got him prone on his stomach again, he became non-responsive and was again put on his side and given more Narcan. He stopped breathing, so life saving measures were started, and American Medical Response (AMR) was called. He eventually started breathing shallowly on his own, and when the ambulance arrived, he was taken to Marian Regional Medical Center in Santa Maria.

He was pronounced deceased just before 11:00 a.m. which was less than two hours after being processed at the jail.

The Santa Barbara County District Attorney's (DA) office investigated the circumstances surrounding JG's death for over a year and publicly released the results of that investigation on February 14, 2024. The DA's report stated that the Intake Nurse had cleared him to be booked into jail. The DA's office concluded that JG's death was an accident, as did the Santa Barbara County Coroner's Bureau in the postmortem exam report completed a week after JG's death.

The Coroner's Bureau listed four causes of death for JG, the primary being methamphetamine intoxication. Other significant contributing factors were listed as dilated cardiomyopathy, obesity, and physical restraint. The manner of death was listed as an accident.

JG had gained 105 lbs. in the nine months since his last incarceration. It is a fact that when an obese person is placed in a prone position with his hands cuffed behind him, a great deal of physical stress is placed on his heart, lungs, and airways, making it difficult to breathe. JG had become unresponsive both times he was restrained in a prone position.

A similar situation occurred in the Main Jail in January 2022 and was reported by the 2022-2023 Grand Jury: A Death In Custody – Lessons Learned

(See Findings and Recommendations 1, 2, and 3.)

LR died on September 3, 2023, age 37.

LR was arrested on the morning of August 31, 2023, due to a failed sobriety test administered after a motor vehicle accident. Before being taken to the Main Jail, LR was taken to Goleta Valley Cottage Hospital where he was treated for injuries sustained in the motor vehicle accident. He was cleared and released.

During his intake screening, LR stated that he used alcohol daily. It was not noted whether LR was in withdrawals at the time of the screening. LR also mentioned that he was not currently experiencing alcohol withdrawals and denied ever having experienced withdrawal symptoms. His intake screening was completed at 10:19 a.m. on August 31, 2023.

After initial placement in the Intake Reception Center (IRC), LR was transferred to a mental health observation cell (IRC H-5). Over the course of the following three days, LR's physical injuries appeared to worsen, and his cognitive abilities deteriorated. On September 2, a custody officer requested a mental health evaluation for LR. At approximately 2:20 p.m. that day, LR appeared confused and disoriented as to time. This worsened to include slowed speech and poor comprehension by the evening. His mood was anxious and he became withdrawn. His immediate, recent, and long-term memory were all impaired.

Jail protocols require safety checks at a minimum of every 15 minutes for safety and observation cells. At approximately 11:45 p.m. a custody deputy walked by IRC H-5 and noticed that LR seemed to be asleep in a seated position and had a very pale face. The deputy called for assistance,

and they entered the cell. LR was found to be unresponsive but with a pulse. The responding deputies started CPR and called for medical assistance.

Records show LR as having severe bruising, no pulse, no pupil dilation, and no chest rising/falling. AMR was called. A defibrillator detected no heartbeat at 11:57 PM. One dose of Narcan was administered with no result, and CPR continued. Paramedics arrived shortly after midnight.

At 12:36 a.m. LR was moved to an AMR gurney and taken to Cottage Hospital in Santa Barbara. LR died at Cottage Hospital on September 3, 2023, at 1:57 a.m. The cause of death was listed as alcohol withdrawal due to chronic alcoholism, alcohol abuse, and blunt force injury. The official manner of death was natural causes.

(See Findings and Recommendations 4, 5 and 6.)

OVERDOSE

The two overdose deaths in this next section of the report illustrate not only the problem of contraband in the jail, but also inadequate monitoring of those who enter the jail under the influence. Both inmates in this report had a history of multiple incarcerations over many years as well as long histories of drug addiction. Both deaths occurred within two days of being jailed.

