Justice in the Jail

"The degree of civilization in a society can be judged by entering its prisons." – Fyodor Dostoevsky

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Summary

A number of events over the past four years illustrate that "we have a problem." They include inmate deaths, violence, and equipment failures at the Main Jail and criminal conduct including sexual assaults by correction officers. These events may seem unrelated, but they are connected. This report examines the operation of the Main Jail, matters affecting the nature of the inmate population, the specific events in question, and staffing and budget issues. In the end it comes down to issues of management, having enough resources, and a need for more effective oversight and public transparency.

Background

The Grand Jury's investigation and this report relate to events occurring in, and the management of, the Water Street Maximum Security Correctional Facility ("Main Jail"). California Penal Code Section 919(b) requires each year's grand jury to "inquire into the condition and management of the public prisons within the county." (see Appendix A) Previous Santa Cruz County Grand Juries have issued reports dealing with unfortunate events occurring in our county's jails, including a report issued in 2014 entitled "Five Deaths Santa Cruz" and a report issued in 2016 entitled "Another Death in the Jail."[1] [2]

News articles and other media have reported on problems in the Main Jail. The Grand Jury received written complaints from citizens. Although Santa Cruz County's adult correctional facilities have had fewer deaths in custody than many other counties of similar size (see Appendix B), troubling incidents as reported in the press and in press releases issued by the Sheriff's Office (SO) in 2018, 2019, and 2020 warrant both examination and explanation to the public. However, this report will not discuss the details of those events that are involved in pending criminal and/or civil litigation beyond indicating that an event occurred and what was released by the SO itself.

The events addressed in this report are:

- Allegations of sexual assault and/or illegal sexual conduct by Corrections Officers (COs) in 2017 and in 2020 resulting in convictions.[3] [4]
- An inmate's self-mutilation in 2018.[5]
- An inmate assaulted by other inmates in 2018.[6]
- A suicide and then a homicide where discovery was delayed for over 30 hours, both occurring in a two day period in October 2019.[7] [8] [9]
- The death of an inmate diagnosed with mental illness in May 2020.[10] [11]
- A total power outage where power was not restored for over 24 hours in September 2019[12]

> These are important. Each goes to the heart of concerns over inmate safety and the management and oversight of the Main Jail facility.

The COVID-19 pandemic has impacted the Main Jail, just as it has impacted virtually every aspect of our collective lives. However, none of the events that gave rise to our investigation and report are COVID-19 related. Although a few COs tested positive after an ill-advised off duty social event in November 2020, those officers and a number of other officers who came in contact with them were quarantined. No infections have been reported in the Jail population since the pandemic began.[13] The Sheriff's Department is to be commended for doing everything in its power to avoid an outbreak of COVID-19 among the inmate population.

Our investigation, our findings, and our recommendations address five overriding questions concerning management and oversight raised by the events that prompted our inquiries:

- What is the Main Jail's management doing right to promote and maintain inmate and staff safety?
- How can the management of the Main Jail be improved to promote and maintain inmate and staff safety?
- How much oversight of the Main Jail's operations exists?
- What are the potential benefits of increased institutional oversight?
- How can oversight benefits be maximized?

Scope and Methodology

The subject of the investigation is the Santa Cruz County's Main Jail, its management, and its oversight by the Board of Supervisors (BoS) as well as public transparency of jail operations. During the course of this investigation the Grand Jury toured the Main Jail, the Blaine Street Women's facility, and the Rountree facility. Among others we interviewed members of the Sheriff's Office's (SO) management, and private citizens allegedly having knowledge germane to our investigation. We reviewed numerous newspaper reports, statistics compiled by governmental agencies, court records, and a number of scholarly articles. The SO produced a large volume of documents and records, including but not limited to logs, policies and procedures, training materials, and investigative and administrative reports. We examined data and documents posted on the SO's website. Further, we had access to the numerous reports of prior grand juries dealing with the jails in Santa Cruz County and to the statistics and other printed materials that had been used to support the facts stated in those reports. The SO was cooperative with the Grand Jury and did not attempt to interfere with, limit, or frustrate this investigation.

Investigation

The SO's Correction's Policy Manual (CPM) prioritizes inmate and staff health and safety.[14] The Grand Jury undertook this investigation to evaluate the performance of the management of the Main Jail in the wake of numerous incidents of violence, suicide, deaths, and CO misconduct.

The SO's management interviewees were open and forthright. We received direct answers to our questions that were comprehensive and unfettered. No areas of concern were off limits to our inquiries, and our requests for documents were promptly honored. We commend the office and its management for their candor and cooperation.

We start with an examination of the structure and organization of the Main Jail, and the factors affecting the number and nature of the Main Jail's inmate population. Then we discuss what our investigation revealed about the incidents involving inmates and the various Correction policies relevant to those incidents. Lastly, we discuss issues concerning staffing, staff morale.[13] funding (budgets), and then oversight and transparency, which lead to our findings and recommendations.

The Corrections Bureau

The SO is divided into three Bureaus:

- The Operations Bureau covers patrol and most investigations.
- The Administration Bureau covers over-all administration and internal affairs investigations.
- The Corrections Bureau administers the jails, inmate transportation, and the secure areas of the downtown and Watsonville courthouses.

The SO also has a Cannabis Compliance Unit that works closely with the County Cannabis Licensing Manager to reduce non-regulated cannabis cultivation.[15]

The Corrections Bureau operates three adult detention facilities. The Main Jail is a maximum security facility now rated for 319 inmates. Next to the Main Jail is the Blaine Street medium security women's facility rated for 32 inmates. The third is Rountree, a medium security men's facility divided between two units together rated for 96 inmates and a separate Rehabilitation and Release unit for 64 inmates.[16]

A Chief Deputy leads the Corrections Bureau. A lieutenant is in charge of both the Main Jail and Blaine Street facilities, and a lieutenant is in charge of Rountree.[17] [18] All state prisons and county jails are subject to standards and regulations established by the California Board of State and Community Corrections (BSCC).[19] [20] [21]

The Corrections Bureau has expanded educational, motivational, and life skills programs available to inmates who are classified as medium security. The Main Jail lacks the space to have extensive educational programs, with only a few small rooms available for classes. Staff seeks to motivate female inmates who qualify to earn transfer to Blaine Street through their behavior, and for male inmates to rate being transferred to Rountree. Male inmates at Rountree are then urged to earn transfer to the Rehabilitation and Release Unit (Unit T), which has even more extensive educational and life skills programs. Inmates in Unit T who have not graduated from high school are required to complete their GED equivalency. Inmates in Unit T are required to attend both classes and occupational training in either hospitality, construction, or agriculture.[17] [22]

Management is rightly proud of these programs. We commend the Sheriff, the Sheriff's Office, and the Chief Deputy of the Corrections Bureau for adopting these innovative programs designed to promote reentry and reduce recidivism.

