SANTA BARBARA COUNTY
CIVIL GRAND JURY

2024-2025

CONSOLIDATED REPORT

Representing the citizens of Santa Barbara County by investigating, evaluating, and reporting on the actions of local governments and special districts

2024-2025 SANTA BARBARA COUNTY
CIVIL GRAND JURY

CONSOLIDATED REPORT

www.sbcgj.org

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Grand Jury
Santa Barbara County

June 30, 2025

The Honorable Patricia Kelly
Presiding Judge, Santa Barbara County Superior Court
312 E. Cook Street
Santa Maria, CA 93454

Dear Presiding Judge Kelly:

The 2024-25 Santa Barbara County Grand Jury hereby delivers its annual Consolidated Report. The Consolidated Report reproduces in serial order the 12 distinct investigative reports we have issued during the year and also includes an essay that summarizes the Jury's additional public activities. I am proud to submit this comprehensive overview of our efforts on behalf of the citizens of Santa Barbara County.

While no one on the Jury is allowed to reveal the substance of our private deliberations, I wish to share some observations from a process perspective that illustrate the character and commitment of my colleagues on this panel. During this term, behind closed doors I have observed Jurors collaborate effectively, advocate passionately, compromise appropriately, indulge others patiently, persist diligently, and sacrifice their time and efforts generously. Grand Jury service is not motivated by personal gain or glory; it is the epitome of selfless community service. The Jury's shared values, goals, and dedication are the impetus that has driven us to our accomplishments. This Consolidated Report distills them for the community.

Our work benefitted tremendously not only from our Jurors' central contributions, but also from the support of outstanding court staff who are highly motivated, efficient, and proud to work on the team led by Court Executive Officer Darrel Parker. The Jury thanks each and every one of them who have contributed meaningfully to our achievements, as well as Mr. Parker for his effective leadership and always helpful guidance.

Grand Jury legal procedures are complex and unique. A jury could not function effectively in this realm without extensive legal consultation and advice. Senior Deputy County Counsel Michael Muñoz devoted countless hours to assist us, many during evenings and on weekends whenever sensitive issues emerged unexpectedly. Mr. Muñoz consistently shared relevant knowledge that enhanced our investigations and helped to guide us toward more effective outcomes as we probed a broad range of community concerns during our term. We are most grateful for his many contributions to our efforts.

Finally, I wish to thank former Presiding Judge Pauline Maxwell, who impaneled this Jury and guided it for the first half of our term; as well as yourself for your consistent support of the Grand Jury and your diligent review of our reports during the second half of our term.

The Santa Barbara County Grand Jury was a hallowed institution before this year's Jurors set foot inside its chambers. We have done our best to maintain and enhance its reputation and stature as a unique community asset. As our term reaches a close, we convey best wishes to those who will follow us and share our gratitude for the opportunity to serve. This Jury departs with optimism that the findings and recommendations of its investigations may serve to make this wonderful County an even better place in which to live.

Respectfully yours,

Dale Kunkel
Foreperson

INTRODUCTION TO THE SANTA BARBARA COUNTY GRAND JURY

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MISSION

“The Santa Barbara County Civil Grand Jury is dedicated to serving as an independent and impartial watchdog, promoting accountability and transparency in local government. Through thorough investigations and thoughtful recommendations, we strive to identify opportunities for improving the efficiency, effectiveness, and responsiveness of public agencies in serving the needs of all Santa Barbara County residents. By fostering a culture of civic engagement and good governance, we aim to strengthen public trust and enhance the overall quality of life in our community.”

VISION

"To be the trusted guardian of good governance and community wellbeing in Santa Barbara County, empowering residents through independent oversight, transparent reporting, and collaborative partnerships that drive continuous improvement in public services and strengthen the bond between the community and its government. Guided by the vision of 'One County, One Future', we strive to ensure that Santa Barbara's government and public institutions work together seamlessly to create a vibrant, prosperous, and equitable future for all."

2024 - 2025

SANTA BARBARA COUNTY CIVIL GRAND JURY

MEMBERS

DARREN L. BROWN* - ORCUTT

RYAN M. BROWN - SANTA BARBARA

BRIAN COX - SANTA BARBARA

KENT W. DUNN - SANTA BARBARA

JEFFREY LONG - SANTA BARBARA

JOHN RICHARDS* - ORCUTT

ANNIE SANCEDO - SANTA BARBARA

KIETH STAUB - SANTA BARBARA

DR. KEN WAXMAN - SANTA BARBARA

ROBERT WHITTIER - ORCUTT

REYNALDO YBARRA - GOLETA

EXECUTIVE COMMITTEE OFFICERS

DALE KUNKEL - SANTA BARBARA
FOREPERSON

GWEN RIGBY* - SANTA BARBARA
PRO-TEM

MARCIA GREEN - SANTA BARBARA
TREASURER

SUNANDA BHARGAVA - SANTA BARBARA
CORRESPONDING SECRETARY

JACQUELINE ANKER - SANTA BARBARA
RECORDING SECRETARY

DAN VORDALE - LOMPOC
SPEAKER COORDINATOR

CARLYLE DECKER - SANTA BARBARA
IT COORDINATOR

*DENOTES HOLDOVER JUROR

2024-2025

Jury Photo

Special Thanks to Kelly West of
Kelly West Photography

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A UNIQUE OPPORTUNITY FOR CIVIC ENGAGEMENT

Summary of 2024-2025 Civil Grand Jury Activities

Serving on the Santa Barbara County Civil Grand Jury is a unique opportunity to engage deeply with local government and contribute to the public good. While the role is primarily voluntary, with a modest daily stipend and mileage reimbursement, the experience offers invaluable rewards to those who serve. One of the most significant benefits is the unparalleled access to the inner workings of local government. In that sense, the Grand Jury is much like a practical and immersive civics lesson for those who serve.

Throughout the past year, the Grand Jury benefited from presentations by a wide array of public officials and community leaders. These interactions not only inform the Grand Jury's work but also help build a comprehensive understanding of the challenges and priorities faced by the County. Elected officials, department heads, and other key figures shared their expertise and insights, fostering open communication and transparency. This exchange of information allowed the jury to ask critical questions, clarify processes, and ultimately make well-informed recommendations in the reports included herewith.

The educational experience of serving as a grand juror is a meaningful opportunity. Each jury leaves its term with a deeper appreciation for public service, a stronger grasp of local governance, and the satisfaction of having contributed to the community.

This year, the Grand Jury had the privilege of meeting with numerous officials, whose contributions were vital to its understanding and deliberations. The following list highlights the individuals who spoke to the jury as invited guests in a non-investigatory environment. It is a longstanding tradition state-wide that grand juries invite leading community officials to share knowledge and opinions about local concerns to help ground the Grand Jury's activities and efforts throughout the year. The list also provides a transparent view and an account of some of the non-investigatory time spent by the 2024-2025 Grand Jury.

The members of the Grand Jury wish to thank the following individuals:

- The Honorable Pauline Maxwell, Presiding Judge, Santa Barbara County Superior Court 2022-2024
- The Honorable Patricia Kelly, Presiding Judge, Santa Barbara County Superior Court 2025-2027
- Mark Infanti, Mayor, City of Solvang
- La Mer Kylie-Griffiths, Assistant Public Defender, Santa Barbara County Public Defender's Office
- Jarrett Morris, Lieutenant & Sheriff's Adjutant, Santa Barbara County Sheriff's Office
- Raquel Zick, Public Information Officer, Santa Barbara County Sheriff's Office

- Lisa Plowman, Director of Planning and Development, County of Santa Barbara
- John Savrnoch, District Attorney, County of Santa Barbara
- Bill Brown, Sheriff-Coroner, County of Santa Barbara, Santa Barbara County Sheriff's Office
- Laura Capps, Chair of the Board of Supervisors representing the 2nd District
- Joan Hartmann, Santa Barbara County Supervisor representing the 3rd District
- Bob Nelson, Santa Barbara County Supervisor representing the 4th District
- Darrel Parker, Court Executive Officer & Jury Commissioner, Superior Court of Santa Barbara County
- Holly Benton, Chief Probation Officer, County of Santa Barbara Probation Department
- Michael Muñoz, Deputy County Counsel, County of Santa Barbara, Grand Jury Legal Advisor
- Kelly Gordon, Chief of Police, Santa Barbara City Police Department
- Dr. Susan Salcido, Superintendent, Santa Barbara County Schools
- Kelly McAdoo, City Administrator, City of Santa Barbara
- Daniel Nielson, Director, Santa Barbara County Social Services
- Chris Chirgwin, Chief Information Officer, County of Santa Barbara
- Michael Prater, Executive Director, Santa Barbara Local Agency Formation Commission
- Tanja Heitman, Assistant County Executive Officer, Santa Barbara County Executive Office
- David Silva, Mayor, City of Buellton
- Mark Hartwig, Fire Chief, Santa Barbara County Fire Department

Proclamation

In a special session that underscored the profound and sometimes unforeseen duties of protecting our civic institutions, the Santa Barbara County Civil Grand Jury took the rare step of issuing a public proclamation to honor a moment of exceptional bravery. On November 7, 2024, in a ceremony held in the Jury Assembly Room in Santa Maria, the Grand Jury presented a Proclamation of Heroic Bravery to Mr. Steve Neil, a security guard whose quick thinking and courageous actions prevented a greater tragedy at the Santa Maria Superior Courthouse. This honor is one the Grand Jury bestows only on rare occasions, reserved for citizens who demonstrate extraordinary service to the community. The commendation followed a harrowing incident on September 25, 2024, when an individual threw a backpack containing a homemade explosive device into the courthouse lobby. The subsequent detonation injured five people. As the assailant fled toward his vehicle, where he had stored additional weapons for a larger planned attack, Mr. Neil, a guard with Triumph Security, took immediate action. Without hesitation, he

pursued the suspect, successfully subduing and detaining him until law enforcement officers arrived. His decisive intervention in the face of extreme peril undoubtedly saved lives and protected the sanctity of the court.

In recognizing Mr. Neil, the Grand Jury acknowledged an act that went far beyond the expected duties of his post. Grand Jury Foreperson Dale Kunkel stated, "Mr. Steve Neil placed himself at great peril to protect others, and to defend the Santa Barbara County Superior Court, the institution that is the home of the Grand Jury. We honor and applaud him for his heroic action that saved lives." The ceremony served not only to commend a single heroic act but also to highlight the vital role that dedicated individuals play in ensuring the safety and security of the public spaces central to our justice system. The Grand Jury felt it was imperative to publicly share its praise and appreciation for Mr. Neil's selfless courage.

Grand Jury

Santa Barbara County

Proclamation

HONORING THE HEROIC BRAVERY OF

STEVE NEIL

Whereas: on September 25, 2024, a dangerous incident occurred at the Santa Maria Courthouse, where an explosive device was detonated; and

Whereas: this attack was premeditated by an individual who further intended to cause widespread harm, evidenced by his possession of weapons, ammunition, Molotov cocktails and other explosive devices; and

Whereas: in the face of imminent danger, Steve Neil a dedicated Court Security Officer with Triumph Protection Group demonstrated extraordinary courage and quick thinking by taking decisive action that prevented the bombing suspect from fleeing the scene; and

Whereas: Steve's actions not only ensured the safety of those present but also exemplified the highest ideals of selfless public service and heroism; and

Whereas: his commitment to the safety and well-being of our community reflects the values we hold dear in Santa Barbara County; and

Whereas: the Santa Barbara County Civil Grand Jury recognizes the importance of honoring individuals who act selflessly in the face of peril;

Now, Therefore, be it Resolved, that the 2024-2025 Santa Barbara County Civil Grand Jury, on behalf of a grateful County, extends our deepest appreciation with utmost admiration to Steve Neil and wish him continued success in all his future endeavors.

Be it Further Resolved, that this proclamation serves as a testament to his bravery and dedication to public safety, inspiring others in our community to uphold these values.

Passed and Accepted by the Plenary, Santa Barbara County Civil Grand Jury, State of California this 7th day of November 2024, by an acknowledged motion and unanimous vote by all members present.

Attest: _____

Dale Kunkel, Foreperson

Denise El-Amin - Jacqueline Anker - Sunanda Bhargava - Darren Brown
Ryan Brown - Brian Cox - Carlyle Decker - Kent Dunn - Marcia Green
Jeffrey Long - John Richards - Gwen Rigby - Annie Sancedo- Daniel Vordale
- Dr. Kenneth Waxman - Robert Whittier - Reynaldo Ybarra- Keith Staub

Tour – Public Safety Training Complex, Allan Hancock College, Lompoc, CA

This year, the Grand Jury had the unique opportunity to tour the Public Safety Training Complex (PSTC) at Allan Hancock College in Lompoc. Spanning 68 acres, this state-of-the-art facility is a premier training site for programs in Administration of Justice, Emergency Medical Services, Fire Technology, Law Enforcement, and Wildland Fire Technology. The tour provided Jurors with a firsthand look at the cutting-edge resources and rigorous training environments that prepare public safety professionals to serve the community. Such visits deepen

the Jury's understanding of essential county operations, and the investments made in public safety and emergency preparedness.

The Jury's decision to visit the PSTC was based on the fact that several agencies in Santa Barbara County rely on the PSTC to train their employees. These include local law enforcement agencies such as the Santa Barbara County Sheriff's Office and municipal police departments, including those in Santa Barbara, Lompoc and Santa Maria. Fire departments, including city and county fire agencies utilize the facility for Fire Technology and Wildland Fire Technology training. Additionally, Emergency Medical Services (EMS) providers, including ambulance services and public health departments, benefit from the complex's resources. The facility also supports training for probation officers, corrections personnel and other public safety roles, ensuring that employees across the County are equipped with the skills and knowledge necessary to serve and protect their communities effectively.

In the last 12 twelve months, 36 graduates from the Public Safety Training Complex joined the Santa Barbara County Sheriff's Office. Of the new hires, 31 were assigned to work as Custody Deputies helping to fill consistent shortages within the department. The remaining five Deputies who received law enforcement officer training were assigned to Patrol Operations.

Tour – Santa Barbara County Historic Courthouse

The Grand Jury also participated in a special docent-led tour of the Historic Santa Barbara County Courthouse. Renowned for its stunning architecture and rich history, the County Courthouse serves not only as a symbol of justice but also as the location of the Grand Jury chamber where the Jury performs the bulk of its work. This provides a secure and confidential space for deliberations and plenary meetings. The tour offered Jurors a deeper appreciation of the County Courthouse's historical significance while underscoring its vital role in supporting the Jury's responsibilities.

Touring the entire Courthouse enriched our understanding of the role of grand juror by connecting us to the historical and institutional significance of our work. Walking through the courthouse's storied halls and learning about its architectural and civic legacy underscored the gravity and responsibility of our duties aligning us with our mission and vision. Having privileged access to the Grand Jury Chamber where we deliberate, analyze findings, and hold plenary meetings reinforces the importance of our contributions to government oversight and accountability. The experience has fostered a deeper sense of pride and purpose among the members, highlighting our place in the broader continuum of civic service and justice. Special thanks and acknowledgment to Georgia Gates Derr, Group Tours Coordinator, Santa Barbara County Courthouse Docent Council for her generous time guiding the tour.

Election Observation

During the November 2024 General Election cycle, select members of the Grand Jury served as election observers for the Santa Barbara County Election Division, providing an invaluable civic service rooted in transparency and accountability. Their role encompassed observing the full spectrum of election activities, from the opening and closing procedures at polling sites to the meticulous processes at the central counting site. Jurors carefully monitored election-related activities, made detailed notes, and gathered information from the precinct index, ensuring adherence to proper protocols. They also observed the canvass of vote activities following the election, as well as the processing of vote-by-mail and provisional ballots. While maintaining a respectful, non-intrusive presence, jurors engaged with poll workers, voters, and supervisors, asking questions to deepen their understanding of the proceedings without interfering with the conduct of the election. This hands-on experience reinforced the Grand Jurors' commitment to ensuring integrity in public processes and also enriched the Jurors' insight into the democratic systems that underpin local governance.

Elector Group	Counting Group	Cards Cast	Voters Cast	Registered Voters	Turnout
Total					
	Poll	25,159	25,159		10.27%
	Mail	162,717	162,717		66.43%
	Total	187,876	187,876	244,943	76.70%

Certified Election Results

Santa Barbara County Coroner's Bureau

As part of our year-long commitment to understanding the critical functions of County operations, this Jury followed the previous Grand Jury and participated in an enlightening tour of the Santa

Barbara County Coroner's Office. This specialized department, part of the Santa Barbara County Sheriff's Office, plays a vital role in determining the time and cause of death, particularly in cases of sudden or unexpected fatalities. Jurors gained insight into the meticulous processes involved in identifying deceased individuals, notifying next of kin, and returning personal belongings to grieving families. Jurors learned how the Coroner's Office maintains detailed death records that serve a variety of critical purposes, from supporting criminal investigations to resolving insurance claims and monitoring public health trends. The tour provided a profound understanding of the Office's responsibilities and its essential contributions to public safety, justice, and community well-being.

Tour – Santa Barbara County Main Jail and Northern Branch Jail

During the year, the Grand Jury also undertook visits to both the Northern Branch Jail and the Santa Barbara County Main Jail as mandated by California Penal Code Section 919(b) which requires the Grand Jury to "inquire into the condition and management of the public prisons" within the County. Each tour offered a stark look at the complexities of incarceration within the county. At the Northern Branch Jail, jurors observed the modern design and intended operational model, which aims to provide a more direct supervision environment with increased access to medical, mental health, educational, and vocational services. This contrasted with our visit to the Santa Barbara County Main Jail, an older facility that has faced challenges related to

overcrowding, infrastructure, and the provision of adequate healthcare services. These visits provided us with a comprehensive view of the County's correctional system, highlighting both the progress made in modernizing facilities and the ongoing need to address systemic issues impacting inmate well-being and rehabilitation.

Through these tours, we gained a deeper understanding of the physical and operational realities of the county's jail system, including the challenges of providing adequate medical and mental health care, managing overcrowding, and ensuring the safety and security of both inmates and staff. The insights gleaned from these visits helped to inform us during our deliberations leading to findings and recommendations regarding the management and improvement of correctional facilities within Santa Barbara County.

Tour – Susan J. Gionfriddo Juvenile Justice Center – Santa Maria

In order to better understand the county's justice system, the Grand Jury toured the Susan J. Gionfriddo Juvenile Justice Center located in Santa Maria. This facility plays a critical role in rehabilitating and supporting at-risk youth while ensuring public safety. During the visit, jurors observed the Center's operations, including its secure housing units, educational programs, and counseling services designed to address the unique needs of juveniles in the justice system. Staff members provided an overview of the center's rehabilitative approach, which emphasizes accountability, skill-building, and the development of positive behavioral patterns to help youth reintegrate into the community. Jurors also learned about the challenges faced by the Center, including resource limitations and the complexities of addressing mental health issues among its youth. The visit offered valuable insight into the county's efforts to balance rehabilitation and accountability, underscoring the importance of early intervention in fostering long-term success for young people.

Tour – Charles Meyer Desalination Plant and the Corona Del Mar Treatment Plant

The Grand Jury conducted insightful tours of two pivotal facilities that play a critical role in maintaining the water security of Santa Barbara County: The Charles Meyer Desalination Plant in Santa Barbara and the Corona del Mar Water Treatment Plant in Goleta. At the Charles Meyer Desalination Plant, jurors

observed the cutting-edge reverse osmosis technology that transforms seawater into potable water, a process vital to ensuring the region's resilience against drought and climate variability. Serving as a key component of Santa Barbara's water supply, the plant is capable of providing up to 30% of the city's water needs during times of scarcity. The tour emphasized the plant's operational intricacies, environmental considerations such as energy efficiency, and its importance in complementing other local water sources.

At the Corona del Mar Water Treatment Plant in Goleta, jurors explored the facility's role in producing safe, high-quality drinking water for the region. The plant, which processes water from Lake Cachuma, employs advanced filtration and disinfection methods to meet stringent state and federal water quality standards. The tour provided a comprehensive overview of how the plant integrates with the broader water distribution system, ensuring reliable service to residents and businesses in Goleta and surrounding communities. Jurors also learned about the challenges of maintaining infrastructure, adapting to regulatory changes, and planning for future demand amid ongoing water supply uncertainties.

These visits offered the Grand Jury a deeper understanding of the region's multifaceted water management strategies and highlighted the importance of investing in infrastructure to ensure the long-term sustainability and reliability of Santa Barbara County's water supply.

Conclusion

Drawing from these comprehensive tours and experiences throughout the year, the Grand Jury gained an invaluable understanding of the multifaceted operations that sustain Santa Barbara County's infrastructure, public safety, and essential services. From observing the democratic process during the November 2024 Presidential Election to examining the complexities of water security at desalination and treatment facilities, from understanding the delicate work of the Coroner's Office to witnessing the challenges within both adult and juvenile correctional systems, each visit reinforced the interconnected nature of County governance. The educational journey through these diverse facilities not only enriched the Jury's perspective on local government operations but also helped develop a deeper appreciation for the complexities and responsibilities inherent in public service, ultimately strengthening the ability to fulfill the Grand Jury's oversight role with greater insight and understanding.

SANTA BARBARA COUNTY AGENCIES RESPOND TO 2023-2024 GRAND JURY REPORTS

FILED MARCH 6, 2025

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SANTA BARBARA COUNTY AGENCIES RESPOND TO 2023-24 GRAND JURY REPORTS

SUMMARY

The 2023-24 Santa Barbara County Grand Jury issued nine reports. The current 2024-25 Grand Jury has assembled the responses to the prior Jury's reports. The following report is based on the responses that agree or disagree with the Jury's findings and recommendations. This Response Report is also meant to allow the public to become more familiar with their local agencies by reading their answers to the Grand Jury's reports, found on its website: www.sbcgj.org. Overall, Santa Barbara County agencies agreed with the 2023-24 Jury's findings 46 times (64.8% of the time) and stated that they either have implemented or will implement the Jury's recommendations 56 times (58.4% of the time).

INTRODUCTION

In California, each county grand jury writes reports after looking into the operations of various local government entities. These reports are sent to the local agencies, who then are required to write a response to the jury's findings and recommendations that are addressed to them. The agencies can agree with the jury's findings and recommendations, and this can lead to changes in how policies are implemented. Agencies can also disagree with the jury, which can happen just as often. In these cases, the agencies explain their position and their actions in their responses.

Either way, the investigative process informs the public how our local government agencies work. While the agencies might not always agree with a grand jury, everyone is working together to improve their function in the community. This is, at its core, a collaborative effort.

A grand jury is considered the watchdog for the public. Grand jury members are able to directly interview members of the government and private citizens and gather information that is not always available to the public. In this way, a grand jury has a unique ability to "shine the light" on our civic processes.

The 2024-25 Santa Barbara County Grand Jury invites the public to contact it regarding areas of future investigations. A form to request an inquiry can be found on the Grand Jury website: www.sbcgj.org. Letters can be mailed to: Santa Barbara County Grand Jury, 1100 Anacapa Street, Santa Barbara, CA 93101.

DISCUSSION

The following reports are listed in order of their publication date during the 2023-24 Santa Barbara County Grand Jury's (Jury) term. The first report was published on March 22, 2024, and the last report was issued on June 26, 2024.

Lompoc Tourism Improvement District Management Agreement 2019-2028
March 22, 2024

The Grand Jury investigated the finances of the Lompoc Tourism Improvement District (LTI) and the monitoring of those finances done by the City of Lompoc. A Grand Jury report from the 2011-2012 Jury had also identified Lompoc's failure to adopt a non-profit audit policy, which was again mentioned in a 2013-14 Grand Jury report.

The Grand Jury analyzed the annual reports prepared by LTI and identified a $500,000 discrepancy between the carry-over funds and expenditures. It also noted that $800,000 of the funds collected had been placed in a money market fund. The Grand Jury found that the City of Lompoc had exercised no financial control over the LTI and had not required an audit or implemented other monitoring measures. The 2023-24 Jury recommended that the City of Lompoc require financial reporting from the LTI and also that the City monitor the expenditures of the LTI.

In response, the City of Lompoc disputed some aspects of the financial analysis, agreed with two of the findings of the report, and partially disagreed with four, mostly related to its limited oversight role on the finances of the LTI. The City advised that none of the recommendations would be implemented because the City does not have the authority to implement financial controls over the LTI. The City serves only as a "passthrough" for funds collected from the hospitality industry and dedicated to LTI. The City noted that its agreement that created the LTI only required that the LTI issue an annual report, and that requirement had been met.

Potential Perceived Conflict of Interest for Death in Custody Investigations
April 15, 2024

The Grand Jury explored ways in which the Sheriff-Coroner could avoid a perceived conflict of interest when autopsies are conducted for in-custody deaths. While recognizing the Jury's concerns, the Sheriff's Office disagreed with the Jury's finding of a real or perceived conflict of interest in the Sheriff-Coroner's jurisdiction over in-custody deaths. The Sheriff-Coroner responded that the experience and expertise of its staff ensured impartial and ethical investigations into these deaths. To allay doubts about influence over its own investigative team, the Sheriff-

Coroner pointed out that the Coroner's Bureau falls outside the Custody Division's chain of command, and the pathologist acts independently. As for the Jury's finding that there is no succession plan for hiring pathology technicians, there was no answer to the finding itself.

The Jury also recommended an independent investigation into all deaths in custody. The Sheriff-Coroner responded that this has been implemented, as the District Attorney does specifically investigate all cases of use-of-force or restraint by officers, and this practice may be expanded to all deaths in custody. The Sheriff disagreed with the Jury's recommendation that an independent medical team be used for all deaths in custody, as this would be cost-prohibitive and duplicative of its own services.

For the Jury's recommendation of a succession plan for officers with the specific skills needed in the Coroner's Bureau, the Sheriff avowed that they have been working on this with the County, and a plan would be finalized by September 2024; that is, the Jury's recommendation would be implemented.

Wellpath Contract Services Provided to Santa Barbara County and the Sheriff's Office
April 19, 2024

The Grand Jury issued its report on the Wellpath contract during the negotiations between the Sheriff's Office, Wellpath and the Board of Supervisors (Board) in April 2024. Because of this parallel timing, the Sheriff's responses, due within 60 days of the issuance of the Jury's report, reflected the inability to announce any definitive changes to the contract. When the Board of Supervisors published its responses to the Jury report 30 days later, it responded similarly to the findings and recommendations of the Jury although it was more specific about the changes being made to the Wellpath contract. The true measure of response came when the contract was finalized in June 2024 and the Jury's concerns were met with the positive changes in the Wellpath contract.

The Jury focused on four areas for discussion of the contract: lack of accountability for staff vacancies, lack of 24/7 mental health coverage, accounting shortfalls, and lack of timely annual reporting. According to the Sheriff's Office, it has cooperated with Wellpath on strategies to mitigate the impact of staff vacancies, and together they have invested in recruitment. As for accounting for staff vacancies, the Sheriff's Office wrote that the pandemic and the opening of a new jail complicated how to count staff. Although the Sheriff confirmed the shortfalls, the response partially disagreed with the Jury's finding.

The Board of Supervisors generally mirrored the Sheriff's responses. The Board did point out that Wellpath's annual report for service to the Probation Department was not late; it was only its

annual report for the Sheriff's Office—a partial disagreement with the Jury's finding. Otherwise, there were no Board comments on the findings.

Contract negotiations were underway at the time that the Sheriff's Office was preparing its responses. Recommendation items on the table included additional positions, accountability, billing procedures, and oversight from Public Health. Its response for most of the Jury's recommendations were "will be implemented." As for increased training on critical mental health issues, the Sheriff's Office felt that both Wellpath nurses and custody officers are well trained, and it did not need to impose more training. Likewise, telepsychiatry was defended as available at all times, although the Jury's recommendation was for a thorough assessment of telepsychiatry's efficacy, with particular attention to the issue of available care during the overnight hours.

Both the Sheriff and the Board could not respond to all recommendations because matters such as compensation and incentives for hiring nurses were not under their purview, but that of Wellpath. Both entities responded that they would not implement those Jury recommendations.

The Board was able to commit to anticipated staffing increases as its responses to the Jury took form further along in the negotiation process. It also had taken steps to assure contractual compliance by approving two new positions in the Public Health Department expressly for working with Wellpath in the jails. These medical advisors will assess performance of Wellpath staff. The Board also directed Behavioral Wellness (BWell) to staff mobile crisis units to be available to respond to situations at the jail during evening and nighttime hours, as advised by the Jury. The Board is encouraging a cooperative working arrangement between BWell and the jail staff. For on-time annual reports, the Board placed responsibility on the Sheriff's Office more than on Wellpath and denied the recommendation to penalize Wellpath for late reports.

When the Board considered the Seventh Amendment to the current Wellpath contract in June 2024, it addressed the Jury's concerns about staffing and increased Wellpath's budget by $13,232,153.75. The amendment added 16.6 FTE (full-time equivalent) positions, which included 2.5 FTE positions in mental health care. The tardy annual report was anticipated in the next month at the writing of the Board's responses. Moreover, the Board of Supervisors reported that cost reimbursements for Wellpath services not rendered were in progress. Overall, the Board acknowledged the Jury's concerns.

Civil Grand Jury Compensation
May 30, 2024

The 2023-24 Grand Jury reviewed its compensation and recommended an increase. Disagreeing with the Jury, the Board of Supervisors indicated that they raised Jury compensation in 2001, or

23 years ago and not 25, and in doing so increased the compensation more than for what most grand juries in other counties in California currently receive (42 out of 57 counties) and more than what trial jurors receive. The Board agreed with the finding that commuting to South County for those living in North County does add to the overall budget expense because of the mileage money they receive from driving rather than telecommuting.

For the Jury's recommendation that the Board raise the per diem from $25/day to $50/day, as received by two counties in Southern California, the Board questioned the Jury's comparison of Santa Barbara County with Los Angeles and Orange Counties, rather than the 42 other similarly sized or smaller counties for pay equivalencies. Moreover, the Board did not see raising the per diem compensation as a method for attracting a more diverse applicant pool; the Jury's schedule itself restricts who applies for the Jury, as meetings occur during normal working hours and 20 hours per week are suggested, which precludes many who do not have that time to devote to the Jury.

For the costs of commuting to South County, where the Jury has a private room with office amenities, it would not help the budget to dedicate similar space in North County according to the Board because more jurors would be commuting in the opposite direction for those meetings. Instead, the Jury should find a room which has an optimal set-up for virtual meetings in North County, and the County and the Court are currently identifying sites for that purpose. The Board agreed to implement only one of the two Jury's recommendations.

Santa Barbara County Coroner Facility and Equipment: A Hazardous Environment
June 13, 2024

In several reports over the past years, the Grand Jury found that the Sheriff's Office operates an outdated and hazardous Coroner's facility. The Sheriff's Office agreed but relies on the Board of Supervisors to approve improvements at the facility and prioritize its replacement in the Calle Real Campus Master Plan.

In the two months following the issuance of the 2023-24 Jury's report criticizing the Coroner's building as a health hazard, the Sheriff's Office made the repairs recommended by the Jury. Thus, it disagreed with the Jury's findings that repairs were needed immediately because they had already been completed. The Sheriff's Office then was able to answer the Jury recommendations for a new roof, mold abatement, and exterminator treatment with "has been implemented" or "will be implemented" soon. Rather than hire independent contractors as recommended by the Jury, the Sheriff's Office used the County's General Services Department to address the problems.

The responses from the Board of Supervisors mostly followed those of the Sheriff's Office, noting that satisfactory repairs had taken place. Additionally, the Board saw no reason to go outside the County's General Services Department for repairs, and the passing of inspections by the Environmental Health Department validated the work. Likewise, the Board saw no need to add a safety officer at General Services when other departments already provide such services. The Jury's photos of mold, wood rot, and termite damage did not persuade the Board that action by outside parties would be preferable.

The Sheriff's Office and the Board of Supervisors split on moving up the replacement of the Coroner's facility in the Calle Real Campus Master Plan as a priority before the end date of 2039. The Sheriff's Office endorsed this action, but the Board of Supervisors referred to a decision in the Five-Year Capital Improvement Program to improve, not replace, the aging building. The Board, who controls the budget, judged that after the recent repairs, replacement would be "costly with limited benefit."

As for the Jury's recommendation that there be six months of testing of the new toxicology instrument, the Sheriff's Office felt that thorough reviews and verification of results were adequate. Added toxicology testing would be excessively costly and unwarranted.

Detention Facilities in Santa Barbara County
June 17, 2024

In its visits to the Detention Facilities in the County, the Jury determined a need for improvement at two sites: a cell door at Cuyama Sheriff's Substation and uncomfortably small cells and poor air ventilation at the Santa Barbara Superior Court Holding Facility.

According to the Sheriff's Office, the cell door in Cuyama had been officially inspected and certified. As for the Superior Court Figueroa Courthouse cells, the Sheriff's Office acknowledged the recommendation to remove the single cells and agreed to work with General Services to conduct a thorough analysis of the situation before the end of 2024 while at the same time saying that the single cells have a purpose when separating some inmates. The Sheriff's Office responded that it would work with General Services and commission an analysis of indoor air quality.

Individuals in Crisis
June 21, 2024

The Grand Jury addressed the past practice of not allowing Santa Barbara County law enforcement officers to write a Welfare and Institutions Code section 5150 hold for people in an acute mental

health crisis that endanger themselves or others. It discovered that the origin of this practice was a money saving step after the passage of State Proposition 13 in 1978. There were no legal impediments to allowing law officers to write a 5150 hold rather than restricting this process to clinicians of the County Behavioral Wellness Department (BWell). Since the 1978 state law, BWell has assumed the role of intervening in emergency situations for people with mental health disorders with its Mobile Crisis Teams. However, with recent staff shortages, BWell's responses to such situations have not always been timely. The Jury encouraged the addition of law enforcement officers with training in issuing 5150 holds.

The Board of Supervisors and the Sheriff's Office agreed with the policy of training law officers for mental crisis intervention and stated in fact this has been a part of the Academy training and has been put into effect with the Co-Response teams (one law officer and one BWell clinician) for a number of years. Yet while agreeing in principle, both the Sheriff's Office and the Board of Supervisors did not see a need for more training for law enforcement officers. The Board of Supervisors pointed to a recent study that showed the local Co-Response teams received low volumes of calls and therefore concluded that the recommendation to increase such units would not be implemented. The Sheriff's Office stated that it would defer to the Co-Response Teams and BWell's Mobile Crisis Team before instructing Sheriff's deputies to respond to mental health emergencies. The one city that responded to this report, Lompoc, will train its police officers in the assessment for 5150 holds. In essence, these parties agreed that having more police officers available for issuing 5150 holds, when necessary, would benefit the persons involved and the community, but the need for empowering more officers does not appear to be a pressing issue at this time.

Although required, the cities of Santa Barbara and Santa Maria did not respond to this report.

Homeless Encampments in Santa Barbara: Becoming Part of the Community Again June 25, 2024

In 2021, the County of Santa Barbara adopted a Homeless Encampment Resolution Strategy. This action plan was scheduled for renewal in June 2024, which motivated the Grand Jury to assess "successes and the continued challenges" of encampment programs. The Jury's report coincided with the hearing before the Board of Supervisors (Board) and the adoption of a renewal.

The Jury's findings and recommendations were essentially a study of what had worked and what didn't work in clearing, or "resolving," encampments, and the Board agreed with all the Jury's findings. The Board of Supervisors – which had already been working with a team approach for sweeps, clean-up of encampments, the principle of Housing First, warnings before weather

emergencies, mapping and collaborative funding – responded that it had implemented the Jury's recommendations in these areas.

Even though the Board stated that County agencies cleaned up after encampments, it showed resistance to supplying more sanitation measures, e.g., porta-potties. The City of Goleta affirmed a similar position and stated that to do more would enable the homeless individuals to stay there as in a "de facto shelter" rather than try to improve their living situation, an estimation that the City of Carpinteria seconded. Carpinteria also pointed out that providing sanitary facilities in encampments would divert resources from their housing initiatives. Santa Barbara also declined to add any bathroom facilities because it would suggest a sponsored encampment. Also, the City of Santa Barbara is unique in that there are several day centers for the unhoused and many parks where bathrooms are available. Lompoc felt that it was complying with this recommendation by sending the residents elsewhere, where there were sanitary facilities. The city councils of Guadalupe, Solvang and Buellton, on the other hand, could not confirm any actual response because there are no encampments in their cities. There seems to be a unified approach among cities to sanitation in encampments. They recognized that it is essential for health and safety but were wary about enabling the unhoused to stay in encampments rather than strive for better housing options.

Although required, the city of Santa Maria did not respond to this report.

Deaths in Custody in Santa Barbara County Jails: Our County Jails Meet Many Needs June 26, 2024

In the six deaths in custody cases that the 2023-24 Grand Jury investigated, errors were discovered and for the most part, the Sheriff's Office acknowledged them. The Sheriff's Office agreed with ten of the fourteen findings by the Jury.

To some degree, many of the Jury's recommended actions had already been initiated with Public Health and Behavioral Wellness (BWell) Departments sharing some supervision of medical and mental health care in the jail. In other cases, the Sheriff readily adopted the Jury's suggestions of changing intake forms for better communication and supervision checks. Another distinguishing feature of the Sheriff's responsiveness to change was the newly required revision and oversight of protocols for its healthcare provider, Wellpath. In these ways, the Sheriff's Office could answer most of the Jury's findings with "Agree" and most of the recommendations with "Will be implemented" or "Has been implemented." This confirms the era of cooperation occurring within the criminal justice system in Santa Barbara County, generated by the 2020 *Murray* Case and Disability Rights California.