The Crisis Stabilization Unit (CSU), under the direction of Behavioral Wellness, will be re-opening adjacent to the Main Jail with the goal of assessing "clients for Mental Health or Substance Use Disorders and any co-occurring disorders or medical services," as stated in the August 29, 2023 letter to the Board of Supervisors. This small eight-bed facility will be able to monitor people, including arrestees, who are in need of immediate care during withdrawals or other dangerous

states due to drug or alcohol use. Working with an experienced provider could lead to accepting arrestees for the critical observation period when first entering the jail at the CSU.

The CSU in North County is at a distance from the NBJ. But the NBJ does have a medical unit with ten individual rooms where arrestees going through withdrawal could have access to immediate medical help when in crisis.

The jails have a highly regarded program for addictions: Medication Assisted Treatment Program (MAT). At the first indication of addiction, the intake nurse puts the arrestee on monitoring and will notify the doctor, making sure medications are available, and tries to get the incarcerated individual into MAT. However, there are not enough clinicians in this program to serve everyone in need at the jail, and there is a wait list. Some assistance may be available as more healthcare providers are trained to work with MAT, and the collaboration with Public Health may expand its role into MAT.

When arrestees enter the jail and look for access to contraband drugs, they have sometimes been able to find drugs that could kill them. However, it is important to note that no jail deaths due to overdoses have occurred since May 2023. New screening technology and the use of drug sniffing canines have contributed to saving as many as 200 lives in the jails. Despite the fact that the jails are adding new and advanced detection technology, the existence of contraband in the jails may always be a problem.

RU died on May 25, 2023, age 45.

RU was arrested at his home on four felony counts including possession for sale of over one pound of methamphetamine, two ounces of fentanyl, and more than an ounce of heroin.

He was booked into the Main Jail in the afternoon of May 24, 2023. In his initial screening RU stated that he used methamphetamines, fentanyl and heroin every day. He said that he was going through withdrawal at that time and had done so before. The information was entered and triggered an Active Withdrawal Alert into his screening report and signed him up for Clinical Opioid Withdrawal Scale (COWS) checks every eight hours.

With the alert for withdrawals and the COWS inscription, RU was under an observation schedule. During his COWS check at 7:00 a.m. on May 25, he refused to give a urine sample.

RU may have had access to contraband drugs in his jail unit. A post-mortem review of jail videos showed RU talking with other incarcerated persons. Those individuals went to another cell where something was passed under the door and then brought to RU.

RU had another COWS check at 3:00 p.m. When a dayroom program became available at 4:00 p.m., RU did not come out of his cell.

At 10:50 p.m. a Wellpath nurse and a Custody Deputy went to his cell for a COWS check. RU was unresponsive, foaming at the mouth, and had no pulse. CPR was started, and an ambulance was called at 10:58 p.m. He was administered Narcan three times. AMR declared RU deceased at the scene at 11:25 p.m.

The toxicology report showed polysubstances as the cause of death. RU's manner of death was listed as accidental.

DL died on May 29, 2023, age 57.

On May 27, 2023, DL was pulled over for a window tint violation. Upon contact with DL, deputies observed drug paraphernalia inside the vehicle, which led to a probable cause search that resulted in finding 35 grams of fentanyl, 1 gram of cocaine, scales, assorted drug paraphernalia and over $600 in cash. He was arrested in Santa Maria and brought to the NBJ, where he was booked on drug-related charges, including felony possession of narcotics for sale, felony transportation of a controlled substance, misdemeanor possession of narcotics and possession of drug paraphernalia.

DL had been jailed over a dozen times between 1988 and 2015 for drug related charges.

On the day of DL's death, vital signs were checked at 8:00 a.m. At 2:00 p.m. a deputy and a nurse began testing inmates for COVID. DL did not appear at the check-in for the test, so the officers went to his cell looking for him. They found DL lying unresponsive on the floor of his cell and "pale blue." A radio call for deputies went out at 2:12 p.m. Two deputies and medical personnel responded. Calls for first aid and emergency services went out at 2:15 p.m.

Two deputies and medical personnel moved DL from his cell and began CPR with AED equipment. Two doses of Narcan were given. Jail staff rotated performing chest compressions until the Fire Department arrived at 2:17 p.m. AMR arrived at 2:22 p.m. Paramedics continued life-saving measures. At 2:46 p.m. all measures were stopped, and DL was pronounced dead at that time.