Structure and Organization of the Main Jail

The Main Jail's structural layout dictates its organization. The building, originally completed in 1981 to house 92 inmates, was expanded by adding a second phase in 1986 to house an additional 138 inmates. It was expanded again in 1999 to house an additional 91 inmates bringing its then total capacity to 311 inmates.[23] [24] Sheriff's management has opined that the Main Jail facility is approaching the end of its useful life, and that it should be replaced by a new facility designed and built reflecting current needs and technology. We were also told that the cost of doing so is prohibitive and that the Main Jail will be needed for years to come.[13] [25]

The Main Jail houses inmates in three wings, noted as North, South, and West. Each wing is divided into units, with each unit having a number of one- and two-person cells. A separate “O Unit” (“O” for observation) is located in the West wing, with 16 cells currently set aside for quarantining incoming inmates to prevent the spread of COVID-19, and for inmates under special observation (e.g., suicide risks). Female inmates are housed in a separate unit in the North wing. In addition, the facility has a medical office with two examination rooms and a dental room. The facility has areas set aside for food and clothing distribution areas, as all laundry and cooking is done at the Rountree Facility and transported to the Main Jail and the Blaine Street women's facility. Each housing unit has a day room and exercise area, the exercise area being enclosed but open to the sky through a closely woven steel mesh roof. There is a central Control Room that allows monitoring, through live video, of all housing units.[17]

The corrections facilities are staffed on two twelve-hour shifts (Day and Night). This is standard practice for COs working in custodial areas, and reportedly is preferred by most COs, rather than three eight-hour shifts. Fewer shift changes in a 24-hour day provide for greater safety to the COs, and it is reported that inmates seem to feel more secure dealing with only two COs per day.[17]

Inmate medical care for the Santa Cruz County Jail system is contracted out to Wellpath, a private company that specializes in providing medical services to county jail inmates. Wellpath staffs the Main Jail medical office with an RN on duty 24/7, and a doctor is present on site three days a week. The remaining two days the doctor is at the Rountree facility. Mental health services are currently provided by the Santa Cruz County Health Department.[17]

At the Main Jail each shift is headed by a Watch Commander, with two Senior Correction Officers, one supervising housing and the other supervising booking.

- The day shift operates with a minimum of twelve additional COs: booking, intake, release, North, South-1, South-2, West-1, West-2, O Unit, Control-1, Control-2, and Flex-1 (a “floater”).
- The night shift operates with one less CO, as only one CO is in the Control Room at night. This is the minimum staffing, and at least one off-duty CO is on overtime standby if needed which happens regularly.
- The staffing chart provides for additional COs noted as Flex-2, North-2 and Intake-2 but, apparently due to budgetary issues, the Main Jail has not operated with these positions for a number of years.[17] [26] [27] [28]

Every arrestee not cited and released by the arresting agency is brought to the Main Jail for booking. The transporting officer for the arresting agency submits a completed “Arresting Agency Suicide Assessment” form.[29] Arrestees are processed one at a time, through an intake-booking process that includes a lengthy “Housing Assignment Risk Assessment/Preclassification Assessment" with 48 distinct observations and questions that are used in determining housing assignments. Once housed, inmates may submit a request for reassignment.[30] [31] [32]

COVID-19 Protocols

Due to the COVID-19 pandemic, the jail instituted strict protocols designed to minimize the risk of infections among inmates and staff. All staff are tested weekly. All inmates are tested at booking and are strictly quarantined for 14 days. Thereafter inmates are tested weekly. All staff are required to wear N95 masks at all times while in the facility. All visitation is "virtual," and a special arraignment court operates in the Main Jail to reduce the need to transport inmates to the courthouse.[13] These efforts have worked. No inmate has contracted COVID-19 since the pandemic protocols were implemented in March 2020.[13] [17] [33]

Population Issues

In Santa Cruz all incoming inmates are processed at the Main Jail, and the SO cannot refuse to house an inmate because "there is no room at the inn." People charged with serious felony charges who do not make bail are housed in the Main Jail until the cases against them are fully resolved. The Sheriff of each county in California is required to house any inmate lawfully remanded to the Sheriff's custody until either released or transferred according to law.[17]

During the period when the incidents occurred that prompted this investigation, that is 2018, 2019, and early 2020, a number of factors had an impact on the size and nature of the inmate population in the Main Jail. Overcrowding was endemic for most of this time, and earlier. While the Main Jail's rated capacity was 311, the daily average was around 350, and rose as high as 390 in April 2019.[34] As reported in the 2016-2017 Grand Jury Report, Assembly Bill 109 (AB109) enacted in 2011 was the leading cause of overcrowding.[35]

AB 109 (the "Public Safety Realignment Act")

AB109, the "Public Safety Realignment Act" applied to some 500 designated non-serious, non-violent felonies, and to non-registerable sex offenses. Those convicted of one of these offenses, if not otherwise disqualified based on prior convictions, would serve their sentences of up to four years in their local county jails instead of state prisons. The stated assumption was that recidivism would be reduced if certain classes of inmates were incarcerated closer to their homes and had county-based programs and supervision. What wasn't stated, but was understood by all, was that California's Department of Corrections was under a court order to drastically reduce prison populations, and the realignment would save millions of dollars.[36] As a direct and immediate consequence, increasing numbers of inmates in our county's jails were incarcerated for much longer times than previously.