The Sheriff's Office agreed with the Grand Jury's findings on the circumstances in the six deaths. When the Sheriff's Office disagreed that there was not enough observation, it was mostly a matter of opinion over the degree of direct observation and the timing in cases of those who have just entered the jail. Newly booked inmates are critically vulnerable at this time, a point emphasized by the Jury. The Sheriff's Office agreed with this matter of critical timing for the one suicide where there was no immediate supervision. For the other five cases, the Sheriff's Office pointed to evasive measures on the part of the inmates. The Sheriff's Office and the Jury also disagreed over the intensity of harm done during restraint of an inmate as well as the danger posed to others in the jail because of outbursts.

Further, the Sheriff disagreed with the finding that the release of documents to the Grand Jury was delayed, citing changes made in the Office to specifically have documents available earlier.

As for the Jury's recommendations, the Sheriff's Office disagreed with four recommendations, saying it would not implement them, but stated that of the other 16 recommendations, 12 had been implemented and four would be. The Sheriff has been working with the Board of Supervisors and two other County Departments, Public Health and BWell, to effect change.

As for the details of the Jury's recommendations, the Sheriff's Office was most responsive when creating forms that could improve the communication of critical information and when collaborative working partners are involved. The Sheriff's Office also declared that it will henceforth expect more accountability from Wellpath, the healthcare provider. Other improvements will come with Public Health positions inside the jail being staffed; the new healthcare officers will oversee Wellpath and complement its services.

The Sheriff's Office disagreed with the Jury's recommendation of utilizing alternative housing – specifically when troubled inmates first arrive at the jail – saying that they could not be lawfully detained outside the jail, other than in a hospital.

The Board of Supervisors underscored the "collaborative system improvements" that were the source for many of the findings and recommendations of the Grand Jury. It encourages the new partnerships, while diplomatically recognizing the main responsibility and decisions rest with the Sheriff.

The Board's ratification of the Wellpath contract on June 25, 2024, moved the Sheriff's Office, the Public Health Department, and Behavioral Wellness forward in supporting new programs, e.g., the medically assisted drug treatment program, or MAT, and the diversion and re-entry program READY. The Board also supported the Public Defender's pilot program in the Northern Branch

Jail being implemented in the Main Jail. The Jury's report emphasized how collaboration among county departments will benefit inmates.

CONCLUSION

The 2023-2024 Santa Barbara County Grand Jury's findings and recommendations endorsed many actions taking place in and among county agencies, serving to highlight positive changes. The Jury would like to acknowledge what it notes as a high degree of cooperation among agencies and the Jury in this past year. Overall, agencies agreed with the Jury's findings 46 out of 71 times (64.8%), and over half of the Jury's 96 recommendations either have been implemented or will be (31.3% Have Been Implemented and 27.1% Will Be Implemented). The Jury's reports spotlight the agencies' actions so that the citizens of the County can participate to best ensure that the changes are carried out in a timely manner.

The Jury thanks the agencies and other local entities that provided their responses to the 2023-24 Jury's reports in a timely manner. The Jury further commends them for their commitment to implementing the Jury's recommendations and improving the services they provide to our local communities.

FINDINGS AND RECOMMENDATIONS

Finding 1: County agencies agreed with most of the 2023-24 Jury's findings and implemented a majority of the 2023-24 Jury's recommendations, which reflects an encouraging level of cooperation among local agencies and the Jury.

This Response Report has no recommendations.

REQUIREMENTS FOR RESPONSES

This Response Report does not require a response from any governmental agency.

IS THE SANTA BARBARA COUNTY PUBLIC HEALTH DEPARTMENT PREPARED FOR THE NEXT EPIDEMIC?

FILED MARCH 12, 2025

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IS THE SANTA BARBARA COUNTY PUBLIC HEALTH DEPARTMENT PREPARED FOR THE NEXT EPIDEMIC?

SUMMARY

Another epidemic in Santa Barbara County is not merely a possibility—it is an inevitability. The emergence of new infectious agents that may cause devastating outbreaks is occurring at an alarming rate. The 2024-2025 Grand Jury has identified shortcomings in Santa Barbara County's readiness for a new epidemic. Our County must adopt a proactive approach to preparedness. This includes utilizing up-to-date technologies, implementing proactive risk assessment and disaster planning strategies, strengthening early detection, and improving communication to prepare for bioterrorism threats. (References 1-3)

The Santa Barbara County Public Health Department is the front line. While federal and state agencies may provide guidance, it is the County Public Health Department's responsibility to plan for and respond to infectious epidemics that might occur in Santa Barbara County.

BACKGROUND

Infectious disease epidemics, such as COVID-19, have devastating effects on communities. They overwhelm existing health care resources, result in massive illness and death, and have terrible consequences for public health, education, and the economy.

County public health departments have defined responsibilities under California law (California Health and Safety Code, Part 3, Chapter 2, Sections 101025 – 101165). County health departments are tasked with protecting public health, which includes planning for, preventing, and managing outbreaks of infectious diseases. Their responsibilities include:

1. Surveillance and Monitoring: Tracking the spread of diseases and identifying outbreaks through data collection and analysis.
2. Preparedness Planning: Developing and maintaining public health emergency response plans, including those for epidemics and pandemics.
3. Education and Outreach: Informing the public about disease prevention measures and providing resources to mitigate the spread of illnesses.
4. Coordination: Working with state and federal agencies, healthcare providers, and other local entities to respond effectively to public health threats.
5. Vaccination and Treatment: Organizing vaccination campaigns and ensuring access to medical treatment during an epidemic.

Three potential sources of new epidemics could impact our County:

- Natural disease epidemics. There is potential for current endemic disease to mutate and create epidemic risk. For example, new and more virulent strains of COVID-19 or influenza viruses could emerge (such as avian influenza). Further, with increases in international travel and migration, diseases which were once isolated to confined regions of the world may rapidly become global. Examples include Mpox and Ebola, once confined to East Africa; mosquito-borne diseases such as malaria, Zika, and West-Nile virus; and, polio, historically isolated to localized populations. (References 4-6)
- Laboratory leaks. Technology to alter infectious microorganisms using genetic engineering has rapidly evolved, has become widely available, and is now being utilized in numerous research and commercial laboratories across the globe. There are currently no international regulations to ensure the safety of this technology, resulting in a risk of new virulent pathogens escaping and disseminating. (References 7-8)
- Bioterrorism. Genetic engineering may also be utilized to alter dangerous microorganisms to create potential biological weapons. Such engineering has been detected in Russia, China, North Korea, and Iran, and among independent terrorist organizations. The weaponization of such agents as Smallpox, Anthrax, Corona, Ebola, and influenza viruses is a real and present threat. The strategic importance of the Vandenberg Space Force Base makes this a potential target that would threaten the greater Santa Barbara County. (References 9-11)

Given these threats, there is a high likelihood of an infectious epidemic occurring again in Santa Barbara County.

METHODOLOGY

The Grand Jury used the following investigative methods:

- Requests for information from County departments.
- Interviews with public health experts, epidemiology experts, community physicians, representatives from Vandenberg Space Force Base, County department employees and County officials.
- Review of information on websites of:
    - The Santa Barbara County Public Health Department
    - The World Health Organization (WHO)
    - The Centers for Disease Control and Prevention (CDC)
    - The National Association of County and City Health Officials (NACCHO)
    - The California Department of Public Health

    - The US Department of Homeland Security
    - The California Office of Emergency Services
- Review of news articles reporting new epidemic threats.
- Review of scientific literature and recently published books (see References section at the end of this report).

DISCUSSION

According to its website, the CDC recommends several key strategies for developing a comprehensive local epidemic preparedness plan:

- Surveillance and Monitoring: Establish robust systems for continuous surveillance and monitoring of disease trends. This includes collecting data from hospitals, laboratories, and public health departments to identify unusual patterns or increases in disease incidence.
- Risk Assessment: Perform ongoing evidence-based risk assessments to determine which infections are most likely to occur. This involves analyzing the most current epidemiologic data to prioritize potential threats.
- Emergency Operations Plan (EOP): Develop an Emergency Operations Plan that includes specific actions for before, during, and after an outbreak. This plan should outline procedures for screening, testing, contact tracing, physical distancing, isolation, and mask use.
- Communication and Coordination: Ensure effective communication and coordination with law enforcement, first responders, healthcare providers, and hospital staff. Establish clear channels for sharing information and coordinating responses.
- Resource Allocation: Allocate resources effectively, including vaccines, treatments, and medical supplies. Ensure that there are sufficient stockpiles and distribution plans in place.
- Training and Exercises: Conduct regular training and practice exercises with all partners involved in the response. This helps ensure that everyone is prepared and knows their roles in the event of an outbreak.
- Public Education: Educate the public about the importance of preparedness and the steps they can take to protect themselves. This includes promoting vaccination, hygiene practices, and awareness of symptoms.

The Santa Barbara County Public Health Department is aware of the risk of future epidemics and the important role that it must play in epidemic preparedness and response. However, based on numerous interviews and review of recent scientific literature, the Grand Jury has identified that there are some important approaches to epidemic preparedness that are currently not utilized in Santa Barbara County. These include the use of new technologies to identify and document the specific infectious agents that pose the greatest risks of potential future epidemics. Such tools can be utilized to formulate the current risk assessment to identify the pathogens most likely to cause

an epidemic in Santa Barbara County. Additionally, based upon evidence-based and disease-specific risk assessment, the Santa Barbara County Public Health Department could develop disaster response plans specific to each potential epidemic risk.

Determination of Epidemic Risks

The Grand Jury has learned from testimony and from literature review that the following three proactive approaches would improve the preparedness and response to potential new infectious epidemics in Santa Barbara County.

Current Technologies

The first important tool to lessen potential epidemic risk is use of up-to-date technologies. The Santa Barbara County Public Health Department currently relies upon reporting of selected diseases by Santa Barbara County hospitals and health care providers. These events can be entered into a state program called the California Reportable Disease Information Exchange (CalREDIE). Reports from other California counties are also available through CalREDIE. However, witnesses have testified that CalREDIE program does not provide sufficient information, in part because many potentially dangerous diseases that occur in Santa Barbara County and elsewhere in California are not reported. There is usually no reporting for non-hospitalized patients, even if they have symptoms of an infection that could pose a risk of spread. Hospitals might also not report potentially dangerous infections to CalREDIE because of HIPAA concerns. In addition, patients with unusual and unexplained symptoms might not be reported, as their diseases are not recognized as reportable. Furthermore, the current system only includes selected cases that have been reported from within California. It does not systematically utilize or analyze data from national or international threats.

The currently available computer software platforms have the power to provide much more robust information regarding risk assessment and the early detection of possible epidemic threats. Such systems utilize artificial intelligence to collect and analyze infectious risk signals from many sources, not just locally, but also around the state, nation, and globally. Data are gathered not just from case reports, but also from testing laboratories, pharmacy sales, migration and travel data, and more. Geo-mapping and big data analytics are utilized to assess the likelihood of potential threats to local jurisdictions. Such software allows local public health departments to perform evidence-based risk assessment to facilitate proactive preparedness for potentially dangerous organisms and infections. (References 12-18)

Examples of contemporary software tools available to county health departments now include:

A. ESSENCE: The Electronic Surveillance System for the Early Notification of Community-based Epidemics, available from the US Department of Defense.
B. Bio Sense Platform: A cloud-based platform for agencies to analyze data and identify potential epidemic risk.

C. Epi Info: A platform that supports outbreak investigations, including risk analysis.
D. HealthMap: A platform that provides real-time tracking of emerging health threats globally and analyzes local threats.
E. ArcGIS: A geospatial platform allowing public health departments to map and analyze epidemic risks.
F. BlueDot: An AI model that collects world-wide data to track infectious disease and provides early warning of potential local risks.
G. Metabiota: A software platform that uses AI to project the likelihood of potential outbreaks.
H. Epidemic Intelligence from Open Sources (EIOS): An open-source, web-based system for epidemic intelligence from WHO.
I. PHC Global: New software platform for epidemic detection, which may be available for beta testing.

Wastewater Testing

A second important tool for the determination of epidemic risk is epidemic wastewater testing. The technology to detect threatening infectious microorganisms that may cause epidemics by testing their presence in wastewater has rapidly evolved and is now widely implemented, including in most California counties. In Santa Barbara County, wastewater treatment plants have traditionally tested wastewater for organisms such as E-coli, which pose a threat to streams and beaches.

However, more sophisticated testing for organisms that might cause epidemics has not been widely implemented. One notable exception is a site in Lompoc where epidemic wastewater testing is ongoing with the support of a private grant. These data are reported to a California database, data.wastewaterscan.org. The Goleta Sanitary District has also recently begun to perform testing, in partnership with the California Department of Public Health. There was a previous testing site funded by a nonprofit agency in the City of Santa Barbara, but this is no longer operating. There is currently no testing in other major population centers, including Santa Maria.

Wastewater testing for pathogens to track potential outbreaks and coordinate early responses is now an essential component of epidemic preparedness, which is the legal responsibility of California county public health departments. Many California county public health departments have assumed the responsibility to assure that wastewater testing for potential epidemic pathogens has been implemented in their counties. These public health departments include those in the counties of Los Angeles, San Francisco, Sacramento, Santa Clara, Fresno, Riverside, Orange, Kern, and Alameda. However, the Santa Barbara County Public Health Department does not operate or supervise any wastewater testing facilities, nor does it routinely receive results. In addition, while the Public Health Department might informally review some wastewater testing results, there is currently no defined process or procedure for the Public Health Department to review local and regional wastewater test results nor to incorporate these reviews into risk analysis. (References 19-22)

Information Sharing

The third important tool in determining epidemic risk is optimal communication. The County Public Health Department currently has useful communication with the California Department of Public Health and with officials from other county health departments in the state. These conversations facilitate important information sharing regarding public health issues throughout California.

In addition, communication amongst local care providers is an important component of effective epidemic preparedness. Sharing information regarding suspicious infections and other potential risks that have been identified in the County can provide early warning of new epidemic risks. Several California public health departments have established community task forces or advisory groups for epidemic preparedness. These task forces typically include public health officials, healthcare providers, emergency responders, community leaders, representatives from jails and prisons, and sometimes representatives from local businesses and schools. Their goals include:

- Early detection of new infections in the community
- Coordinating response plans: Ensuring that local hospitals, clinics, and first responders have a unified strategy.
- Public communication: Developing clear messaging for residents about risks, prevention, and available resources.
- Adequate resource allocation: Planning for supplies, vaccines, and treatments.
- Community engagement: Addressing specific needs of vulnerable populations.

The California Department of Public Health works with county health departments to facilitate these efforts. Many public health departments, including those in Los Angeles and San Francisco, have established dedicated pandemic planning groups. The Santa Barbara County Public Health Department has recently participated in meetings with local healthcare providers, including physicians as well as representatives from healthcare and educational institutions about local epidemic risks. However, these community meetings have not occurred regularly, nor are any recommendations documented or formally communicated. Furthermore, representatives from other important stakeholders such as public health officials from surrounding counties have not been included in these meetings, nor have representatives from the county jails, Vandenberg Space Force Base, nor the Federal Correctional Complex in Lompoc.

Risk Assessment and Disaster Planning: Proactive or Reactive?

Although Santa Barbara County engaged a consultant to develop an epidemic disaster plan in 2024, it is not specific to Santa Barbara County. The plan has not been fully disseminated or practiced and does not identify specific responses to potential high-risk epidemics. The current plan lacks detailed responses for specific epidemics identified through risk analysis as having a high likelihood of occurrence. Most importantly, the plan remains reactive.

In contrast, a proactive approach would involve performing ongoing evidence-based risk assessments derived from the most current epidemiologic data to determine which infections are most likely to occur in Santa Barbara County. Based on these risk assessments, the County could develop specific disaster plans for each potential epidemic infection. (References 23-26)

An example of a process to perform proactive risk assessment would be to utilize all available information through up-to-date computer software with artificial intelligence, wastewater testing data, and effective communication to identify those infections which pose the greatest potential risks to the citizens of Santa Barbara.

The following is a hypothetical example of a proactive risk assessment.

Based upon global and regional event reporting, geo-mapping, and artificial intelligence, the greatest epidemic risks to Santa Barbara County might be:

1. Avian influenza
2. Mpox
3. New coronavirus strain
4. New influenza strain
5. Introduction of anthrax by bioterrorism
6. Introduction of smallpox by bioterrorism
7. Reemergence of polio
8. Mosquito-borne influx of Zika virus infections
9. Mosquito-borne influx of West Nile Virus
10. Mosquito-borne influx of Dengue Fever

Currently, the epidemic response plans in Santa Barbara County are primarily reactive. If an epidemic outbreak occurs, the County will respond by determining the necessary actions and then begin to implement them. This reactive approach is likely to result in delays in detecting the outbreak and providing the necessary resources for effective responses, including testing, vaccination, antimicrobials, isolation, communication, and medical care.

In contrast, the Santa Barbara County Public Health Department could implement a proactive approach. In response to risk assessments, ongoing disaster planning can be performed based upon the epidemics of greatest threat. For example, if an evidence-based risk assessment identified that a potential avian influenza epidemic posed a significant risk, a specific disaster plan would be formulated in advance. Such a plan might include how the County would:

- Rapidly deploy testing.
- Acquire and distribute vaccinations and anti-viral medication.
- Provide necessary healthcare resources.
- Determine and institute appropriate isolation and contact tracing strategy.

- Mobilize the necessary human and material resources to implement the disaster plan.
- Communicate current information to health care providers and to the public.
- Protect vulnerable populations, including those confined to jails and long-term care facilities.

This proactive planning process can and should occur for each high-risk epidemic threat defined by the evidence-based risk analysis. (Reference 27)

A proactive strategy would help ensure that Santa Barbara County is better prepared to respond swiftly and effectively to future epidemic threats.

Responses to Infectious Epidemics: Reactive Versus Proactive Approaches

Reactive Approach: Current Santa Barbara County Process

Proactive Approach: Recommended Process

As illustrated in the diagram above, if a new infectious epidemic began infecting citizens of Santa Barbara County under the current reactive approach, there may be delayed detection and a delay in formulating a response plan. In contrast, under the suggested proactive approach, the start of the epidemic would be detected without delay and the response would already be formulated and ready for implementation.

Bioterrorism

The widespread availability of genetic engineering technology has enabled hostile organizations and nations to develop potential weaponized microorganisms, significantly increasing the threat

of bioterrorism. Santa Barbara County is particularly vulnerable to a microbiological bioterrorism attack, especially given the strategic importance of Vandenberg Space Force Base.

The federal government recognizes bioterrorism as a significant risk and actively monitors and gathers information on this threat. Witnesses have testified that federal agencies, including the Department of Defense and the Department of Homeland Security, are employing significant resources to detect potential bioterrorism attacks. Bioterrorism preparedness is essential for county health departments to protect public safety, coordinate rapid responses, and prevent widespread casualties. While federal agencies help identify the risks of bioterrorism, county health departments must be prepared to effectively respond. However, there is currently no formal communication regarding these risks between the Santa Barbara County Public Health Department and federal agencies.

In contrast, a number of California county public health departments actively collaborate with federal agencies regarding bioterrorism threats through communication protocols and partnerships with agencies including the CDC, Department of Homeland Security, the Federal Bureau of Investigation, and the Department of Defense. Examples of California county public health departments that regularly communicate with federal agencies about bioterrorism threats include those in Los Angeles County, San Francisco County, Sacramento County, San Diego County, Alameda County, and Orange County. (References 28-29)

Bioterrorism poses an additional risk that new epidemic diseases could be spread in Santa Barbara County.

CONCLUSION

As new strains of infectious diseases develop, our local health care services struggle to protect the community, as happened at the inception of the COVID-19 pandemic. This is a dangerous state of affairs for Santa Barbara County. A more proactive approach by the County Public Health Department can ensure that the citizens of the County have ready access to healthcare and medications.

Much of what is necessary to be ready for another outbreak is already available. The Santa Barbara County Public Health Department needs to avail itself of advanced software, wastewater testing, working task forces, and begin proactive disaster planning for specific threats to public health. The County Board of Supervisors would be wise to recognize the risks of delayed proactive actions, support the Public Health Department's acquisition of the innovative technologies, and encourage the employment of new networking organizations.

FINDINGS AND RECOMMENDATIONS

The 2024-2025 Santa Barbara County Grand Jury finds that:

F1. The Santa Barbara County Public Health Department has not developed proactive pathogen-specific risk assessments based upon evidence-based risk analysis.

F2. The Santa Barbara County Public Health Department has not developed proactive pathogen-specific disaster plans based upon evidence-based risk analysis.

F3. The Santa Barbara County Public Health Department has not employed current, more comprehensive software for the early detection of potential epidemic risks.

F4. The Santa Barbara County Public Health Department has the obligation to ensure wastewater testing is carried out throughout Santa Barbara County but is not currently fulfilling its responsibility.

F5. Even though bioterrorism is a growing threat, Santa Barbara County has not established effective channels of communication with federal, regional, and other stakeholders to learn of and apply threat assessment at the local level.

F6. The Santa Barbara County Public Health Department has not established a process to assure effective communication between regional healthcare providers regarding local epidemic risks.

The 2024-2025 Santa Barbara County Grand Jury recommends that:

R1. The Board of Supervisors require the Santa Barbara County Public Health Department to perform ongoing evidence-based assessments to determine the potential pathogens that pose the highest risk in Santa Barbara County. Risk assessments should be updated every three months, or more frequently if new threats are identified. To be implemented by September 1, 2025.

R2. The Board of Supervisors require the Santa Barbara County Public Health Department to develop disaster plans specific to each of the pathogens identified by risk assessment to be at highest risk of causing an epidemic. Disaster plans should be updated every three months, or more frequently if new threats are identified. To be implemented by September 1, 2025.

R3. The Board of Supervisors require the Santa Barbara County Public Health Department to identify, acquire, and implement current, more comprehensive software for the early detection of potential epidemic risks. To be implemented by December 1, 2025.

R4. The Board of Supervisors require the Santa Barbara County Public Health Department to ensure that sufficient wastewater testing sites are operational in Santa Barbara County, to include at least the major population centers. To be implemented by September 1, 2025.

R5. The Board of Supervisors require the Santa Barbara County Public Health Department to seek to institute regular communication with relevant federal agencies, including Vandenberg Space Force Base, regarding the current threat of bioterrorism, and incorporate this information into risk analysis and disaster planning. To be implemented by September 1, 2025.

R6a. The Board of Supervisors require the Santa Barbara County Public Health Department to establish a community task force for epidemic preparedness by instituting regular meetings and inviting participation by health care providers within Santa Barbara County, as well as public health representatives from surrounding counties, the county jails, Vandenberg Space Force Base, and the Federal Correctional Complex, Lompoc. To be implemented by September 1, 2025.

R6b. The Board of Supervisors require the Santa Barbara County Public Health Department to ensure that the recommendations of the community task force be documented, shared, and acted upon by responsible entities within Santa Barbara County. To be implemented by September 1, 2025.

REQUIREMENTS FOR RESPONSES

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

Responses to Findings shall be either:

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

Responses to Recommendations shall be one of the following:

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

Santa Barbara County Board of Supervisors - 90 Days
Findings 1, 2, 3, 4, 5, 6
Recommendations 1, 2, 3, 4, 5, 6a, 6b

REFERENCES

1. Rivers, Caitlin. *Crisis Averted: The Hidden Science of Fighting Outbreaks*. New York: Viking Press, 2024.

2. Pringle, Eleanor. "Disease forecasters are convinced there's a 27% chance of another COVID-like pandemic within 10 years—but experts believe there's a silver bullet." *Fortune Magazine*, April 18, 2023. https://fortune.com/well/2023/04/18/disease-forecasters-predict-new-covid-like-pandemic-within-10-years/

3. Sinha, Michael S., Wendy E. Parmet, and Gregg S. Gonsalves. "Déjà Vu All Over Again—Refusing to Learn the Lessons of Covid-19." *New England Journal of Medicine* 391, no. 6 (2024): 481–483. https://doi.org/10.1056/NEJMp2406427

4. Baker, Rachel E., et al. "Infectious Disease in an Era of Global Change." *Nature Reviews Microbiology* 20, no. 4 (2022): 193–205. https://doi.org/10.1038/s41579-021-00639-z

5. Lim, Poh Lian. "Travel and the Globalization of Emerging Infections." *Transactions of the Royal Society of Tropical Medicine and Hygiene* 108, no. 6 (2014): 309–310. https://doi.org/10.1093/trstmh/tru051

6. McMichael, Celia. "Climate Change-Related Migration and Infectious Disease." *Virulence* 6, no. 6 (2015): 548–553. https://doi.org/10.1080/21505594.2015.1021539

7. Casadevall, Arturo, and Michael J. Imperiale. "Risks and Benefits of Gain-of-Function Experiments with Pathogens of Pandemic Potential, Such as Influenza Virus: A Call for a Science-Based Discussion." *mBio* 5, no. 4 (2014). https://doi.org/10.1128/mBio.01730-14

8. Shin, Gee Yen, and Rohini Manuel. "Covid-19 Laboratory Leak Hypothesis: How a Few Kept the Many from Considering Alternative Possibilities." *BMJ* 374, no. 2003 (2021). https://doi.org/10.1136/bmj.n2003

9. Linder, Ann, and Dale Jamieson. "Blind Spots in Biodefense." *Science* 379, no. 6633 (2023): 621. https://doi.org/10.1126/science.adg9237

10. Rathish, Balram., et al. "Comprehensive Review of Bioterrorism." In *StatPearls*, StatPearls Publishing, 2023. https://www.ncbi.nlm.nih.gov/pubmed/34033376

11. Hwang, Kun. "Possible Bioterrorism by North Korea and South Korea's Preparedness." *Infectious Chemotherapy* 56, no. 3 (2024): 300–307. https://doi.org/10.3947/ic.2024.0068

12. Li, Ziqi, et al. “Reviewing the Progress of Infectious Disease Early Warning Systems and Planning for the Future.” *BMC Public Health* 24, no. 3080 (2024). https://doi.org/10.1186/s12889-024-20537-2

13. Tran, Bach Xuan, et al. “Global Mapping of Epidemic Risk Assessment Toolkits: A Scoping Review for COVID-19 and Future Epidemics Preparedness Implications.” *PLOS ONE* (2022). https://doi.org/10.1371/journal.pone.0272037

14. Shadbolt, Nigel, et al. “The Challenges of Data in Future Pandemics.” *Epidemics* 40, no. 100612 (2022). https://doi.org/10.1016/j.epidem.2022.100612

15. Turtle, James, et al. “Accurate Influenza Forecasts Using Type-Specific Incidence Data for Small Geographic Units.” *PLOS Computational Biology* 17, no. 7 (2021). https://doi.org/10.1371/journal.pcbi.1009230

16. Rosenfeld, Roni, and Ryan J. Tibshirani. “Epidemic Tracking and Forecasting: Lessons Learned from a Tumultuous Year.” *Proceedings of the National Academy of Sciences* 118, no. 51 (2021). https://doi.org/10.1073/pnas.2111456118

17. El Morr, Christo, et al. “AI-Based Epidemic and Pandemic Early Warning Systems: A Systematic Scoping Review.” *Health Informatics Journal* 30, no. 3 (2024). https://doi.org/10.1177/14604582241275844

18. MacIntyre, Chandini Raina, et al. “Artificial Intelligence in Public Health: The Potential of Epidemic Early Warning Systems.” *Journal of International Medical Research* 51, no. 3 (2023). https://doi.org/10.1177/03000605231159335

19. Singh, Surabhi, et al. “A Narrative Review of Wastewater Surveillance: Pathogens of Concern, Applications, Detection Methods, and Challenges.” *Frontiers in Public Health* 12 (2024). https://doi.org/10.3389/fpubh.2024.1445961

20. Mao, Kang, et al. “Biosensors for Wastewater-Based Epidemiology for Monitoring Public Health.” *Water Research* 191 (2021): 116787. https://doi.org/10.1016/j.watres.2020.116787

21. Girón-Guzmán, Inés, Gloria Sánchez, and Alba Pérez-Cataluña. "Tracking Epidemic Viruses in Wastewaters." *Microbial Biotechnology* 17, no. 10 (2024). https://doi.org/10.1111/1751-7915.70020

22. Boehm, Alexandria B., et al. “Wastewater Concentrations of Human Influenza, Metapneumovirus, Parainfluenza, Respiratory Syncytial Virus, Rhinovirus, and Seasonal Coronavirus Nucleic-Acids During the COVID-19 Pandemic: A Surveillance Study.” *Lancet Microbe* 4 (2023): e340–e348. https://doi.org/10.1016/S2666-5247(22)00386-X

23. Gao, Tilei, Tiebing Li, and Peng Xu. “Risk Analysis and Assessment Method for Infectious Diseases Based on Information Entropy Theory.” *Scientific Reports* 14 (2024). https://doi.org/10.1038/s41598-024-67783-3

24. Dean, Brandon, et al. “Los Angeles County Department of Public Health's Health Hazard Assessment: Putting the 'Health' into Hazard Assessment.” *Journal of Public Health Management and Practice* 19, Suppl 2 (2013): S84–S90. https://doi.org/10.1097/PHH.0b013e3182928e63

25. World Health Organization. *Strategic Toolkit for Assessing Risks: A Comprehensive Toolkit for All-Hazards Health Emergency Risk Assessment*. Geneva: World Health Organization, 2021. https://iris.who.int/bitstream/handle/10665/348763/9789240036086-eng.pdf?sequence=1

26. U.S. Environmental Protection Agency. “Human Health Risk Assessment.” *U.S. Environmental Protection Agency.* Last modified January 31, 2025. https://www.epa.gov/risk/human-health-risk-assessment

27. Centers for Disease Control and Prevention. “Infection Control Assessment and Response (ICAR) Tool for General Infection Prevention and Control (IPC) Across Settings.” *Centers for Disease Control and Prevention.* Published April 16, 2024. https://www.cdc.gov/healthcare-associated-infections/php/toolkit/icar.html

28. World Health Organization. *WHO Guidance on Preparing for National Response to Health Emergencies and Disasters*. Geneva: World Health Organization. Published December 20, 2021. https://www.who.int/publications/i/item/9789240037182

29. Centers for Disease Control and Prevention. “Bioterrorism Overview.” *Centers for Disease Control and Prevention.* Published February 28, 2006. https://stacks.cdc.gov/view/cdc/44106

DO VACCINTION RATES IN SANTA BARBARA COUNTY CREATE A PUBLIC HEALTH RISK?

FILED MAY 29, 2025

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DO VACCINATION RATES IN SANTA BARBARA COUNTY CREATE A PUBLIC HEALTH RISK?

SUMMARY

If our friends and neighbors are unvaccinated against childhood diseases for whatever reason, the entire community may be put at risk. Over past decades, there has been increasing public discourse about the potential risks of vaccines, which may help to explain why vaccination rates have decreased across the United States. Exacerbating this trend has been an unfortunate lack of information about the differences between the various vaccines, most importantly the significant difference between childhood vaccinations and others.

This report focuses on vaccinations that protect against serious childhood diseases such as mumps, measles, and polio. The investigation examines the level of community protection in Santa Barbara County provided by vaccinations administered to children and adults. It also considers vaccination concerns in the county's juvenile detention facilities and adult jails, both of which are congregate settings from which a disease outbreak could quickly grow and impact the public.

Santa Barbara County does an excellent job of assuring that children who attend public and private schools receive mandated vaccinations. However, there are no readily available data in Santa Barbara to determine the level of vaccination rates in adults, who make up over 75 percent of the County population. It is therefore unknown whether there are significant numbers of unvaccinated individuals in the County. If this is the case, there is a real risk of a resurgence of dangerous diseases in our community. The Grand Jury recommends studies to determine whether our County has reached a tipping point below which reduced vaccination levels pose a significant risk of an outbreak.

BACKGROUND

Many studies over decades have shown that mandated vaccinations given in childhood to prevent communicable diseases, such as measles, mumps, chicken pox, diphtheria, pertussis, and polio have been proven to provide enormous benefits. For example, a recent report from the Centers for Disease Control and Prevention (CDC) projected that among U.S. children born from 1994 to 2023, routine childhood vaccinations prevented approximately 508 million illnesses, 32 million hospitalizations, and more than 1 million deaths. Global projections from the World Health Organization (WHO) indicate that since 1974, routine childhood vaccinations have averted 154 million deaths worldwide. That total includes 101 million infant deaths, accounting for 40 percent of the observed decline in global infant mortality (Reference 1-3). Following the California

requirement for school immunization in 1977, the number of cases of measles in the state decreased by over 99 percent, and by 2000 measles had been eliminated.

Herd Immunity

Herd immunity refers to the indirect protection against an infectious disease that occurs when a large enough proportion of a population becomes immune, either through childhood vaccination or previous infection. When most individuals are immune, the overall amount of pathogen transmission is reduced, which in turn protects those who are not immune, such as people who cannot be vaccinated for medical reasons. This protective effect depends on the virus' basic reproduction rate, with highly contagious diseases requiring a higher percentage of immune individuals to interrupt transmission. Consequently, maintaining high vaccination coverage is essential for achieving and sustaining herd immunity, thereby preventing large-scale outbreaks and reducing disease burden across the entire community (Reference 4-5).

The loss of herd immunity would occur if childhood vaccination rates dropped below the required thresholds brought on by:

1. Increased vaccine hesitancy causing people to refuse vaccines; and
2. Global mobility bringing infections into communities with lower immunity.

The Common Good: Balancing Rights and Responsibilities

Concerns about vaccine safety and mandates must be balanced with an appreciation of the enormous benefits of certain childhood vaccines against dangerous diseases, including measles, mumps, rubella, chicken pox, diphtheria, whooping cough, and polio. Accurate information is critical to address public distrust of vaccine mandates and recommendations from governmental and public health agencies.

In any community there must be a consideration of the common good, which involves a balance between individual rights and the responsibility of the individual to society. There has been a growing number of individuals who are questioning whether or not to vaccinate themselves and their children. This concern about vaccinations is associated with a growing distrust of government recommendations regarding vaccines, in part associated with confusing media coverage about the effects of vaccinations. The trend has been termed vaccine hesitancy, which has been determined by the World Health Organization to be one of the greatest current threats to global health. Currently, many citizens of Santa Barbara County and across the United States are vaccine hesitant; they believe they should have the freedom to choose whether or not to receive vaccinations. The question can be rephrased in terms of whether the choice regarding vaccination is a right or whether vaccination is a responsibility of individuals to protect other citizens in the community (Reference 1, 6-9).

There are some useful analogies when discussing the issue of mandatory vaccination. Our society has decided that individuals do not have the right to drive while intoxicated, because doing so puts the lives of other citizens at risk. Requiring seatbelts when in automobiles and wearing helmets when operating motorcycles are losses of freedom. However, there is consensus that seatbelts and helmets are responsibilities because they lessen the burden on the community of caring for preventable injury and disability. Similarly, the freedom to use a cellphone while driving has been removed because of the risk of preventable crashes.

Some vaccinations—but not all—fall into this same category. For some vaccinations, there is a risk of spread of dangerous diseases if enough individuals choose to refuse vaccination. This is because there is a threshold of vaccinated individuals which creates the level of herd immunity that protects the greater population. This is particularly true of childhood vaccinations. Failure to accept such vaccinations puts the greater community at risk. In other words, it can be argued that it is the responsibility of individuals to forgo their freedom to refuse vaccination for the good of the community. In contrast, there are some other types of vaccinations that have benefits for vaccinated individuals, but have not been proven to protect the community, and, while controversial, it is reasonable to allow individuals the freedom to choose whether or not to receive these vaccinations.

The Grand Jury fully supports the right of individuals to choose whether to receive vaccines that may offer only personal benefit. Such vaccines include those against COVID, influenza, RSV, shingles, and others (see Appendix). However, childhood vaccines which have been proven to protect herd immunity are essential for the health of the entire Santa Barbara population. These include the vaccine against measles, mumps and rubella (MMR), the polio vaccine, the tetanus and diphtheria vaccine (Tdap), and the varicella (chicken pox) vaccine. Therefore, this report will focus upon this important subset of childhood vaccinations.

Vaccination Rates

In California, children entering kindergarten are required to be vaccinated against certain communicable diseases. As a result, vaccination rates have remained above the national level and are at more than 95 percent overall.

After a 2015 measles outbreak, California implemented stricter laws (SB277 (2015)) eliminating non-medical exemptions for school vaccinations. As a result, overall vaccination rates in California have remained relatively high. Santa Barbara childhood vaccination rates have remained above the California average; however, regional rates within California vary. In 2023, about one-third of California counties reported measles, mumps and rubella (MMR) rates for children below the herd immunity threshold of 95 percent, and a number of counties had rates below 90 percent, including Sutter County (76%), El Dorado County (80%), and Glenn County (81%) (Reference 10-12).

Importantly, the Jury has found no data on the vaccination rates in adults, who comprise more than 75 percent of the population, neither nationally nor locally. As of 2025, most adults in Santa Barbara County who attended school in California can be assumed to have been vaccinated, but the actual number who were not vaccinated is unknown. There are no available data on vaccination rates for adults in Santa Barbara County, so the overall vaccination rates in the population have not been documented. Potential unvaccinated people in the County include:

- Santa Barbara County adults who did not receive school vaccinations prior to the 2015 change in the exemption law;
- Unvaccinated individuals who moved to Santa Barbara County as adults;
- Unvaccinated workers who commute to Santa Barbara County from adjacent counties;
- Unvaccinated domestic and international tourists;
- Children who are home schooled;
- Children with medical exemptions; and
- Unvaccinated immigrants living in Santa Barbara County.