At 3:30 p.m. a forensics team arrived, consisting of a Detective Sergeant and a Criminal Investigation Detective who processed the scene. A suspicious powder was found, which turned out to be Gatorade. Their inspection ended at 4:34 p.m. That night, the whole unit was searched from 9:00 p.m. to 11:30 p.m. Video footage of the housing unit showed no narcotics passed around that day, and no narcotics were found.

Toxicology reports confirmed a polysubstance intoxication was the cause of death. The official manner of death was listed as accidental.

(See Finding and Recommendation 6.)

SUICIDES

Many incarcerated individuals have mental health issues and/or drug and alcohol problems. Being arrested and incarcerated is an extremely stressful experience and may exacerbate depression and other mental health issues already affecting the individuals in custody.

Accordingly, attempted suicides are not uncommon. Safety cells, which place inmates in an environment where they cannot be a danger to themselves or others, are effective in preventing suicides. Their use is, however, restricted because they can only be held for a limited duration. Direct observation of inmates at all times could significantly reduce the opportunity for suicide attempts, but staffing and facility issues make that option impossible.

Within the existing circumstances and limitations, the Sheriff's Office exercises many systems and procedures to prevent suicides. Those systems and procedures are continually under review and improvement. As an example, the Public Defender’s Office has begun a holistic approach with arrestees entering the jails. At the NBJ, representatives from this Office meet with the newly incarcerated for an in-depth conversation to understand their needs. From this discussion, a plan can be developed to incorporate applicable programs into their schedule. This personal approach acts as an intervention, and it may divert some arrestees from suicidal ideation. A connection with the incarcerated is maintained until discharge.

PG died on October 21, 2023, age 64.

PG was arrested by the Santa Barbara Police Department and booked into the Santa Barbara County Jail on September 29, 2023, on charges of assault with force/possibility of great bodily injury. On October 3, 2023, additional charges were filed for probation violation and DUI. PG had a long history of arrests and incarcerations in Santa Barbara County dating back to 1986.

During intake PG denied any mental health issues, but he mentioned depression. PG also mentioned that he had cancer and was subject to withdrawal from alcohol. Medical staff was notified of his claim to have cancer.

PG's mental condition appeared unstable, and his behavior was erratic. Other incarcerated persons reported that he was sometimes belligerent, shouting at times. Also, his maximum-security status and arrest history included signs of aggressive behavior.

His initial housing location in general population was changed to NWC cell 3 (a single man cell in a mental health unit) on October 15, 2023, after other inmates asked that he be moved due to his poor hygiene. PG remained in that housing location until his death on October 21, 2023.

At approximately 5:30 a.m. on October 21, PG was observed in his cell by custody staff during a security check. At approximately 6:18 a.m. PG was discovered unresponsive, lying face down on his bunk. There was a strip of cloth tied around a part of the upper bunk and wrapped around PG's neck. He had turned his back to the door and gotten as close to the far corner of his bunk as possible. The ligature was tied to the front of his neck, where it would not be easily seen by someone on the other side of the door.

Custody Deputies moved PG to the day room floor and along with jail medical staff began life saving measures. AMR and fire personnel arrived at approximately 6:30 a.m. and took over

medical treatment. In total, three doses of Narcan were administered. At approximately 7:00 a.m. PG was declared dead by AMR staff.

An autopsy was performed on October 26, 2023, by the Coroner's Bureau. The manner of death was listed as suicide, and the cause of death was determined to be hanging. A toxicology report showed no prescription or controlled substances.

SP died on December 31, 2023, age 61.

On December 28, 2023, a Santa Barbara County Sheriff Deputy was dispatched to St. Athanasius Orthodox Church in Goleta at the request of a concerned party who described a suicidal suspect. SP had threatened to end his life by jumping in front of a moving train or bus. During the field interview, SP expressed his desire to end his life due to being upset about his homeless status and frustrated by a lack of available resources to help him find stable housing.