Housing the Mentally Ill [37]

Inmate population has also been impacted by county jails becoming *de facto* one of the principal housing locations for people who appear to have mental illnesses or addiction issues. Over a number of decades California has sharply reduced state resources available to house and treat people with mental illness. Current estimates reveal that about 45% of state prison inmates have been treated for mental illness, and the Los Angeles County Sheriff characterizes the LA County Jail as the largest mental health

provider in his county.[38] According to BSCC statistics, the number of inmates in California county jails receiving medication for mental illness each month in 2019 increased by a factor of 42% over what had been the case in 2009.[39]

Our county's situation is in line with state averages.[40]. A survey of jail records for 10 different dates in September and October 2019 indicate that an average of 17 inmates in the Main Jail population awaiting disposition of their cases had been found mentally unfit to stand trial.[41] Senior correctional officials in our county have acknowledged that many inmates are arrested and detained for actions that appear to be consequences of mental illness and/or addiction.[28] [42] Santa Cruz is a relatively small county and it does not have a mental health facility with sufficient security features, beds, and staffing to house and treat inmates found to be both seriously mentally ill and charged with criminal offenses. Even if an inmate might be ordered to a state hospital, the length of time before a bed becomes available and the inmate can be transported to a state facility is measured in months and years, not days and weeks.[17] [38]

The Main Jail was designed as a maximum security facility for inmates either awaiting disposition, post conviction transfers, or serving misdemeanor sentences of no more than one year. Before passage of AB109 as noted above, the actual time inmates were housed in the Main Jail was measured in days or weeks, and occasionally months, but not years. Yet now increasing numbers of inmates are serving longer sentences, are waiting longer for disposition or transfer, and more often seem to have mental illnesses and/or addiction. All of which means that policies and procedures designed to protect inmates from harm, whether self-imposed or from other inmates, are more important than ever.

Events

A number of incidents occurred in the Main Jail between 2017 and 2020 in which inmates sustained harm, or which increased the risk of harm.

Conviction of Correction Officers for criminal conduct

In 2018, and in 2021, individual COs were convicted of criminal conduct. In 2020 a CO was arrested for two counts of unlawful sexual activity with a detained person and for three counts of bringing drugs into the jail. In 2021 the CO pled "guilty/no contest" (as stated in the court record) to all charges, and received a suspended sentence and two years formal probation.[43] [44]

The earlier case involved the arrest and conviction of a CO for committing a sexual assault in 2017 on a female inmate. The CO was charged with two counts of unlawful sexual assault on a detained person and one count of assault by a public officer. He pled "guilty/no contest" (as stated in the court record) to the charge of assault by a public officer (PC § 149), and received a suspended sentence and three years formal probation.[45] He had entered a cell occupied by a female inmate alone, which was strictly against policy, and assaulted her.[46] This prompted the SO to require COs to activate their Body Worn Camera whenever entering a housing unit or cell. The CO's arrest and the policy change was reported in the press.[3] [47] [48]

COs receive specific training in PREA, the Prison Rape Elimination Act of 2003 as decribed in the CPM §606.[49] PREA forbids COs from engaging inmates in any sexual acts, banter, inapprorpriate written communications, and the like. Such prohibitions extend to any ex-inmate within a year of such inmates' release. PREA also prohibits any sexual discrimination, harrassment, and unequal tratment of inmates based on the inmate's sexual orientation, identity, or status. Under PREA, COs of the opposite sex of inmates in any housing unit must announce their presence upon entering the unit, and COs shall not enter the cell of an inmate of the opposite sex unless accompanied by a CO of the inmate's sex except in emergency situations.[50]

October 12-14, 2018 – Inmate A

An event concerning Inmate A is the subject of pending litigation, and we are precluded from further elaboration.[6] [51] [52]

December 30, 2018 – Self-mutilation by Inmate B

Inmate B's criminal matter was pending trial, and he had been in custody since his arrest.[5] The SO's investigation revealed that at about 11:30 p.m. a medical emergency was discovered in Unit K in West Housing. Another inmate had pressed the emergency call button in the Unit's dayroom because Inmate B was bleeding profusely. Inmate B was in a single cell as opposed to a two-person cell based on correction housing policies. He was immediately transported to the medical unit in a wheelchair, where it was discovered that he had used a razor blade in an act of extreme self-mutilation. A tourniquet was applied by medical staff to arrest the bleeding and Inmate B was transported to the hospital by ambulance. Video surveillance revealed that at about 10 p.m. that evening safety razors were distributed to inmates in the Unit including Inmate B, who was confined to his cell. It was reported that about 15 minutes before Inmate B's self-mutilation was discovered, the razor was recovered lying by the door where Inmate B pointed to it. It was noted that there was no blood on it but that it appeared to have been tampered with.[53]

October 13, 2019 – Suicide of Inmate C

Inmate C had been in custody since his arrest. He was discovered dead at 5:45 a.m. lying in bed in his one-person cell in the D Unit in West Housing when he failed to appear for breakfast. The SO's investigation revealed that Inmate C had used razor blades to sever his femoral artery and had bled to death. He was pronounced dead at the scene.[7] [54] [55]

Jail records revealed that Inmate C had previously attempted suicide in July, 2017, and had been placed on suicide watch several times. He was placed in "O" Unit on suicide watch once again in September 2019, and had been returned to the general population only six days before his death.[55] SO regulations provide that inmates designated suicide risks are checked by COs every 15 minutes, while inmates in the general population are checked hourly. The SO's CPM provides that COs shall "verify an inmate's welfare by direct visual observation of breathing and by seeing the skin of the inmate. If unable to verify an inmate's welfare and presence (such as an inmate sleeping under a blanket), the officer shall take immediate action to confirm the inmate's

presence and welfare."[56] Reportedly COs are trained not to disturb inmates' sleep by waking them or shining flashlights on their faces. Inmate C was last observed to move when checked at about 1:15 a.m. Inmate C seemed to be sleeping on his back at each of the later hourly checks, but only his legs were visible as he was under the covers and had draped a towel or blanket near his head, which was common practice by inmates who did not want to be awakened.[55]

The investigation revealed that when Inmate C's body was discovered in his cell, two safety razors were seen lying on a book next to Inmate C's head, each covered with blood, and one bearing a large amount of congealed blood. There is no indication in the investigation report of how Inmate C managed to acquire two razors.[55]

Correction Policies Regarding Razors and other grooming equipment

The CPM states that inmates are allowed freedom over their personal grooming in most cases. The only specific mention of razors is in Section 607.4 stating that inmates are allowed to shave daily, but an inmate who appears to be a danger to himself or others may be denied access to a razor. Section 607.6 provides that: "Grooming equipment is to be inventoried and inspected by the staff at the beginning of each shift and prior to being issued to inmates. The staff shall ensure that all equipment is returned by the end of the shift and is not damaged or missing parts."[57] [58] Existing policies in the CPM appear to be deficient in that inmates are allowed to be in possession of razors in their cells, and there is no policy regarding how long inmates may have razors in their possession.