Disease Outbreaks

Measles

The decline in vaccination rates in the United States has led to recent outbreaks of preventable diseases. For example, due to successful vaccination, the Centers for Disease Control and Prevention (CDC) declared measles to be eliminated in the United States in 2000. However, due to decreased rates of vaccination, measles has reemerged. For example, there was a 2015 outbreak linked to Disneyland, which resulted in at least 131 infections among California residents. Also, there were six measles outbreaks in California totaling 73 confirmed cases in 2019, primarily associated with healthcare settings (Reference 13-14).

As of May 6, 2025, there is currently an active reemergence of measles cases across the United States. In Texas, there have been more than 702 cases in 2025, resulting in numerous hospitalizations and two childhood deaths. This outbreak has spread to neighboring Oklahoma and New Mexico, where one adult has died, and at least fifteen other states, including California, where nine cases have been confirmed. The current measles outbreaks are directly related to low vaccination rates (Reference 15-16).

National and local data on vaccination rates are available for children attending public schools. Nationally, the rates of vaccination have progressively declined in school-aged children over the past two decades, and this rate of decline is accelerating. For children entering public kindergarten in 2019, the national rate of MMR vaccination was 95 percent but decreased to 93.1 percent in 2023. A notable shift has been that the number of states achieving herd immunity levels has fallen. Nearly 75 percent of states had MMR coverage below the 95 percent target in 2023, and 12 states plus the District of Columbia fell below 90 percent. Measles outbreaks are likely to continue to

spread in populations that have fallen below the 95 percent herd immunity vaccination rate (Reference 12, 17).

The vaccination rate against measles in the overall Santa Barbara County population is unknown. At the time of this report, there have been no measles cases reported in Santa Barbara County in 2025. However, if the rate of vaccination is below the herd immunity threshold of 95 percent in the overall population, Santa Barbara County is at risk of a measles outbreak.

Whooping Cough

There has also been a resurgence of whooping cough in the United States, causing the highest number of cases in a decade. In 2024, over 35,000 cases were reported, a five-fold increase from 7,063 in 2023. While 2025 data is incomplete, the number of whooping cough cases in the United States appears to continue to increase. In California, available data show that there were over 2,000 whooping cough cases between January and October of 2024, an increase from a total of 400 cases in 2023. These 2024 cases resulted in 62 infant hospitalizations and one death (Reference 18-20).

In Santa Barbara County, there were 12 whooping cough cases reported in 2024 as of October 2024 (Reference 21). Again, increasing whooping cough cases appear to be related to decreased vaccination rates. If immunity in a population is below the herd immunity threshold of 92-94 percent, a whooping cough outbreak is a risk (Reference 22). The immunization rate against whooping cough in the overall Santa Barbara population is unknown.

Chicken Pox

Chicken pox (varicella) remains a threat in the United States, but rates of infection have declined dramatically since widespread varicella vaccinations in the mid-1990s. Before the development of a vaccine, an estimated 4 million cases of chicken pox occurred in the United States each year. The infection rate has since decreased by over 95 percent. There were approximately 5,000 cases reported nationally in 2019, although not all states have mandatory chicken pox reporting. The number of reported chicken pox cases decreased between 2020-2021, most likely associated with fewer children attending school during the COVID-19 pandemic. However, rates of reported chicken pox cases have increased nationally since 2022. In California, the Department of Public Health only requires reporting of chicken pox cases that result in hospitalization or death (Reference 23-25).

Data are not available on the number of chicken pox cases in Santa Barbara County, but no hospitalizations or deaths have been reported in 2025 to date. If the immunization rate of vaccination against chicken pox falls below the herd immunity threshold of 90 percent, an outbreak of chicken pox is a threat. The immunization rate against chicken pox in the overall Santa Barbara population is unknown. Of note, vaccination against chicken pox may also reduce the risk of shingles later in life.

Mumps

Mumps remains endemic in the United States, but rates of infection are currently relatively low. In 2024, there were 259 reported cases in the United States. However, mumps remains common in Africa and Asia in communities with low vaccination rates. The World Health Organization reports that there were at least 387,000 cases of mumps globally in 2024, and probably more as most countries do not have mandatory reporting (Reference 26-28).

The herd immunity threshold for mumps is 75-86 percent (Reference 22). If vaccination rates fall below this threshold in a population, a mumps outbreak is a risk. The vaccination rate against mumps in the overall Santa Barbara population is unknown. No mumps cases were reported in Santa Barbara County in 2024.

Rubella

Rubella, also known as German measles, is a viral infection that can cause severe disease. It is especially dangerous if contracted during pregnancy, as it can lead to serious birth defects. Rubella was declared eliminated from the United States in 2004, due to the effectiveness of widespread MMR vaccinations. However, the disease persists in countries with low vaccination rates. There have been no recent cases in Santa Barbara County. The vaccination rate against rubella in Santa Barbara County is unknown. The herd immunity threshold for rubella is 80-85 percent. If the MMR vaccination rate were to fall below that threshold, populations would be at risk of reemergence of rubella (Reference 22).

Diphtheria

Diphtheria cases have not been reported in the United States in recent years, but the disease continues to cause severe illnesses and deaths in countries with low vaccination rates. The herd immunity threshold for diphtheria is 85 percent. If the rate is below this threshold, diphtheria could reemerge in US populations. The vaccination rate against diphtheria is unknown in the overall Santa Barbara population (Reference 22, 30).

Polio

Polio (poliomyelitis) is a highly infectious viral disease. Polio often causes only mild symptoms, but in a subset of infections the virus invades the nervous system and can then cause paralysis and death. Polio was historically a common cause of death and disability in the United States. Following introduction of vaccines, polio was eradicated in the United States by 1979; this was a major public health success. Unfortunately, however, polio has now reappeared in the United States, with one recent case of paralytic polio appearing in Rockland County, New York (Reference 31-32).

There are two types of polio outbreaks currently occurring globally. Vaccine-derived polio is caused by infection from the weakened polio virus found in oral polio vaccines. In rare cases, the weakened polio virus can circulate in under-immunized communities, mutate and become a strain capable of causing polio outbreaks. The case that was detected in New York was from a vaccine-derived polio strain transmitted by a traveler to the United States. These oral polio vaccines are no longer approved in the United States but continue to be utilized in parts of Africa and Asia. In addition, the more virulent naturally occurring wild poliovirus continues to remain endemic in several countries, including Pakistan and Afghanistan. While wild polio virus cases have not been reported in the United States since 1979, there continues to be a potential risk, particularly if vaccination rates decrease below the herd immunity rates of 80-86%. The vaccination rate against polio in the total Santa Barbara population is unknown (Reference 22, 33-34).

Table: Herd Immunity Thresholds and Vaccination Rates in Santa Barbara County

Disease	Herd Immunity Threshold	Overall Vaccination rate in Santa Barbara
Measles	95%	Unknown
Mumps	75-86%	Unknown
Rubella	80-85%	Unknown
Chicken Pox	90%	Unknown
Diphtheria	85%	Unknown
Pertussis	92-94%	Unknown
Polio	80-86%	Unknown

Vaccinations in Immigrants

Applicants for immigration are currently required to receive the following vaccinations: MMR, Polio, Tdap, Hepatitis A and B, Varicella, Meningococcal disease, and Influenza. Immigrants are required to be vaccinated during a medical examination conducted by a physician certified by the United States Immigration Service. However, data on compliance with mandated vaccinations is not available for documented immigrants. Additionally, there are no data available to document the number of immigration medical examinations or vaccinations that are performed, either in California or in Santa Barbara County. Thus, the actual vaccination rates in this population are unclear.

Further, there are no data available on the vaccination status of the estimated 44,000 undocumented immigrants in Santa Barbara County. The most relevant study found by the Jury was published by the National Center for Farmworkers Health in 2023, which primarily examined migrant farmworkers, including documented and undocumented individuals, from a number of U.S. counties (not including Santa Barbara). This survey showed that vaccination rates were low, with MMR vaccination rates of 68 percent and Tdap vaccination rates of 59 percent. While the

vaccination rates of Santa Barbara County immigrants or migrant workers have not been studied and are unknown, the above considerations provide reason to believe that they may also be low (Reference 35).

Vaccinations in the Santa Barbara County Jails

The inherent conditions in jails and prisons create a high-risk environment for infectious disease outbreaks. Correctional facilities are particularly vulnerable to disease outbreaks due to factors such as overcrowding and limited healthcare resources. Implementing robust infection prevention and control measures, including vaccination programs, is essential to mitigate the risk of outbreaks in these environments. While California does not have a legal requirement for vaccination in county jails, the Federal Bureau of Prisons requires a review of each inmate's immunization status. For inmates who are unvaccinated, vaccines are administered with the inmate's consent. In addition to childhood vaccinations, other vaccinations, such as against respiratory viruses, meningitis, and hepatitis may also prevent disease outbreaks in jail populations (Reference 36).

To highlight the risks, there have been instances of serious disease outbreaks in U.S. detention facilities. Notably, in 2016, a measles outbreak occurred at a privately operated Immigration and Customs Enforcement (ICE) detention facility in Arizona (Reference 37). Other well-publicized examples are outbreaks of chickenpox which occurred in 2012 in the San Quentin State Prison, highlighting the need for better prevention and disease control measures in detention centers (Reference 38). In the Santa Barbara County jails, there have been no recent reports of outbreaks of childhood diseases, but the experience during the pandemic illustrates the risk.

The experience with COVID-19 disease during the pandemic illustrates the challenges of managing outbreaks in the County jails. Outbreaks of COVID-19 in the Santa Barbara County Jails were severe and poorly prevented or contained. In February of 2021, 26 inmates contracted COVID-19. Subsequently, in August of 2021, 83 additional inmates and 5 staff contracted COVID-19. In December of 2021, another outbreak of COVID-19 occurred at the Santa Barbara County Main Jail, when 249 inmates contracted the disease, nearly a quarter of the jail's population. In May of 2022, 64 further COVID-19 cases occurred at both the Main Jail and the Northern Branch. During these outbreaks, 338 staff members of the Sheriff's office also contracted the disease.

METHODOLOGY

The Jury conducted the following:

1. Interviews with public health officials, infectious disease physicians, and staff of the California Department of Public Health involved with the California Immunization Registry (CAIR), researchers from the University of California, Santa Barbara, staff of California Forensic Medical Group, Inc. (Wellpath) and, staff of the County of Santa

Barbara Health Department (County Health) and Santa Barbara County Office of Education.
2. Review of data from the websites of the County of Santa Barbara Health Department, the California Department of Public Health and CAIR, the Centers for Disease Control and Prevention (CDC), and the World Health Organization (WHO).
3. Review of published scientific literature and news articles (see References section at the end of this report).

DISCUSSION

Vaccination in Children Attending School

The vaccination team of County Health has demonstrated that they are dedicated to meeting state law requirements for vaccinations in children attending public and private schools. They have done an exemplary job of educating schools on vaccination requirements and collecting data on compliance. The rates of vaccination in children attending Santa Barbara public and private schools exceed the state averages and are above the 95 percent threshold to protect herd immunity.

California does not allow exemptions for religious preference or for personal belief. Families with students attending public and private schools in Santa Barbara have complied with this law.

There are vaccination exemptions allowed for children for legitimate medical reasons, such as immunosuppression. Such exemptions require certification by physicians who are registered with the State (CAIR). The rate of reported medical exemptions in Santa Barbara County school children is approximately 1 percent, consistent with the numbers in other California counties.

County Health Department does not collect data on vaccination status for children who are home-schooled. A 2020 report documented that 8.7 percent of California children were being educated in home school; the number of home-schooled children was increasing, and this trend was likely to continue. There are no data available on the number of home-schooled children in Santa Barbara County. Thus, the number of unvaccinated children attending home schools in Santa Barbara County is unknown (Reference 39-40).

Vaccination Rates in Adults in Santa Barbara County

Adults comprise more than 75 percent of the Santa Barbara County population. County Health has not studied, nor does it have data on the vaccination status of this adult population. Thus, the vaccination rates of adults in Santa Barbara County are unknown.

Potential data regarding the adult vaccination rates in Santa Barbara County could be available from the California Immunization Registry (CAIR). CAIR is the primary statewide vaccine

database used by healthcare providers, schools, and public health officials. It records vaccines administered in and reported by clinics, pharmacies, hospitals, and public health departments. The primary function of CAIR is to provide vaccination information on individuals. California residents can request their personal vaccine records from CAIR online, and healthcare providers can access the CAIR database to obtain the vaccination status of individual patients.

At the present time, CAIR does not provide aggregated population data on vaccination rates, neither at the state nor county level. In discussion with California Department of Public Health and County Health Department staff involved with CAIR, there is acknowledgement that useful population vaccination data could be extracted from the CAIR database. However, at the present time, this has not been done.

How Could Santa Barbara County Obtain Data on Adult Vaccination Rates?

There are several additional methods which have been utilized in other populations to estimate adult vaccination rates. These include:

- The Centers for Disease Control and Prevention has a population Immunization Survey Tool. This tool utilizes statistical samples of populations to determine rates of vaccination against multiple diseases. A survey in Santa Barbara utilizing this tool could estimate the adult vaccination rate. Survey results could also identify whether there may be certain vulnerable populations within the County that may have especially low vaccination rates (Reference 41).
- Pharmacies have data related to the vaccines they administer. This data could be obtained from the pharmacies for study.
- Insurance claims help track vaccine uptake across different demographics. Such data could be collected to provide information on the number of adults receiving vaccinations.
- Current wastewater testing technology allows antibody testing to estimate the degree of immunity in the community. This technology is new but is rapidly developing. Wastewater testing has the additional benefit of acting as an early indicator to detect the presence of a disease outbreak in the community (Reference 42-43).
- Individuals who do not know their immunization status can have their immunity tested with blood tests (titers). This method can also be utilized in specific high-risk populations such as jails or chronic care facilities to determine vaccination rates, both in individuals and in populations (seroprevalence). For example, Genesis Healthcare, a national network of nursing homes, uses titers for staff and residents with uncertain vaccination records. As another example, the California Department of Corrections and Rehabilitation uses MMR and hepatitis B titers to check immunization status of high-risk prisoners. In 2020, the Santa Clara County Public Health Department performed a community-based seroprevalence study using titers on sample populations to estimate the incidence of immunity against COVID-19 (Reference 44-46).

These methods, used alone or in combination, can be utilized to determine vaccination rates in populations. Data could be obtained to estimate vaccination rates not only in the population as a whole, but also in vulnerable communities within the population. Obtaining these data is an important first step in assessing the need for vaccination improvement, both in the overall population and in subsets who would benefit from vaccination outreach efforts tailored to address barriers such as culture and language.

At the current time, none of these methods have been utilized to measure adult vaccination rates in Santa Barbara County.

Public Education and Information

County Health Department has engaged in public education to attempt to increase community vaccination rates. County Health maintains an immunization webpage (https://www.countyofsb.org/1637/Immunization) that provides excellent information. Most of the County Health information and educational effort has focused upon school vaccinations and seasonal respiratory vaccinations such as influenza.

To its credit, County Health released a statement in March 2025 to the local press recognizing that measles was a threat in Santa Barbara County and recommending that the public get vaccinated (Reference 47). However, the public statement did not identify where or how individuals could receive vaccinations, nor did the statement identify which groups in Santa Barbara County may be at particular risk.

Furthermore, to date there have not been sufficient initiatives or resources allocated to identify, educate, and provide access to adult populations who may not have received childhood vaccinations. Additional efforts which would have further benefit include:

1. Public Education & Awareness Campaigns
    - Publish reliable information to dispel vaccine misinformation.
    - Leverage media – social media, TV, radio, and community events can spread vaccine awareness.
    - Personalize messaging – Tailor outreach for different communities, addressing specific concerns such as cultural and ethnic differences.
2. Improve Access & Convenience
    - Offer vaccines in more locations – Pharmacies, workplaces, schools, and community centers.
    - Mobile & pop-up clinics – Bring vaccines to underserved or rural areas.
    - Extend clinic hours – Evening and weekend availability can help working individuals.
3. Partner with Healthcare Providers
    - Train doctors & nurses – Ensure they consistently recommend vaccines.

- Use reminder systems – Texts, calls, or emails to notify people when they're due for shots.
- Integrate vaccines into routine care – Offer them during regular check-ups.

4. Implement Policy & Mandates
    - School & workplace requirements – Enforce vaccination for students and employees in healthcare or public service.
    - Financial incentives – Discounts on insurance, tax credits, or small rewards for getting vaccinated.
    - Remove financial barriers – Ensure vaccines are free or low-cost through public programs.
5. Engage Community Leaders & Influencers
    - Partner with faith-based, non-profit, and cultural organizations – Trusted leaders can encourage vaccination.
    - Use peer ambassadors – Train community members to advocate for vaccines.

Combining these strategies can increase trust, accessibility, and motivation, leading to higher vaccination rates and better public health outcomes.

Vaccinations in Santa Barbara County Jails and the Juvenile Justice Center

Medical care in the County jails is provided by Wellpath. The County Board of Supervisors has designated County Health to oversee the medical care provided by Wellpath. At the present time, the Santa Barbara County contract with Wellpath does not require that medical providers check inmates for childhood vaccination status, nor that they provide childhood vaccinations to those who are unvaccinated.

The County's jails do not include determining childhood vaccination status in their medical intake or evaluation processes. As a result, neither County personnel nor Wellpath employees have any information about whether or not inmates have received childhood vaccinations. The Sheriff's Office, working with Wellpath, has not established a program to offer vaccination to inmates who have not received childhood vaccinations. Thus, the number of unvaccinated in the County's jails is unknown.

The only vaccination that has been administered in the County's jails over the past three years is the influenza vaccine. This is also the only vaccine stocked in the jails' pharmacies. In 2023, 46 influenza vaccines were administered in the jails; in 2024, 46 doses were administered. No influenza vaccines have been administered as of March 2025.

The County jail pharmacies do not store or provide any childhood vaccinations. There is no record of a childhood vaccination being administered in the County's jails over the past three years.

As the vaccination status of inmates is unknown, there is also no process to isolate unvaccinated individuals from the general jail population.

In contrast, the Juvenile Justice Center of Santa Barbara County does have a robust vaccination program administered by Wellpath. Medical staff at the Juvenile Justice Center inquire about childhood vaccination status on intake of all new detainees. In addition, the vaccination history of new detainees with undocumented vaccination status is verified with the California Immunization Registry. The Juvenile Justice Center pharmacy stores and dispenses a variety of vaccines, including vaccines against MMR, Varicella, Hepatitis A and B, Tdap, polio, HPV, meningitis, influenza and COVID-19.

CONCLUSION

Vaccination rates against childhood diseases have decreased in many communities in the United States. As a result, there has been a disturbing trend of new outbreaks of dangerous diseases across the County. In the overall Santa Barbara County population, the vaccination rates against childhood diseases are unknown. If the numbers of vaccinated individuals have fallen below herd immunity thresholds, our County is also at risk of outbreaks.

The Jury recommends that County Health carry out studies to determine childhood vaccination rates. These studies should focus upon adults, and be inclusive of diverse populations, including immigrants and migrant workers. In addition, the Jury recommends that two particular at-risk populations require special attention: children who are receiving home schooling, and inmates in the County jails.

COMMENDATIONS

1. The 2024-25 Santa Barbara County Grand Jury commends the County of Santa Barbara Health Department for its work in achieving high vaccination rates among children in public and private schools.

2. The 2024-25 Santa Barbara County Grand Jury commends the Santa Barbara County Probation Department for its work in monitoring and achieving high vaccination rates in incarcerated youths.

FINDINGS AND RECOMMENDATIONS

Finding 1: The lack of County-wide childhood vaccination data for homeschooled children means that County Health knowledge of community immunity levels is incomplete.

Recommendation 1: The Grand Jury recommends that the County Board of Supervisors require County Health to study and estimate childhood vaccination levels of homeschooled children in the County. To be implemented by December 1, 2025.

Finding 2: The lack of County-wide childhood vaccination data for adults means that County Health knowledge of community immunity levels is incomplete.

Recommendation 2: The Grand Jury recommends that the County Board of Supervisors require County Health to study and estimate childhood vaccination levels of adults in the County. To be implemented by December 1, 2025.

Finding 3: The Sheriff's Office has not determined childhood vaccination rates of inmates in County jails, potentially placing the inmates and staff at risk.

Recommendation 3: The Grand Jury recommends that the Sheriff's Office collect data during health intake screenings at the County's jails to determine childhood vaccination rates. To be implemented by December 1, 2025.

Finding 4: There is no program in place at the County's jails to provide childhood vaccinations to unvaccinated inmates, increasing risk for the inmates and staff.

Recommendation 4: The Grand Jury recommends that the Sheriff's Office implement a program to administer required childhood vaccinations to unvaccinated inmates. To be implemented by December 1, 2025.

Finding 5: There is no procedure in place at the County's jails on when or how to isolate unvaccinated inmates, increasing potential risk of a disease outbreak in the jails.

Recommendation 5: The Grand Jury recommends that the Sheriff's Office develop and enforce a procedure on when and how to isolate unvaccinated inmates. To be implemented by December 1, 2025.

REQUIREMENTS FOR RESPONSES

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

Responses to Findings shall be either:

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

Responses to Recommendations shall be one of the following:

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

Santa Barbara County Board of Supervisors - 90 Days
Findings 1, 2, 3, 4, 5
Recommendations 1, 2, 3, 4, 5

Santa Barbara County Sheriff's Office - 60 Days
Findings 3, 4, 5
Recommendations 3, 4, 5

GLOSSARY

The California Immunization Registry (CAIR): The California vaccine registry developed in 1997 that contains information on individuals who have been vaccinated.

Childhood Vaccinations: Immunizations required by the State of California to be given to infants, children, and adolescents to protect them from serious infectious diseases.

Chicken Pox (also known as Varicella): A highly contagious viral infection. It primarily affects children but can occur at any age. The disease is usually mild, but can result in hospitalization and death, especially in high-risk populations.

COVID-19: A highly contagious viral infection, usually spread by airborne droplets from infected individuals.

Diphtheria: A serious bacterial infection that is highly contagious. Diphtheria can cause severe disease resulting in hospitalization and death.

Endemic: A disease that is consistently present within a population. Unlike epidemics, endemic diseases persist over time without causing large-scale outbreaks.

German Measles: See Rubella

Herd Immunity: A form of indirect protection from infectious diseases that occurs when a large percentage of a population becomes immune to infection.

Influenza: A highly contagious seasonal viral infection spread by respiratory droplets from infected individuals. It can result in serious complications, hospitalizations, and deaths.

Santa Barbara Juvenile Justice Center: The Santa Barbara County facility focusing on the detention, rehabilitation, and supervision of minors who have been detained. It is operated by The Santa Barbara County Probation Department.

Measles: An extremely contagious viral infection spread by respiratory droplets from an infected individual. Measles can result in hospitalization and death, and in serious complications including pneumonia, brain inflammation, and blindness.

MMR: The vaccine against measles, mumps and rubella.

Mumps: A viral infection spread by respiratory droplets or contact with contaminated surfaces. It can cause severe disease resulting in hospitalization and death.

Pertussis (also known as whooping cough): A highly contagious bacterial infection caused by the bacterium Bordetella pertussis. It can result in serious complications, hospitalization, and death, especially in infants.

Polio (also known as poliomyelitis): A highly contagious viral disease that can lead to serious complications (including paralysis) and death. Polio was previously nearly eradicated worldwide but remains endemic in parts of the world where vaccination rates are low.

RSV (Respiratory Syncytial Virus): A highly contagious virus spread through respiratory droplets or direct contact. It can cause severe disease, especially in infants and older individuals.

Rubella (also known as German Measles): A highly contagious viral infection spread by respiratory droplets. Rubella is especially dangerous for pregnant women, as it can cause severe birth defects.

Seroprevalence: The use of blood tests (titers) to determine the number of individuals in a population who have immunity against an infectious disease.

Shingles (also known as herpes zoster): A painful infection caused by reemergence of the latent varicella virus.

Tdap: The immunization against tetanus, diphtheria, and pertussis.

Tetanus: A serious bacterial infection caused by bacterial spores entering the body through cuts, wounds, or burns.

Titer: A blood test performed on an individual to determine whether antibodies are present to indicate immunity to a specific disease.

Vaccine hesitancy: Vaccine hesitancy refers to a delay in acceptance or refusal of vaccines despite the availability of vaccination services. It is influenced by factors such as mistrust in healthcare systems, misinformation, cultural or religious beliefs, concerns about vaccine safety, and complacency regarding disease risk.

Varicella: See chicken pox.

Whooping cough: See pertussis.

REFERENCES

1. Zhou, Fangjun, et al. “Health and Economic Benefits of Routine Childhood Immunizations in the Era of the Vaccines for Children Program — United States, 1994–2023.” *Morbidity and Mortality Weekly Report* 73, no. 31 (2024): 682–685. https://doi.org/10.15585/mmwr.mm7331a2

2. Shattock, A. J., et al. “Contribution of Vaccination to Improved Survival and Health: Modelling 50 Years of the Expanded Programme on Immunization.” *The Lancet* 403, no. 10441 (2024): 2307–2316. https://doi.org/10.1016/S0140-6736(24)00850-X

3. Roush, Sandra W., and Trudy V. Murphy. “Historical Comparisons of Morbidity and Mortality for Vaccine-Preventable Diseases in the United States.” *JAMA* 298, no. 18 (2007): 2155–2163. https://doi.org/10.1001/jama.298.18.2155

4. Ashby, Ben, and Alex Best. “Herd Immunity.” *Current Biology* 31, no. 4 (2021): R174–R177. https://doi.org/10.1016/j.cub.2021.01.006

5. National Institutes of Health. “Community Immunity: How Vaccines Protect Us All.” *NIH News in Health*, Published October 2011. https://newsinhealth.nih.gov/2011/10/community-immunity

6. Tekin, Ç., et al. “Reasons for Parental Hesitancy or Refusal of Childhood Vaccination in Türkiye.” *East Mediterranean Health Journal* 29, no. 5 (2023): 343–353. https://doi.org/10.26719/emhj.23.059

7. Ali, K. A., and L. P. Celentano. “Addressing Vaccine Hesitancy in the ‘Post-Truth’ Era.” *Eurohealth* 23, no. 4 (2023): 16–20. https://iris.who.int/handle/10665/332615

8. World Health Organization. “Immunization Coverage.” *World Health Organization*. Last modified July 15, 2024. https://www.who.int/news-room/fact-sheets/detail/immunization-coverage

9. Jones, Jeffery F. “Far Fewer in U.S. Regard Childhood Vaccinations as Important.” *Gallup News*. Published August 7, 2024. https://news.gallup.com/poll/648308/far-fewer-regard-childhood-vaccinations-important.aspx

10. Wiley, H., Nelson, L. J., & Nakajima, K. “Fewer California Kindergarten Students Immunized Against Measles Last Year, New Data Show.” *Los Angeles Times*, March 19, 2025. https://www.latimes.com/california/story/2025-03-19/california-school-vaccines-measles-immunity

11. Seither, R., et al. "Coverage with Selected Vaccines and Exemption Rates Among Children in Kindergarten — United States, 2023–24 School Year." *Morbidity and Mortality Weekly Report* 73, no. 41 (2024): 925–932. https://doi.org/10.15585/mmwr.mm7341a3

12. "ChildVaxView Interactive!" *Centers for Disease Control and Prevention*. Published August 26, 2024. https://www.cdc.gov/childvaxview/about/interactive-reports.html

13. California Department of Public Health. "Measles." *California Department of Public Health.* Last modified May 21, 2025. https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/measles.aspx

14. "Measles (Rubeola) | Questions About Measles." *Centers for Disease Control and Prevention*. Last modified March 29, 2024. https://www.cdc.gov/measles/about/questions.html

15. "Measles Outbreak – May 6, 2025." *The Texas Department of State Health Services*. Published May 6, 2025. https://www.dshs.texas.gov/news-alerts/measles-outbreak-2025

16. "Adult Infected with Measles Dies in New Mexico, Health Officials Say." *The Guardian*. Published March 6, 2025. https://www.theguardian.com/us-news/2025/mar/06/measles-death-new-mexico

17. "Measles and Herd Immunity: What It Is and How It Protects Our Community." *Carnegie Science Center.* March 25, 2025. https://carnegiesciencecenter.org/herd-immunity/

18. "Pertussis." *World Health Organization*. https://www.who.int/health-topics/pertussis#tab=tab_1

19. California Department of Public Health. "As Whooping Cough Cases Increase, CDPH Encourages Tdap Vaccination." *The Santa Barbara Independent*. Published January 6, 2025. www.independent.com/2025/01/06/as-whooping-cough-cases-increase-cdph-encourages-tdap-vaccination/

20. "2024 Provisional Pertussis Surveillance Report." *Centers for Disease Control and Prevention*. Published January 2025. https://www.cdc.gov/pertussis/media/pdfs/2025/01/pertuss-surv-report-2024_PROVISIONAL-508.pdf

21. "Pertussis Snapshop." *California Department of Public Health.* Published October 31, 2024. https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Immunization/Pertussis_Report_OCT2024.pdf

22. "Herd Immunity Threshold for Selected Global Diseases as of 2013." *Statista*. Published September 27, 2013. https://www.statista.com/statistics/348750/threshold-for-herd-immunity-for-select-diseases/

23. "Impact of U.S. Chickenpox Vaccination Program." *Centers for Disease Control and Prevention*. Published April 22, 2024. https://www.cdc.gov/chickenpox/vaccination-impact/

24. Epidemiology and Immunization Services Branch. "Monthly Communicable Disease Report: September 2021." Vol. 5, no. 9 (October 15, 2021). https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/Epidemiology/Monthly_CD_Report_September_2021.pdf

25. Egeskov-Cavling, Amanda Marie, et al. "Evaluating the Impact of Moderate and Severe Varicella Infections on Danish Children Under 18 Years Old: A Comprehensive Analysis From 2015 to 2023." *The Pediatric Infectious Disease Journal* 44, no. 3 (March 2025): 270–276. https://doi.org/10.1097/INF.0000000000004612

26. "Mumps Vaccination." *Centers for Disease Control and Prevention*. Last modified January 17, 2025. https://www.cdc.gov/mumps/vaccines/index.html

27. "New Cases of Mumps per 100,000 Population in the U.S. from 1970 to 2019." *Statista*. Published September 2022. https://www.statista.com/statistics/186404/cases-of-mumps-in-the-us-since-1970/

28. "Mumps – Number of Reported Cases." *World Health Organization.* https://www.who.int/data/gho/data/indicators/indicator-details/GHO/mumps---number-of-reported-cases

29. "Impact of U.S. MMR Vaccination Program." *Centers for Disease Control and Prevention*. Published January 17, 2025. https://www.cdc.gov/rubella/vaccine-impact/index.html

30. "About Diphtheria, Tetanus, and Pertussis Vaccines." *Centers for Disease Control and Prevention*. Last modified September 6, 2022. https://www.cdc.gov/vaccines/vpd/dtap-tdap-td/hcp/about-vaccine.html

31. Rai, Anushree, et al. “Polio Returns to the USA: An Epidemiological Alert.” *Annals of Medicine and Surgery* 82 (October 2022): 104563. https://doi.org/10.1016/j.amsu.2022.104563

32. Whitehouse, Erin R., et al. “Wastewater Surveillance for Poliovirus in Selected Jurisdictions, United States, 2022–2023.” *Emerging Infectious Diseases* 30, no. 11 (November 2024): 2279–2287. https://doi.org/10.3201/eid3011.240771

33. “Polio Vaccination.” *Centers for Disease Control and Prevention*. Last modified July 9, 2024. https://www.cdc.gov/polio/vaccines/index.html

34. “Poliomyelitis.” *World Health Organization*. Last modified April 2, 2025. https://www.who.int/news-room/fact-sheets/detail/poliomyelitis

35. “Vaccination Coverage Among Farmworkers in Selected U.S. Counties in 2022.” *National Center for Farmworker Health, Inc*. Published August 2023. https://www.ncfh.org/uploads/3/8/6/8/38685499/vaccine_fact_sheet.pdf

36. Federal Bureau of Prisons Clinical Guidance. *Immunization*. October 2020. https://www.bop.gov/resources/pdfs/immunization_202105.pdf

37. Venkat, Heather, et al. “Measles Outbreak at a Privately Operated Detention Facility: Arizona, 2016.” *Clinical Infectious Diseases* 68, no. 12 (June 2019): 2018–2025. https://doi.org/10.1093/cid/ciy819

38. CBS San Francisco. “Chickenpox Outbreak Locks Down San Quentin.” *CBS News*. Published October 30, 2012. https://www.cbsnews.com/sanfrancisco/news/chickenpox-outbreak-puts-san-quentin-state-prison-on-lockdown/

39. “California.” *Homeschool Hub*, Johns Hopkins, School of Education, Institute for Education Policy. Last modified March 2025. https://education.jhu.edu/edpolicy/policy-research-initiatives/homeschool-hub/states/california/

40. Thorpe, E. L., et al. “Homeschooling Parents’ Practices and Beliefs About Childhood Immunizations.” *Vaccine* 30, no. 6 (2012): 1149–1153. https://doi.org/10.1016/j.vaccine.2011.12.019

41. “About the National Immunization Surveys (NIS).” *Centers for Disease Control and Prevention*. Last modified February 26, 2025. https://www.cdc.gov/nis/about/

42. “How Wastewater Monitoring Works.” *Centers for Disease Control and Prevention*. Last modified March 18, 2025. https://www.cdc.gov/nwss/how-wws-works.html

43. Agan, Marie LittleFawn, et al. “Wastewater as a Back Door to Serology.” Preprint, *medRxiv* (October 20, 2023). https://doi.org/10.1101/2022.11.11.22282224

44. “Nationwide Commercial Laboratory Seroprevalence Survey.” *Centers for Disease Control and Prevention*. Last modified February 23, 2025. https://data.cdc.gov/Laboratory-Surveillance/Nationwide-Commercial-Laboratory-Seroprevalence-Su/d2tw-32xv/about_data

45. “Occupational Health: Services.” *MercyOne Genesis*. https://www.genesishealth.com/genesis-at-work/occupational-health/services/

46. Bendavid, Eran, et al. “COVID-19 Antibody Seroprevalence in Santa Clara County, California.” *International Journal of Epidemiology* 50, no. 2 (April 2021): 410–419. https://doi.org/10.1093/ije/dyab010

47. County of Santa Barbara Health Department. “Santa Barbara County Health Department Advises Residents on Measles Vaccination.” *The Santa Barbara Independent*. Published March 20, 2025. https://www.independent.com/2025/03/20/santa-barbara-county-health-department-advises-residents-on-measles-vaccination/

APPENDIX

Vaccinations Not Covered by This Report

Vaccinations for Respiratory Viruses

1. COVID-19 Vaccination

COVID-19 vaccines have been developed to protect against the SARS-CoV-2 virus, which causes COVID-19. Several vaccines are available, including mRNA vaccines (Pfizer-BioNTech and Moderna) and viral vector vaccines (Johnson & Johnson). These vaccines are not 100% effective in preventing infections nor in eliminating contagiousness but have proven effectiveness in reducing severe illness and death. However, COVID-19 vaccinating has been disappointing in not providing herd immunity. This is in part because the coronavirus rapidly mutates, making immunologic protection temporary.

2. Influenza Vaccination

The influenza vaccine is administered annually to protect against the flu, a respiratory illness that can lead to severe complications, especially in young children, the elderly, and individuals with certain health conditions. The efficacy of the influenza vaccine varies by year, as the virus continuously mutates. Although influenza vaccine is not 100% effective, it does decrease the risk of becoming infected and decreases the severity of disease and risk of hospitalization and death if infection occurs. However, the influenza virus mutates, so immunity is seasonal at best. Thus, the influenza virus does not provide permanent herd immunity.

3. Respiratory Syncytial Virus (RSV)

RSV is a common respiratory virus that can cause severe disease, especially in infants and older adults. To combat this, childhood and adult vaccines have been approved. Herd immunity is not achieved by RSV vaccination, but individuals are protected. Nirsevimab is recommended for all infants younger than eight months. While not a true vaccine, it is a monoclonal antibody that provides protection for approximately five months, covering the typical RSV season duration. For adults older than 60, several vaccinations against RSV are available.

4. Pneumococcal vaccines

Pneumococcal vaccines protect against pneumococcal disease caused by pneumococcus bacteria, which can cause pneumonia, meningitis, and bloodstream infections. These vaccines do not result in herd immunity but are protective against severe disease in high-risk individuals. They are recommended for children under 2 years old, adults over 65, and individuals with certain health conditions.

5. Hemophilus influenza vaccinations (H. Flu)

H. Flu vaccination protects against infections caused by the Hemophilus Influenza virus, which can cause serious disease in infants and young children but is also a risk in certain adult populations, such as individuals with kidney disease and those with weakened immunity.

Vaccines for Other Viruses Proven to Benefit Individuals and Special Populations

1. Hepatitis A

Hepatitis A is primarily transmitted through ingestion of contaminated food or water but can also be transmitted through sexual contact or illicit drugs. Hepatitis A vaccinations may provide some degree of herd immunity, particularly in high-risk populations. Hepatitis A vaccination is recommended for children as well as for high-risk adults and for international travelers.