A standard records check revealed an active warrant for SP's failure to appear in court on charges including receiving stolen property, vandalism, petty theft, possession of burglary tools, possession of a controlled substance, and disobeying a court order. SP was taken into custody without incident, transported to the Main Jail, and held on $40,000.00 bail. His arraignment was scheduled for January 2, 2024.

During SP's medical screening, the intake nurse recognized the need for additional mental health screening and summoned the Mental Health Practitioner (MHP) on duty. The MHP addressed SP's suicidal thoughts. SP responded by saying he would "find a way to do it." As a result, the MHP ordered SP to be placed in a safety cell to reduce the risk of self-harm and prevent any possible harm to custody staff.

After completing the screening process, Custody Deputies escorted SP to safety cell SC3, located within the Inmate Reception Center (IRC) 300. SP's clothing was removed, and he was provided with a safety/modesty smock. He was locked inside the cell for observation at 12:00 p.m., with safety checks logged every 15 minutes, until 8:25 a.m. the following morning, December 29th, totaling nearly 21 hours of observation.

A mental health practitioner visited SP and spoke to him through the slot in the safety cell door. SP appeared anxious and disheveled, vehemently denying any suicidal intentions and requesting to be released from the cell. As a result, the MHP decided to move SP to a mental health observation cell (H6) where he would continue to be monitored for the next 24 hours. Crisis and Recovery Emergency Services (C.A.R.E.S.) was not contacted to evaluate SP at 12 hours as required by policy. Safety cell documents are used to record observed behaviors every quarter hour. It was noted that SP was visited by an MHP only once, one hour after being transferred to the observation cell. Subsequently, there was a gap before the next MHP assessment, during which time SP received medical staff visits for medication administration and vital checks on seven occasions. After the initial MHP visit, no further mental health check-ins occurred for almost 24 hours.

At 9:00 a.m. on December 30, 2023, a decision was made to release SP from observation. The decision was based on SP's statement that he no longer had suicidal thoughts and his complaint about the lack of a mattress, blanket, or sweatshirt, causing him discomfort throughout the night. It was reasoned that someone concerned about their environment and seeking comfort was unlikely to harm themselves. SP was fixated on leaving the observation cell and voiced little more than that. Consequently, SP was reclassified into regular housing and transferred from the mental health observation cell to IRC 321. The standard process of developing a collaborative safety plan with an incarcerated individual prior to discharge from a mental health observation cell was not conducted. IRC 321 is located on a second-story tier. SP was housed alone.

On December 31, 2023, New Year's Eve, SP remained in IRC 321, awaiting his scheduled arraignment on January 2, 2024. At approximately 8:10 a.m. that morning, SP jumped off the

second-story tier of the module. SP had no interaction with other incarcerated individuals housed in the module and was alone in the dayroom at the time of the incident.

Reviewing the surveillance footage, it was observed that SP exited his cell and approached the railing on the second-floor tier, outside his cell door. He leaned on the railing for approximately 17 seconds, appearing to contemplate jumping. Then, he turned left and walked to the adjacent side of the second-floor tier, climbing over the railing. The entire process, from leaning on the railing to climbing over it, took approximately 30 seconds.

Once SP positioned himself over the railing, he faced away from it while gripping it behind him. After about six seconds, in a deliberate action, he leaned forward and let go of the railing, jumping from the second tier. He leaned forward and downward, seemingly aiming to make contact with the floor below using his head and shoulders. Upon impact, SP immediately collapsed and became unresponsive, showing no further movement.

Initially, none of the incarcerated individuals housed in the module were aware that SP had jumped over the railing. Approximately one minute and five seconds later, an incarcerated person on the first floor noticed SP on the floor and attempted to use the intercom in his cell to notify the custody staff. The incarcerated individual was unaware that the intercom system was non-operational due to ongoing system upgrades in the IRC 300 Module. Additionally, the surveillance system providing video feed to the control module was not functioning correctly, and the electronic locks on the cell doors were also not operational and had to be locked and unlocked manually.