October 12-14, 2019 – Death of Inmate D

Inmate D was the subject of two SO Media Releases as follows:

> *On October 14th, 2019* (Inmate D) *was found deceased in his cell at the Santa Cruz County main jail.* (Inmate D) *was being held in jail since April of 2013 on murder charges. The forensic pathologist determined* (Inmate D's) *death was caused by strangulation as a result of homicide.* (Inmate D) *shared a cell with two other inmates:* (Inmate X)*, in custody for a murder charge and* (Inmate Y)*, in custody on firearms charges. All three shared a cell in a housing unit designated for active gang members. Detectives are still investigating this case and are working closely with the District Attorney's Office.*[8]
>
> *October 30th, 2019 detectives arrested* (Inmate X) *and* (Inmate Y) *for the October 13th, 2019 murder of* (Inmate D)*.* (Inmate D) *had been in custody at the main jail for murder since April of 2013. He was found deceased in his cell around 11 a.m. on October 14th, 2019. Following an autopsy and investigation by our forensic pathologist and detectives, it was determined* (Inmate D) *was strangled sometime between midnight and early morning October 13th.* (Inmate X)*,* (Inmate Y) *and* (Inmate D) *shared a cell in a housing unit designated for active gang members.* (Inmate X) *has been in custody since August 2018 on murder charges.* (Inmate Y) *has been in custody since January 2019 on felony weapons charges. The investigation is ongoing. Detectives*

> *are working closely with the District Attorney's Office to file charges against* (Inmate X) *and* (Inmate Y).[9]

These matters are the subject of pending litigation, and we are precluded from further elaboration.

May 10, 2020 – Death of Inmate E

Inmate E was the subject of two SO Media Releases as follows:

> *On May 10th around 6:00 p.m. Correctional Officers found an unresponsive male inside his cell at the Santa Cruz County Main Jail. Correctional Officers began performing life saving measures and called paramedics. Despite their efforts he was pronounced deceased at the jail. He is identified as* (Inmate E). (Inmate E) *was arrested in January 2020 for domestic violence related charges.* (Inmate E) *did not share a cell with anyone, there is no foul play suspected and no signs of trauma or visible injuries.* (Inmate E) *was not showing any signs or symptoms related to COVID-19. The forensic pathologist is performing an autopsy and toxicology test to determine cause and manner of death.*[10]

> *On May 10, 2020* (Inmate E) *died suddenly and unexpectedly while in custody at the Santa Cruz County Jail. A thorough investigation was conducted by the Coroner's Unit which included comprehensive testing to include Covid-19. Our forensic pathologist determined* (Inmate E's) *cause of death to be acute water intoxication, due to the over consumption of water in a short period of time. The over consumption of water was influenced by* (Inmate E's) *underlying mental health issues. This water consumption led to an electrolyte imbalance, which caused* (Inmate E's) *organs to fail, leading to* (Inmate E's) *death. The autopsy, testing and investigation showed no evidence of trauma, foul play, Covid-19 or other evidence that he had ingested any caustic or poisonous substances.* (Inmate E's) *death was classified as an accident.*[11]

This matter is the subject of pending litigation, and we are precluded from further elaboration.

Policies Concerning Inmate Safety and Housing

The SO's Correction's Policy Manual (CPM) states that the first priority is to "prevent deaths in custody."[14] Many of the policies concerning both the facilities and the duties of the COs are designed to promote inmate health and safety and prevent foreseeable harm. The policies and procedures inherently recognize that inmates are largely, if not entirely, dependent on their custodians for their health and safety. At the most elemental level, being in custody means not being free to provide one's own basic necessities of life and take care of one's health and safety. The CPM has over 392 pages plus index, and what follows are certain policies that bear directly on the events that gave rise to this investigation and report.

Safety Checks (CPM § 503)

Safety checks are mandatory. They must be "sufficient to determine whether the inmate is experiencing distress or trauma." COs are required to "verify an inmate's welfare by direct physical observation of breathing and seeing the skin of the inmate. If unable to verify an inmate's welfare and presence (such as an inmate sleeping under a blanket) the officer shall take immediate action to confirm the inmate's presence and welfare."[59] Inmates under suicide watch are to be checked every 15 minutes. Other inmates under special special observation, such as detoxification, or other physical or mental health conditions, are to be checked not less often than every 30 minutes. All other inmates shall be checked hourly, as well as at the beginning of each shift, when meals are given out, and during clothing exchanges.[56] [60]

Classification and Housing (CPM § 506)

How inmates are classified and where and with whom they are housed are essential to inmate safety, and gathering important information is critical. It begins with a one page "Arresting Agency Suicide Assessment" to note if the detainee being booked into the Main Jail seems to be a suicide risk.[29] Then the intake officer completes a detailed "Housing Assignment Risk Assessment" form which includes pertinent information given by the inmate, the intake officer's observation of the inmate's behavior and appearance, and a series of questions to provide even more information about the inmate.[30] A Special Classification Officer then scores the inmate's assessment to determine the inmate's security level and appropriate housing based on a number of factors including charges, prior criminal and incarceration history, gang affiliation, sexual orientation, gender identity, and LGBTQ identity. Housing determinations are reviewed 30 days after booking, and then bi-monthly thereafter. Inmates may appeal, or request alternative housing, and their request and the response are recorded in the inmate's record.[61]

September 28-29, 2019 – Power Outage at the Main Jail

As was thoroughly reported by the 2019-2020 Grand Jury's Report "Fail in the Jail," [12] electrical power (from PG&E) was lost, and stayed off for about 26 hours, while the backup generators were mostly inoperative. After the incident the Board of Supervisors (BoS) approved a budget allocation of about $1.5 million to replace the inadequate backup system. As reported by last year's Grand Jury, a design had been contracted out and a new fully operational backup power system was to be in place by late 2021.[12] [62]