2. Hepatitis B

Hepatitis B is a viral infection that can lead to acute infections of the liver. In addition, chronic hepatitis B infection can lead to cirrhosis and liver cancer. Hepatitis B may be spread from infected mothers to babies, through sexual transmission, or through blood-blood. Herd immunity against hepatitis B may be achieved if 50-80 per cent of a population is vaccinated. The CDC recommends hepatitis B vaccination for all children and adults.

3. HPV (Human Papillomavirus) Vaccine

The HPV vaccine protects against the human papillomavirus. While a threshold for achieving herd immunity is not established for HPV, vaccination has been demonstrated to reduce the prevalence of the disease. HPV is usually asymptomatic, but infection is associated with developing several cancers, including cervical cancer, as well as genital warts. HPV is primarily transmitted by sexual contact with infected individuals. It is recommended for preteens and young adults.

4. Meningococcal Vaccine

The meningococcal vaccine protects against meningococcal disease, a serious bacterial illness that can cause meningitis and bloodstream infections. Transmission occurs through respiratory droplets or close contact with an infected person. Herd immunity against meningococcus has not been clearly demonstrated, as there are different types of the disease, and efficacy of immunization may also decrease over time. However, meningococcal vaccination in high-risk populations has been shown to significantly reduce the risk of disease. Vaccination is especially recommended for adolescents and young adults, particularly those living in close quarters such as dormitories, as well as in some high-risk populations such as those in sub-Saharan Africa.

5. Shingles Vaccine

The shingles vaccine protects against shingles, a painful rash caused by the reactivation of the varicella-zoster virus (the same virus that causes chickenpox). It is recommended for adults over 50 years old.

6. Rotavirus Vaccine

Rotavirus is a highly contagious virus that causes severe gastroenteritis, particularly in infants and young children. Oral vaccines protect against severe infections and are recommended for administration as a two-dose series, beginning in infancy.

7. Tetanus Vaccine

Tetanus is a serious bacterial infection caused by bacterial spores entering the body through cuts, wounds, or burns. Previously common in the United States, tetanus is currently rare due to the widespread administration of tetanus vaccine to children. Elsewhere in the world, where vaccination rates are low, tetanus remains a common cause of serious illness and death. Tetanus vaccine does not achieve herd immunity, as the disease is not spread between people. However, the vaccine offers enormous individual benefit.

Travel Vaccinations

These vaccines are not meant to provide herd immunity but are protective for individuals traveling to locations where infections may be present. They may also be required for entry into certain countries.

1. Yellow Fever Vaccine

The yellow fever vaccine is required for travel to certain countries in Africa and South America. Yellow fever is a viral disease transmitted by mosquitoes, and vaccination is necessary to prevent outbreaks.

2. Typhoid Vaccine

The typhoid vaccine protects against typhoid fever, a bacterial infection spread through contaminated food and water. It is recommended for travelers to areas where typhoid is common.

3. Rabies Vaccine

The rabies vaccine is recommended for travelers who may be at risk of exposure to rabid animals, particularly in areas where rabies is prevalent. Rabies is a fatal viral illness if not treated promptly.

4. Cholera Vaccine

Oral cholera vaccines are available for travelers who may be at risk of disease from contaminated water. The protection from these vaccines is limited to a period of months.

Other Vaccines

1. Smallpox Vaccine

The smallpox vaccine was the first successful vaccine to be developed and has played a crucial role in the eradication of smallpox, a devastating infectious disease. The World Health

Organization declared smallpox eradicated in 1980, thanks to an extensive global vaccination campaign. Although smallpox is not a current naturally occurring threat, the vaccine is still produced and stored as a precautionary measure against potential bioterrorism.

2. M-Pox Vaccine

The M-Pox vaccine is designed to protect against monkeypox, a viral disease similar to smallpox but generally less severe. The vaccine is recommended for individuals who may be at high risk of exposure, such as laboratory personnel, certain healthcare workers, and individuals participating in M-pox outbreak response efforts. While its efficacy is uncertain, it could be a useful public health resource for high-risk individuals or if an M-Pox outbreak became widespread.

3. Anthrax Vaccine

Anthrax is a serious infectious disease caused by the bacterium Bacillus anthracis. The anthrax vaccine is primarily recommended for individuals who are at higher risk of exposure, such as military personnel, laboratory workers handling anthrax, and individuals who work with animals or animal products that may be contaminated. The vaccine can help prevent all three types of anthrax infections: cutaneous, inhalation, and gastrointestinal. Anthrax vaccine would become a valuable public health resource in the event of a bioterrorism attack.

4. Malaria Vaccine

The malaria vaccine is a groundbreaking development in the fight against malaria, a mosquito-borne disease caused by Plasmodium parasites. Malaria remains a significant global health challenge, particularly in sub-Saharan Africa, where it is a leading cause of illness and death. The vaccine offers a promising tool for reducing the burden of malaria, especially among young children who are most vulnerable. It is currently recommended for use in areas with moderate to high malaria transmission and is administered in multiple doses to ensure optimal protection.

4.Ebola Vaccine

Vaccines against the Ebola and other hemorrhagic fever virus, such as Marburg disease, have been developed but have largely only been tested in animal models. They are not currently widely utilized but might be a valuable tool in case of a large-scale outbreak.

5. HIV Vaccine

The HIV vaccine is a critical advancement in the fight against the Human Immunodeficiency Virus (HIV), which causes AIDS. Despite significant progress in treatment and prevention, HIV remains a major global public health issue, particularly in regions like sub-Saharan Africa. The development of an effective HIV vaccine has been a challenging endeavor due to the virus's high mutation rate and ability to evade the immune system. Current research includes various approaches such as vector-based vaccines, protein subunit vaccines, and mRNA vaccines. While

no fully effective HIV vaccine is available yet, ongoing clinical trials and scientific breakthroughs provide hope for a future where HIV can be prevented through vaccination.

6. ZIKA Vaccine

The Zika vaccine is a significant stride in combating the Zika virus, which has emerged as a notable public health threat in recent years. Transmitted primarily by Aedes mosquitoes, the Zika virus can cause severe birth defects in unborn children when pregnant women are infected. The development of a Zika vaccine has been driven by the urgency to protect those most at risk, particularly in regions prone to mosquito-borne diseases.

Vaccination efforts have focused on creating immunity in populations where Zika virus outbreaks are likely, including parts of South America, Central America, and the Caribbean. Researchers are exploring various vaccine platforms, including DNA-based vaccines, inactivated virus vaccines, and vector-based vaccines, to ensure safe and effective immunization.

Clinical trials have shown promising results, with several vaccine candidates moving forward in the development pipeline. The Zika vaccine aims to provide long-term immunity and prevent the severe consequences associated with congenital Zika syndrome. As these vaccines become more widely available, they will play a crucial role in safeguarding vulnerable populations and curbing future outbreaks.

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WATER MANAGEMENT IN SANTA BARBARA COUNTY

FILED JUNE 13, 2025

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WATER MANAGEMENT IN SANTA BARBARA COUNTY

Keep Up the Good Work

SUMMARY

Water availability has been a concern in the region of Santa Barbara County since the earliest settlements of the Chumash. The most recent drought, ending in 2023, refocused attention on the need to both conserve water and to seek new sources. Water scarcity is an ongoing fact of life in the County. The unique geography of the South Coast makes it particularly susceptible to drought; however, the entire County faces a scarcity of both ground and surface water.

Historically, groundwater resources have been depleted by both agricultural and urban uses, without regard for sustainability. Seawater intrusion into our aquifers due to overuse of the groundwater is a real threat.

The last three winters have seen heavy precipitation across Santa Barbara County leading to full reservoirs and somewhat replenished aquifers. Nevertheless, complacency is not a luxury County residents can afford. As another drought is inevitable, the 2024-25 Santa Barbara County Grand Jury (Jury) undertook an investigation to determine whether Santa Barbara County as a whole is adequately prepared.

The Jury reviewed ongoing concerns about water availability, particularly in light of state-mandated increases in housing in the County. The Jury considered the recommendations of past Grand Juries regarding the water management situation in the County and found that circumstances have substantially improved since the issuance of these previous reports. The professionalism and commitment of all individuals interviewed as well as the high degree of constructive coordination among the County Water Agency, local water districts, and local groundwater sustainability agencies impressed the Jury.

BACKGROUND

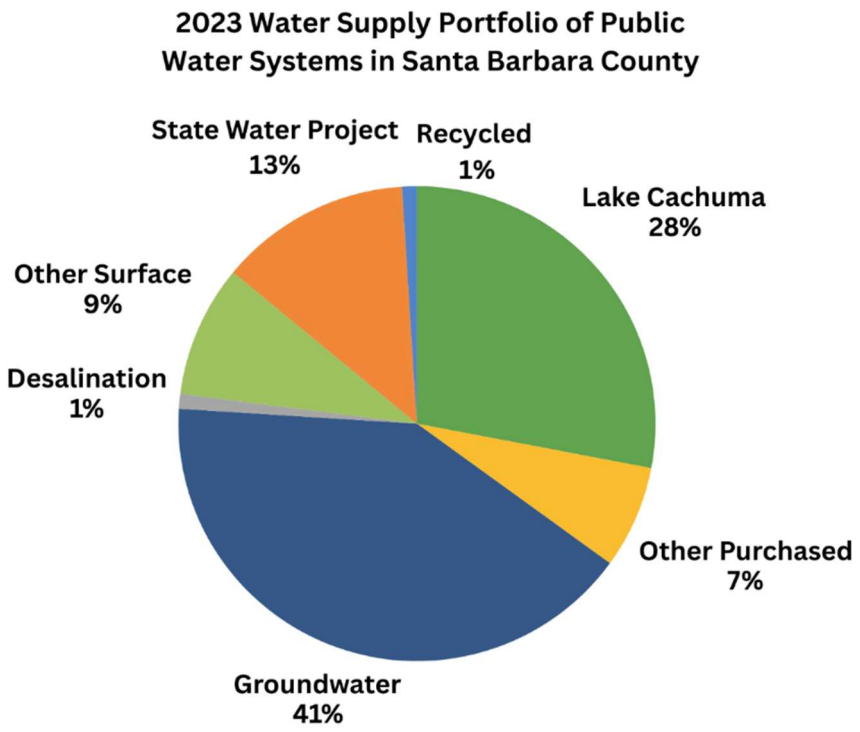
Santa Barbara County is not small. Although all of the County must contend with water supply issues, the conditions in different parts of the County can vary greatly. For example, the weather station at Gibraltar Dam records an annual average rainfall of 26.5 inches, Santa Barbara City has an average of 18.5 inches, and Santa Maria records an average of only 13.4 inches. In addition, those averages don't show the extreme variability from year to year in the County's rainfall: of the last 10 years, six have had below average rainfall (only 48 percent of average in 2021) and four have had above average rainfall (203 percent in 2023).

Water Sources

Because of our mountainous topography, there are several watersheds in the County, each independent of the other. The Cuyama River follows the northern boundary of the County for much of its path and feeds a largely agricultural area until it flows into the reservoir created by Twitchell Dam. Water is released from the dam as needed for the Santa Maria River and to replenish the groundwater used by Santa Maria and other communities in the North County.

Much of the water for the County comes from the Santa Ynez River. It flows through the center of the County and feeds the groundwater needs for the communities of Solvang, Santa Ynez, Buellton and Lompoc. It also supplies much of the water used by South Coast communities from reservoirs created by dams: the Gibraltar Reservoir was created by the Gibraltar Dam in 1920; the Jameson Reservoir was created by the Juncal Dam in 1930; and Lake Cachuma was created by the Bradbury Dam in 1953. There are tunnels through the mountains from each of these reservoirs that carry water to the South Coast.

Figure 1



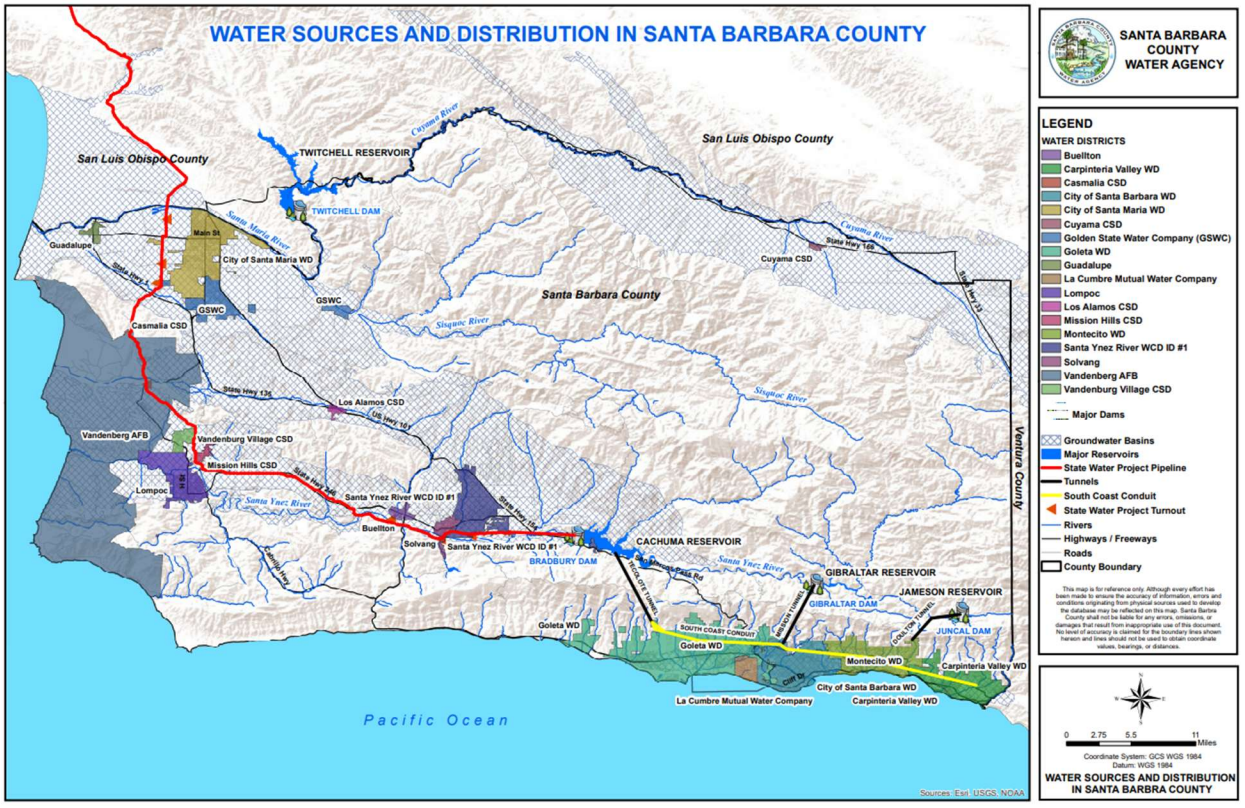
Source: WaterWise Santa Barbara

Lake Cachuma is the major water source for most of the South Coast water. Up to 65 million gallons can flow through the Tecolote tunnel each day; the Goleta Water District diverts about 5 million gallons daily to its water treatment plant, and the rest goes into a tunnel that feeds Santa Barbara, Montecito and Carpinteria.

The California State Water Project provides water to some County communities. That water flows from Northern California into Lake Cachuma as required. The City of Santa Barbara, the City of Santa Maria, the Montecito Water District, the Santa Ynez River Water Conservation District, Improvement District No. 1, the City of Buellton, the Goleta Water District, the City of Guadalupe, and the Carpinteria Valley Water District all have contracts with the State that allow access to that water. However, this source is unreliable and much more expensive than other resources; it is used only in times of severe drought.

The many sources of water used in Santa Barbara County are shown above in Figure 1. Figure 2 shows that those sources are widely distributed throughout the County.

Figure 2



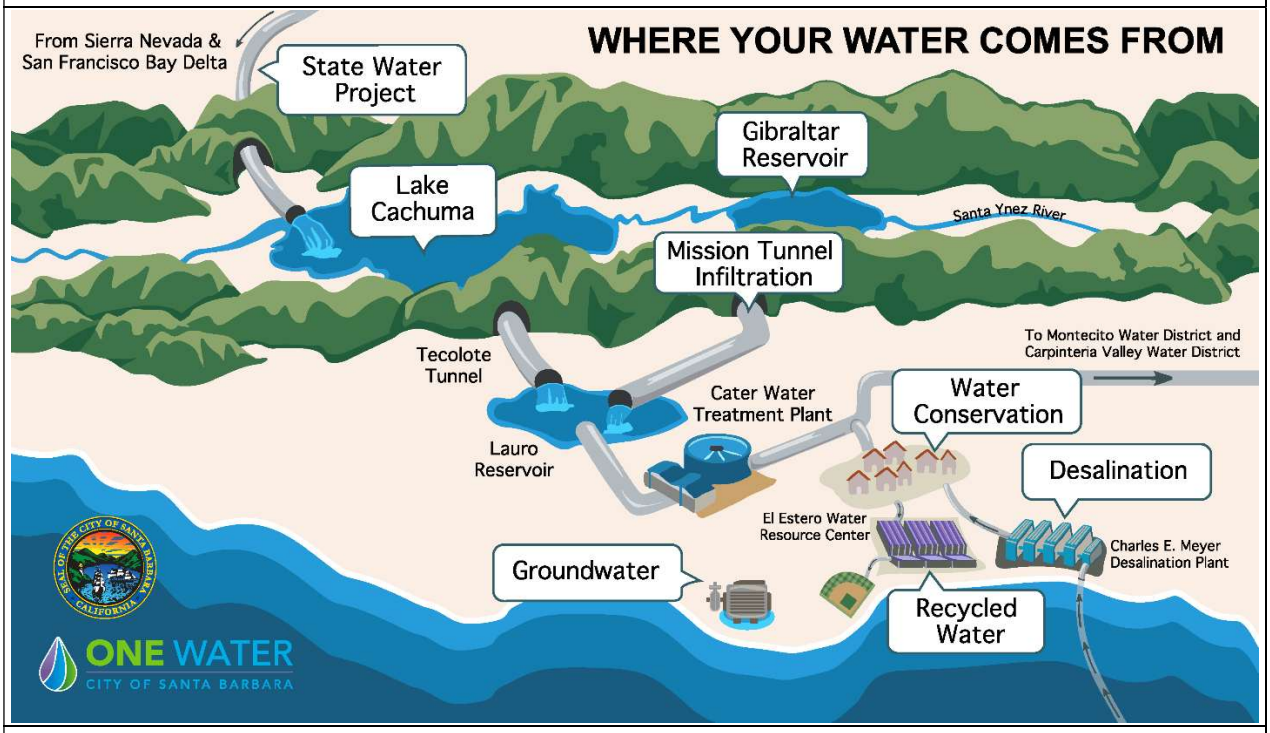
Source: County of Santa Barbara Public Works

The City of Santa Barbara was one of the first cities in California to incorporate desalinated water into its program in the 1980s. Its first plant was completed in 1992 at a cost of $34 million, shared with Montecito and Goleta. Because of the abundant rainfall in that and subsequent years, the plant was put into standby mode, and a portion of the reverse osmosis membrane equipment was sold. Not until 2015, in response to exceptional drought conditions, did the City Council vote to modernize and reactivate the plant. In May 2017, at a cost of $72 million, partially offset by a $10

million grant from the State Department of Water Resources, the plant began contributing water into the City's water system. The plant can now produce up to three million gallons of water per day, or about 30 percent of the City population's current needs. Plans are underway to expand the existing plant to meet future needs as the City's population grows. The plant's design is modular, so its expansion is cost effective and only limited by the physical space it will occupy.

Several local communities also have successful programs to recycle wastewater to meet the demand for non-potable water. The City of Santa Barbara and the Goleta Water District are particularly successful utilizing this supplemental source. Figure 3 illustrates how the City of Santa Barbara gets its water.

Figure 3



Source: City of Santa Barbara Public Works Department

Water Management

A number of different entities manage the distribution and conservation of water in the County:

- Cities have the responsibility for supplying water to their residents, although they may contract with private companies to provide that service, as Santa Maria does with the Golden State Water Company.
- Water districts are generally charged with the distribution of water to end users and are responsible for water supply, quality, and infrastructure. There are water districts in the Carpinteria Valley, Montecito, Goleta Valley, and the central portion of the Santa Ynez Valley, including the communities of Solvang, Santa Ynez, and Buellton. Similar functions

are performed by community services districts in smaller communities such as Cuyama, Los Alamos, and Vandenberg Village. These are independent special districts governed by elected boards.

- Mandated by the State's 2014 Sustainable Groundwater Management Act (SGMA), Groundwater Sustainability Agencies (GSAs) are responsible for managing groundwater resources and watershed basins identified as having over-drafted groundwater. Their mandate is to bring basins into balance between pumping and recharge. There are GSAs for the Carpinteria Valley, Montecito, the San Antonio Creek Valley, the Cuyama Valley, and the Santa Ynez Valley. Generally, these agencies have been created by the local water districts and community services districts work closely with them.

The GSAs are required to develop plans to balance extraction with recharge while considering factors like aquifer characteristics and the area's climate. Key aspects of groundwater basin management include:

- Monitoring groundwater levels and collecting data on groundwater usage.
- Creating a groundwater sustainability plan (GSP) as required by the Sustainable Groundwater Management Act. These plans provide a roadmap to sustainability by obtaining and assessing data on current water usage and groundwater resources, identifying sustainable groundwater levels, and developing policies and tools to restore groundwater resources.
- Monitoring aquifer recharge.
- Planning and coordinating water use and groundwater replenishment by managing surface and groundwater resources.
- Using data to create water basin computer models.
- Communicating issues of groundwater management and the need for replenishment with residents, farms, and businesses within the basin.
- Monitoring and enforcing compliance with groundwater regulations.

All GSAs in the County now have plans in place that have been approved by the California Department of Water Resources to ensure long-term groundwater sustainability.

The County also has its own Water Agency to monitor water resources and work with other agencies as required, creating such initiatives as "WaterWise Santa Barbara," which seeks to inform, educate, and encourage water conservation. The County Water Agency has the specific responsibility to contract with the State and the federal government for water supplies. It also conducts a cloud seeding program to increase precipitation.

Water districts in all of Santa Barbara County know and understand that the drought cycle is a fact of life. Recognizing that fact, water districts face challenges in providing water for residential, commercial, and agricultural needs as well as meeting state-mandated housing requirements.

METHODOLOGY

The Jury reviewed previous Grand Jury reports and recommendations as well as documents prepared by many of the entities that are involved in the supply and management of water in Santa Barbara County. We interviewed staff of the following:

- Santa Barbara County Water Agency
- Goleta Water District
- Carpinteria Valley Water District
- Carpinteria Groundwater Sustainability Agency
- Santa Ynez River Water Conservation District, Improvement District No. 1
- San Antonio Basin Water District
- San Antonio Basin Groundwater Sustainability Agency
- Santa Maria Valley Water Conservation District
- City of Santa Barbara Water Resources Division
- Cuyama Basin Groundwater Sustainability Agency

We also addressed water availability and management issues in interviews with elected officials and senior staff of the County and several cities, including Santa Barbara, Goleta, Carpinteria, Solvang, and Buellton.

Additionally, the Jury toured the City of Santa Barbara's desalination plant and the Goleta Water District's water treatment facility.

A planned visit to the Bradbury Dam and review of local water agency involvement in the management of the water resources in Lake Cachuma was cancelled by the United States Bureau of Reclamation, a federal agency that supervises the dam, due to personnel and policy uncertainty.

DISCUSSION

Each local city, district, and agency has its own unique approach to how it sources, processes, and delivers water to consumers due to the varied geography of North and South Santa Barbara County.

The 2016-17 Grand Jury conducted an extensive review of water management and issued a report recommending, among other things, that the Santa Barbara County Water Agency assume a coordinating role for water management. Although this recommendation of coordination through the County Water Agency was not implemented, it is apparent now that staff of the County Water Agency maintains relations with the other agencies and works collaboratively as necessary. The implementation of the State's Groundwater Management Plan and the requirement for sustainability plans are positive developments in the outlook for water in the County.

The Jury also learned that the residents of Santa Barbara County have responded to public campaigns that emphasize the need to conserve water. For example, the average daily per capita water use in the Goleta Valley Water District is now less than 50 gallons, compared with the state average of 85 gallons per person per day. Agriculture has adapted to water shortages by identifying alternative crops that are still profitable but less thirsty.

Each of the water agencies and districts that the Jury investigated has prepared plans to cover expected water use in the future, to plan for infrastructure improvements, and to develop additional water resources as required. The Jury has reviewed each of these plans and confirmed that they take into account forecasted population growth, changes in agriculture use, groundwater replenishment, climate change, and some new technologies to meet demand. Increased use of recycled water is also included in the plans.

The Jury was particularly concerned that the substantial increases in housing mandated by the State for the next six years could compromise future water supplies. To the contrary, each of the agencies and districts the Jury investigated has plans in place to provide needed water. The rural districts stated that an increase in residential use would not add significantly to future water needs, given the already heavy demand by agriculture. All of the cities the Jury investigated have made provisions to secure additional water for residential use, whether from their traditional sources or from innovative sources such as recycled water or the desalination plant in Santa Barbara.

Despite these overall positive findings, those responsible for treating and distributing water in Santa Barbara County should be aware that there are still issues to be addressed in providing water to its residents:

- Some new technologies can provide needed water, but they are very expensive. For example, water from the desalination plant in Santa Barbara is currently around 75 percent more expensive than treated water from the Tecolote tunnel.[1] Experience has shown that in our "wet" years the commitment to maintaining alternative technologies can wane with the result that communities are forced to invest large sums to recover those capabilities at the next drought.
- All of the infrastructure that serves County residents is aging, and much is in need of repair. Capital plans have been created to replace or repair infrastructure, such as upgrading water pipes, but completing the work will incur significant costs. In this time of restricted budgets and multiple needs, it is important that the commitment to these projects continue.
- It has been seen in the past that a few "wet" years lull the residents of Santa Barbara County into complacency, and water use increases again. It is essential that emphasis on water conservation remains central in agencies and districts' public discussion and outreach about water.

[1] Treated water from the Tecolote tunnel now costs $1,982 per acre/foot. Water from the desalination plant currently costs $3,400 per acre/foot.

CONCLUSION

Water continues to be a scarce resource in Santa Barbara County, one which must be managed if the needs of the County—residential, commercial, and agricultural—are to be met. The Jury investigated the current status of water management in the County and was pleased to learn that not only are the current, relatively abundant, water resources being well managed, but also that all of the agencies the Jury examined have solid plans in progress or ready for implementation for the next inevitable drought.

Water agencies and districts in Santa Barbara County know and understand that the drought cycle is a fact of life. Recognizing this, water agencies and districts face challenges in providing water for residential, commercial, and agricultural needs as well as meeting state-mandated housing requirements. Nevertheless, each entity the Jury interviewed has plans in place to both meet fluctuating drought pressures as well as future demand due to population growth and development.

Yet the people of Santa Barbara County, and the officials tasked with providing their water, should not be complacent in these good tidings. Appropriately meeting Santa Barbara County's water needs in the future requires the maintenance of existing water treatment and distribution infrastructure and a continued insistence on water conservation.

FINDINGS AND RECOMMENDATIONS

Finding 1: Despite community concerns about water scarcity, all of the public entities the Jury investigated that provide and manage water in Santa Barbara County have made proactive plans to fortify against future droughts and provide sufficient water necessary to support future housing growth and commerce.

Finding 2: Despite a 2016-17 Grand Jury finding that limitations existed in coordinating water management, the Jury finds that coordination among different water management entities in the County has improved significantly.

Finding 3: The City of Santa Barbara has gone beyond the basic management of water resources for its residents by utilizing desalination to innovatively expand local water availability.

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

City of Santa Barbara – 90 Days

Findings 1, 2, 3

Board of Directors, Santa Barbara County Water Agency – 90 Days

Findings 1, 2

Goleta Water District – 90 Days

Findings 1, 2

Carpinteria Valley Water District – 90 Days

Findings 1, 2

Carpinteria Valley Groundwater Sustainability Agency – 90 Days

Finding 1, 2

Santa Ynez River Water Conservation District – 90 Days

Finding 1, 2

San Antonio Basin Water District – 90 Days

Finding 1, 2

San Antonio Basin Groundwater Sustainability Agency – 90 Days

Finding 1, 2

Santa Maria Valley Water Conservation District – 90 Days

Finding 1, 2

Cuyama Basin Groundwater Sustainability Agency – 90 Days

Finding 1, 2

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CANNABIS TAXATION AND EXPENDITURES

FILED JUNE 20, 2025

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CANNABIS TAXATION AND EXPENDITURES

SUMMARY

The 2024-25 Santa Barbara County Grand Jury (Jury) investigated the current Santa Barbara County cannabis tax revenue and expenditures and how they are reported. During its investigation, the Jury learned that Santa Barbara County's (County) tax revenues from the cannabis industry have been declining steadily since cannabis was approved for recreational use in California in 2018. In this same period of time, the County's expenditures in regulating the cannabis industry have increased. As a result, the expenditures covering the County's cannabis industry-related management and taxation operations (Cannabis Program) are on track to become a financial burden in the near future unless the County takes corrective measures.

The Jury also found that a significant number of growers have left the Santa Barbara County cannabis industry due to high cost of operations, price collapse, and market oversupply in part due to black-market competition.

Currently, budgeting, tax collection, and compliance activities are the responsibility of different agencies and departments in the County. Inefficiencies in the management and required reporting of the Cannabis Program can be mitigated by the creation of a centralized information database that tracks the budget, tax revenues, expenses, and administrative activities related to licensing and compliance. In addition, Cannabis Program spending can be reduced by allocating tax revenues to support only operating expenses directly related to it. Given the volatility of the cannabis market, the Jury further recommends that the County maintain the solvency of the Cannabis Program by ensuring that expenditures do not exceed cannabis tax revenues each year.

This Grand Jury Report was based on an investigation conducted from August 2024 to May 2025. The Report was in the final stages of production on June 3, 2025, when the Santa Barbara County Board of Supervisors initiated significant changes to the County's Cannabis Program, many of which are consistent with the Findings and Recommendations in this Report. This Report was not altered or amended in any way following the Board's actions.

BACKGROUND

On November 8, 2016, California voters passed Proposition 64, which legalized the cultivation and sale of cannabis for recreational and/or medicinal purposes. At that time, even though cannabis

remained illegal under Federal law, the Federal government chose not to interfere with those states that legalized it for recreational and/or medicinal use. Going forward, this legal discrepancy would create a unique challenge for California and Santa Barbara County in developing, implementing, and enforcing a cannabis program. For example, because an IRS Code (26 U.S.C., § 280E) prohibits cannabis businesses from deducting ordinary business expenses, limiting deductions for cannabis cultivators only to the cost of goods sold, cannabis businesses carry a heavier tax burden overall than other types of businesses. Further, because cannabis is still listed as a Schedule I drug (similar to heroin, cocaine, LSD, ecstasy, etc.) under Federal law, many major financial institutions are hesitant to work with cannabis businesses.

Because cannabis is still illegal under Federal law and regulated as a Schedule I drug, California has contracted with METRC Inc, a track and trace technology company, to create a customized version of their Marijuana Enforcement Tracking Reporting Compliance (METRC) software that incorporates the State's regulatory adjustments. This system is called the California Cannabis Track-and-Trace (CCTT) System that is used statewide by cannabis businesses to record the inventory and movement of cannabis and cannabis products though the commercial supply chain of the cannabis industry - "from seed to sale."

With CCTT, every plant is tagged with a tracking number and can be followed from seed germination, through cultivation, to distribution, manufacturing, and finally to retail sale. Santa Barbara County utilizes the State's CCTT system to monitor and confirm that gross receipts from cannabis are being accurately reported by local cannabis businesses to the Santa Barbara County Tax Collector.

Once the industry was legalized at the State level, the County set about developing ordinances to regulate the newly created cannabis industry within the County (Cannabis Program). To assist it in this task, the County hired Hinderliter, de Llamas & Associates (HdL) to develop a tax model for cannabis. HdL's report/recommendation, dated October 14, 2017, was presented to the County's Board of Supervisors on December 14, 2017.[1]

HdL's report listed four possible approaches for the County to tax the various cannabis activities:

- Tax on the cultivation area by square foot;
- Tax on the gross receipts of a cannabis business;
- A per-unit tax on the product by weight or volume; or
- A retail sales tax at point of sale.

[1] See the 2019-2020 Santa Barbara County Grand Jury's Report entitled "Cannabis," p. 15-18. https://sbcgj.org/wp-content/uploads/2022/02/Cannabis.pdf

Ultimately, HdL recommended, and the County agreed, on a tax model that was based on the gross receipts of the various cannabis businesses, with quarterly reporting to the County.[2] The various cannabis business taxable categories and their respective tax rates are:

- Nursery: 1% of gross receipts. Nurseries include operations which, in essence, deal with seedlings, immature plants, and clones.
- Distributor: 1% of gross receipts (excludes Distributors for Transport Only). Distributors are involved in the procurement, sale, and/or transport of cannabis and cannabis products between two or more cannabis businesses.
- Manufacturing: 3% of gross receipts. Manufacturers are those operators who are engaged in the processing, packaging, holding/storing, and labeling of cannabis.
- Cultivation: 4% of gross receipts. Operators are those who plant, grow, (whether indoor or outdoor) and harvest mature plants.
- Retail: 6% of gross receipts. Retailers are those who work in storefront and non-storefront, e.g., web-based, settings.
- Microbusiness: 6% of gross receipts. A microbusiness is a business that is engaged in any of the above-described categories except Nurseries.

Because of declining tax revenues and concerns about the transparency of a cannabis business' gross receipts report, the Jury has focused its investigation on the County's cannabis tax revenue, expenditures, and related administrative processes.

METHODOLOGY

In support of its investigation, the Jury interviewed:

- Santa Barbara County Supervisors
- Santa Barbara County Tax Collector staff
- Santa Barbara County CEO staff
- Cultivators in Santa Barbara County
- Knowledgeable industry observers and analysts

The Jury also reviewed:

- Documents from the Offices of the County CEO, Tax Collector, and the Sheriff's Office
- Tax data from the Santa Barbara County Cannabis Program
- Published articles and literature on cannabis taxation within Santa Barbara County

The Jury also visited the facilities of multiple local cannabis businesses.

[2] See Santa Barbara County Code, Chapter 50A.

DISCUSSION

Cannabis Tax Revenue

While initially the County received a "green rush" of cannabis tax revenue, that revenue has since declined steadily from its high of $15.7 million in 2020-2021 to less than $6 million in 2023-2024. Since 2017, there has been no change in the County's cannabis tax model/structure, which remains based on a cannabis business' gross receipts. Table 1 reflects these declining tax revenues based on the financial data the Jury collected during its investigation.

Issues adversely impacting tax revenues of the County's Cannabis Program include the following factors:

- Market oversupply has caused cannabis prices to drop from approximately $1,200 per pound in 2020 to a low of $250 per pound in 2025[3]
- Competition from out-of-County illegal suppliers has also driven the market price of cannabis down, reducing the profit margins of legitimate cannabis businesses and thereby, reducing their ability to recoup their costs
- Unregulated and cheaper synthetic products have also adversely impacted the sale price of cannabis products
- High tax rates have resulted from the unavailability of Federal tax deductions for cannabis businesses, which means their tax burden, compared to other businesses, is higher
- High cost of permits, licenses, and compliance fees:
  A. Initial Application Fee: Ranging from $5,180 to $10,450, depending on the license type and operational scope
  B. Annual Renewal Fee: Between $2,803 and $4,989
  C. Compliance Management Fee: Fixed fees ranging from $2,593 to $4,276, replacing the previous deposit-based model
- High start-up costs related to infrastructure, security, and maintenance are forcing many of the cultivators out of business because they cannot recoup their initial investments and be profitable

The combined effects of all these factors have led to a steady decline in cannabis tax revenue in Santa Barbara County. The current Cannabis Program revenue in the first quarter of fiscal year 2024-25 was only $1.3 million. This is the lowest first-quarter cannabis tax revenue since the Cannabis Program's inception in 2018.

[3] Burns, Melinda. "The Downward Trend in Cannabis Tax Revenues." *The Santa Barbara Independent*, Published January 27, 2025. https://www.independent.com/2025/01/27/the-downward-trend-in-cannabis-tax-revenues/

Cannabis Tax Expenditures

When Santa Barbara County approved the cultivation, processing, manufacturing, distribution, and sale of cannabis products for recreational use in Santa Barbara County in 2018, the County developed expenditure projections based on the expected "green rush" of cannabis tax revenue.

The initial Cannabis Program operating budget was developed to cover the full cost of staff time associated with licensing, application reviews, compliance checks, renewals and enforcement, and to provide funding for County deferred maintenance and capital projects. Unfortunately, the steady decline in cannabis tax revenue since 2020-2021 is projected to make the Cannabis Program a financial burden to the County in the future after the reserves, which are kept in a dedicated fund, are spent if the cannabis tax revenue and expenditures are not balanced (see Table 1).