Since there was no video feed into the control module, there was no custody deputy stationed there. Incarcerated individuals began banging loudly on their cell doors to attract the attention of the custody staff. It was noted by the Jury that there were only 11 Custody Deputies on duty at the time of the incident. Optimal staffing is 19 Custody Deputies. The facility routinely operates with

fewer positions filled. It took approximately 3 minutes and 20 seconds for the first custody staff member to arrive at the scene after SP's impact on the floor.

Upon entering IRC 300, custody staff observed SP on the ground and immediately called a "man down" code, alerting additional staff and medical personnel. AMR and fire department personnel arrived shortly after, and their combined efforts were able to revive SP.

AMR then transported SP to the Emergency Department at Santa Barbara Cottage Hospital. Despite emergency room efforts, SP's prognosis was determined to be extremely poor. A Do Not Resuscitate (DNR) order was subsequently issued by a family member. Shortly after, advanced life support measures were discontinued, and SP was pronounced dead at 3:16 pm on the last day of 2023.

Coroner's Bureau Detectives investigated the jail cell and the surrounding area where the incident occurred. The decedent's body was then recovered from the hospital and transported to the Coroner's Facility. An autopsy was performed on January 9, 2024, and the report listed the manner of death as suicide, with the cause of death being blunt force trauma.

(See Findings and Recommendations 7, 8, 9, 10 and 11.)

CONCLUSION

Two overdoses, two suicides, and two medically complicated incidents. These deaths in custody occurred in part due to insufficient observation, occasional lack of effective and timely communications between jail Custody Deputies and healthcare staff, and inadequate resources. In order to help those who enter the jail experiencing medical or mental health issues, there needs to

be more custody officers, more healthcare attendants, and better housing and equipment. These improvements are difficult to obtain given the current job market and the burdened County budget.

The Sheriff's Office and the jails can develop solutions by combining resources with other County departments. Behavioral Wellness, the Public Defender's Office, and Public Health are poised to be collaborative partners in observing, tending, and caring for those inside the jails. Santa Barbara County jails have the opportunity to create a better model for the County's principal mental health institutions, drug treatment centers, and healthcare centers that we call jails.

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

FINDINGS AND RECOMMENDATIONS

Finding 1

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

Recommendation 1

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

Finding 2

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

Recommendation 2

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

Finding 3

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

Recommendation 3a

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

Recommendation 3b

The Grand Jury recommends revising the medical screening questionnaire to prioritize the most critical information. Specifically, a question like "Are you currently experiencing any pain or are you suffering from an acute condition?" should be placed as the first question on the questionnaire.

This simple change could ensure that individuals with immediate medical needs are identified and addressed promptly.

Finding 4

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

Recommendation 4

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

Finding 5

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

Recommendation 5

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

Finding 6

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

Recommendation 6a

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

Recommendation 6b

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

Recommendation 6c

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

Finding 7

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

Recommendation 7a

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

Recommendation 7b

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

Finding 8

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

Recommendation 8a

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

Recommendation 8b

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

Finding 9

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

Recommendation 9

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

Finding 10

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

Recommendation 10

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

Finding 11

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

Recommendation 11a

The Grand Jury recommends that the Santa Barbara County Sheriff's Office immediately review and revise its incarcerated housing and classification placement protocols. Going forward, the Sheriff's Office must ensure that individuals who have made suicidal statements or exhibit a desire to harm themselves are never assigned to cells or housing units that offer ready access to methods of self-harm such as elevated areas from which an incarcerated individual could jump.

Recommendation 11b

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

Finding 12

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

Recommendation 12

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

Finding 13

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

Recommendation 13

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

Finding 14

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

Recommendation 14

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

Request for Response

Santa Barbara County Sheriff's Office – 60 days

Findings 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14

Recommendations 1, 2, 3a 3b, 4, 5, 6a, 6b, 6c, 7a, 7b, 8a, 8b, 9, 10, 11a, 11b, 12, 13, 14

Santa Barbara County Board of Supervisors – 90 days

Findings 5, 6, 12, 14

Recommendations 5, 6,c, 12, 14

Requirements for Responses:

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

Responses to Findings shall be either:

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

Responses to Recommendations shall be one of the following:

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