However, the Grand Jury learned that as of April 2021, data analysis to determine the needs of the system is still being conducted, the new system has not yet been designed, and it remains more than a year away from being operational. GSD, which is the department that handles the county's infrastructure, had control of the project.[17] [42]

Policies relating to the facilities, like custodial protocols, work both ways: to protect and care for the inmates and also to assure the safety of those who work there. It is important that all of the communication, security and safety systems and equipment operate if the power feed from PG&E should be interrupted. The CPM requires that the backup generators be tested weekly, and that weekly tests be documented. If repairs are required they are to be expedited, and if the backup system can't be brought online in eight hours a temporary emergency system must be brought in.[63]

The lack of a fully adequate operational backup system constitutes a continuing risk to the safety of both staff and inmates. That risk grows more serious when considering the probability of more frequent power outages. During California's fire season PG&E will occasionally shut down power to prevent its outdated equipment from starting wildfires as had previously occurred.[64]

The principal communications between the SO and GSD concerning correctional facilities maintenance issues were, and are, informal monthly meetings between the Chief Deputy for Corrections and the Director or Assistant Director of GSD. However, there is no formal documentation of such meetings nor are there monthly reports generated concerning the status of necessary repairs which could be reviewed by the BoS and the County Administrative Officer.[13] [42] [65] [66] Although the After Incident Report[67] acknowledged the "total failure to assure generators can power minimum critical operations" and that there were no policies or procedures that established response times or when response is required, no such policies or procedures have been put in place.

The BoS and the SO agreed with the 2019-2020 Grand Jury's finding that there had been a total failure to follow necessary policies designed to assure the backup system was operational when needed, yet they rejected all of that Grand Jury's recommendations to address greater accountability for maintenance management.[66] [68] If a lack of established procedures and accountability did not work then, how can it be assured it would work now? The continued unexplained delays in replacing the admittedly inadequate system illustrate even more strongly that corrective measures are called for.

Turnover at the top

While not an excuse for any of these events or incidents, we note that over the course of when they occurred the Chief Deputy leading the Corrections Bureau changed twice, first in late 2018, and again in spring 2020.[13] [27] [28]

Staffing Issues

The SO's senior leadership believes that more staffing is most needed to improve performance and safety.[13] [27] [28] [42] For the past several years the Corrections Bureau has operated with the minimal staffing thought to be necessary, and mandatory overtime to staff each shift has been more the rule than an exception.[69]

The Main Jail day shift includes the Watch Commander (a sergeant), two Senior Corrections Officers (SCO) for housing and booking, and thirteen COs assigned to specific posts in the facility. The night shift has the same number of senior people as working on days, but with one less CO, as at night there is only one CO in the Control Room instead of two. Assignments for each shift are noted on a chart with the names of the CO assigned to each position on that shift. Beneath these levels is a "red line" below which are slots for three additional COs, but they are never filled.[26] A substitute is called in whenever a CO assigned to work one of the slots calls in sick, is injured, or otherwise is unable to work. Normally COs get three days off for every three 12-hour shifts they work. Often this results in filling the shift roster with COs being required to

work mandatory overtime. As a consequence it is not uncommon for COs to put in five, and even six shifts per week.[13] [17]

The work is both stressful and exhausting. COs are responsible for filling out reports and other paperwork that document their activities. The COs assigned to housing units supervise them from a control booth outside the locked units. But COs are constantly going in and out of the units like yo-yos. Their duties include mandatory hourly safety checks, serving three meals per day, collecting dirty laundry and distributing clean laundry, distributing and collecting grooming supplies, distributing commissary items purchased by inmates, dealing with requests by individual inmates, supervising inmate movements in and out of the housing units, supervising open time, assuring that inmates are in their assigned cells when it's time for "lock down," and often responding to calls for assistance from other COs when needed. Intake, booking, and release COs deal with all movement in and out of the facility including new bookings, releases, and inmates being processed in and out for court appearances, as well as assisting COs in the various housing areas as needed. When the CO assigned to a specific area is not at the control booth he/she will not hear a call from an inmate's in-cell intercom.[17]

Employee turnover among COs is frequent. Many COs see their employment as a stepping stone to law enforcement, and will leave if they are able to switch into the SO's Operations Bureau or another agency.[33] [42] Further, the pay scale for beginning COs in Santa Cruz County is at the lower end of pay scales in neighboring counties. It is $579 less per month than in Monterey County and $1240 per month less than in Santa Clara County (see Appendix C). Many COs have long commutes to work in the Main Jail. Few, if any, can afford to live in close proximity given the extraordinary cost of housing in most of Santa Cruz County, and a good number of COs live "over the hill" or beyond into the Central Valley where affordable housing is in greater supply.[33] [42]

Management has lauded the dedication and competence of the COs. Yet low morale, burn-out, and employee retention are both persistent and problematic.[17] [42]

Budget and Board of Supervisors' Oversight

Budget

The budget for the Sheriff's Department is reviewed annually by the BoS. In June 2020 county budget reviews were conducted; the adopted budget detail may be found in the "The County of Santa Cruz Adopted Budget | Fiscal Year 2020-21."[70] In particular, the Sheriff's budget was reviewed on June 23, 2020 as item no. 52.[71] The Board Letter, which introduced the proposed Sheriff's budget, stated that:

> *Over the next year, the department will be focused primarily on public safety and the community we serve as well as providing care and resources for the population in our correctional facilities.*[72]

An examination of the specifics of the Corrections Bureau budget, found on pages 236-238 of the County budget document, shows the following:

- The 2020-21 Corrections Bureau budget is increased approximately $2.2M over the 2019-20 budget.
- Salary and benefits increases account for all of this increase.
- Total staffing equals 151 positions, 11 positions remain unfunded.[73]

The total staffing (151) does not mean that there are 151 people available to work. The number of people able to work is reduced by the number of unfilled positions due to resignations, terminations, and retirement, or people unavailable to work due to illness, injury or vacation. What is apparent is that for many years the Main Jail has operated with the fewest possible number of people on the job each day, and then only by requiring COs to put in mandatory overtime to the extent that it has had a negative effect on both morale and performance. Poor morale and overworked, tired workers lead to mistakes.