Table 1
Cannabis Program Tax Revenues and Expenditures

	Tax Revenue	Ongoing Expenditures	One-time Expenditures	FY Net	Fund Ending Balance
FY 2018-19	$ 6,760,700	$ 2,190,500	$ 2,847,800	$ 1,722,400	$ 1,722,400
FY 2019-20	$ 12,182,200	$ 3,216,500	$ 1,822,300	$ 7,143,400	$ 8,865,800
FY 2020-21	$ 15,746,600	$ 4,889,700	$ 4,056,900	$ 6,800,000	$ 15,665,800
FY 2021-22	$ 8,718,800	$ 7,883,200	$ 2,933,400	$ -2,097,800	$ 13,568,000
FY 2022-23	$ 6,117,400	$ 7,763,000	$ 3,641,200	$ -5,286,800	$ 8,281,200
FY 2023-24	$ 5,770,300	$ 4,291,100	$ 1,055,200	$ -1,148,800	$ 7,132,400
FY 2024-25	*$ 5,411,300*	$ 6,794,500	$ 1,547,400	*$ -2,930,600*	*$ 4,201,900*[4]
FY 2025-26	*$ 5,529,800*	*$ 6,715,900*	*$ 2,682,500*	*$ -3,868,600*	*$ 1,203,700*[5]

Figures in italics are based upon projected estimates.

Since taxes are based on self-reported gross receipts, there has been concern about potential underreporting of cannabis revenue by individual operators. A sum of $300,000 was allocated by the Board of Supervisors to develop a cannabis tax auditing process and perform auditing of cannabis businesses. Hinderliter, de Llamas & Associates (HdL) was hired to assist the County with the development of a cannabis application fee structure, tax structure, and to perform fiscal analysis and audits. HdL completed three audits for a total cost of $27,000 in the fiscal year 2024-2025 with the following results:

- 1 audit completed with no issues;
- 1 audit completed with objections (under review); and
- 1 audit never completed because the business license was relinquished.

The Jury learned that six additional audits are planned for the next fiscal year.

[4] This figure excludes $2,090,600 in earmarks for deferred maintenance and capital projects.
[5] This figure is based on a projected July 1, 2025, fund balance of $5,072,300.

The 2025-2026 Santa Barbara County cannabis compliance and enforcement expenditure allocation of $3,290,800 takes up a large portion of the Cannabis Program budget (see Table 2). However, compliance and enforcement actions are less imperative now that illegal cannabis cultivation activities are declining in the County. In addition, the number of licensed cannabis businesses has also been declining. Consequently, cannabis compliance and enforcement costs should be readdressed to evaluate opportunities for lowering the current enforcement expenditures and the number of personnel supporting cannabis compliance.

Table 2

Cannabis Revenue vs. Compliance and Enforcement Costs

	Tax Revenue	Compliance & Enforcement Costs
FY 2018-19	$ 6,760,700	$ 2,104,300
FY 2019-20	$ 12,182,200	$ 2,711,800
FY 2020-21	$ 15,746,600	$ 2,755,400
FY 2021-22	$ 8,718,800	$ 2,419,400
FY 2022-23	$ 6,117,400	$ 2,391,000
FY 2023-24	$ 5,770,300	$ 3,129,500
FY 2024-25	*$ 5,411,300*	$ 3,242,900
FY 2025-26	*$ 5,529,800*	*$ 3,290,800*

Figures in italics are based upon projected estimates.

Cannabis Tax Oversight, Compliance, and Enforcement

Santa Barbara County has faced significant challenges with its cannabis tax revenue system due to its reliance on self-reported gross receipts from cannabis operators. This approach has led to issues with compliance, transparency, and revenue shortfalls. Current problems include:

- Cannabis businesses can fail to submit tax reports, report zero earnings, or submit late reports. Operators may exploit legal loopholes by selling products to themselves at artificially low prices to minimize tax liabilities.
- The County's Tax Collector staff can have issues with verifying the accuracy of self-reported figures, making enforcement difficult and time-consuming.
- The cannabis-related expenditures associated with oversight, compliance, enforcement, and the County’s planned non-cannabis deferred maintenance and capital projects are projected to surpass the revenues collected from cannabis taxes.
- The County's reliance on self-reported gross receipts has made it difficult to evaluate their accuracy. This self-reporting system has made it challenging for budget analysts to predict revenue and for auditors to ensure compliance.

A further disadvantage is that Santa Barbara County does not have a central cannabis reporting department/program. The County relies on multiple departments, agencies, and programs for cannabis oversight, compliance, and enforcement as shown below:

- The County Executive Office's Cannabis Division oversees the regulation and licensing of commercial cannabis activities, including issuing permits, ensuring compliance with local ordinances, and managing the licensing process.
- The Sheriff's Office is responsible for enforcement against illegal cannabis activities. It also collaborates with multiple agencies and departments to ensure oversight and enforcement of cannabis regulations.
- The County's Department of Planning and Development is required to ensure the proposed activity aligns with zoning regulations and to monitor ongoing compliance.
- A County cannabis business license is issued by the Tax Collector after obtaining a land use entitlement; this license is required for all commercial cannabis operations and must be renewed every year.

Santa Barbara County, as in all of California, continues to struggle with a market oversupply of cannabis largely due to out-of-county illegal competition. Estimates suggest approximately 60% of California's cannabis is sold through illicit channels.

While the illicit cannabis retail market poses a large problem throughout the State, the illicit cannabis cultivation problems have been declining in Santa Barbara County. The Jury discovered that the law enforcement reports filed with the State indicate that there has been negligible illicit cannabis cultivation activity in Santa Barbara County for the past three years. In addition, the Jury learned that the State provides grants to counties to combat illegal cannabis activity; the Santa Barbara County Sheriff's Office received grants from the State in excess of two million dollars for such purposes within the past few years.

CONCLUSION

The Cannabis Program began with the expectation that it would provide a windfall of tax revenue to Santa Barbara County. However, those expectations are no longer being met due to changing market conditions. Cannabis tax revenue has been steadily declining in Santa Barbara County since fiscal year 2021-22. Current County expenditures from cannabis tax revenue on deferred maintenance and capital projects, licensing, monitoring, compliance, and enforcement are projected to become a financial burden to Santa Barbara County in the near future if the current cannabis tax structure and expenditures are not reviewed and revised to account for the continuing decline in cannabis tax revenue.

FINDINGS AND RECOMMENDATIONS

Finding 1: Cannabis tax revenues have been declining due to market oversupply and price collapse, stressing the County's operating expenditures for the Cannabis Program.

Recommendation 1: The Grand Jury recommends that the Board of Supervisors ensure that the Cannabis Program's annual operating expenditures do not exceed annual cannabis tax revenues.

Finding 2: The County's allocation for deferred maintenance and capital project expenses from cannabis tax revenue has not been adjusted to reflect the decline in tax revenue over the past five years.

Recommendation 2: The Grand Jury recommends that the Board of Supervisors revisit its capital projects allocation to be funded by cannabis tax revenues, ensuring that such allocations do not exceed available funds.

Finding 3: Current County budget projections indicate that Cannabis Program ongoing expenditures will exceed expected cannabis tax revenues by $1.1 million in fiscal year 2025-26, posing a burden on County taxpayers.

Recommendation 3: The Grand Jury recommends that the Board of Supervisors prioritize covering the direct operating costs of the Cannabis Program so as to achieve more balanced budgets in the future.

Finding 4: Currently Santa Barbara County's budgeting, tracking, and reporting of cannabis-related revenue, expenses, and compliance violations are decentralized, making it difficult to provide comprehensive and detailed information on demand.

Recommendation 4: The Grand Jury recommends that the Board of Supervisors direct the County Executive Officer to develop an automated and centralized information database to track and report the budget, revenues, expenses, and administrative activities related to licensing and compliance specific to the Cannabis Program.

Finding 5: Despite declining illicit cannabis cultivation activity in the County, a significant portion of the County's cannabis tax revenues continue to be allocated to combat this activity each fiscal year.

Recommendation 5: The Grand Jury recommends that the Board of Supervisors annually re-evaluate the allocation of cannabis tax revenue for combating illicit cannabis cultivation activity in the County.

REQUIREMENTS FOR RESPONSES

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

Responses to Findings shall be either:

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

Responses to Recommendations shall be one of the following:

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

Santa Barbara County Board of Supervisors - 90 days

Findings 1, 2, 3, 4, 5

Recommendations 1, 2, 3, 4, 5

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SANTA BARBARA COUNTY
SOUTH COAST HOUSING CRISIS

FILED JUNE 23, 2025

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SANTA BARBARA COUNTY SOUTH COAST HOUSING CRISIS
A CALL TO ACTION

SUMMARY

The housing shortage in Santa Barbara County's South Coast, particularly for low- and moderate-income residents, is reaching crisis levels. This growing concern is now a frequent topic at public hearings, advocacy meetings, and in news reports.

The root of the problem is a lack of new housing development for many years. The situation has been made worse by the rise in short-term rentals and an increasing number of second or third homes left vacant for much of the year. While the County has met its obligation under the California Regional Housing Needs Allocation (RHNA) to plan for increased housing supply, there are serious barriers to building this housing, particularly affordable and workforce housing.

Numerous barriers continue to stand in the way of actual construction. These include high land and labor costs, development fees, restrictive zoning, and neighborhood opposition (commonly known as "Not In My Back Yard" or NIMBY). Complex regulations further delay or block projects. The many federal and state programs that offer subsidies for affordable housing are underfunded, oversubscribed, and beset with confusing rules and deadlines. Recent shifts in federal policy have cast uncertainty on the future of these programs.

Although RHNA only mandates planning, not building, housing, the County and cities do have tools to directly facilitate construction. These include expanding ministerial approvals, using objective design standards for accessory dwelling units (ADUs), revising restrictive codes, and rezoning land specifically for affordable and workforce housing.

The 2024-25 Santa Barbara County Grand Jury (Jury) observed that our local governments on the South Coast, local non-profit organizations, many developers, and some employers are striving to create more housing, but much more needs to be done. To truly address the South County's housing needs and meet RHNA goals, local agencies must go beyond planning. They must commit meaningful resources to the actual development of this needed housing.

BACKGROUND

The South Coast of Santa Barbara County is known for its beauty, climate, and geography. Residents have long sought to preserve this unique character, often by supporting regulations that slow housing development. However, due to increasing population and workforce growth, the

region now faces a severe housing shortage, especially for low- and moderate-income families. Currently, more than 65 percent of local workers cannot afford to live in the area and are forced to commute long distances to work. As of March 25, 2025, the City of Santa Barbara Housing Authority (HASB) had 7,732 households on its Section 8 (see Glossary) waitlist. On that date, HASB announced it would pause new voucher issuances due to uncertainty over federal housing funding.

The California State Legislature has long recognized the need for more affordable housing, passing numerous laws over decades to support local governments, agencies, and developers. The State Legislature continues to introduce more legislation aimed at producing more affordable housing.[1]

Since 1969, California's Department of Housing and Community Development (HCD) has required local governments to plan for the housing needs of all income levels through California's Housing Element Law. This planning is guided by the Regional Housing Needs Allocation (RHNA), which assigns housing targets to each region every eight years across six income categories based on the Area Median Income (AMI). In 2024, the AMI for Santa Barbara County was $119,100.

The Santa Barbara County Association of Governments (SBCAG) reviews state-assigned housing targets and distributes them among cities and unincorporated areas (see Additional Resources). Each jurisdiction must then adopt a Housing Element in its General Plan to meet these targets.

Previously, housing targets were weighted toward North County due to greater land availability. However, the current cycle shifts the focus to the South Coast, where housing needs are most acute. The South Coast now bears approximately 60% of the County's total RHNA allocation of 24,856 units, The allocation of units for the South Coast is shown in Table 1. Accordingly, the Jury has focused its attention on the South Coast.

Table 1: Current Santa Barbara County RHNA Allocation

South Coast Jurisdiction	RHNA Allocation	Allocation by Income Level			
		Very Low	Low	Moderate	Above Moderate
Carpinteria	901	286	132	135	348
Santa Barbara	8,001	2,147	1,381	1,441	3,032
Goleta	1,837	682	324	370	461
Unincorporated	4,142	809	957	1,051	1,325

[1] Buffy Wicks, "California Legislature Releases Sweeping Bill Package to Fast Track Housing Production," press release, March 27, 2025. https://a14.asmdc.org/press-releases/20250327-california-legislature-releases-sweeping-bill-package-fast-track-housing

Historically, Santa Barbara County has failed to meet its RHNA targets in terms of actual construction, largely due to overly optimistic planning and local resistance to housing development.

In the current RHNA cycle (2023–2031), the State has imposed significantly higher housing targets and enacted stricter laws with real penalties for missing deadlines for Housing Element adoption. This includes stronger enforcement tools, such as AB 1893 (2024) (Builder's Remedy, see Glossary), for jurisdictions that missed their Housing Element deadlines.

Progress to Date by Local Jurisdiction for the South Coast Housing Element

All the jurisdictions on the South Coast missed the initial deadlines for obtaining State approvals for their completed Housing Element plans but were spurred into action when developers threatened to invoke Builder's Remedy exemptions on pending or proposed projects. As of March 2025, all Housing Elements in the County have been approved by the State and have been incorporated into each jurisdiction's respective General Plan. These are readily available on the County and city websites (see Additional Resources).

All jurisdictions on the South Coast have prudently identified additional sites to exceed the RHNA requirements by 10 to 15 percent to avoid falling short should any sites become unavailable for development by 2031. The County and cities are only required to identify suitable sites and are not directly responsible for actually building housing. They are, however, required to make it as easy as possible for developers to be able to build housing in the various categories needed. As detailed in the documents listed in the Additional Resources section of this report, each Housing Element includes a variation of the following key goals, each of which is expanded into specific implementation plans and programs:

- Process improvements
- Changes to existing design standards
- Relaxation of existing regulations
- Funding
- Fee structures
- Public and private development partnerships

METHODOLOGY

The Jury reviewed documents and conducted interviews to investigate the reasons behind the housing shortage on the South Coast. The Jury focused on affordable housing because the availability of market rate housing does not present a significant problem. Data on affordable housing was analyzed based on the RHNA definitions. The Jury's methods of investigation included:

- Interviews with city (Santa Barbara, Goleta, and Carpinteria) and County staff and housing providers
- Interviews with Santa Barbara County Association of Governments (SBCAG) staff
- Attendance at County Board of Supervisors meetings and city council meetings
- Review of California housing laws
- Review and analysis of the County's and South Coast cities' General Plans and Housing Elements for the 2023-31 cycle
- Review of the County's and South Coast cities' ordinances and resolutions related to affordable housing
- Review and analysis of affordable housing agreements between developers and the County
- Examination of building permit applications, approved projects under development, news media coverage, and public hearings

DISCUSSION

The Jury reviewed the Housing Elements of the County and cities on the South Coast and found there is a critical need for housing for people who cannot afford market-rate housing. Therefore, the Jury decided to focus on the obstacles to affordable housing development and potential solutions.

Housing Developments in Progress

Several housing projects with 100 percent affordable units have been launched by non-profit organizations, such as People's Self-Help Housing, and public agencies, such as HASB and the Housing Authority of Santa Barbara County (HASBARCO). Some projects have been completed (e.g., a 60-unit project in Goleta), others are under construction, and many are still in the planning phase. Some private developments incorporate inclusionary housing requirements where a proportion of units must be affordable, although terms vary and are often negotiated between developers and local governments. Accessory Dwelling Units (ADUs) and Junior ADUs (JADUs) are also being built under streamlined state laws, such as ministerial approvals using objective design standards (see Glossary), although only about 65 percent are expected to qualify as affordable.

For example, in the City of Santa Barbara over a thousand ADUs have either been completed or are under development. Local employers such as Yardi Systems, Inc., the Rosewood Miramar Hotel, the Santa Barbara Cemetery Association, Cottage Health, and others have also begun sponsoring affordable housing projects for their employees.

In addition, the County, cities, and public agencies have identified and started to develop housing projects on land that they do not anticipate using. Some examples include:

- The City of Santa Barbara is working with HASB to develop workforce housing on a vacant lot and has designated the current site of the Santa Barbara Police Department for future housing
- The Santa Barbara Unified School District has leased two parcels of land to HASBARCO to build affordable housing
- The Santa Barbara Metropolitan Transit District (MTD) has reached an agreement with a private developer to build transit-oriented, multi-family rental housing, which will include 15% affordable units, on MTD's vacant property

While the County and some of the municipalities have included a few parcels of publicly owned land in the Housing Element, there is more land owned by them and other public agencies that could be identified and repurposed for affordable and workforce housing. Utilizing these publicly owned lands would help to foster public-private partnerships since the cost of land will become less of an obstacle to building affordable and workforce housing.

Obstacles to Development

South Coast residents have historically supported land use policies that preserved neighborhood character, which has unintentionally contributed to severe housing shortages. Costly development fees, community opposition, labor costs, land acquisition costs, and prolonged development entitlement processes (see Glossary) further stall progress. Though some employers and school districts are leveraging their land for housing, such efforts are infrequent.

1. Funding Limitations

Affordable housing depends on a complex mix of federal, state, and private funds. Each of these funding sources has its own criteria and timelines. The availability of federal and state funding for affordable housing construction is predicated on meeting strict eligibility requirements and tight timing windows. The complexity of this process requires successful participants in these programs to have experienced and dedicated staff or consultants to navigate the process. The State of California produces a Notice of Funding Availability (NOFA) calendar[2] to assist those who want to use grant or credit programs to build more affordable housing. The complexity of this chart reflects the complexity of this funding process.

Typically, these sources are oversubscribed and subject to unexpected rule changes. For example, current uncertainties about federal funding have caused the Housing Authority of the City of Santa Barbara to cease issuing the Section 8 vouchers. Developers often factor the availability of these vouchers into decisions about whether to include affordable units.

Even though some cities have implemented creative financing mechanisms and public-private partnerships, these efforts have not kept pace with the rising need for affordable housing.

[2] See the HCD's website for the latest NOFA calendar: https://www.hcd.ca.gov/grants-and-funding/nofa-calendar

The County of Santa Barbara and the City of Santa Barbara have both established housing trust funds certified as Community Development Financial Institutions (CDFI, see Glossary). These funds are intended to supplement the development of affordable housing projects. The County has deposited fees collected from developers into their fund. In addition to depositing developer fees, the City of Santa Barbara has also transferred some resources into their fund from their contingency reserves.

On June 10, 2025, the City of Santa Barbara budgeted $3.5 million to be added to their housing trust fund to fund affordable housing over the next two years; the Jury applauds this action, but believes that much more needs to be done given the pent-up demand for affordable housing in the City. Recent experience has shown that one unit of affordable housing may cost as much as one million dollars to build in the City of Santa Barbara.

Both the City of Santa Barbara and the County need to access other sources to increase the impact of these funds. For example, the County of Ventura actively promotes its housing trust fund and advertises for contributions from the philanthropic community.

Neither the City of Goleta nor the City of Carpinteria have established CDFI-certified housing trust funds to date.

2. Regulatory and Legal Complexity

Streamlined approval processes are now in place for affordable housing and ADUs, but many projects still face delays due to overlapping agency jurisdictions (e.g., Coastal Commission), siloed city and county permitting and approval processes, appeals, lawsuits, and neighborhood objections. These barriers disproportionately affect affordable housing projects, which are unable to absorb high carrying costs during such delays.

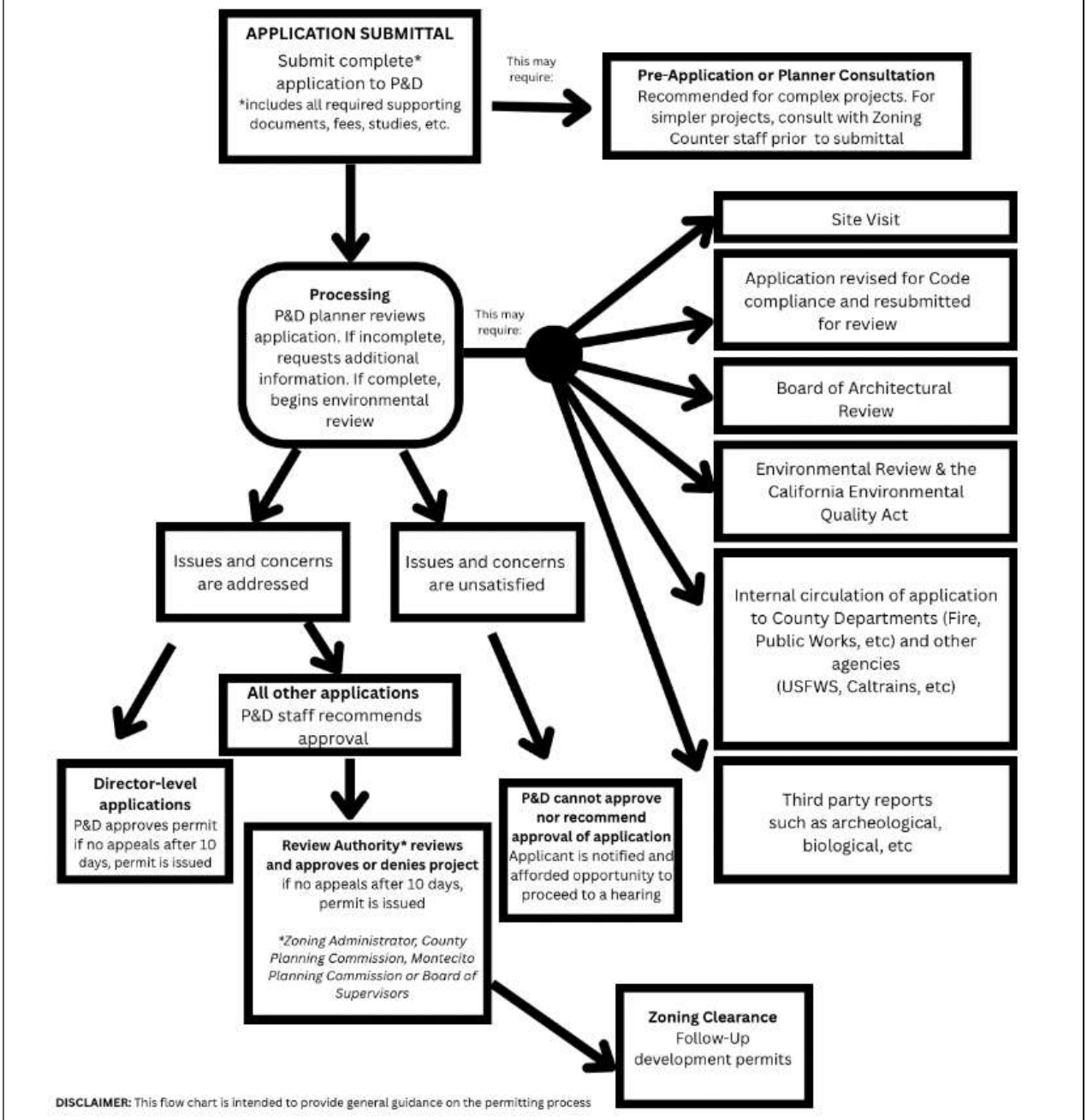
Within this system, there is no single individual tasked with assisting developers of affordable housing to navigate this complex process and to deal with multiple regulatory agencies. Figure 1 (below) illustrates the planning permit process in Santa Barbara County.

3. Development Costs

Government fees, prevailing wage requirements, interest on loans, and prices of land and material all drive up costs for affordable housing. Any uncertainty in the development process, such as appeals, litigation, and unexpected delays in approvals, can add to project costs.

Deed restrictions and rent caps required by inclusionary housing mandates often discourage developers from proceeding with below market rate housing projects.

Figure 1



Source: County of Santa Barbara Planning and Development Department

Strategic Solutions

The current housing crisis has created a flurry of activity at the state and local levels. Every day, new measures are taken: bills are proposed in the legislature; ordinances are drafted at the local levels; and solutions are proposed in the media. The Jury recognizes all these efforts and hopes that some of the solutions will be realized.

All of the governments in the South Coast are working diligently on these problems, and the Jury applauds their efforts. However, to make significant numbers of housing units available, the region must adopt a more unified, forward-thinking approach. All aspects of the development process, from application to completion of construction and occupancy, must work seamlessly together and all the involved agencies must collaborate to help the developer navigate the steps involved in an expeditious manner. The County and municipalities on the South Coast could consider taking measures such as those listed below:

A. Modernize Local Ordinances

- Update zoning, design standards, and utility requirements for density and affordability
- Ensure alignment with state mandates to avoid development delays and legal vulnerability

B. Streamline Approval Processes

- Shift to parallel permitting processes across jurisdictions
- Increase use of ministerial approvals for qualifying projects
- Establish a mechanism for parallel processing across jurisdictions, both municipal and separate agencies, from whom developers must obtain approvals
- Specify guidelines that will allow developers to qualify for exemptions from some requirements of the review process if project criteria are met up front
- Provide navigation assistance to allow developers to move expeditiously through the approvals required from various agencies

C. Expand and Stabilize Funding

- Develop and promote housing trust funds to leverage the benefits of Community Development Financial Institutions and philanthropic partnerships
- Reinvest market-rate development fees into affordable housing

D. Utilize Public and Surplus Land

- Inventory land owned by cities, school districts, and special districts and repurpose any that is surplus to their operational requirements
- Prioritize high-opportunity areas near jobs and transit

E. Community Engagement and Public Outreach

- Continue community forums used during the Housing Element update
- Publicly track and share development milestones
- Promote understanding of housing's role in community resilience

CONCLUSION

The affordable housing crisis on the South Coast remains a complex and urgent challenge, shaped by high land costs, state and local regulatory hurdles, and limited financial resources. The development process is often slow and fragmented, and affordable housing projects face competition for limited funding.

Although the jurisdictions on the South Coast will meet the RHNA goals that require identification of suitable building sites, it is unlikely that the target of increasing the inventory of affordable and moderate-income housing on the South Coast will be realized by 2031.

Ultimately, providing needed housing on the Santa Barbara South Coast will require sustained collaboration among local governments, developers, community stakeholders, and the broader public to build a more inclusive, affordable, and resilient housing landscape.

FINDINGS AND RECOMMENDATIONS

Finding 1: Santa Barbara County and the cities of Santa Barbara, Goleta, and Carpinteria own land that is surplus to their operational requirements, some of which could be used for affordable housing.

Recommendation 1a: The Grand Jury recommends that the Santa Barbara County Board of Supervisors and City Councils of Santa Barbara, Goleta, and Carpinteria identify publicly owned properties within their jurisdiction that could be utilized for affordable housing.

Recommendation 1b: The Grand Jury recommends that the Santa Barbara County Board of Supervisors and City Councils of Santa Barbara, Goleta, and Carpinteria invite public and private developers to work with them to build affordable housing on the publicly owned land identified as available.

Finding 2: The process for issuance of a permit for affordable housing development projects in the County and the cities of Santa Barbara, Goleta and Carpinteria is costly, time consuming, and complicated.

Recommendation 2a: The Grand Jury recommends that the Santa Barbara County Board of Supervisors and City Councils of Santa Barbara, Goleta, and Carpinteria each create a position to be staffed by a qualified person who can coordinate and facilitate the application and approval processes for affordable housing projects, with the authority to bring together all interested parties to arrive at an expeditious resolution of any issue.

Recommendation 2b: The Grand Jury recommends that the Santa Barbara County Board of Supervisors and City Councils of Santa Barbara, Goleta, and Carpinteria review their processes for development approvals to prioritize affordable housing projects.

Recommendation 2c: The Grand Jury recommends that the Santa Barbara County Board of Supervisors and City Councils of Santa Barbara, Goleta, and Carpinteria apply the ministerial approval process to all development projects comprising seventy five percent or more of low-income housing.

Recommendation 2d: The Grand Jury recommends that the Santa Barbara County Board of Supervisors and City Councils of Santa Barbara, Goleta, and Carpinteria conduct a review of all development and impact fees and find ways to waive, reduce or amortize fees for affordable housing projects.

Finding 3: There are insufficient funds available to develop needed affordable housing.

Recommendation 3a: The Grand Jury recommends that the City Councils of Goleta and Carpinteria establish dedicated housing trust funds, certified as Community Development Financial Institutions, to facilitate the building of affordable housing.

Recommendation 3b: The Grand Jury recommends that the Santa Barbara County Board of Supervisors increase funding to the Housing Trust Fund of Santa Barbara County to facilitate the building of affordable housing.

Recommendation 3c: The Grand Jury recommends that the Santa Barbara City Council further increase funding to the City of Santa Barbara Local Housing Trust Fund to facilitate the building of affordable housing.

Recommendation 3d: The Grand Jury recommends that the Santa Barbara County Board of Supervisors and the City Councils of Santa Barbara, Goleta and Carpinteria promote contributions to their housing trust funds by other non-governmental organizations, the philanthropic community, and the public.

REQUIREMENTS FOR RESPONSES

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

Responses to Findings shall be either:

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

Responses to Recommendations shall be one of the following:

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

Santa Barbara County Board of Supervisors – 90 Days

Findings 1, 2, 3
Recommendations 1a, 1b, 2a, 2b, 2c, 2d, 3b, 3d

City of Santa Barbara – 90 Days

Findings 1, 2, 3
Recommendations 1a, 1b, 2a, 2b, 2c, 2d, 3c, 3d

City of Goleta – 90 Days

Findings 1, 2, 3
Recommendations 1a, 1b, 2a, 2b, 2c, 2d, 3a, 3d

City of Carpinteria – 90 Days

Findings 1, 2, 3
Recommendations 1a, 1b, 2a, 2b, 2c, 2d, 3a, 3d

GLOSSARY

AB (Assembly Bill): A bill introduced in the California State Assembly (e.g., AB 1893).

ADU (Accessory Dwelling Unit): A secondary housing unit on a property, such as a converted garage or standalone structure.

Affordable Housing: Affordable housing refers to housing that is priced on the basis of ability to pay and not on the market rate of a housing unit. If the total housing expense of a family remains at or below 30% of their gross household income, then the housing unit is considered affordable.

Area Median Income (AMI): The income value at which an equal number of families earn more, and an equal number of families earn less. The AMI value is derived from census data and is determined annually by the US Department of Housing and Urban Development (HUD) and is specific to an area. Thus, the AMI on the South Coast of Santa Barbara varies for each city and for the unincorporated of the County and is defined in their respective Housing Elements.

Builder's Remedy: A legal provision in California that allows developers to bypass local zoning restrictions when cities or counties fail to comply with the Housing Element Law. The Builder's Remedy can be invoked when a city or county fails to obtain state approval for its Housing Element by the State's deadline either because it has not been submitted in time or because the Housing Element proposals do not meet the State's requirements. Under such circumstances, developers can propose housing projects that do not conform to local zoning regulations if at least 20% of the units are designated as affordable housing, or 100% are moderate-income housing. The city or county cannot reject these projects based on some zoning or General Plan inconsistencies.

CDFI (Community Development Financial Institution): A non-profit financial institution that supports affordable housing and economic development. The federal CDFI Fund was created to help certified CDFIs generate economic growth and opportunity. It provides funding, resources, and technical assistance to help local financial institutions take a market-driven approach to support the economic needs of a community. By being a certified CDFI, a housing trust fund is eligible to receive funding and other assistance from the CDFI fund to build affordable housing.

Development Entitlement Process: The entitlement process is a critical phase in real estate development, involving the legal and regulatory approval required to proceed with a development project to ensure compliance with zoning laws, building codes, and other regulations. Steps in the entitlement process include zoning approval, land use permits, environmental impact assessments, site plan approval, public hearings, and permits. Such approvals are necessary to ensure legal compliance, to manage legal and environmental risks, to obtain community support, and to confirm project feasibility.

HASB (Housing Authority of the City of Santa Barbara): The agency responsible for managing affordable housing programs in the City of Santa Barbara.

HASBARCO (Housing Authority of Santa Barbara County): The public agency focused on affordable housing development and management in Santa Barbara County, excluding the City of Santa Barbara.

HCD (California Department of Housing and Community Development): The agency tasked with developing housing policy and administering funding and development programs in the State of California.

Housing Element: The component within local government's General Plans that meets the state requirement that all cities and counties in California adequately plan to meet the housing needs of everyone in their communities at all income levels.

HUD (U.S. Department of Housing and Urban Development): The federal agency responsible for housing policy and programs.

Inclusionary Housing: To be considered inclusionary, a housing development is required to have a certain percentage of affordable housing units (typically five to 20 percent) to be included when market-rate housing is being built.

JADU (Junior Accessory Dwelling Unit): A smaller unit within the primary home, usually repurposed from existing space.

Ministerial Approval: Ministerial approval is a faster and less complex approval process compared to discretionary review, which involves public hearings and more subjective judgment.

NIMBY (Not in My Backyard): A term describing opposition to development projects, especially housing.

Notice of Funding Availability (NOFA): A NOFA or Notice of Funding Opportunity (NOFO) is a document that announces a funding opportunity for grants. NOFAs can be used to announce funding opportunities for various housing-related programs, such as HUD's housing counseling programs, Community Development Financial Institution programs (CDFI), and programs for rural housing.

Objective design standards: Projects seeking ministerial approval must demonstrate compliance with clear, objective standards and regulations, often outlined in zoning ordinances or specific codes.

RHNA (Regional Housing Needs Allocation): A state-mandated process that assigns housing development targets to cities and counties based on projected needs.

SBCAG (Santa Barbara County Association of Governments): A regional, independent public agency that coordinates transportation and housing planning among Santa Barbara County and all eight incorporated cities in the County.

SB (Senate Bill): A bill introduced in the California State Senate (e.g., SB 35).

Section 8 – now called Housing Choice Program: This is the federal government's largest program for assisting low-income families, the elderly, and the disabled in being able to afford decent, safe, and sanitary housing in the private market. A housing subsidy is paid by an authorized housing authority to the landlord on behalf of a participating family. The family pays rent based on their income, and the housing authority pays the difference between that amount and the market rent.

South Coast: The South Coast of Santa Barbara County is defined by SBCAG in their Regional Housing Needs Allocation Plan, July 15th, 2021, as follows: "For purposes of the RHNA methodology, the County is divided into two subregions, referred to as the South Coast and North County Housing Market Areas, and further divided into the incorporated cities and unincorporated areas contained within these two subregions." See Figure 2.

Figure 2

Source: County of Santa Barbara Planning and Development Department

The South Coast Housing Market Area includes the cities of Carpinteria, Santa Barbara, and Goleta, as well as unincorporated Montecito, Summerland, Toro Canyon, Mission Canyon, Eastern Goleta Valley, Isla Vista, Hope Ranch, UCSB, and Gaviota.

Workforce Housing: For purposes of this report, workforce housing refers to housing that is needed for households who do not qualify for affordable housing because their income exceeds the AMI for moderate income in any city or County area on the South Coast, but cannot afford market rates for housing for rent or sale. A large number of the workers employed by public and private employers fall within this category.

ADDITIONAL RESOURCES

Housing Elements for the 2023-2031 Cycle:

1. City of Santa Barbara:
   https://santabarbaraca.gov/HousingElement
2. City of Goleta:
   cityofgoleta.org/home/showpublisheddocument/29869/638375666841470000
3. City of Carpinteria:
   https://carpinteriaca.gov/city-hall/community-development/planning/housing-element-update/
4. County of Santa Barbara:
   https://www.countyofsb.org/3177/Housing-Element-Update

Housing Element Annual Progress Reports for 2024:

1. City of Santa Barbara Housing Element Annual Progress Report, 2024:
   https://santabarbaraca.gov/sites/default/files/2025-03/HE%20APR%20SantaBarbara2024.pdf
2. City of Goleta Housing Element Annual Progress Report, 2024:
   https://www.cityofgoleta.org/home/showpublisheddocument/31599/638785768381830000
3. City of Carpinteria Housing Element Annual Progress Report, 2024:
   https://carpinteriaca.gov/wp-content/uploads/2025/05/2024-HE-APR-Staff-Report-with-Attachments-3-10-2025.pdf
4. County of Santa Barbara Housing Element Annual Progress Report, 2024:
   https://content.civicplus.com/api/assets/1aa7eb3e-858e-450a-82fb-549760e6fee8

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FATAL HEAD INJURY AT THE NORTHERN BRANCH JAIL

FILED JUNE 24, 2025

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FATAL HEAD INJURY AT THE NORTHERN BRANCH JAIL
A Custody-Related Death Investigation

SUMMARY

Approximately seven hours after his initial booking at the Santa Barbara County Northern Branch Jail on August 29, 2024, an inmate (AAO) suffered a traumatic head injury when he fell from standing height onto the linoleum floor of his housing unit due to an apparent seizure. After spending 19 days in the hospital and undergoing significant medical intervention, AAO was pronounced dead on September 17, 2024.

The 2024-2025 Santa Barbara County Grand Jury (Jury) investigated the facts and circumstances surrounding AAO's arrest and subsequent booking, intake health screening, incarceration, and injury at the Northern Branch Jail. In this case, the Jury found deficiencies and limitations relating to the intake screening process and the electronic health record, which ultimately meant that medical staff could not and did not make fully informed decisions regarding AAO's health needs and risks when he arrived at jail. The Jury further identified a lack of communication regarding inmate health risks an area of concern. The Jury offers its findings and recommendations with the intention of improving system-wide operations at our local jails.

BACKGROUND

The Grand Jury's Purpose in Death-in-Custody Investigations

Pursuant to its duties outlined in California Penal Code §919(b), the Santa Barbara County Grand Jury investigates the deaths of inmates that occur within Santa Barbara County's jails, including the deaths of those who were hospitalized following an in-custody incident or injury. The Jury's death-in-custody investigations are conducted with the primary aim of improving the conditions of and the care provided to inmates within Santa Barbara County's correctional system.

Narrative and Timeline of the Present Case

This Report details the case of inmate AAO—a Spanish-speaking man who was 40 years old at the time of his death. AAO suffered from homelessness, struggled with alcohol use, and had been incarcerated in the County's jails on multiple occasions in, but not limited to, the years 2022, 2023, and 2024.

On August 29, 2024, at approximately 11:30 a.m., AAO was arrested by officers of the Santa Maria Police Department on a felony no-bail warrant for a violation of probation. At the time, AAO was calm, cooperative, and seemingly sober. He was taken into police custody without any

use of force. Of note, AAO was asked in Spanish by arresting officers if he needed or wanted medical attention and answered that he did not have any issues requiring attention. AAO was transported directly to the Northern Branch Jail (NBJ) and arrived at approximately 12:30 p.m.

Medical staff completed AAO's medical receiving screening within 40 minutes of his arrival at the NBJ. Medical staff briefly reviewed AAO's known medical history before joining him in an exam room, noting that AAO had a history of alcohol withdrawal as reported on the receiving screening form from his last incarceration and an alcohol withdrawal alert in his chart. AAO spent approximately seven minutes in the exam room and reportedly communicated with medical staff by means of an English-Spanish interpreter on a language line. During this health screening interview, which consists of over 70 questions that require verbal answers from the patient, AAO denied having any chronic or acute medical problems. While answering affirmatively that he is a user of alcohol, he denied having experienced withdrawal relating to his drinking. AAO's mood was notably anxious to medical staff during this intake.

Based on his answers and the RN's observations, AAO was medically cleared by approximately 1:10 p.m. for placement in a holding cell. The intake medical staff did not communicate any information regarding the patient's history of alcohol withdrawal, nor did she communicate her finding that the inmate was demonstrating notable signs of anxiety. At this time, deputies removed AAO's handcuffs, and following a quick pat-down search, he joined another inmate in a holding cell in the booking area. AAO's six-hour stay in this holding cell was punctuated by two short excursions: one at approximately 3:30 p.m. for a 10-minute classification interview with a custody deputy, and a second at approximately 4:20 p.m. for fingerprinting and a photograph. At around 4:55 p.m., a third inmate joined them in the holding cell. At 5:00 p.m., deputies delivered a packaged dinner to AAO in the holding cell, which he readily consumed. Overall, in the course of those six hours in the holding cell, AAO was anxious and frequently fidgeted with his hands, though he retained the ability to follow the instructions of custody deputies and communicate with others.

At approximately 7:20 p.m., AAO was taken from the holding cell and escorted to a dress-in room, where he took a shower and received jail clothing. Exiting the dress-in room at 7:45 p.m. in clean clothing, AAO was escorted by two movement deputies to the booking area to undergo a full-body x-ray scan. At this time, AAO's eyes appeared glassy and bloodshot. Once deputies had established that AAO was clean of any contraband, he joined another inmate for an escort to their assigned housing cells in B-Unit. At approximately 7:50 p.m., the two movement deputies handed off AAO and the other inmate through a sallyport (a controlled access point) to the custody deputy who was supervising B-Unit. During this initial period of over seven hours, there was no documentation of any handoff communication between staff regarding AAO's alcohol withdrawal alert or his anxiety, which was noted during the receiving screening.

Within a minute of walking into the housing unit, AAO became unresponsive while standing. Having noticed AAO's blank stare, bloodshot eyes, and dilated pupils, a deputy in B-Unit began waving his hands in front of AAO's face in an attempt to get his attention. Within seconds, AAO jolted his right arm upward, became rigid, and fell, striking the left side of his head on the linoleum floor without any attempt to break or cushion his fall. AAO continued to seize on the floor as blood flowed from his head.

After a man-down radio call, other custody staff and medical staff arrived within two minutes. During this time, AAO was conscious but disoriented and at times combative towards those providing emergency care. Following the application of a cervical collar at 7:55 p.m., a group of custody staff and medical staff remained with AAO until he was loaded on a gurney by paramedics, removed from the NBJ, and taken to the local hospital at approximately 8:20 p.m.

Emergency surgery after his arrival at the hospital revealed severe brain damage from bleeding due to recent head trauma. AAO spent the last 19 days of his life at Marian Regional Medical Center in Santa Maria, succumbing to the complications of his head injury on September 17, 2024. Both the Coroner's report and treating physicians concluded that AAO's death could only have been caused by brain injury from his fall in the jail. The Coroner's report and autopsy report revealed that AAO fell because of a seizure, though the cause of his seizure remains unknown.

METHODOLOGY

The Jury obtained the information contained in this Report from a number of sources:

- The Jury reviewed the documentation provided by the Santa Barbara County Sheriff's Office (SBSO) of AAO's stay at the NBJ. This documentation included booking and classification documents, internal emails, audio recordings of interviews, security camera recordings of AAO's movements inside the NBJ, and, soon after, AAO's autopsy report.
- The Jury surveyed AAO's health records—both those maintained by California Forensic Medical Group, Inc. (Wellpath) as well as those generated by AAO's stay at Marian Regional Medical Center after his injury
- The Jury considered the County's previous and current contracts with Wellpath, the *Murray* Remedial Plan, reports on the County's progress in implementing the *Murray* Remedial Plan, several policy manuals, and previous Grand Jury reports
- The Jury consulted several published guidelines, including the National Commission on Correctional Health Care's (NCCHC) *Standards for Health Services in Jails* (2018), the American Society of Addiction Medicine's (ASAM) *Clinical Practice Guideline on Alcohol Withdrawal Management* (2020), and the U.S. Department of Justice's (DOJ) *Guidelines for Managing Substance Withdrawal in Jails* (2023)

- The Jury inspected the Northern Branch Jail and followed the path taken by AAO through the facility
- The Jury received a demonstration from medical staff on the electronic health record (EHR) software employed by Wellpath
- The Jury examined the bodycam and dashcam footage of AAO's arrest
- Finally, the Jury conducted over 20 interviews with individuals knowledgeable of the events and matters at issue in this Report, including custody staff and Wellpath medical staff who interacted with AAO on the day of his injury. Other individuals questioned include medical staff who provided emergency care to AAO at the hospital and Coroner's Bureau staff who worked on AAO's case after his death.

DISCUSSION

The following sections of this Report detail the Jury's observations about the intake health screening process at the jails, the organization and display of important health history in the EHR maintained by Wellpath, the process for initiating withdrawal monitoring for at-risk inmates, the health-related training required for custody staff, and the sharing of patient medical information between medical staff and custody staff. These observations are joined by the Jury's analysis of how the facts of AAO's case indicate deficiencies and limitations in some of these areas.

Overview of the Receiving Screening Process

Since 2017, Santa Barbara County has contracted with Wellpath to provide medical and mental healthcare to those incarcerated in Santa Barbara County's jails. As a part of its contractual obligations, Wellpath staffs the jails with Registered Nurses (RNs), who are responsible for completing initial health screenings of arrestees when they arrive at jail. RNs are instructed to complete these health screenings as soon as possible, and at a minimum, within two hours of an arrestee's arrival barring exigent circumstances. The RN completes a receiving screening form during this intake, which takes account of—but is not limited to—the arrestee's vital signs, current medications, mental status, chronic health conditions, and acute problems such as physical trauma or substance withdrawal. Apart from the taking of an arrestee's vital signs, a supplemental COVID test, and the listing of an arrestee's allergies and medications, the receiving screening consists of approximately 13 pages of binary (yes-or-no) and multiple-choice questions. While most questions require the arrestee to respond verbally, a series of observational questions require the RN to input answers directly. If the RN determines that the arrestee does not need immediate medical evaluation or care at a hospital, the arrestee will be cleared to enter custody in the jail.

The receiving screening form, once completed, becomes part of the health record that Wellpath maintains for each patient. If an arrestee has previous health records on file from prior

incarcerations, the RN is additionally required to review this history in the EHR during the intake screening process.

This immediate health screening serves a critical purpose: it is designed to enable jail staff to quickly obtain information on an arrestee's physical and mental health status before the arrestee is housed as an inmate, providing a means by which a new arrival's health needs can be addressed quickly and accommodated appropriately. In many instances, those who are cleared for housing at the jail still require monitoring, treatment, or accommodations for their conditions. Examples include inmates' needs for mobility devices, medications, and monitoring and treatment for potential intoxication and substance withdrawal symptoms.

Patient Medical History in the Electronic Health Record

One of the challenges inherent to the receiving screening process is its inevitable reliance on the self-reporting of health information. Simply put, arrestees are not always willing to disclose or able to recall all of the health information asked of them during the screening interview. While information from arresting officers and the RN's clinical observations and judgment are important supplements to any self-reported information, medical intake staff could also consult prior health records if an arrestee has been incarcerated in one of Santa Barbara County's jails within the past seven years. In AAO's case, his prior health records at the jail contained information that was crucial for evaluating his health risks and needs when he was brought to the NBJ on August 29, 2024.

AAO consistently indicated to jail medical staff over the course of many incarcerations that he was a long-time user of alcohol who still actively drank, and this was reflected on forms in the EHR. Additionally, the Jury found that AAO had suffered from delirium tremens as a result of alcohol withdrawal within the past year, and that such information could also be found in prior receiving screening forms in the EHR. These answers automatically generated a permanent alert in AAO's chart for alcohol withdrawal. AAO had also undergone alcohol withdrawal monitoring in the jail as recently as 2023 following an arrest for public intoxication. During that period of recognized withdrawal risk in 2023, AAO was prescribed a benzodiazepine to be taken every eight hours, evaluated every eight hours with a symptom severity scoresheet, given vitamins and minerals every 24 hours, and assigned to a bottom bunk for five days.

An additional risk factor that could have been recognized during intake involved the fact that AAO had suffered a head injury as a result of an altercation during a previous incarceration at the NBJ in March 2024. With a large bump on his left temple resulting in a moderate degree of discomfort, AAO was taken to an emergency room via ambulance. The Jury's investigation revealed that AAO had a history of brain injury dating back to at least 2021, though all such developments prior to the incident in March 2024 would have occurred outside of the jail and therefore would not have been noted in the EHR at the jail. This history was verified by evidence of old hemorrhage from

prior brain trauma noted during AAO's initial emergency brain operation at Marian Regional Medical Center following his seizure and fall at the NBJ. The March 2024 head injury was noted in the EHR, but only in a sick call note. In any case, the note recounting AAO's head injury from March would have been sufficient in itself to establish a history of head injury and possible traumatic brain injury when his medical records were reviewed upon intake on August 29, 2024.

While alcohol withdrawal typically begins with milder symptoms such as tremors, anxiety, nausea, and sweating in the six to 12 hours after cessation or a significant reduction in alcohol intake, in some individuals—especially those with a history of withdrawal seizures, underlying seizure disorders, or brain injury—an alcohol withdrawal seizure might occur without any preceding signs or symptoms. While AAO was not placed on withdrawal monitoring following his intake screening despite his history and risk, the Jury discovered that medical staff did not notice all of this history while reviewing his chart at intake due to its organization.

There is no internal policy that governs how an RN is supposed to review a returning patient's medical and mental health history in the EHR during intake. However, the Jury learned that RNs, as a standard practice, are expected to review patient alerts, summary sheets, and previous intake forms prior to conducting the receiving screening interview. In AAO's case, a review of his medical history consistent with this typical practice was completed. However, the note describing AAO's head injury from March 2024 could not have been readily noticed during intake because the injury was not included in his master problem list, in a separate list of alerts, or in any previous receiving screening forms. In fact, AAO's master problem list in the EHR was completely blank despite his prior head injury at the NBJ and his known alcohol use and withdrawal history.

The County's previous and current contracts with Wellpath state in section 10.4 (under Exhibit A, Statement of Work) that the contractor "shall maintain a comprehensive and accurate Problem List in each medical record." The importance of that provision is obvious. Incomplete problem lists can compromise quality of care and put patients at risk. And while AAO's medical record as a whole contained a great deal of information regarding the general state of his health and health risks, an informed decision about AAO's risk-based need for alcohol withdrawal monitoring should not have required an RN at intake to read every note, form, and flowsheet in his extensive medical record. Accurate and comprehensive problem lists, alerts, and other summary sheets should allow RNs conducting intakes to better review, identify, and address the specific needs of returning patients without the need to search the entire medical record for possible health issues and other concerns.

Per a Service Level Agreement (SLA) outlined in Exhibit H of the County's new contract with Wellpath, approved by the Board of Supervisors on April 1, 2025, the County has identified incomplete master problem lists as an area of concern. If Wellpath does not achieve a 90 percent

compliance threshold in ensuring that inmates "have an accurate problem list in their medical records," the organization may face monetary penalties moving forward.

Initiation of Withdrawal Monitoring and Treatment

Previous Santa Barbara County Grand Jury reports have found that the first few days of an inmate's incarceration are the most critical, and the Jury finds that this case is no different. With the sudden need to adjust to a new lifestyle within the jail after an arrest, inmates' health—both physical and mental—might be put under a great deal of strain. Withdrawal from drugs or alcohol in new arrivals at the jail is a prime example of this.

The Jury collected data from the SBSO showing that of approximately 800 inmates at both of the County's jails on one day in March 2025, 175 were marked with an alert for drug withdrawal, and 68 had alerts for alcohol withdrawal. These numbers exclude an additional 48 alternative sentencing inmates, such as those on house arrest, who also have alerts for either drug or alcohol withdrawal. Per the NCCHC, intoxication resulting in subsequent withdrawal or related injury is one of the leading causes of death in jails. Such a common and potentially life-threatening condition requires clear, objective criteria for when an inmate should receive monitoring or treatment.

Current Wellpath policy states that the initiation of withdrawal monitoring or treatment is based on a patient's risk, history, and, ultimately, an order by a health care provider. An RN is required to evaluate a patient's risk and collect a history by asking a series of questions during the receiving screening. Specifically on alcohol use and withdrawal, the receiving screening asks the following questions:

- Do you use alcohol?
- Type?
- Amount?
- Date of last use?
- Frequency of use?
- Duration of use?
- Prior withdrawal (Tremors, Seizures, DTs)?
- Date of last withdrawal?
- Currently withdrawing?

AAO reported that he used alcohol during his two most recent intake screenings, one in May 2024 with the other being this most recent arrest in August 2024. In May 2024, AAO reported using alcohol one to five times per week, drinking three to four beers at a time. However, during his intake in August 2024, AAO reported only drinking one to three days per month, drinking one to two beers at a time. And while AAO reported having recently experienced delirium tremens during his May 2024 screening, he did not report any history of prior withdrawal episodes during his

August 2024 intake. Importantly, the date of AAO's last use of alcohol was left blank on his August 2024 receiving screening form; this omission left medical staff in the dark about a critical risk factor.

As the DOJ suggests in its specific guidance for management of withdrawal in jails, any new arrival who is symptomatic, reports regular heavy drinking, or "reports past-week alcohol use and a history of complicated alcohol withdrawal," such as a history of delirium tremens, should be referred for immediate clinical assessment. The DOJ guidelines also state that any new arrival who reports to be a risk for withdrawal or who "reports recent alcohol use below the threshold specified for immediate clinical assessment AND does not report a history of complicated alcohol withdrawal" should still be monitored for the emergence of withdrawal symptoms.

While AAO's self-reported alcohol use patterns would not meet the definition of "unhealthy alcohol use" under ASAM's withdrawal guidelines, which Wellpath staff are required to adhere to under section 1.2A of the County's contract with Wellpath, his anxiety and affirmative answer to alcohol use at intake combined with his withdrawal history documented in the EHR were important factors to consider regarding potential treatment or monitoring. As ASAM's guidelines indicate, "evaluating risk as opposed to current presentation is recommended" since "signs and symptoms can escalate quickly, and the trajectory of alcohol withdrawal can vary considerably among patients."

Monitoring would have been beneficial in this case in at least one important way: It would have led to closer and regular evaluation by medical staff of AAO with a symptom severity assessment scale.

While the Jury learned that identifying when an essentially asymptomatic patient needs withdrawal monitoring can feel like a gray area for some intake medical staff, the County has recently taken steps to address this as an area of general concern. An SLA outlined in Exhibit H of the County's new contract with Wellpath requires that Wellpath "maintain a written policy to provide adequate monitoring to patients experiencing drug and/or alcohol withdrawal consistent with" the DOJ's guidelines outlined above, explicitly including "an evidence-based screening" upon intake for withdrawal risk. Wellpath could face monetary penalties in the future if it fails to meet a compliance threshold of 100 percent.

Health-Related Training for Custody Staff

The Jury recognizes that the custody staff in our local jails have an important and stressful job with demanding responsibilities: They work closely with incarcerated individuals day in and day out to help ensure the functioning of a fair and humane criminal justice system in the County. With the responsibility of supervising incarcerated individuals, custody staff by their position are the most readily available to identify inmate problems in the facility and are the first to respond to

emergencies. In that line of thinking, as the NCCHC states in its standards, custody personnel have an important part to play "in the early detection of illness and injury."

Per NCCHC standards, biannual health-related training for correctional officers is considered essential and is required for NCCHC accreditation. Required topics of training include, but are not limited to, acute manifestations of certain chronic illnesses, adverse reactions to medications, and intoxication and withdrawal. Section 10.2 of the County's contract with Wellpath as well as internal Wellpath policy promulgate guidelines for biannual training of custody officers that include all of the areas required for NCCHC accreditation. At the County's jails, it is Wellpath's contractual obligation to provide such trainings in ways that foster interaction between medical staff and custody officers. Additionally, section 1.2C of the Wellpath contract, both previous and current, specifically requires annual training on withdrawal:

> The Contractor shall ensure that all health care and custody staff are trained in recognizing the signs and symptoms of withdrawal from drugs, alcohol, and other substances in the period following reception and assignment to housing. Training shall be conducted annually at a minimum and include withdrawal timelines, signs and symptoms to a variety of substances common and uncommon to the local population.

Section IX of the *Murray* Remedial Plan also stipulates that custody staff receive training on "general correctional health care issues, including… recognizing different types of medical and mental health conditions and appropriate responses." Per the Remedial Plan, custody staff shall receive at least eight hours of such training biannually, and the "County shall keep records documenting all such trainings and training participants."

AAO's case demonstrates why such training is essential: He spent the vast majority of his approximately seven pre-injury hours at the NBJ interacting solely with custody staff and other inmates. In such a scenario, it is custody staff who are best positioned to notice any acute health needs that may have been missed during the receiving screening or that emerge or increase in severity soon after intake. As the DOJ recommends in its withdrawal guidelines, "custody staff should be alert to emerging signs and symptoms of withdrawal in individuals who initially screen negative, particularly in the first 72 hours after intake" because new arrivals "may not be forthright about recent substance use or withdrawal risk."

The Jury learned that when AAO was interacting with custody staff, his eyes were noticeably altered—glassy, bloodshot, and dilated, by several descriptions—for at least five minutes before his fall. However, these symptoms were not reported to medical staff before his fall. These symptoms are consistent with alcohol withdrawal, but only one person could recall associating in the moment the observed symptoms with drug or alcohol use, mentioning intoxication specifically.

Consequently, the Jury inquired into the extent of the health-related training actually performed for the benefit of custody staff. After extensive investigative efforts, which included the questioning of multiple supervisors and employees at both the SBSO and Wellpath, the Jury has found reason to believe that the jails in the County are currently meeting NCCHC biannual health-related training requirements.

As the County continues to pursue NCCHC accreditation for the NBJ, the Jury emphasizes that the purpose of such training per the NCCHC is to ensure that custody staff "are trained to recognize the need to refer an inmate to a qualified health care professional." While AAO's eye-related symptoms were noticed by custody, no action was taken to alert medical staff of the observation.

Sharing of Inmate Health Information

A 2022-23 Santa Barbara County Grand Jury report titled "Death on Electronic Monitored Home Release" touched on the issue of a lack of information sharing between the County's healthcare contractor at the jails and the SBSO and Probation Department. All County parties agreed in the aftermath of that report's publication that important exemptions in federal law under HIPAA allow information sharing when it is necessary to protect the health and safety of the patient or others.

Currently, there are certain instances in which medical staff share a limited amount of patient health information with custody staff to ensure inmate and staff safety. One such example of this practice is the use of a medical treatment order (MTO) when such a form is generated by medical staff. For example, if medical staff determine during intake that an arrestee needs to undergo sobering or withdrawal treatment, they will generate an MTO and provide a copy to custody by email to ensure that custody staff are aware of the patient's needs. Another potential example of information sharing, the Jury learned, are some of the alerts that appear in an inmate's file in the Jail Management System (JMS), which is used and maintained by custody staff. For example, alerts such as "diabetes" will appear in the alerts section of the JMS for a diabetic inmate. Computers located throughout both jails give custody staff ready access to the JMS, even within housing units in many instances.

Given the principle that custody staff have an important role to play in the detection of illness and injury, and should receive training to that effect, any basic information that could increase custody's awareness of an inmate's known areas of risk could save lives. As the DOJ asserts in its guidelines on withdrawal, both "health care and custody staff should be alert to… the risk of withdrawal in all new arrivals," and should therefore foster "a sense of teamwork" with each other to facilitate "a unified response to substance withdrawal."

In AAO's case, custody staff as a whole were not made aware of his alcohol withdrawal risk by medical staff directly or by an alert in the JMS despite the existence of AAO's alcohol withdrawal alert in the EHR. As a matter of fact, there is no current process or requirement for handoff

communication between the intake nurse and custody staff following medical evaluation. And while custody's interactions with AAO during the hours-long booking and classification process presented an opportunity to watch for possible signs or symptoms of withdrawal as they emerged, custody staff had no awareness that AAO was at any greater risk than any other inmate.

The ability for custody to preliminarily identify at-risk inmates through information sharing with medical staff, as allowed by law, would be valuable in cases where withdrawal monitoring or treatment was missed or not initiated at intake, as in AAO's case. A system of shared alerts and requirements for handoff communication could allow custody staff to gain awareness of inmates' need-to-know health risks within hours of their arrival at jail. Without such awareness, custody staff's ability to supervise and care for inmates with health concerns is undoubtedly compromised.

CONCLUSION

The first 72 hours of an inmate's arrival at jail is a time of particular sensitivity, requiring careful attention from medical staff and custody staff. In the course of this custody-related death investigation, the Jury identified a number of areas relating to the screening and observation of new arrivals at the County's jails that require improvement.

An incomplete master problem list in the electronic health record, which meant that medical staff could not accurately assess whether AAO needed alcohol withdrawal monitoring or not, encompasses important areas where AAO's case demonstrates shortcomings in provided medical care at the County's jails. Two Service Level Agreements in the County's new contract with Wellpath demonstrate that the County is taking steps to correct these deficiencies. A lack of communication regarding withdrawal risk between medical staff and custody staff, or between their respective information systems, was also identified as an area of concern by the Jury.

With increased oversight by County agencies over Wellpath's operations at the County's jails following the signing of the new contract in April 2025, the Jury is increasingly hopeful that the concerns it raises in this Report will result in system-wide improvements at the jails.

COMMENDATION

The County has taken important steps to implement oversight mechanisms at the jails to improve Wellpath's compliance with the new contract and the jails' adherence to national care standards. The Jury commends the Santa Barbara County Board of Supervisors, the Sheriff's Office, the County of Santa Barbara Health Department, the Santa Barbara County Department of Behavioral Wellness, and their staff for their recent work in these pursuits.

FINDINGS AND RECOMMENDATIONS

Finding 1: Because of the lack of an accurate and comprehensive master problem list in AAO's electronic health record, Wellpath medical staff did not make fully informed decisions regarding AAO's health needs and risks when he came to the Northern Branch Jail on August 29, 2024.

Recommendation 1a: The Grand Jury recommends that the Board of Supervisors instruct the County of Santa Barbara Health Department to conduct systematic audits of inmates' charts in the electronic health record to determine the extent to which master problem lists maintained by Wellpath accurately and comprehensively reflect inmates' known health problems. To be completed by July 1, 2026.

Recommendation 1b: The Grand Jury recommends that if non-compliance is discovered in the form of incomplete or inaccurate master problem lists so as not to meet performance measures established by the Wellpath contract, the County exact monetary penalties pursuant to the Service Level Agreement (Area 5. Incarcerated Person Problem List) in the new contract.

Finding 2: AAO's known medical history at the jail provided clear indicators for serious alcohol withdrawal risk, but no such identification occurred.

Recommendation 2a: The Grand Jury recommends that the Board of Supervisors instruct the County of Santa Barbara Health Department to conduct audits to determine if Wellpath staff are appropriately identifying, monitoring, and treating at-risk inmates consistent with the U.S. Department of Justice's *Guidelines for Managing Substance Withdrawal in Jails*. To be completed by July 1, 2026.

Recommendation 2b: The Grand Jury recommends that if non-compliance is discovered in the form of missed cases of withdrawal monitoring or treatment, or performance of monitoring or treatment duties inconsistent with the U.S. Department of Justice guidelines so as not to meet performance measures established by the Wellpath contract, the County exact monetary penalties pursuant to the Service Level Agreement (Area 1. Withdrawal Management).

Finding 3: Custody staff were not aware that AAO had an alcohol withdrawal alert or history because it was not communicated to them by medical staff or by means of an alert in the Jail Management System, though such communication would have been valuable.

Recommendation 3a: The Grand Jury recommends that the Sheriff's Office require a standardized verbal communication process upon inmate handover from the registered nurse performing the health receiving screening to the relevant on-duty classification deputy, specifically

requiring the sharing of health-related findings or history insofar as necessary to provide for the health and safety of the inmate or others. To be implemented by January 1, 2026.

Recommendation 3b: The Grand Jury recommends that the Sheriff's Office develop a comprehensive and automatic system of shared health alerts between the healthcare contractor's electronic health record and the Jail Management System so that critical health-related alerts appear automatically in the Jail Management System. To be implemented by January 1, 2026.

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

REQUIREMENTS FOR RESPONSES

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

Responses to Findings shall be either:

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

Responses to Recommendations shall be one of the following:

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

Santa Barbara County Board of Supervisors – 90 days

Findings 1, 2, 3
Recommendations 1a, 1b, 2a, 2b, 3b

Santa Barbara County Sheriff's Office – 60 days

Findings 1, 2, 3
Recommendations 3a, 3b

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ANOTHER SUICIDE IN THE SANTA BARBARA COUNTY JAIL

FILED JUNE 24, 2025

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ANOTHER SUICIDE IN SANTA BARBARA COUNTY JAIL

Inmate's Death Should Have Been Prevented

SUMMARY

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

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

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

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

METHODOLOGY

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

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

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

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

OBSERVATIONS

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

Related Incident Two Weeks Prior to Death

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

CC had a history of suicide attempts. She was diagnosed with psychosis, malingering, conversion, and depression with psychotic features.[4] During the examination, CC's alter ego "Patricia" was manifesting. Patricia was typically more agitated and ruder to people than she was.

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

November 8, 2024

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

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

November 9, 2024

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

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

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

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

staff at the hospital that she tried to choke herself when visiting deceased relatives at a cemetery that day. She stated that she was taking Xanax but had stopped taking her other medications, including medications for bipolar disorder. CC told hospital staff she was suicidal. A member of the hospital's mental health staff documented that CC needed psychiatric hospitalization.

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

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

November 10, 2024

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

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

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

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

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

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

November 11, 2024

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

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

November 12, 2014

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

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

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

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

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

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

November 13, 2024 – Day of Suicide

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

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

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

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

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

After Death Events

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

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

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

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

Board of Supervisors Hearing Regarding Jail Health Monitoring

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

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

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

DISCUSSION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONCLUSION

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

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

FINDINGS AND RECOMMENDATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

REQUIREMENTS FOR RESPONSES

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

Responses to Findings shall be either:

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

Responses to Recommendations shall be one of the following:

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

Santa Barbara County Board of Supervisors – 90 days

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

Santa Barbara County Sheriff's Office – 60 days

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

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PREVENTABLE DEATH AT THE NORTHERN BRANCH JAIL

FILED JUNE 24, 2025

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PREVENTABLE DEATH AT THE NORTHERN BRANCH JAIL

A Death-in-Custody Investigation

SUMMARY

On the fifth day after her incarceration at the Santa Barbara County Northern Branch Jail on March 24, 2025, inmate CF, a 57-year-old woman, was found unresponsive in her cell and could not be successfully resuscitated. The autopsy report concluded that CF died because of peritonitis (infection in the abdominal cavity) caused by a perforated gastric ulcer.

The 2024-25 Santa Barbara County Grand Jury investigated the facts and circumstances surrounding CF's death at the Northern Branch Jail. The Jury found that CF had repeatedly complained of abdominal pain for the last two days of her incarceration. Moreover, the autopsy indicated that CF's stomach had perforated days before her death.

Throughout her incarceration, the medical care provided to CF did not meet numerous jail medical procedure requirements. For example, her complaints of pain were never appropriately evaluated, which meant that CF did not receive treatment. CF was never seen by a physician during her incarceration. Her requests for transfer to an emergency room were not documented nor acted upon by medical staff. As a result, a diagnosis of CF's perforated stomach was never made. Had CF's complaints been evaluated, she would have received treatment for her perforated ulcer, and her death could have been prevented.

While the Sheriff's Office released a statement that CF's death was unavoidable, the Jury concludes that there were opportunities to prevent this death.

BACKGROUND

Timeline of the Present Case

On Wednesday, March 19, 2025, CF, a Lompoc resident, was arrested at her home at 6:35 p.m. by Deputies of the Santa Barbara County Sheriff's Office (SBSO) on a felony no-bail warrant for possessing a firearm and ammunition as a prohibited person. During the booking process at the Northern Branch Jail (NBJ), Deputies documented that CF had chronic back injury, PTSD, and psychosis. During the health receiving screening, medical staff documented that CF denied lower abdominal pain. CF's self-reported prescription use of a narcotic pain medication for chronic back pain was noted during this screening. There was no documentation that CF had ever abused narcotic pain medication, nor that she otherwise utilized other narcotic drugs. CF also denied that she had ever experienced withdrawal symptoms related to her use of a narcotic pain medication.

CF was medically cleared by the registered nurse at 9:44 p.m. and was placed in a holding cell in the booking area at 9:55 p.m. Rather than bridge, or continue, CF's narcotic prescription, a nurse practitioner ordered via telephone that CF be placed on an opioid withdrawal monitoring protocol, which included prescriptions for medications to treat vomiting, nausea, and diarrhea and nursing assessments every eight hours. In addition, the telephone order included administration of acetaminophen (Tylenol) for pain. CF did not exhibit any signs of opioid withdrawal when she was first evaluated for symptoms at 1:00 a.m. on Thursday, March 20th. When the booking process was completed, CF was removed from the holding cell at 1:17 a.m. and was escorted to G Unit as a minimum-level, general population inmate.

On several different occasions throughout the day on March 20th, CF was evaluated for withdrawal symptoms, but scored so low on each assessment that it raised no concerns.

On March 21st, CF was transported to court for her arraignment along with another female inmate from G Unit. CF left the NBJ at 7:14 a.m. for her hearing, where she was remanded back to custody. She returned to jail at 3:54 p.m. Following her return to the jail on March 21st, CF was seen twice by registered nurses for opioid withdrawal assessments with no issues documented.

On March 22nd, CF was evaluated three times for opioid withdrawal symptoms, with no abnormalities found except an elevated resting pulse rate on two of the assessments.

Early on the morning of March 23rd, custody staff became aware that CF was causing a disturbance in her cell in G Unit. CF was observed to be hyperventilating, moaning, and screaming. At that time, CF described intense abdominal pain and arm pain and indicated that she believed she was having a heart attack. custody deputies removed CF from G Unit and brought her to a waiting cell in the NBJ's clinic at 5:23 a.m. While a member of medical staff reportedly evaluated her while she was in this waiting cell, the Jury has found no documentation in the electronic health record of that medical evaluation. In fact, the forms that nursing staff are expected to complete for documenting pain assessments were not utilized in response to this or any of CF's subsequent complaints of intense pain. The end result of CF's screaming and complaints of pain on the morning of March 23rd was her placement in a mental health observation cell. CF was not seen by a mental health provider until 11:30 a.m. that morning.

During the entirety of her 35-minute encounter with mental health staff on March 23rd, CF was moaning, grunting, and grimacing due to pain. CF stated that her "guts are all twisted up." At this time, the observation cell's floor appeared to be covered in various spots of spit mixed with vomit.

At 10:15 p.m., CF was again assessed by a member of mental health staff. CF again expressed that she was in a great deal of abdominal pain. Medical staff assessed CF at the request of mental health staff at this time. Medical staff stated that CF was experiencing opioid withdrawal symptoms.

During this assessment, a pain assessment form was not utilized, nor was a hands-on examination performed. After CF was administered Tylenol, she was willing to continue speaking with mental health staff for a brief period of time.

At 11:00 p.m., a member of medical staff conducted another withdrawal symptom assessment, this time documenting nausea, loose stool, diffuse discomfort, increasing anxiousness, and an elevated resting pulse rate. CF was repeatedly administered Tylenol each day from March 21st until her death. No other pain medications were administered. The Jury has found no documentation in the medical record whether CF's pain ever improved on this regimen.

On March 24th at approximately 8:15 a.m., CF was again seen by a member of mental health staff. CF complained of abdominal pain and requested to go to an emergency room. Although this request was relayed to medical staff, it was not acted upon. CF was cleared for stepdown from mental health observation, and was relocated at 8:55 a.m., returning to G Unit later that day.

CF took a shower upon returning to G Unit and then remained in her cell throughout the afternoon. Medical staff arrived in G Unit to perform another withdrawal symptom assessment at 3:00 p.m., though, at this point, CF could not walk to the exam room in G Unit where the assessment was supposed to take place. This was taken to be a refusal of clinical services, and the withdrawal symptom assessment was not performed.

At approximately 5:00 p.m., a custody deputy delivered a tray of food to CF in her cell for dinner. CF was sitting on her bed in the cell and made a grunting noise in acknowledgement of the food delivery. At 5:15 p.m., when the custody deputy returned to collect the tray, CF had not touched any of the food.

Only twenty minutes later, at 5:35 p.m., CF was discovered unresponsive in her cell, slumped over, with lips that had become blue in color. Lifesaving measures were immediately initiated by custody and medical staff, which included the use of an AED, chest compressions, five doses of Narcan, and two doses of epinephrine. These resuscitative measures were unsuccessful, and CF was declared dead at 6:11 p.m.

The autopsy report concluded that CF died because of a perforated gastric ulcer.

Gastric Ulcers

A gastric ulcer is a type of peptic ulcer that occurs on the lining of the stomach. It is basically a sore or lesion that forms due to an imbalance between the stomach's aggressive digestive acids and the protective mucus lining. Common causes include Helicobacter pylori (H. pylori) infection, long-term use of medications like ibuprofen or aspirin, excessive alcohol use, smoking, and/or chronic stress.

Perforation is a serious and life-threatening complication of a gastric ulcer. It happens when the ulcer erodes completely through the stomach wall, creating a hole. This allows stomach contents (acid, food, bacteria) to spill into the abdominal cavity, causing peritonitis—a severe infection of the abdominal lining. If untreated, perforation of a gastric ulcer invariably results in sepsis and death.

The signs and symptoms of perforated gastric ulcer include severe abdominal pain (often in the upper abdomen), rigid, board-like abdomen on physical examination, nausea, and vomiting.

The diagnosis of a perforated gastric ulcer begins with obtaining a history from the patient of abdominal pain, and a physical examination showing abdominal tenderness. Diagnostic tests include an X-ray or CT scan of the abdomen, which shows fluid and air in the abdominal cavity.

The treatment of a perforated gastric ulcer is emergency surgery to close the perforation. Intravenous fluids and antibiotics are adjuncts to surgical treatment. If treated promptly, only a short hospital stay is usually required.

The prognosis of perforated gastric ulcer is excellent if treatment is instituted immediately, with a survival rate of approximately 90% in reported series.[1,2] However, if diagnosis is delayed, treatment is less successful, and death from sepsis is more likely.

Evaluation of Inmates in Pain at County Jails

Pain evaluation in county jails (or any correctional facility) must balance clinical care, security, and legal standards. Pain assessment is a mandatory requirement for the humane treatment of inmates, and should be performed following medical, ethical, and legal guidelines. As of 2025, the National Commission on Correctional Health Care (NCCHC) continues to utilize its 2018 edition of the *Standards for Health Services in Jails*. Section 11.2 of the County's contract with California Forensic Medical Group, Inc. (Wellpath), the contracted healthcare provider for the County's jails, requires that Wellpath attain and subsequently maintain NCCHC accreditation for both jails in the County. Elements of essential policy established in the *Standards* (J-E-07) are reflected in Wellpath policy.

Wellpath policy states that when inmates complain of pain either verbally or in writing, they must be evaluated in a clinically appropriate time frame. Furthermore, reaction to an inmate's reports of pain must be based on the patient's perceptions of their own pain. Initial triage and history must be performed by a qualified healthcare provider (registered nurse, nurse practitioner, physician's

[1] Arshad, Seyed A., Patrick Murphy, and Jon C. Gould, "Management of Perforated Peptic Ulcer: A Review," *JAMA Surgery* 160, no. 4 (2025): 450–54. https://doi.org/10.1001/jamasurg.2024.6724

[2] Noguiera, Carlos, et al., "Perforated Peptic Ulcer: Main Factors of Morbidity and Mortality," *World Journal of Surgery* 27, no. 7 (2003). https://doi.org/10.1007/s00268-003-6645-0

assistant, or physician) upon complaint. When a patient seeks health services more than two times with the same complaint, he or she receives an appointment to see a nurse practitioner, a physician's assistant, or a physician.