The Grand Jury is aware that there are many competing interests for limited county resources. Both the COVID-19 pandemic and the CZU Lightning Complex Fire imposed unprecedented and unforeseen pressure on those resources. However, we note that the county is currently defending three civil actions related to events in the jail at a substantial cost to the County. Might these resources be better spent on prevention, i.e., on adequate staffing?

Board of Supervisors' Oversight

The BoS is ultimately responsible for setting the county budget and overseeing how public funds are spent, including if they are spent properly, wisely, and are sufficient for doing whatever needs to be done. Historically the BoS receives information regarding events, issues, and needs of the SO's Corrections Bureau through various sources. They include informal one-on-one communications with the Sheriff, articles appearing in the local press, or what individual supervisors may read or be told by others. When serious events occur, the Sheriff may call individual supervisors, and if necessary, appear before the BoS in closed session. But there is no formal structure or transparency by which the BoS is timely and regularly kept informed about the Corrections Bureau.[42] [74] [75] [76] [77]

As a result, all the public ever knows is what appears on line, in the local press or on the local news. Stories concerning the Corrections Bureau make the news almost exclusively when bad things happen in the jail, of which there have been far too many.

In fact, the only established recurring process or communication concerning the operation of the Corrections Bureau occurs when it is time to address budgeting. The process involves the Sheriff interacting with the County Administrative Officer concerning the budgetary needs of the SO including its Corrections Bureau. The Sheriff will make a written and/or oral presentation to the BoS when the SO's budget is on the agenda. When special circumstances have warranted it, the Sheriff has gone to the board and requested and obtained special allocations.[42] One example is the approximately $1.5M allocated in February 2020 to replace the defective and outmoded emergency backup generators by late 2021.[12] The money's there, but it will be another

year and a half before the Main Jail has adequate backup power capacity to run essential systems.[17] [42] This illustrates why ad-hoc, informal communications cannot provide the oversight and transparency that could and would make for better, more efficient, and less costly operations.

Grand Jury Oversight

It might be argued that an oversight board is not needed because of the Grand Jury. California law mandates that every county in the state impanel a Civil Grand Jury each year. Each year, the County Superior Court convenes a Civil Grand Jury of 19 jurors with a term of one year. Like most juries, grand jurors are individual citizens who volunteer their time and energies. Their responsibilities include examining resident complaints, inquiring into the "public prisons in the county," and conducting investigations and producing reports on topics they select intended to improve the operations of a wide range of local governmental boards, agencies and departments.[78]

The Grand Jury's oversight broadly encompasses every aspect of local government, including county, city, education, and other aspects of local concern. On the other hand a Sheriff Oversight Board or an Inspector General will develop an ongoing and in-depth understanding of the SO's entire operations including corrections, financial needs, funding opportunities, and state requirements.

The Case for a Sheriff Oversight Board or Inspector General, as Provided in Assembly Bill 1185 (Government Code § 25303.7)

Assembly Bill No.1185, which added § 25303.7 to the Government Code, was enacted and signed by Governor Newsom on September 30, 2020, and became effective January 1, 2021. It allows the board of supervisors in each of California's 58 counties to establish either an appointed "sheriff oversight board" or "inspector general" to assist the board of supervisors in its duty to supervise the conduct of county sheriffs. The law specifically states that such oversight shall not obstruct the "independent prosecutorial functions of the sheriff and district attorney." Nor does the law limit the board's budgetary authority over the sheriff.[79] Appendix D has the full text.

The statute makes no provision regarding compensating a sheriff oversight board or inspector general. The BoS can appoint citizens willing to volunteer their time or it can establish compensation as it does for any board-appointed advisory board or commission. There is no requirement that costs associated with an oversight board or inspector general come out of the sheriff's budget.

Even before AB 1185 was enacted, the counties of Orange, Los Angeles, Sacramento, Sonoma, and Santa Clara each had adopted provisions creating independent bodies to monitor county corrections and law enforcement functions. Since AB 1185 was signed into law, San Francisco County's voters adopted it, and Santa Clara, Sonoma, and Los Angeles Counties amended their respective ordinances to give their oversight board subpoena power as authorized in Government Code § 25303.7.[80]

An oversight board or an inspector general would have similar investigatory powers as does the Grand Jury but with both significant differences and additional advantages:

- It would not cease to exist, and need to start fresh each year with a new group of citizens.
- It could act as an advocate for the Sheriff's needs for resources before the Board of Supervisors.
- It could issue periodic reports calling attention to issues of public interest concerning the operation of the Sheriff's Office including its Corrections Bureau.
- It would provide the public with greater transparency of the operations of the Sheriff's Office, which every year consumes the single largest slice of all local and state taxes expended by the county.[81]
- In the end it will save money because oversight will bring about more efficiency, improved morale and working conditions, and reduce human error.

Conclusion

Based on everything learned in this investigation we believe that it is critically important that everything be done to assure the health and safety of jail staff and inmates alike, and to go the extra mile to compensate for the reported structural deficiencies of the Main Jail. This paramount need includes the SO and the General Services Department making every effort to prioritize maintaining the necessary equipment and systems and upgrading them when necessary as expeditiously as possible. This need includes assuring that the Correction's Policy Manual is current, and that necessary amendments be adopted to better control inmates' access to potentially dangerous items. This need includes providing the Corrections Bureau with sufficient personnel to both fully staff the facility and reduce the dependence on mandatory overtime that is detrimental to both morale and efficiency.

Last, but certainly not least, we believe that it is essential and in the public interest to improve oversight by adoption of a Sheriffs Oversight Board or Inspector General as authorized by Government Code § 25303.7. The Grand Jury strongly recommends that the issue be brought up before the Board of Supervisors. If the Board won't adopt it, put it on the ballot and let the voters decide.

Findings

F1. The Board of Supervisors has failed to assert and exercise proper oversight within their purview of the Main jail.

F2. Adoption of a Sheriffs Oversight Board or Inspector General under Government Code § 25303.7 will provide necessary public transparency and structure to support the Board of Supervisors' supervision of the Sheriff's Office Corrections Bureau.