In terms of generally accepted clinical practices for pain assessment, the history gathered should include the location, intensity, and duration of pain. The type of pain should also be characterized (sharp, dull, burning, etc.).

Healthcare providers should employ evidence-based pain assessment tools to characterize the pain. These tools help ensure that the severity of the pain is documented, and that appropriate treatment is initiated. Such validated tools include:

- Numeric Rating Scale (0–10)
- Visual Analog Scale (VAS)
- Wong-Baker Faces Pain Scale (especially for those with communication difficulties)
- For non-verbal patients: use behavioral cues (grimacing, guarding, agitation)

Each pain assessment should be documented in a medical record. The documentation should include:

- Patient's reported pain level
- Clinical observations
- Vital signs
- Interventions taken (medications, referrals)
- Patient response

Patients should be immediately referred to a physician or for emergency care if:

- Pain is severe or escalating
- Pain does not improve after prescribed pain medication administration
- Pain is associated with serious symptoms (e.g., chest pain, bleeding, behavioral or neurological abnormalities)

METHODOLOGY

The Jury obtained the information contained in this Report from:

- Documents and other evidence provided by the Santa Barbara County Sheriff's Office and Coroner's Bureau. This evidence included, but was not limited to, booking and classification documents, security camera video recordings, audio recordings of internally conducted interviews, and CF's autopsy report.
- The health record maintained by Wellpath for CF during her incarceration
- The County's current and previous contracts with Wellpath and several policy manuals

- Published guidelines, including the NCCHC's *Standards for Health Services in Jails* (2018) and the Federal Bureau of Prisons' *Pain Management of Inmates: Clinical Guidance* (2018)
- Published scientific resources on gastric ulcers and clinical standards for pain assessment
- Live interviews with individuals knowledgeable of the events and matters at issue in this Report, including employees of Wellpath, the SBSO, and the County of Santa Barbara Health Department (County Health)

DISCUSSION

For the two days prior to her death, CF repeatedly complained of intense abdominal pain, but the Jury found no indication that medical staff performed even rudimentary assessments of this pain. The Jury has found no medical documentation of the severity of her pain or its nature. Though CF was repeatedly given Tylenol, the Jury has found no documentation whether CF's pain was ever reduced following medication administration. In addition, the Jury has found no documentation that any medical professional physically examined CF for abdominal tenderness during her incarceration. CF was never referred to, or evaluated by, a nurse practitioner, physician's assistant, or physician following her many repeated complaints of pain to nursing staff.

CF's persistent complaints of pain were repeatedly left unaddressed by medical staff because they attributed her pain to the diagnosis of narcotic withdrawal. This perception led nursing staff to not appropriately assess her repeated pain complaints.

In the records provided to the Jury, there is no evidence that medical staff ever utilized any evidence-based process or form to document the severity and nature of CF's pain. The Jury learned that Wellpath nurses caring for inmates in the County's jails are expected to document pain assessments in the electronic health record utilizing standardized pain assessment forms, but this was never done in response to CF's repeated complaints of pain. The withdrawal assessment forms that were used to assess CF only evaluate the severity of specific opioid withdrawal symptoms after a withdrawal diagnosis has been made. In contrast, pain assessment forms are used to evaluate the intensity and characteristics of a patient's perceived pain; these two types of forms serve distinctly different purposes at the jails.

Though CF requested transfer to an emergency department just nine hours before her death, the Jury found no documentation that medical staff ever thoroughly evaluated whether this transfer was needed nor found any documentation explaining why the request was not honored. The Jury learned that such documentation should have been completed but was not.

The autopsy revealed that the cause of CF's death was from a perforated gastric ulcer. The nature of the fluid, inflammation, and adhesions in the abdominal cavity indicated that this perforation had occurred days before her death; this was the clear cause of CF's pain during her incarceration.

On March 25, 2025, the SBSO released a Notice of In-Custody Death to local media describing the circumstances of CF's death, and on March 27th, the SBSO issued a public update on the case. In the update, which was released the day following the initial autopsy examination, the SBSO stated that CF's death was unavoidable. In contrast, the Jury found that there were opportunities that might have prevented this death had the gastric perforation been discovered and treated. To date, the SBSO's statement that this death was unavoidable has not been revised.

CONCLUSION

After five days of incarceration in the Santa Barbara Northern Branch Jail, inmate CF died because of an untreated perforated gastric ulcer. For at least two days during her jail stay, CF repeatedly complained of pain, yet her pain was never appropriately evaluated. While the jail had established tools and forms to evaluate inmates' pain, these were never utilized, though their use was expected. Had an appropriate evaluation of CF's pain occurred, with subsequent treatment rendered immediately, CF's death could potentially have been avoided.

FINDINGS AND RECOMMENDATIONS

Finding 1: CF repeatedly complained of abdominal pain for at least two days prior to her death, but these complaints were not assessed by medical staff in accordance with jail medical policy, procedure, and protocol.

Recommendation 1: The Grand Jury recommends that the Sheriff's Office require that qualified medical professionals assess and treat pain according to accepted medical standards and in accordance with existing policy, procedure, and protocol when inmates in the County's jails complain of pain.

Finding 2: Nursing staff at the Northern Branch Jail did not follow an evidence-based process to evaluate or treat CF for her abdominal pain, though such pain assessment forms were available and their use expected.

Recommendation 2: The Grand Jury recommends that the Sheriff's Office instruct all medical staff at the County's jails to utilize available evidence-based pain assessment forms to evaluate and document inmates' pain complaints.

Finding 3: Inmate CF's death might have been prevented if she had received appropriate medical assessment in jail.

Recommendation 3a: The Grand Jury recommends that the Board of Supervisors direct County Health to thoroughly assess the medical care provided to CF by Wellpath. To be implemented by January 1, 2026.

Recommendation 3b: Based on the investigation of the care provided to CF, the Grand Jury recommends that the Board of Supervisors direct County Health make public a report identifying opportunities for systemic improvements in the quality of medical care in the County's jails. To be implemented by January 1, 2026.

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

REQUIREMENTS FOR RESPONSES

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

Responses to Findings shall be either:

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

Responses to Recommendations shall be one of the following:

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

Santa Barbara County Board of Supervisors – 90 days

Findings 1, 2, 3
Recommendations 3a, 3b

Santa Barbara County Sheriff's Office – 60 days

Findings 1, 2, 3
Recommendations 1, 2

E-BIKES IN SANTA BARBARA

FILED JUNE 25, 2025

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E-BIKES IN SANTA BARBARA
What Will It Take to Make Them Safe?

SUMMARY

Electric bicycles, or e-bikes, have become an increasingly common mode of transportation. Whether they are used by students going to school or adults traveling to work, they have become a part of our culture of being on the go. This is evident in Santa Barbara, where City officials have been redesigning City pathways to encourage bike, and now e-bike, traffic. However, the rapid rise of e-bike usage since the pandemic—particularly among younger riders—has led to increased frustrations and dangers for riders, pedestrians, and even automobile drivers. Public safety is at risk.

The proliferation of e-bikes has presented significant challenges for Santa Barbara County's South Coast, and especially the City of Santa Barbara, where State Street has become an e-bike promenade. City officials initially waited to determine appropriate traffic laws applied specifically to e-bikes and only recently enacted new laws in the spring of 2025 regarding unsafe e-bike riding. The question now is how the new ordinance will be enforced.

It is with a sense of urgency that the 2024-25 Santa Barbara County Grand Jury studied the matter of e-bikes in the City of Santa Barbara. Numerous postings on social media by local citizens cite bad behavior and near accidents on the part of e-bike riders. Accidents have been verified by local police and hospital records. Riders and pedestrians are at risk of critical injuries and death. The advent of e-bikes marks a broad cultural shift in how the community interacts in shared spaces, and addressing this change will require a collective effort to educate the public on the City's new e-bike ordinance.

BACKGROUND

California State Law

The standard pedal-propelled bicycle is still a mainstay of American culture, but the e-bike has grown rapidly in popularity since the 1990s. There are now a substantial number of e-bikes on public roads. But in California, there is still no requirement for registration or a license to use e-bikes, nor is there a requirement for insurance. As with many rapidly emerging technologies that present safety concerns, state and city governments have been slow to respond with updated legislation to institute effective enforcement of traffic safety laws for e-bikes.

The federal government enacted its first e-bike law in 2005. The California State Legislature passed its first e-bike law in 2015. The first step, with the passage of California AB 1096 (2015), was to define what qualifies as an electric bike, differentiating e-bikes from gasoline-powered bicycles, mopeds, or motorcycles. As a result, as of 2017, all e-bikes in California are required to have a label that describes its class, maximum motor-assisted speed, and motor wattage.[1] The maximum wattage for e-bikes is 750 watts. Any wattage above that could require that e-bike be reclassified as a moped or motorcycle, necessitating licensing and registration.

Like many other states, California classifies e-bikes into three categories based on top speeds and whether pedaling is a necessary function for motor assistance. The following categories are defined in California Vehicle Code section 312.5, subdivision (a) 1-3:

- A Class 1 electric bicycle, or "low-speed pedal-assisted electric bicycle," is equipped with a motor that provides assistance only when the rider is pedaling and that ceases to provide assistance when the bicycle reaches the speed of 20 miles per hour.
- A Class 2 electric bicycle, or "low-speed throttle-assisted electric bicycle," is equipped with a motor that may be used exclusively to propel the bicycle and that is not capable of providing assistance when the bicycle reaches the speed of 20 miles per hour. A throttle provides a boost without pedaling.
- A Class 3 electric bicycle, or "speed pedal-assisted electric bicycle," is a bicycle equipped with a motor that provides assistance only when the rider is pedaling, that is not capable of exclusively propelling the bicycle, and that ceases to provide assistance when the bicycle reaches the speed of 28 miles per hour. A Class 3 e-bike is equipped with a speedometer.

California has few restrictions on where e-bikes can be ridden. All three classes of e-bikes can utilize properly designated bike lanes on public roadways, and, generally, all classes of e-bikes are allowed on bike paths and multi-use trails. Though Class 3 e-bikes were initially restricted from bikes paths and multi-use trails, California AB 1909 (2022) amended section 21207.5 of the California Vehicle Code in 2023 to remove this restriction. However, local authorities do have the ability to impose restrictions on designated trails such as equestrian or hiking trails within their jurisdiction. Moreover, local governments can decide where e-bikes cannot go, including sidewalks, to safeguard their communities.

There are currently no statewide age restrictions for riders of Class 1 and 2 e-bikes. E-bike riders under the age of 18 must wear protective headgear. All Class 3 e-bike operators need to be 16 years or older and must wear a helmet regardless of age.[2]

Following the passage of AB 1096 in 2015, the State Legislature has generally focused its efforts on e-bikes in two specific areas: the first, restrictions on consumers' ability to modify their e-bikes;

[1] See Cal. Vehicle Code section 312.5, subdivision (c).
[2] See Cal. Vehicle Code section 21213.

and, the second, studies and pilot programs aimed at gathering data as groundwork for future legislative efforts. SB 1271, signed into law in 2024, clarified the definitions of Class 1 and Class 3 e-bikes, and restricted consumers' ability to modify an e-bike to reach speeds beyond 20 mph on motor power alone, exceed 750 watts of motor power, or remove the operable pedals. In a similar vein, AB 1774, passed in 2024, amended section 24016 of the California Vehicle Code to clarify that modifications to an electric bicycle are allowed only if it can still meet the legal definition of an e-bike, and prohibited the sale of devices that alter its speed capability to exceed that definition.

Following the passage of SB 381 in 2023, which authorized a comprehensive study by San Jose State University of e-bike injury patterns and policy prescriptions, the State Legislature passed two separate bills in 2024 enabling two California counties to enact pilot programs enforcing stricter laws for e-bikes, including stricter age requirements.[3] AB 2234 allows local authorities within San Diego County to prohibit a person under 12 years from operating a Class 1 or 2 e-bike, with a warning for the first 60 days following the adoption of the ordinance or resolution and a $25 fine thereafter. Parents or guardians will be jointly liable for the fine. The State requires the County to report how many riders were detained for violations and the results of each detainment. Similarly, AB 1778 allows local authorities within Marin County to prohibit youth under 16 from operating Class 2 e-bikes and to require the use of helmets for all Class 2 e-bike riders, with a warning for the first 60 days following adoption of an ordinance or resolution and a $25 fine thereafter. Peace officer actions on traffic stops for violations will be again studied—how many underage youths were stopped and the results of that action. Both pilot programs end on January 1, 2029. The State Legislature is reportedly waiting for the outcomes of these two programs before entertaining more restrictive e-bike laws at the state level.

Santa Barbara E-bike Law

The City of Santa Barbara has only recently finalized an ordinance with guidance on e-bikes. The City's 2016 Bicycle Master Plan made no mention of e-bikes. It emphasized the "safety of all road users" as its first goal. Likewise, the City's 2018 Vision Zero plan "to eliminate all severe and fatal transportation-related collisions on City streets by 2030" did not refer to e-bikes. However, the proliferation of e-bikes after the COVID-19 pandemic and the concomitant rise in e-bike related injuries since 2019 necessitated an overdue review of street safety with e-bikes in mind.

Many citizens have voiced support for e-bikes as well as criticism of them. The Santa Barbara City Council has often been caught in the middle. The City Council, with its support of clean air and green alternatives to motor traffic, as seen in its 2024 Climate Action Plan, had been reluctant to create anti-e-bike rules. Yet when the closing of State Street to motor traffic in 2020 allowed an explosion of e-bikes on the pedestrian mall, the e-bike traffic brought on increasingly insistent calls for local e-bike regulations.

[3] See Cal. Vehicle Code section 21214.5 and section 21214.7.

In October 2024, the City's Ordinance Committee considered stricter local regulations on unsafe e-bike riding. Some were inspired by more punitive laws enacted by the City of Huntington Beach, another beachside city with e-bike problems. Following the Ordinance Committee's October meeting, a few of the proposed elements of the ordinance were sent back for restructuring. In February 2025, the City Council approved a final version of the ordinance that made unsafe riding, as now defined in the municipal code, punishable by administrative fines. The City of Santa Barbara is now at a decisive point in determining how strictly to enforce its new rules.

METHODOLOGY

After initial deliberation on the scope of the e-bike issue in Santa Barbara County, the 2024-25 Santa Barbara County Grand Jury (Jury) decided to focus on the City of Santa Barbara, where unsafe e-bike riding had become a public concern and a contested issue. The Jury based this report on the following:

- Data on serious e-bike injuries and e-bike-involved accidents from Santa Barbara Cottage Hospital and the Santa Barbara Police Department
- Local social media postings, articles from local news outlets, and publications on state and national e-bike use, accident, injury, and legislative trends
- Pedestrian survey of State Street and other areas of active e-bike use, noting rider behavior and law enforcement presence
- Observations of Santa Barbara City Council meetings

The Jury also gathered information from interviews with the following:

- Santa Barbara City Council members and City staff members
- Local law enforcement officers
- Local school officials
- Members of the California State Legislature and officers of California Highway Patrol
- Directors of local bike advocacy organizations and local e-bike store owners

DISCUSSION

After years of declining retail business, the COVID-19 pandemic led to discussions about substantial change in downtown Santa Barbara. The outcome was to close State Street to automobile traffic and have a pedestrian promenade. Once the isolationism of the pandemic ended, traffic came back, but in the form of pedestrians, pedal bikes, and e-bikes, not cars. This brought new problems, even dangers, with no immediate solutions. E-bikes were often the target for citizen frustrations with calls for more public safety regulations. There have been numerous serious crashes involving e-bikes in Santa Barbara, providing validation for public complaints. The Santa

Barbara City Council was slow to react, as it wanted to maintain its identity as a pro-bike city, to encourage young people to be active outdoors, and to promote a friendly, healthy atmosphere. In the winter of 2024-2025, public complaints compelled the City to take definitive action to restore public safety on the streets.

E-Bike Injuries

Nationwide, as e-bikes have become more popular for personal transportation and leisure activities, emergency departments (EDs) have been attending to an increase in injuries. These commonly include head and traumatic brain injuries, broken bones, back and spinal issues, and garden variety cuts and bruises. A 2023 report by the U.S. Consumer Product Safety Commission (CPSC), "Micromobility Products-Related Deaths, Injuries, and Hazard Patterns," showed that injuries associated with e-bikes have trended upward significantly in recent years, increasing from an estimated 3,500 ED-treated injuries in 2017 to over 24,000 in 2022.[4] Fractures, followed by contusions/abrasions, were the two most common injuries. The most frequently injured body areas are the upper and lower limbs, as well as the head and neck. The CPSC also documented a dramatic national increase in fatalities associated with e-bikes over the same time period, reporting zero e-bike-related deaths in 2017, yet a sharp rise to 42 deaths by 2022.

Similarly, research published in *JAMA Network Open* shows that e-bike injuries in the U.S. increased by 30 times from 2017 to 2022, and hospitalizations rose by 43 times.[5] During that 5-year period, there were more than 45,000 visits to emergency rooms stemming from e-bike injuries, and more than 5,000 hospitalizations. The head injury findings among e-bike riders were the most striking, particularly amid the decline in helmet usage.

Locally, on October 29, 2024, the Santa Barbara City Council brought to light a study by the National Traffic Safety Administration, which found that of 105 cities of similar size in California, Santa Barbara ranked #1 in bicycle crash victims (83) in 2021, and #1 in 2020 with 76 bicycle crash victims. In comparison, for total road injuries and fatalities, Santa Barbara ranked 15th and 30th respectively in similarly sized California cities. These shocking statistics were highlighted when the City Council was considering an action plan to prevent traffic-related injuries and fatalities. This study, however, did not differentiate bicycle accidents from e-bike accidents. Nonetheless, the statistics for bicycle victims validated the public's concern over e-bikes.

This report came on the heels of an October 16, 2024, Santa Barbara City Council meeting, in which the Santa Barbara Police Department announced that there had been 80 collisions involving

[4] James Tark, *Micromobility Products-Related Deaths, Injuries, and Hazard Patterns: 2017–2021* U.S. Consumer Product Safety Commission, 2022. https://www.cpsc.gov/content/Micromobility-Products-Related-Deaths-Injuries-and-Hazard-Patterns-2017-2021

[5] Adrian N. Fernandez, et al., "Injuries with Electric vs Conventional Scooters and Bicycles," *JAMA Network Open* 7, no. 7 (2024): e2424131. https://doi.org/10.1001/jamanetworkopen.2024.24131

e-bikes so far that year (with the e-bike riders at fault 48 times), compared to 73 in all of 2023 and only 10 in 2022. The Jury later learned that the Police Department only counts collisions when there is damage to a car because of insurance reports or when someone goes to the hospital. Thus, the number of accidents involving bikes and e-bikes reported could be only a small percentage of those that actually occur. It should also be noted that e-bike involvement specifically is now on traffic accident forms, but not on traffic citation forms, which are set by the State. Again, e-bike traffic statistics are thus underreported as they are not counted if there is no official accident report.

Santa Barbara Cottage Hospital disclosed statistics to the Jury for e-bike crash victims with injuries severe enough to be taken to the Santa Barbara Cottage Emergency Department. Over a two-year period, there was a significant number of e-bike-related trauma cases arriving at the emergency room.

Between October 2022 and October 2024, 84 patients were seen after e-bike injuries. The causes of the injuries were classified by the hospital and are shown below in Table 1.

Table 1: Causes of Injuries	
Non-collision transport nontraffic accident	24
Non-collision transport traffic accident	15
Collision with car/truck/van nontraffic accident	6
Collision with stationary object nontraffic accident	5
Collision with stationary object traffic accident	3
Collision with non-motor vehicle traffic accident	1
Collision with pedal cycle nontraffic accident	2
Collision with pedestrian/animal nontraffic accident	1

The age ranges of the patients are shown below in Table 2.

Table 2: Age Ranges of Patients	
0-10	0
11-20	**40**
21-30	11
31-40	12
41-50	3
51-60	9
61-70	8
>70	1

Almost all of the injured were the operators of the e-bike; four were passengers.

These figures demonstrate a significant public health problem. A count of 84 patients over a two-year period suggests that nearly one patient per week suffered serious injuries. The age of the patients peaked in the 11-20 age group (40 patients), indicating that the teen-aged population is at greatest risk of injury. The remainder of injuries occurred relatively evenly in older age groups, including in nine individuals over 60 years old.

The types of injuries at Cottage Hospital were also serious. While orthopedic injuries were most common (24), 19 patients also suffered head and neck injuries, four had chest injuries, and two had major vascular injuries. Cottage Hospital did not report any deaths over this time-period.

The Santa Barbara Police Department also provided statistics to the Jury for recent accidents involving e-bikes. Between the dates of January 25, 2022, and August 24, 2024, there was a total of 163 e-bike related incidents, of which 85 were sent to the hospital. Of these 163 incidents, the e-bike rider was at fault just over 52% of the time. The Department also noted the type of vehicle involved, with passenger cars the most frequent. Regarding end-of-year data, the rapid increase in incidents should be noted:

- 6 out of 10 e-bike riders involved in collisions were at fault in 2022
- 32 out of 73 e-bike riders involved in collisions were at fault in 2023
- 71 out of 107 e-bike riders involved in collisions were at fault in 2024

When the data from both local sources is combined, it is clear that e-bike injuries are common and that these injuries are frequently serious and life-threatening. In fact, the City of Santa Barbara experienced its first e-bike-related fatality in May 2025. Along with this increase in related injuries come assorted legal concerns regarding liability. Without helmets or insurance, e-bike accidents on city streets might come at a public cost for medical treatment. Additionally, pedestrians involved in accidents may not have liability insurance. This possibly threatening liability issue has not been publicly discussed by the City Council.

Santa Barbara City Council

Santa Barbara has long held clean air as one of its priorities. This dedication to the environment has been apparent in the City's financial support to increase the use of alternative means of transportation and create a master plan for bikes throughout town. E-bikes are considered a more environmentally friendly mode of transportation. Furthermore, at a time when the City is hoping to convert underused buildings downtown to housing without adding more parking lots, no parking structures are required for e-bikes. These factors favor e-bikes in city planning. However, citizen complaints against unruly e-bike traffic redirected City Council discussion from long-range planning to more immediate action for street safety.

City Ordinances

After State Street closed to vehicle traffic, the close contact between pedestrians, bikes, and e-bikes got to the point that members of the public felt endangered. In reaction, City Council moved to curb unsafe behavior on bikes in Emergency Ordinance 5944 in March 2023. While defining a closed State Street, the City Council pointedly authorized rules for bikes, stating:

> It is contrary to public safety and thus unlawful to use a bicycle, electric bicycle, or similar device in motion upon the ground or pavement within the State Street Promenade in a willful or wanton disregard for the safety of persons or property or in a manner which endangers the safety of persons or property.

The State Street regulations included yielding the right-of-way to pedestrians, no exhibitions of speed, no passengers other than on an attached separate seat, a helmet if under 18, adequate brakes to counter the higher speed and weight of an e-bike, and a lamp and reflectors for night-time use. These laws were basic safety measures for all bikes.

By 2024, just having bike safety rules was not adequate to match the exuberant e-bike activity on State Street and elsewhere, and complaints from citizens put pressure on the City Council to enact an additional ordinance specifically written for e-bikes and certain "bad actors." In the October 15 Ordinance Committee meeting, the report from the City Attorney's Office and Santa Barbara Police Department acknowledged that the previous emergency ordinance had not specifically defined e-bikes, nor had it provided ways to address violations of the safety rules. The proposed amendment to Chapter 10.52 of the Municipal Code regulations stated that enforcement would be done through administrative citations and not Traffic Court citations that would permanently stay on the rider's record. Administrative fines were proposed starting at $100 for the first offense, rising to $200 for the second, and up to $500 for three offenses in one year.

The recommended 2024 regulations against unsafe e-bike behavior specifically included:

- Do not perform "any acrobatics, tricks, wheelies, or stunts on a public street [or] public right of way"
- Use bike lanes or ride close to the correct curb
- Ride in a single file

Riders were again required to yield to all pedestrians, wear a helmet if under 18, use reflectors, have brakes strong enough to stop the e-bike, and not ride on the sidewalk, as stated in the original Ordinance 5944. For enforcement, the report recommended following the Huntington Beach-inspired initiatives of allowing police officers to impound a juvenile's bike or e-bike. A parent would have to retrieve it, thus creating a conversation between the family and law enforcement. Importantly, the proposed ordinance was applied to the entire city of Santa Barbara, not just State Street. Public speakers at the October 15 Ordinance Committee meeting voiced various reactions.

Some of the strong new rules engendered debate, and the proposals were sent back for further review and revision.

At the February 25, 2025, City Council meeting, some revisions to the more punitive elements of the ordinance proposed in October were made. Most notably, attending a Youth Diversion Program with the Council on Alcoholism and Drug Abuse (CADA) for juvenile offenders was offered in place of impounding the bike or e-bike. If a citation was given to the juvenile, attending a two-hour course, ending with a test that would award a certificate, could eliminate the citation and fees. If the class is refused, the youth and the parents would be responsible for the administrative fines. If bad behavior continued, the juvenile would go to Teen Court. But e-bikes still would not be confiscated. (The newer, faster "pocket bikes" are illegal on streets and will be impounded on all occasions.) Adults who contravene the ordinance would continue to receive an administrative citation, not a vehicle code ticket. This way, there are no points on one's driving record, and for juveniles, application for a driver's license would not be impeded.

Other sections were also modified in the ordinance adopted in February 2025. The definition of unsafe behavior depended on if pedestrians or vehicles were "in close proximity." Whether to issue a citation or not depended on the peace officer's discretion, according to at what point the behavior became dangerous. When it came to riding on sidewalks under certain conditions, the City Council felt that this ordinance needed clear boundaries, and e-bikes remained prohibited from sidewalks.

After years of delay, the Santa Barbara City Council enacted this e-bike ordinance in response to calls for action. How it is enforced will make a difference in how it will be recognized and obeyed.

Law Enforcement (Santa Barbara Police Department)

The Santa Barbara Police Department welcomed the ordinance on e-bikes. It gave them the tools to do their job by giving them laws by which to administratively cite offenders. The ordinance came into effect on April 4, 2025.

In the past, the Santa Barbara Police Department had written few citations, especially with juveniles. There were several reasons suggested for this:

- The Police Department is understaffed
- Peace Officers would be working overtime if they added e-bike surveillance to their main duty of fighting crime
- Peace officers and City officials alike do not want a youth's first encounter with the law be a citation
- Peace officers do not recommend chasing after youths on bikes as it could be dangerous

In the month following May 4, enforcement of the new ordinance was moderate and multi-faceted. Ten officers over the course of several days came into contact with bike riders. While the officers

spoke with 70 people, a total of 13 juveniles were issued citations related to the new ordinance. Two juveniles on illegal, high-speed electric dirt bikes had their bikes impounded. Peace officers also contacted several parents. The Department also initiated education through some social and news media posts during these days of direct patrols.

When officers incorporate bike and e-bike watches into their patrols on a regular basis, the new e-bike ordinance will have an impact on the Police Department. Officers may have to work overtime, but there will be no additional funding for overtime, nor for new hires for the additional duties. The Santa Barbara Police Department will instead need to move resources around: people, shifts, and money. This includes having officers strategically placed around schools early in the morning and mid-afternoon, as well as around popular riding areas downtown or on the beach pathways. People often do not see the officers and do not know they are there. Higher visibility of officers will be critical to taming unsafe behavior on e-bikes.

The Santa Barbara Police Department, like many law enforcement agencies in the nation, has had to deal with shortages of police officers in keeping the law. Priorities will always first be for hard crimes, not bike-riding violations. Santa Barbara does have a bike patrol. Ironically, they have not been and will not be assigned to catching e-bike riders who ignore stop signs, ride on sidewalks, speed, or endanger pedestrians, especially if the offenders are young juveniles. Bike Patrol officers do give warnings, but they have not issued and do not currently plan to issue citations. This maintains the community-friendly image of the Bike Patrol.

In the past, there have been few consequences for those e-bike riders creating dangerous conditions on local roads and sidewalks. In addition, the Jury heard from several branches of local government that when the financial burden imposed by an administrative fine is modest, it can fail to make a significant impact. The main goal of the Police Department is to change behavior, not collect fees. Further, the new arrangement for a youth diversion program also minimizes the weight of a citation, as it can easily be erased by a class.

In contrast, police officers in the City of Huntington Beach dedicate two hours of their shift to keep an eye on e-bikes and make sure the riders follow the rules. They have the discretion to issue a civil citation or an infraction with a ticket. For juveniles, the Huntington Beach police officers can impound the e-bike. It is not known at this point if this added police work is making a difference in e-bike safety in that city, but additional cities in Orange County are now in agreement and enacting similar laws. Moreover, because of a sharp increase in e-bike-related injuries and emergency room visits since 2020, the Orange County government enacted laws that came into effect in April 2025 governing speeding and unsafe behavior on e-bikes in unincorporated areas, hoping to additionally encourage consistent e-bike rules among all cities in the county.

The underlying force of all safety rules is accountability. If riders of bikes or e-bikes face no consequences for their reckless or too relaxed behavior, there will no doubt be limited adherence to rules of the road, old or new. And this could only increase cases of injuries or even fatalities. The 2018 Santa Barbara Vision Zero Plan addressed this issue straight on:

> Without enforcement, traffic laws…cannot be expected to reduce traffic fatalities or serious injuries. If traffic laws are not enforced, *or are perceived as not being enforced,* compliance is less likely. Effective enforcement includes establishing, regular updating, and enforcing laws that address collision risk factors. Locations where repeated collisions occur can indicate where robust enforcement is needed. (Emphasis added.)

Schools in Santa Barbara

School districts in the Santa Barbara County area have seen an increase in usage of e-bikes to get to school by students in junior high and high school. Outside each of the three public high schools in the Santa Barbara Unified School District, the Jury observed over 100 e-bikes parked, and almost as many outside junior high schools. E-bikes have allowed parents a break from the daily school commute.

It has been estimated that about 10% of students ride their e-bikes to school. The Santa Barbara Unified School District is concerned about student safety—once they arrive at school. At some of these schools, bike racks have been purposely placed at the periphery of school grounds in attempts to minimize the use of e-bikes in more central parts of campus. How students are getting to school has not been a major concern for school administration. Programs to provide information on e-bike safety have not been required. School-wide presentations—mainly at elementary and junior high schools—take place, but these are initiated by the Police Department; they are not a District promotion. No District funding is currently being specifically allocated for e-bike education.

In the past, there has been no consistent approach to e-bike instruction in the Santa Barbara Unified School District. In contrast, the Huntington Beach Union High School District has a 20-minute e-bike safety video on its website, and students must apply for a school permit before they are allowed to ride their e-bikes to school.

Under California law, rules of the road for e-bikes exist as they do for cars: ride with the flow of traffic; stop at stop signs; obey speed limits; etc. For young riders who have not yet taken a driving test, these rules are not ingrained and sometimes not even known. The Jury learned that not all parents know them either, or they are not aware that these rules apply to young e-bike riders.

A local cycling advocacy group that provides bike education has expanded its focus of attention from bike riding training in elementary schools to include e-bike safety training in junior high and

high schools. Not only do they emphasize traffic rules, but they now also address behavioral issues. It was suggested that such courses include videos of e-bike accidents, much like the crumpled cars that are shown to high school students prior to proms and graduation. This would highlight the danger of reckless riding. The Santa Barbara Police Department has recently begun to coordinate with bike advocacy groups to educate students on topics of e-bike safety.

Most complaints about e-bikes on social media and in public meetings focus on juveniles, including youths utilizing e-bikes for unlawful activities after school such as harassing and intimidating local residents or car drivers. Frequent complaints have been posted on local social media by residents who report damage to property and threats to their person. However, the Santa Barbara Police Department has recently expanded its efforts to more regularly educate students at local elementary and junior high schools, which the Jury believes will have positive and lasting effects.

Public Education

The City of Goleta organized an E-Bike Week in January 2025 and cooperated with two nearby high schools and one junior high for presentations. Working with the California Highway Patrol, the Goleta Police Department, Goleta Valley Cottage Hospital, and a bike advocacy group, the City of Goleta gave safety presentations and distributed helmets and protective equipment at the schools. This came one year after the Santa Barbara Association of Governments (SBCAG) held a similar e-bike safety awareness day in downtown Santa Barbara. These entities and organizations saw the need to educate students and the public of all ages about e-bikes.

The City of Santa Barbara has considered a significant e-bike awareness campaign. Although limited media outreach began, a comprehensive public awareness campaign has not been implemented. After enacting the new ordinance, the entire community will need to be informed about the revised expectations for e-bike riders. With collaboration among City officials, law enforcement agencies, and school administrators, the City of Santa Barbara could stage a powerful education campaign. Bike shops would willingly participate, according to officials and shop owners. But as one bike advocate said, someone has to say, “Make this happen.”

In 2018, the City of Santa Barbara adopted a Vision Zero Strategy to eliminate severe and fatal traffic accidents. The prologue to the Vision Zero program compared the current need for a different approach to traffic safety to the introduction of seat belt requirement laws in the 1980s. People were slow to adapt to the new laws that were more constraining, even if it meant saving lives. The Vision Zero statement credits stronger laws, enforcement, and automobile design changes in addition to education for increases in public acceptance of seat belts. It took years to see meaningful changes in behavior. With increases in public awareness, people accepted wearing a seat belt as part of driving safely. Seat belts have saved lives. Santa Barbara could benefit from

the same all-around approach in order to prevent inevitable crashes and injuries for e-bike riders in the future.

The two California counties that instituted stricter laws for young people on e-bikes, Marin County and San Diego County, were mandated by the state to administer a public information campaign for at least 30 days prior to the enactment of their ordinances or resolutions, including "public announcements in major media outlets and press releases."[6] The City of Santa Barbara should do no less.

CONCLUSION

Riding e-bikes has resulted in many serious injuries in Santa Barbara, particularly among riders 20 years and younger. Santa Barbara experienced its first e-bike-related fatality in May 2025. In February 2025, the City Council enacted a new e-bike ordinance to cut down on certain unsafe riding behaviors, and the Santa Barbara Police Department is rolling out enforcement. It remains to be seen if more robust actions need to be taken to assure compliance with the new laws and more publicity to make an impact on public awareness.

FINDINGS AND RECOMMENDATIONS

Finding 1: Since the City of Santa Barbara's adoption of the new e-bike ordinance, Santa Barbara Police Department officers now have broad discretion in responding to unsafe behavior by e-bike riders, but, as a general principle, behavioral change requires a strategic and consistent approach.

Recommendation 1a: The Grand Jury recommends that the Santa Barbara City Council encourage the Santa Barbara Police Department to establish a plan to strategically and consistently focus enforcement efforts in high-traffic areas so as to achieve high visibility and have the greatest impact on behavior in enforcement operations. To be implemented by December 1, 2025.

Recommendation 1b: The Grand Jury recommends that the Santa Barbara City Council require the Santa Barbara Police Department to give the Council monthly reports on the number and severity of e-bike-involved accidents in the City of Santa Barbara, as well as the number of citations issued. To be implemented by December 1, 2025.

Recommendation 1c: The Grand Jury recommends that the Santa Barbara City Council make available to the public these monthly reports on the number and severity of e-bike-involved

[6] See Cal. Vehicle Code section 21214.5, subdivision (f), and section 21214.7, subdivision (e).

accidents in the City of Santa Barbara, as well as the number of citations issued. To be implemented by December 1, 2025.

Finding 2: The Santa Barbara City Council has tasked the Police Department and its officers with additional responsibilities related to enforcement of the new e-bike ordinance but has not provided additional funding to support those purposes.

Recommendation 2: The Grand Jury recommends that the Santa Barbara City Council conduct a study to determine how much new funding for this additional police work is needed. To be completed by April 1, 2026.

Finding 3: The City of Santa Barbara has initiated only a limited public information campaign about the new e-bike ordinance now in effect, thus limiting awareness of the ordinance.

Recommendation 3a: The Grand Jury recommends that the Santa Barbara City Council initiate an expanded and long-term public information campaign to inform and educate the public about the City's new e-bike rules. To be implemented by December 1, 2025.

Recommendation 3b: The Grand Jury recommends that the Santa Barbara City Council invite the cooperation and participation of secondary schools in the Santa Barbara Unified School District, private organizations that are involved in e-bike education, neighboring cities including Goleta, and local businesses for expanded public outreach on e-bike safety and laws now in effect.

Finding 4: The Santa Barbara Police Department has recently expanded its outreach in Santa Barbara Unified School District to instruct students in e-bike safety and laws, which is a positive development.

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

REQUIREMENTS FOR RESPONSES

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

Responses to Findings shall be either:

- Agree

- Disagree with an explanation
- Disagree partially with an explanation

Responses to Recommendations shall be one of the following:

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

City of Santa Barbara – 90 days

Findings 1, 2, 3, 4

Recommendations 1a, 1b, 1c, 2, 3a, 3b

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UNPERMITTED STREET FOOD VENDORS IN SANTA BARBARA COUNTY

FILED JUNE 26, 2025

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UNPERMITTED STREET FOOD VENDORS IN SANTA BARBARA COUNTY

SUMMARY

Food vendors in Santa Barbara County are required to follow food safety laws to ensure the safety of their products. In recent years, however, the presence of unpermitted street food vendors—push carts, food trucks, and tented restaurants—operating in Santa Barbara County has become widespread. Their unprecedented growth threatens not only the economic vitality of permitted restaurants and food trucks in the region, but, most importantly, the health of customers from sales of food prepared under potentially unsanitary conditions.

The 2024-25 Santa Barbara County Grand Jury (Jury) has found that the County has not been able to effectively enforce permitting requirements or routinely inspect mobile food vendors in Santa Barbara County, as the mobile nature of such food vendors poses barriers to effective enforcement and inspection on several fronts. The Jury recommends that the County allocate funds to hire inspectors sufficient in number to enforce existing food safety laws, and also that law enforcement work closely with inspection personnel to safeguard in-person enforcement and inspection efforts. To protect the public from food-borne illnesses and other harms posed by unpermitted food vendors, the County must meet the challenge with more effective enforcement strategies.

BACKGROUND

Food Safety

Food safety is an important public health priority. Disease transmission from unsafe food is a common cause of illness, which may range from temporary gastrointestinal distress to severe illness causing hospitalizations and deaths. The Centers for Disease Control and Prevention (CDC) has noted that every year, one in six people in the United States gets sick from food-borne illnesses.[1] Nationally, reported food-borne hospital admissions and deaths more than doubled from 2023 to 2024. This increase was mainly due to outbreaks of *Listeria*, *Salmonella*, and *Escherichia coli*.[2] There has also been a dramatic increase of norovirus infections, which are frequently associated with unsafe food handling.[3] It is important to realize that reported numbers are probably

[1] "About Restaurant Food Safety." *Centers for Disease Control and Prevention*. Published March 7, 2024. https://www.cdc.gov/restaurant-food-safety/about/index.html

[2] Harrison, Christopher J. "Expect Increases in Foodborne Illness." *MedScape*. Published May 2, 2025. https://www.medscape.com/viewarticle/expect-increases-foodborne-illness-2025a1000a76

[3] "NoroSTAT Data." *Centers for Disease Control and Prevention*. Published May 20, 2025. https://www.cdc.gov/norovirus/php/reporting/norostat-data.html

huge underestimates of the actual food-borne illness burden (an estimated 48 million illnesses) because most people do not seek medical care and, thus, the illness is not reported. One estimate is that only one in thirty actual cases is reported. Among the 10 million food-borne illnesses or so that are reported annually, 128,000 require hospitalization and 3,000 are fatal.[4]

For example, there was an incident of widespread food poisoning that occurred in Maricopa County, Arizona, in August 2024. A total of 17 patrons purchasing food from a group of unpermitted street vendors subsequently experienced diarrhea and vomiting. Upon investigation, the Maricopa County Environmental Services Department found that these vendors had no handwashing stations on site, were mixing raw meat with cooked meat, and were storing food in garbage bags.[5] Another major food poisoning incident due to food from a food truck was reported in Kirkland, Washington, in September 2023. In total, 34 people got sick from food-borne bacteria.[6]

In Santa Barbara County, data are not currently collected on how often disease transmission from food vendors occurs. However, the proliferation of unpermitted food vendors potentially puts the patrons of these vendors at risk of contracting food-borne illnesses.

Laws Governing Food Safety

To protect citizens from food-borne illnesses, California food safety laws specify requirements for safe storage, labeling, handling, and disposal of food for restaurants, as well as for food carts and food trucks.[7] The conditions outlined in the California Retail Food Code must be met to obtain a health permit, which must be displayed and clearly visible to customers. Inspections by local public health departments are guided by, but not limited to, the following basic food handling and facility requirements for vendors that prepare food:

- store perishable and cooked foods at defined temperatures (below 41°F for cold food storage and above 135°F for hot items), which must be continually monitored
- be equipped with refrigeration for potentially hazardous foods
- have easily cleanable surfaces
- have facilities for the sanitary disposal of liquid waste and garbage
- operate within 200 feet of an available toilet and handwashing facility for employees

[4] Harrison, "Expect Increases in Foodborne Illness."

[5] "Illness Reports Associated with Unpermitted Street Vendors" *Maricopa County Environmental Services Department.* Published August 26, 2024. https://www.maricopa.gov/CivicAlerts.aspx?AID=3085

[6] KOMO News Staff. "34 people contract stomach illness after eating from Kirkland taco truck." *KOMO News*. Published September 20, 2023. https://komonews.com/news/local/taco-truck-food-sick-illness-outbreak-kirkland-washington-el-guero-seattle-king-county-health-department-investigation-private-event-catering-catered-test-diarrhea-abdominal-cramping-nausea-inadequate-refrigeration-improper-cooling

[7] See sections 113700 through 114437 of Part 7 of Division 104 of the Cal. Health and Safety Code, known as the California Retail Food Code. Specifically, see Chapter 4 (sections 113980 through 114094.5) for general food safety requirements and Chapter 8 (sections 114250 through 114259.5) for physical facility requirements.

California state law requires county public health departments to ensure that food vendors are following lawful food safety practices. The Santa Barbara County Environmental Health Services Division (a division of the County of Santa Barbara Health Department) has been charged with permitting food vendors and with performing regular inspections to assure ongoing compliance with food safety standards. Cities in Santa Barbara County have agreements with County Health to enforce food safety laws within incorporated areas, meaning that the Environmental Health Services Division of County Health performs its services related to inspections and permitting in all areas of the County. Inspections of food carts and food trucks are expected to occur at least once per year, but more frequently if there was a prior violation or in response to a public complaint.

It is important to distinguish between "licensing" and "permitting." City municipalities issue business licenses for operation of food vendors and may issue citations and fines if vendors do not comply with licensing requirements. In unincorporated areas, this is the responsibility of the Santa Barbara County Tax Collector's Office. Food vendors that operate in unincorporated areas of the County must report sales tax on certain foods they sell. In contrast, permitting in relation to food safety requirements is enforced by County Health, which may penalize vendors who do not comply with standards. This Report focuses solely upon permitting and enforcement by the County, rather than licensing.

Vendors selling only pre-packaged, non-perishable items are exempt from some of the more stringent health and safety requirements, such as those related to food preparation and equipment. These vendors do not need a permit. However, food trucks and carts which sell prepared food, including cut fruit, juices, and meats, are not exempt from the more stringent food safety standards and are required by law to be permitted.

Individuals operating mobile food vending businesses are classified by state law as "food handlers" as they are "involved in the preparation, storage, or service of food in a food facility."[8] California law requires such individuals to obtain a food handlers card by taking an on-line course provided by the State. All food vendors are required by law to carry this card, and to present it upon demand.

Changes in State Law Governing Food Vending

Two bills passed within the last seven years by the California State Legislature, intended to protect small business owners operating mobile vending businesses, have transformed how local authorities can interact with mobile food vendors.

Senate Bill 946 was signed into law in 2018 and added Chapter 6.2 to Part 1 of Division 1 of Title 5 of the California Government Code. It limited what time, place, and manner restrictions a local authority could impose on sidewalk vendors of food or merchandise, and also restricted local

[8] See California Retail Food Code section 113790.

authorities' ability to penalize sidewalk vendors who violate local vending rules. Activity that could once have been classified as an infraction- or misdemeanor-level offense at the local level can now only be punished with administrative citations. As a result of this, enforcement against the owners of the mobile food carts has become more difficult. The inability for local authorities to promulgate local requirements with infraction- or misdemeanor-level punishments has allowed cart vendors to disregard requirements for permitting even in violation. It is important to note that SB 946 did not affect the applicability of food safety laws to food vendors or affect the County's ability to enforce health permitting requirements.

However, Senate Bill 972, which was signed into law in 2022, decriminalized the California Retail Food Code for sidewalk vendors and operators and employees of compact mobile food facilities who perform limited food preparation.[9] Food safety law violations in these contexts, including permit violations, are only punishable by administrative citations. Still, the bill did not exempt mobile food vendors who perform even limited food preparation from needing county health permits. Despite this, only two food cart vendors in Santa Barbara County have ever applied for permits from County Health as of March 2025.

Additional Problems Surrounding Unpermitted Food Vendors

Although this Report focuses solely on permitting and enforcement of food safety laws in Santa Barbara County, the Jury also notes that there are other troubling issues associated with unpermitted mobile food vendors. The Jury has observed that unpermitted mobile food vendors have been unfairly and illegally competing against properly permitted area restaurants and food trucks, as they do not pay County permitting fees. Additionally, illegal dumping of grease and other waste, violations of local fire codes, and traffic- and parking-related violations were identified as additional concerns during the Jury's investigation.

METHODOLOGY

In developing this Report, the Jury employed the following methods of investigation:

- Interviews with officials from County Health
- Interviews with officials from the cities of Santa Barbara and Solvang
- Interviews with officials from the Santa Barbara County Fire Department
- Interviews with officials from the University of California, Santa Barbara
- Review of documentation provided by County Health
- Research regarding California state laws governing retail food sales
- Visits to 25 food carts and trucks in various neighborhoods throughout Santa Barbara County, including in the cities of Santa Barbara, Goleta, Lompoc, and Santa Maria

[9] For the full definition of "limited food preparation," see California Retail Food Code section 113818.

DISCUSSION

The proliferation of open-air, mobile food vending has surged to unprecedented levels throughout Santa Barbara County in recent years. These food vending operations include roadside "tent" restaurants that in some cases provide sit-down accommodations, food trucks parked on streets, and sidewalk pushcarts that pervade both commercial and residential areas of the County.

Unpermitted food vending—particularly by pushcarts—has become so commonplace that County Health no longer has the resources to effectively enforce existing requirements. The following sections of this report detail the Jury's observations about permitting, inspections, and barriers to effective enforcement of existing food safety laws with regard to mobile food vendors.

Food Safety

The Jury finds that public health is jeopardized by sales of potentially hazardous foods by unpermitted food vendors. As discussed above, food safety involving prepared foods encompasses an extensive number of requirements: the temperatures of cold or hot foods must be maintained and monitored; handwashing facilities must be available in close proximity; food handling certification must be obtained; pests must be controlled and kept away from food; work surfaces and utensils must be properly sanitized.

Members of the Jury visited local mobile food trucks and carts. During direct observation in various locations around Santa Barbara County, Grand Jurors noted numerous violations of food safety laws and ordinances, which included the following:

- There were health inspection permits posted as required for only six of 14 food trucks and zero of 11 food carts observed
- When asked, vendors could show food handler cards on only six of 14 food trucks, and zero of 11 food carts queried
- Zero of 11 food carts had nearby access to handwashing facilities
- Food carts and trucks were both frequently in locations without proximity to restrooms
- Food on food carts included cut fruit and prepared juices that were not stored in a temperature-controlled environment
- Food on food carts sometimes included cooked meat stored in Styrofoam containers that were not temperature-controlled

There is improper and unsanitary handling of food prepared for sale throughout Santa Barbara County by unpermitted vendors. The fact that handwashing facilities are not co-located with food carts that prepare food creates a risk of serious food-borne illness incidents. Without strict enforcement of County health and food safety codes, outbreaks could easily occur.

Enforcement Barriers

The enactment of SB 946 and SB 972 has encouraged a proliferation of sidewalk food sales to the point where the Environmental Health Services Division of County Health lacks sufficient personnel to effectively provide enforcement of food handling or environmental health codes with the numbers of trucks and carts currently in local operation. The County currently employs just three full-time inspectors and one part-time inspector.

The administrative citations that resulted from SB 946 and SB 972 have not proven to be effective enforcement tools against food safety violations by mobile food vendors. In many cases, workers refuse or are unable to identify the owner or the person to whom a citation should be issued. They may also refuse to sign a civil citation. Thus, when individual vendors receive a citation, there is no one to be held responsible, especially since many food trucks and carts come up from the Los Angeles area into Santa Barbara County. As a result, citations are often not issued, and when they are, their remediating effects are minimal.

An additional drawback of this limited enforcement regime is that the financial burden imposed by the fines is so low that they fail to serve as a deterrent. As mandated by the State, a first-time violation of the California Retail Food Code or any provision adopted pursuant to it requires issuance of a warning to the street vendor; a fine for a second violation cannot exceed $100 if the violation occurs within one year of the first violation; a fine for a third violation cannot exceed $200 if it occurs within one year of the first violation; and a fine for a fourth violation and any subsequent violations that occur within a year of the first violation cannot exceed $500.[10] When inspectors have issued citations, the trucks or carts have sometimes simply changed location. Few vendors pay fines or appear in court. The minimal penalties for non-permitted operations and the disregard for food safety laws have enabled mobile vendors to operate with few consequences.

Of equal concern is the fact that it has been difficult for inspectors from the Environmental Health Services Division to approach mobile food vendors due to harassment and intimidation by customers. County inspectors have asked for the presence of law enforcement, and have frequently been accompanied in the City of Santa Barbara by police officers, but are less frequently accompanied by law enforcement in other parts of the County. Ironically, non-permitted food vendors have received unintended validation as local law enforcement personnel have been observed patronizing these vendors.

The lack of effective enforcement is further complicated by the transient nature of many mobile food vendors. While some mobile food vendors operate in established/preferred locations, many move around frequently, making it difficult for any local authority to consistently locate them. Currently, the County does not have a tip line for reporting unpermitted mobile food vendors, nor

[10] See California Retail Food Code section 114368.8.

is there clear information regarding how the public can report unpermitted food vendors on relevant County websites.

Enforcement Strategies

During the summers of 2023 and 2024, the City of Santa Barbara and County Health formed "vendor enforcement teams," which, in addition to health inspectors, included interpreters, personnel from the City's Fire Department, and officers from the Santa Barbara Police Department. They first targeted large "pop-up" restaurants utilizing open-flame devices for cooking, which is a violation of the municipal fire code punishable by more serious charges. While several enforcement actions took place in 2023, resulting in the shutdown of many unpermitted sidewalk restaurants, lack of staffing and impersistent enforcement enabled the violators to soon reappear elsewhere in the city and resume operations.

At the County level, enforcing health codes and performing inspections has been beyond the current capabilities of County Health alone. Creating a task force composed of multiple agencies was proposed as a solution at both a Santa Barbara County Association of Governments (SBCAG) meeting in October 2024 and, later, at a County Board of Supervisors meeting in March 2025. The presence of law enforcement and fire personnel was considered critical, and in working together, they could combine the strengths of each agency to be more effective against unpermitted vendors.

At the Board of Supervisors meeting in March 2025, it was reported that since January 2025, the inspectors from the Environmental Health Services Division had been conducting inspections on weekends and after hours, when mobile vendors are most prevalent. This has incurred additional expenses due to overtime pay for inspectors. They issued 137 notices of violation between January and March for various food safety violations. They also seized food that was in "the danger zone," between 41 and 135 degrees. State law requires that confiscated food be kept for 30 days and kept in condition that it can be returned as it was received. However, the County has run out of refrigerated storage space for freezing seized foods. At this March meeting, the Board of Supervisors voted to adopt a more comprehensive approach to enforcement in the form of a multi-jurisdictional task force.

The Santa Barbara County vendor enforcement task force was partly inspired by on an ongoing 20-month pilot program in Ventura County begun in July 2024. Given a budget of $1.7 million, Ventura County created a team with a full-time coordinator and an additional nine full-time and part-time employees. With the help of law enforcement and fire personnel, the team made sweeps, confiscating unlawful trucks, carts, and equipment. Ventura County paid for the haulers and rented storage space for confiscated equipment.

While Ventura authorities were able to shut down some vendors, they typically came back, just as in Santa Barbara County. Yet impounding the carts or trucks did reduce their number in Ventura

County. At the beginning of their efforts, it was reported that in some well-known locations, the number of illicit trucks went from 30 to five. Vendors could only retrieve their equipment after paying fines and registering with local agencies for health permits and business licenses. The end results for Ventura's pilot program have not yet been released.

For Santa Barbara County, the new task force, based on its composition, will have the ability to enforce rules against unpermitted food vendors from the standpoints of County Health, Public Works, the Sheriff's Office, County Fire, and the District Attorney. The task force shall also include representatives from local cities as well as representatives from key stakeholders, such as Caltrans, the California Department of Fish and Wildlife, and the California Highway Patrol (CHP). To illustrate CHP's role, CHP officers have on occasion assisted inspectors who visit mobile food vendors that operate along Highways 154 and 246.

While the Board of Supervisors voted to create this task force, its initial impact may be limited by the absence of any additional funding to support the initiative. Each County agency involved in the task force was asked to reassign resources for the personnel and time needed to address the issue of unpermitted food vendors.

By adopting this means of multi-jurisdictional enforcement, the County is taking a proactive step to protect the community. However, more steps must be taken to ensure that persistent enforcement happens in all parts of the County where unpermitted food vendors pose risks to public health.

CONCLUSION

While their consequences may have been unintended, SB 946 and SB 972 triggered a surge in unpermitted food vending operations across Santa Barbara County, reaching a scale that now poses a threat to public health and safety.

The County—specifically, the County of Santa Barbara Health Department—is mandated to enforce food safety regulations through permitting and routine inspections of food vendors. However, significant enforcement gaps have emerged, leaving residents and visitors alike vulnerable to health risks posed by unpermitted mobile food vendors who prepare potentially hazardous foods. Among these vendors, there is widespread disregard and defiance of governmental regulations designed to protect public health.

With no foreseeable relief to come at the state level, local authorities must devise their own effective enforcement solutions. While multi-jurisdictional task forces show promising results, they must encompass the full range of appropriate agencies, and funding for inspectors who focus specifically on food safety violations must be prioritized.

FINDINGS AND RECOMMENDATIONS

Finding 1: County Health's ability to inspect mobile food vendors and enforce food safety regulations has been limited by the small number of inspection personnel currently employed in its Environmental Health Services Division.

Recommendation 1: The Grand Jury recommends that the Board of Supervisors provide County Health with sufficient funding to hire additional inspectors to facilitate more frequent inspections of mobile food vendors and to enforce compliance with existing food safety laws if violations are discovered. To be implemented by July 1, 2026.

Finding 2: There is no established process by which the public can report unpermitted mobile food vendors to County Health, thus making enforcement of food safety requirements more difficult.

Recommendation 2: The Grand Jury recommends that the Board of Supervisors direct County Health to establish a tip line for the public to report information about mobile food vendors who are not permitted. To be implemented by January 1, 2026.

Finding 3: County Health efforts to conduct inspections of mobile food vendors have been negatively impacted by safety concerns for inspection personnel.

Recommendation 3a: The Grand Jury recommends that the Santa Barbara County Sheriff's Office delegate deputies to accompany County Health inspectors so that the inspectors, with the support of law enforcement, can safely enforce permitting and inspecting in the unincorporated areas of Santa Barbara County and in incorporated areas where the Sheriff's Office is contracted to provide services. To be implemented by January 1, 2026.

Recommendation 3b: The Grand Jury recommends that the Board of Supervisors direct County Health to partner with municipal law enforcement agencies so that health inspectors, with the support of law enforcement, can safely enforce permitting and inspecting within incorporated municipalities. To be implemented by January 1, 2026.

Finding 4: Food trucks and carts are often not located in proximity to restroom or handwashing facilities for staff and customers as legally required, which poses a significant public health risk.

Recommendation 4: The Grand Jury recommends that the Board of Supervisors direct County Health to focus inspection and enforcement efforts on mobile food vendors who operate without proximity to appropriate restroom or handwashing facilities. To be implemented by January 1, 2026.

REQUEST FOR RESPONSE

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

Responses to Findings shall be either:

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

Responses to Recommendations shall be one of the following:

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

Santa Barbara County Board of Supervisors - 90 Days

Findings 1, 2, 3, 4
Recommendations 1, 2, 3a, 3b, 4

Santa Barbara County Sheriff's Office - 60 Days

Finding 3
Recommendation 3a

FEMALE INMATES AT SANTA BARBARA COUNTY JAILS

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FEMALE INMATES AT SANTA BARBARA COUNTY JAILS
Making Better Choices

SUMMARY

There are two distinct populations in Santa Barbara County's jails: male and female. The 2024-25 Santa Barbara County Grand Jury conducted an investigation into the living conditions for female inmates. As required by the Fourteenth Amendment of the Constitution of the United States, jail administration has the responsibility to ensure that female inmates receive the same consideration as male inmates.

Female inmates only make up approximately 10 to 11 percent of the daily average population at both of the County's jails, and the Jury finds that this results in certain disparities in conditions for male and female inmates. Even minor changes in living conditions could have a remediating effect on female inmates' physical and emotional welfare, extending beyond the jail.

BACKGROUND

The Santa Barbara County Grand Jury (Jury) has a mandate under California Penal Code §919(b) to inspect the local prisons and jails. Almost yearly, the Jury has written a report describing the conditions and management in the County's jails, as well as in the municipal detention facilities that operated until recently. These past reports have played a role in urging the Santa Barbara County Board of Supervisors to build a new jail in North County, to make repairs, and to change practices for better efficiency. This year, the Jury looked at the jails from the perspectives of the female inmates.

In 2024, the average daily female population at the South Branch Jail (Main Jail) was 49 (12 percent of total inmates) and 37 (10-11 percent of total inmates) at the Northern Branch Jail. Women have their own units separated from the men's units. There are no special accommodations for women: they eat the same food; sleep on the same type of beds; and, wear the same type of clothes as the male inmates. Although there are women in the jails who are sentenced for a number of years, most are only in the jail for a short time. Of the 849 female inmates who stayed at either jail in 2024, for example, 533 women, or 63 percent, were there only one day, and 170 women, or 20 percent, were in jail two or three days. Those staying more than ten days numbered 8 percent, or 67 women.

At the older Main Jail, the accommodations are stark. Some of the women live behind bars, as in the jails of old, with a narrow approximately 30' x 15' front area filled by picnic tables with

attached benches, leaving little extra open floor space. A shower stall is on one wall and next to it is a wall-mounted television. Off this central space there are three areas approximately 10' x 7'or 8' for sleeping cells separated by bars, with up to four women in each bunk area. A toilet behind a low partition is at the back of these tight sleeping quarters. The maximum occupancy in the unit is 12, and the average number is between eight and eleven women.

This section of the Main Jail is noisy. A fan runs constantly in the hallway because of the absence of access to outside air and the poor ventilation in the old jail. The noise echoes off the cement wall facing the cell bars. For some time in fresh air, the women are escorted to a large yard, on a set schedule, with a different time slot three days a week (early morning, mid-morning, or early afternoon). They can be outside for two hours, and all in the group cell must go at the same time.

There are other areas in the Main Jail for women where there are two contained living units with cement walls. These have a larger shared open space, or dayroom, which is 950 square feet in one unit and 550 square feet in the second. Metal picnic tables with secured metal stools are about the only furnishings in the dayroom. There is a shower room and a phone stand. A small outside area is accessible, to which the women can have access following a two-hour schedule every day of the week. Only a small window in the door leading to the outside area lets in natural light, leaving the entire unit cold, dim, and hard.

Sleeping cells in these units are on an upper and lower floor against two of the walls. These sleeping quarters have metal doors with a small window. The doors can be locked from the outside to keep the women in their dorm section off and on during the day as well as at night. Depending on the compatibility of the women, each sleeping cell will be allowed in the open day room at various times. The larger unit has 16 sleeping cells for two women each, and each area is a confining 8.5' x 8.5'. The smaller unit has three sleeping cells for four women each in an only slightly larger area of about 10' by 10'. The overall effect is constrictive in the sleeping cells, but the women are able to move around at times and change space, which the women behind the units with bars do not benefit from.

On the other hand, the living conditions at the Northern Branch Jail (NBJ) are more comfortable. The units in NBJ appear more spacious, brighter, and quieter. They feature a dayroom that is more like a central living space, and it is larger and thus able to accommodate couches, picnic tables, a phone station, a water fountain, a wall-mounted television, and a serving station. The shower area is larger here than in the Main Jail.

The NBJ can house a maximum of 48 females—32 general population inmates and 16 additional inmates with particular mental health needs. In the general population unit, the eight sleeping cells have four bunk beds (eight women) and a toilet, which has a partition blocking it off somewhat. The sleeping cells in the units have a large glass window looking out at the central area. These

large windows let in more light, but they can be problematic when male guards make their rounds. Some sleeping units have paper taped to the window for some privacy when male deputies patrol.

The central living space is about 20' x 30' and has been designed to provide a comfortable space. One wall has a large glass window that brings in natural light. It looks out on a small triangular outdoor area, a cement-walled open space. During the two jury visits, many occupants moved around freely, seemingly in constant motion, and often chatting and laughing with others around.

There are nine female custody deputies total at the Main Jail and nine at NBJ, almost enough to cover shifts around the clock. When there is a shortage of female deputies due to absences, a male will stand in. The deputies have a raised enclosed platform between the two female units at the NBJ, but they also move around the unit as needed. The deputies at NBJ undergo extra training for this direct supervision in order to orient them to this different approach to supervising inmates.

Women at the NBJ have their own Behavioral Health Unit next to the female general population unit, configured in the same way with a central open space and two-story sleeping cells. It is next to the women's unit for general population. There are fewer women in this unit, as they each have their own sleeping cell. The 16 single-bed cells are usually at maximum capacity. These women stay within their cells much of the time. Some of them need to be in the open space individually, minimizing risk of confrontations with other inmates. If they can get along, more are let out of their cells at the same time. Staff does have daily supervised group activities for the small cohort of mental health inmates, which gives them some social time. There is no comparable Behavioral Health Unit for women at the Main Jail.

If possible, jail management will move women to the NBJ, where living conditions are better. However, if the unit at the NBJ reaches capacity, some women will be transferred back to the Main Jail. Women can request a transfer to NBJ, but as the women's unit is often full, there is no guaranteed timeline. Roughly ten female inmates are able to transfer each month. The Sheriff's Office makes an effort to place the mental health female inmates in the Behavioral Health Unit of the NBJ as soon as possible, and it is almost always at full occupancy. Not all women choose the more comfortable units up North because a deputy is always in the unit with them, and they would rather not be observed constantly. At the Main Jail, deputies walk down the halls at least once an hour for safety checks, which gives the women a bit more time not under the eyes of deputies.

METHODOLOGY

In addition to full-Jury inspections of living conditions for all inmates at both jails and background research, female jurors visited both jails and interviewed female inmates, going twice to the NBJ and once to the Main Jail. At the Main Jail, a meeting was set up with inmates who volunteered to

speak with jurors; there was one group of four and another group of two. For the NBJ, the jurors went on two different occasions, speaking to three volunteer inmates the first time and two the second time. Comments from the eleven female inmates echoed each other, across groups, and across facilities. In addition, the jurors talked to three female custody deputies at the NBJ, including one who had volunteered to work in the Behavioral Health Unit, and to management staff and one deputy at the Main Jail. Management and staff generally corroborated what these female inmates said.

Jurors also researched articles regarding the experiences and conditions of female inmates in jails and prisons.

OBSERVATIONS

The Female Inmate Perspective on Living Conditions

The female inmates have common concerns and common complaints that vary only somewhat between the two facilities. The complaints ranged from choices for the little things in daily living to options for life-enhancing activities.

One such concern was that men can join work crews and prepare meals in the kitchen, do the laundry, do maintenance, or clean the facility. There are enough men to fill a work crew, and if someone is sick, a replacement can be found. Women, on the other hand, are fewer in number. So, when a female inmate is sick, or does not feel like working, which can happen often, there are not enough women available to fill the crew. The result is that women have few work detail opportunities in the jails at this time.

This loss of work opportunities affects the women in several ways. First, they lose the ability to do something, to be active. Some women are said to be so bored that they sleep all day. Additionally, they do not feel productive, which reduces their self-esteem. Women at both jails described this as a true lack of opportunity. Moreover, the loss of not being able to work is that they are not learning or practicing skills that they could use outside the jail to look for a job. Many do not have a strong support system, and leaving the jail without a job skill or recent experience worried them. Without a family, a social group, or a system to keep them afloat, the women were anxious about being released.

The Sheriff's Office is reconsidering the minimum number of women required for work crews in recognition of their ability and willingness to work. Custody management is looking into allowing fewer women to make a team for some tasks such as cleaning, and are also discussing how to incorporate women into work crews.

Classes in jail can also prepare inmates for release, especially if the classes train for some sort of job. At the NBJ, classes in installing solar panels are in demand. But the females could not join them, again because of not enough female inmates to reach the minimum of ten people to fill a class. The women are cut off from the one job skill preparation class that does exist. The Sheriff's Office is discussing lowering the minimum required to eight people rather than ten. Other job training in the jail is not available at this time with the exception of a program offered at both jails, known as SERVSAFE, which trains for a Safe Food Handling certificate. At this time, however, only male inmates can practice this skill in the jail kitchen duty.

Female inmates also directed the Jury's attention to the commissary. The commissary vendor has reduced the number of options for women. As stated in the April 1, 2025, letter to the Board of Supervisors concerning the new contract for the vendor, the Sheriff's Office wrote:

> Commissary services play a crucial role in the proper management of incarcerated individuals by providing access to items that can improve quality of life, such as snacks, better hygiene products, and other personal care items. Having the ability to choose and buy items helps mimic the out-side world's consumer choices and can contribute to a sense of normalcy among inmates.

The current vendor has reduced the number of options to one kind each for such basic items as shampoo and soap. As a result, shampoo and soap products favor the much larger male population. The vendor is further seen as providing additional items for men only such as aftershave, shaving gel, and shaving cream. For hair conditioner and body lotion, there is only a generic brand in small travel-sized bottles. There is no other choice as there had been with the previous vendor, which had a "feminine package" that included brands more used by women. Since they do not have these options, the women inmates feel robbed of their dignity. This vendor has a one-year contract, and the female inmates hope that the next vendor will provide them with more options.

In addition, the Jury found that, in general, the women were frustrated by the lack of food choices. They were enthusiastic about a new food vendor last fall, but disappointment grew as food offerings became more limited. The initial welcome came with the addition of fruit and fresh vegetables with the new vendor. Unfortunately for the NBJ, while some of the women invented small pies with the fresh fruit, some men saw fruit as an opportunity to make homemade alcohol, causing the vendor to remove fruit from their offerings to both men and women. Women at the Main Jail complained less about the food as they still received fruit. This situation has been remedied, but then the main dinner course offering was reduced to beans and rice for a time, which female inmates criticized for lack of variety. The nutritional value of the food is questioned especially by women who want to keep their weight down, a difficult ambition given the lack of food variety and the lack of exercise available.

A prior disparity between men and women was mentioned for clothing. For a time, men were allowed to wear shorts; the women were not. When the men began to cut off their pants to make them shorts at the Main Jail, once again jail management had to disallow shorts for everyone. Also, there was some confusion over women not being allowed to wear their sweatshirts to classes at NBJ, but the men could. This was eventually resolved in the women's favor, and they can wear the sweatshirts when they leave their unit for another activity.

However, women at the Main Jail will have to wait indefinitely for a different disparity to be resolved: television. Only one channel can be shown at a time across all the televisions in the technologically-challenged Main Jail. Female inmates therefore "watch a lot of soccer" because the Deputies program what the male inmates want to watch. At NBJ, the women's units can select their own choices in television shows and movies.

When inmates have a complaint or a suggestion, the process requires them to file a grievance and get signatures of other inmates. Grand Jurors did not find an example of female inmates petitioning for change. However, when women convey a problem to the custody deputies, they quickly respond to fix it. "They're cool,' one inmate said; "They help."

How Women Benefit from Incarceration

There are educational classes at NBJ provided by Allan Hancock College that have greatly uplifted the inmates, and the female inmates seem particularly aware of the personal growth attained. Hancock College typically teaches three to four credit classes per semester. In fact, the women at NBJ asked for more general education credit classes and expressed a desire to continue studying at the college once released. They are encouraged by Hancock's Rising Scholar program that assists former justice-involved inmates with fitting in, giving them supplies, mentoring, and even loaner laptops. In June 2025, Allan Hancock College awarded certificates of completion to 55 inmates at NBJ; six of these were women. Additionally, the jurors learned of one woman who continued classes until she received a college degree. Allan Hancock College will also start computer classes for credit at the NBJ later in 2025.

Educational offerings at the Main Jail in Santa Barbara have not come back to the pre-Covid level of offerings. Currently, two classes are offered by Santa Barbara City College on alternating semesters at the Main Jail, a stress management class and a "College Ready Study Skills" class. At one time, computer literacy classes were offered at the Main Jail, but now these classes will exist only at NBJ. The return of computer classes at the Main Jail would offer educational and vocational enrichment to this population that is so appreciative of opportunities to change. Classes are available on the personal tablets issued to each woman at the jails, but these classes are not always free. It would benefit the women at the jail to also have the stimulation of contact with teachers and other students.

The Public Defender's Office has staff that meet with inmates as they enter the jail. Their intention is to get to know the inmate, find out what their needs are, and help expedite solutions for their release. The Public Defender's holistic defense program is not as well developed in South County as it is in North County, so there exist fewer Public Defender staff members to direct female inmates to support programs in South County. The female inmates in the Main Jail expressed understanding: "Oh, they're so overworked." The Jury learned that the Sheriff's Office is hoping to arrange a one-year pilot program to boost the Public Defender's program in South County. If this effort succeeds, it will be an important step towards supporting female inmates after their release.

The Sheriff's Treatment Program (STP) has been a successful program for decades. Classes center around personal development and interpersonal skills. Especially noted are the STP classes in drug and alcohol education, criminal and addictive thinking, and anger management. The female inmates mentioned this program and its role in helping them endure incarceration. There are also occasional counseling groups and therapy sessions with volunteers outside the jail that the inmates can attend. In addition to the Sheriff's Treatment Program, each jail has different opportunities provided by different community organizations: at NBJ women meet with Planned Parenthood and yoga groups, and the acclaimed Freedom to Choose program will begin. At the Main Jail, there is a book group for women, and one organization in particular was praised: GOGI, Getting Out by Going In. The emphasis on a better future life by knowing oneself encouraged the female inmates to look ahead, giving them a will to change behavior. Well known organizations such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) also help the inmates. At the moment, NA is not meeting in the Main Jail.

The women at both jails appreciated their access to mental health services. They could request a visit from a mental health counselor, and one would come with no long delay. Counselors help them to help themselves. The Jury learned that one female inmate, who had attended required group counseling at another jail, stated that having to go to group sessions helped her and other inmates and gave them something to do.

Medical care was less praised. The female inmates had to put in a lot of "kites," or call slips, to see someone, and if it was a specialty doctor, there was a long wait time. There is only one full time doctor and only one dentist at the moment who spend their time helping incarcerated individuals. Thus, a request for care can seem to go unanswered for a long time. However, the women affirmed that health issues specific to women were not neglected. Santa Barbara County's new contract (signed April 1, 2025) with the existing healthcare provider at the jails adds more nurses and mental health aides to the jail, which will help to some degree, as there are many inmates inside the jails who need medical care.

Overall, what should be noted is that the female inmates see the jail staff as helping and see themselves as getting help. There are disadvantages that are inherent in being incarcerated. When asked what is bad about being in jail, one woman answered, "You are in jail." All agreed. They also shared the opinion that the hardest aspect of that was being away from their family. There are annoyances such as not enough products for women in the commissary, the mail being extremely slow, and not being able to go outside often enough, but these facts are part of living within the cement walls of a detention facility. Some are grateful to have a bed, food, a shower, and shelter. The women who would be homeless outside the jail were especially relieved. As one said, "It's humbling, but it's a safe place."

Female inmates understand that they are there for a reason. The female inmates also seem to know that they are there for a purpose and recognize that they can change. The benefits of incarceration mentioned by these women were:

- Getting healthier
- Getting into a routine
- Being off drugs and alcohol
- Connecting with your higher power
- Building a foundation
- Learning patience and anger management
- Having time to think
- Getting to know yourself
- Being with the girls

While the women in jail can be frustrated by limited choices in daily living, they know that they can make better choices in life.

CONCLUSION

Meeting with female inmates and hearing them express themselves was an experience that should be shared with administrative staff at the County's jails, the Santa Barbara County Board of Supervisors, and the public. Paying attention to requests for more positive experiences in the jails, such as vocational and educational opportunities, could help these female inmates reach that awakening that we hope every inmate can have. The women at the County's jails want to be heard and want to maintain their dignity. The Jury learned that female inmates want to improve some conditions that are bothersome, but, at the same time, that they want to assure staff and volunteers that their contributions are working.

FINDINGS AND RECOMMENDATIONS

Finding 1: To their detriment, female inmates have fewer work opportunities than male inmates in preparing them for life outside jail.

Recommendation 1: The Grand Jury recommends that the Sheriff's Office provide work detail opportunities to female inmates at both of the County's jails in crews that allow for a more flexible number of women. To be implemented by January 1, 2026.

Finding 2: College classes are not available at the Main Jail to the same extent that they are available at the Northern Branch Jail, depriving women at the Main Jail of equivalent educational opportunities.

Recommendation 2: The Grand Jury recommends that the Sheriff's Office expand current educational and vocational course offerings at the Main Jail in cooperation with local colleges. To be implemented by January 1, 2026.

Finding 3: Women inmates are receptive to therapy and self-improvement groups. While the Sheriff's Treatment Program is available at both of the County's jails, the activities provided by community organizations—such as yoga, book clubs, and mutual-support recovery groups—vary between the two facilities.

Recommendation 3: The Grand Jury recommends that the Sheriff's Office expand its efforts to make more community-provided self-improvement and therapy programs available to educate and motivate inmates at both jails, including the women.

REQUIREMENTS FOR RESPONSES

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

Responses to Findings shall be either:

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

Responses to Recommendations shall be one of the following:

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

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

Santa Barbara County Sheriff's Office – 60 days

Findings 1, 2, 3

Recommendations 1, 2, 3