F3. Adoption of a Sheriffs Oversight Board or Inspector General under Government Code § 25303.7 will provide an effective advocate before the Board of Supervisors and the public regarding the Sheriff's needs.

F4. The Correction's Policy Manual must provide timely, comprehensive, applicable, and consistent guidelines for jail operations that serve to assure the safety of inmates and staff.

F5. The policies in the Correction's Policy Manual regarding razors do not sufficiently assure that razors cannot be used by inmates to harm themselves or others.

F6. Events of violence and death in the Main Jail contrast negatively with the Sheriff's Office mission, visions, and goals.

F7. Old and outdated equipment and systems in the Main Jail are detrimental to safe, efficient, and effective management of the facility.

F8. Long delays in replacing the backup power generators put staff and inmates at risk in the event of a power failure.

F9. Limited staffing and requiring mandatory overtime of Correction Officers at the Main Jail are detrimental to performance, staff morale, and contribute to human error which can threaten the health and safety of staff and inmates.

Recommendations

R1. Within six months the Board of Supervisors should either establish a Sheriff Oversight Board or Inspector General as provided in Government Code § 25303.7, or alternatively place the issue before the voters in the county. (F1–F9)

R2. Within six months the Board of Supervisors should agendize and open for public comment issues raised by Government Code § 25303.7. (F1–F9)

R3. Within six months the Sheriff should propose for the Board of Supervisors' review and approval an increase in Correction Officer staffing and associated budget to reduce the need for mandatory overtime and to sufficiently staff the Main Jail. (F1, F9)

R4. Within six months the Sheriff should amend the Correction's Policy Manual to remove inapplicable provisions and to add provisions relating to razors that more effectively limit and control the conditions of their use by inmates. (F4, F5)

R5. Within three months the Sheriff's Office and the General Services Department should establish formal protocols for regular monthly meetings to review the status of all correctional facilities, including providing estimates of completion for any repairs and/or replacements that are outstanding, and prioritizing items that directly affect the health and safety of inmates and/or staff. Such meetings should be documented and open to inspection by the County Administrative Officer and the Board of Supervisors. (F7, F8)

R6. Within 60 days the Sheriff's Office and the General Services Department should provide a written report to the Board of Supervisors and the Chief Administrative Officer providing both the specifications for, and a timeline for completion of each stage of the project to replace and/or repair the backup emergency power system, and thereafter update such report every thirty days until such project is completed. (F7, F8)

Commendations

C1. The Grand Jury commends the Sheriff, the Sheriff's Office, and the Chief Deputy of the Corrections Bureau for their aggressive, efficient, and entirely successful actions that prevented any outbreak of COVID-19 in the inmate population.

C2. The Grand Jury commends the Sheriff, the Sheriff's Office and the Chief Deputy of the Corrections Bureau for adopting innovative programs designed to promote reentry and reduce recidivism.

C3. The Grand Jury commends the Sheriff, the Sheriff's Office and the Chief Deputy of the Corrections Bureau for fully cooperating with our investigation and providing requested documents and information.

Required Responses

Respondent	***Findings***	***Recommendations***	***Respond Within/ Respond By***
Santa Cruz County Board of Supervisors	F1–F3	R1–R3	90 Days September 15, 2021
Santa Cruz County Sheriff	F1, F3–F9	R3–R6	60 Days August 16, 2021

Invited Responses

Respondent	***Findings***	***Recommendations***	***Respond Within/ Respond By***
Director, General Services Department	F7, F8	R5, R6	90 Days September 15, 2021

Definitions

- **24/7:** 24 hours/day, 7 days/week, without interruption
- **AB 109:** Assembly Bill 109, enacted 2011, "Public Safety Realignment Act"
- **AB 1185:** Assembly Bill 1185, effective Jan. 1, 2021 (Government Code § 25303.7)
- **Blaine Street**: Medium security women's facility
- **BoS:** Santa Cruz County Board of Supervisors
- **BSCC:** California Board of State and Community Corrections
- **BWC:** Body Worn Camera
- **CO:** Santa Cruz County Corrections Officer
- **CPM:** Correction's Policy Manual issued by Santa Cruz Sheriff
- **DTB:** Daily Training Bulletins issued by the SO's Correction Bureau

- **GSD:** General Services Department
- **Main Jail:** Water Street Maximum Security Correctional Facility
- **OPM:** Office Policy Manual issued by Santa Cruz Sheriff
- **PREA:** Prison Rape Elimination Act of 2003, 42 U.S.C. ch. 147 § 15601 et seq., made applicable in California in 2005 by Penal Code § 2635 et.seq.
- **Rountree**: Rountree medium security men's facility and its adjacent Rehabilitation and Release Unit.
- **RN:** Registered Nurse
- **SO:** Santa Cruz County Sheriff's Office
- **TO:** Training Officer

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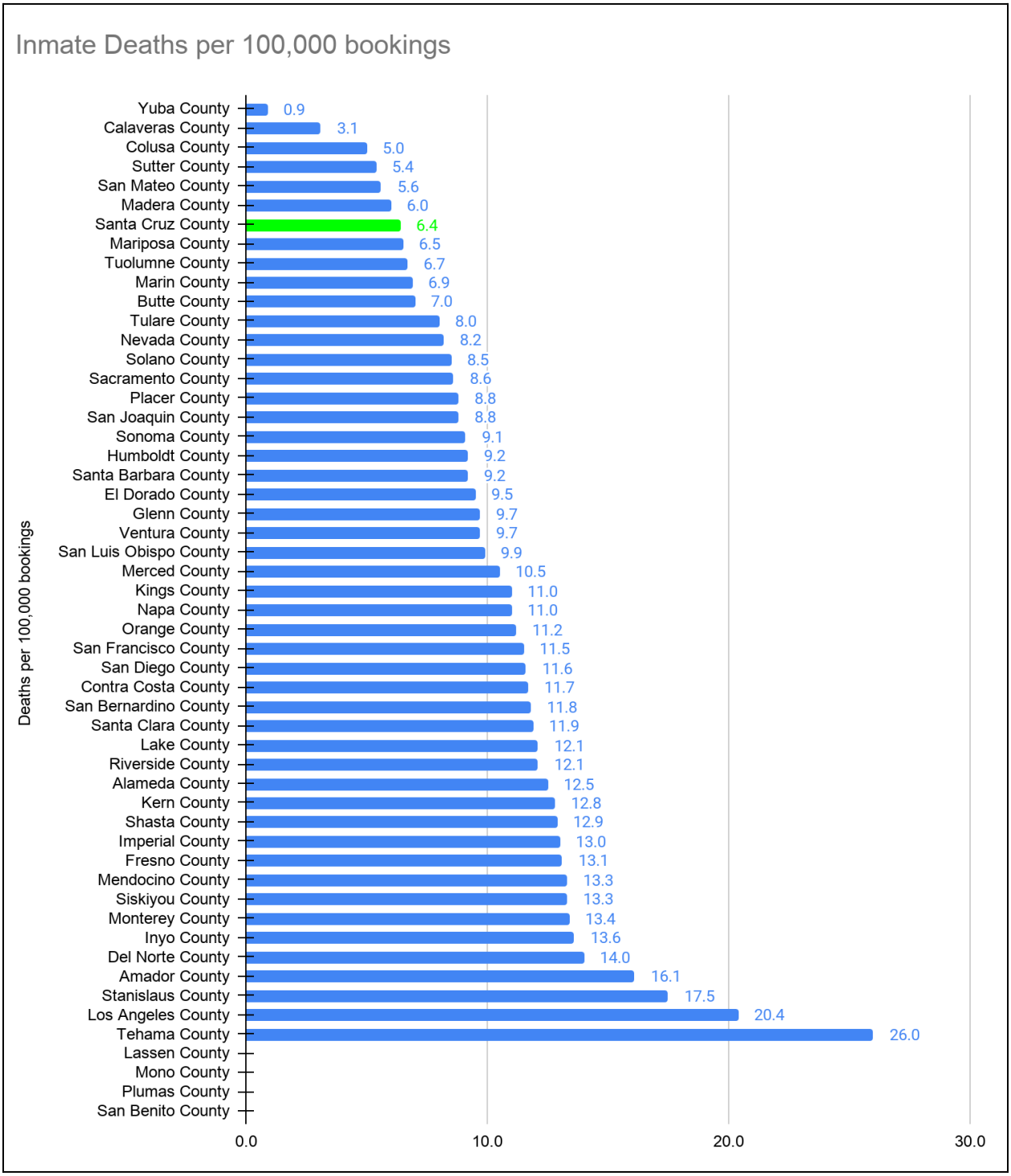
Appendix A – Jail Inspections

Penal Code § 919(b) charges the Grand Jury each year to inquire into the condition and management of the”prisons within the county.” Due to the COVID19 pandemic the 2020-2021 Grand Jury did not begin its service until October 1, 2020, three months later than normal. As such this year’s Grand Jury has had only nine months to complete its work. Further, COVID19 vaccinations did not become available until late this past winter.

Members of the Grand Jury were able to tour the Main Jail and the adjacent Blaine Street Women's facility on March 26, 2021, the Rountree facility on April 2, 2021, and the Juvenile Detention facility operated by the county’s Probation Office on April 23, 2021. Due to time constraints this report is focused on events, conditions, and management of the Main Jail.

The Grand Jury notes that jurors were favorably impressed by the Blaine Street facility and the Rountree facility and its Rehabilitation and Release program. Jurors also note that their tour of the Juvenile Detention facility was informative and thorough, and it appeared that staff was attentive and caring to the wards under their supervision.

Appendix B – Comparative Statistics
Deaths in California County Jails, 2005-2019[82]



Appendix C – Comparative Salaries for Correction Officers

A brief online survey of available positions in each county revealed the following entry-to-top monthly base pay for Sheriff's Correctional Officers in Santa Cruz, Santa Clara, San Mateo, and Monterey Counties:

County	Low ($)	High ($)
Santa Cruz[83]	5845	7817
Santa Clara[84]	7085	8612
San Mateo[85]	6885	8608
Monterey[86]	6424	8744

Appendix D – Text of Government Code § 25303.7[87]

25303.7. (a) (1) A county may create a sheriff oversight board, either by action of the board of supervisors or through a vote of county residents, comprised of civilians to assist the board of supervisors with its duties required pursuant to Section 25303 that relate to the sheriff.

(2) The members of the sheriff oversight board shall be appointed by the board of supervisors. The board of supervisors shall designate one member to serve as the chairperson of the board.

(b) (1) The chair of the sheriff oversight board shall issue a subpoena or subpoena duces tecum in accordance with Sections 1985 to 1985.4, inclusive, of the Code of Civil Procedure whenever the board deems it necessary or important to examine the following:

(A) Any person as a witness upon any subject matter within the jurisdiction of the board.

(B) Any officer of the county in relation to the discharge of their official duties on behalf of the sheriff's department.

(C) Any books, papers, or documents in the possession of or under the control of a person or officer relating to the affairs of the sheriff's department.

(2) A subpoena shall be served in accordance with Sections 1987 and 1988 of the Code of Civil Procedure.

(3) (A) If a witness fails to attend, or in the case of a subpoena duces tecum, if an item is not produced as set forth therein, the chair or the chair authorized deputy issuing the subpoena upon proof of service thereof may certify the facts to the superior court in the county of the board.

(B) The court shall thereupon issue an order directing the person to appear before the court and show cause why they should not be ordered to comply with the subpoena. The order and a copy of the certified statement shall be served on the person and the court shall have jurisdiction of the matter.

(C) The same proceedings shall be had, the same penalties imposed, and the person charged may purge themself of the contempt in the same way as in a case of a person who has committed a contempt in the trial of a civil action before a superior court.

(c) (1) A county, through action of the board of supervisors or vote by county residents, may establish an office of the inspector general, appointed by the board of supervisors, to assist the board of supervisors with its duties required pursuant to Section 25303 that relate to the sheriff.

(2) The inspector general shall have the independent authority to issue a subpoena or subpoena duces tecum subject to the procedure provided in subdivision (b).

(d) The exercise of powers under this section or other investigative functions performed by a board of supervisors, sheriff oversight board, or inspector general vested with oversight responsibility for the sheriff shall not be considered to obstruct the investigative functions of the sheriff.