



**ALAMEDA COUNTY'S
MENTAL HEALTH SYSTEM**

**OAKLAND'S USE OF
FORM 700**

**ELECTION INTEGRITY
IN ALAMEDA COUNTY**

**PROBATE
CONSERVATORSHIPS**

SANTA RITA JAIL

**CAMP SWEENEY
INSPECTION**

**FREMONT JAIL
INSPECTION**

**INDEPENDENT
OVERSIGHT OF BART**

**FIRE INSPECTIONS
IN OAKLAND**

**OAKLAND'S PLANNING &
BUILDING DEPARTMENT**

STUDENT HOMELESSNESS

**2021-2022
Alameda County Grand Jury
Final Report**

[This page intentionally left blank.]

2021-2022 Alameda County Grand Jury Final Report



Rene C. Davidson Courthouse and Lakeside Building/Grand Jury, Oakland

ALAMEDA COUNTY BOARD OF SUPERVISORS

District One	David Haubert
District Two	Richard Valle
District Three	David Brown
District Four	Nate Miley, <i>Vice President</i>
District Five	Keith Carson, <i>President</i>

ALAMEDA COUNTY GRAND JURY

1401 Lakeside Drive, Suite 1104
Oakland, California 94612
(510) 272-6259 | grandjury@acgov.org
www.acgov.org/grandjury



CIVIL GRAND JURY RESOLUTION RECOGNIZING ROB WARREN

WHEREAS, The Alameda County Civil Grand Jury wishes to recognize the life’s work of Rob Warren; and

WHEREAS, Rob Warren was an Alameda County Assistant District Attorney, serving as Advisor to the Grand Jury for much of his career; and

WHEREAS, The Grand Jury believes that Rob Warren demonstrated his passion and commitment to civic engagement to our communities; and

WHEREAS, The Grand Jury saw firsthand Rob Warren’s deep dedication to the law; and

WHEREAS, The Grand Jury experienced Rob Warren’s guidance and mentorship; and

WHEREAS, Rob Warren demonstrated his humility, great sense of humor, and compassion to the Grand Jury; and

NOW, BE IT RESOLVED that the Alameda County Civil Grand Jury thanks Rob Warren for the many years he guided the Grand Jury; and

BE IT FURTHER RESOLVED that Rob Warren’s contributions to the Grand Jury, the people of Alameda County and the District Attorney’s Office be commended by all; and

BE IT FURTHER RESOLVED that the role Rob Warren played as a public servant be celebrated and honored for the talent, compassion, and dedication he demonstrated.

ADOPTED ON THIS DAY: June 6, 2022, by the Alameda County Civil Grand Jury 2021-22

SIGNED: 

FOREPERSON

Table of Contents

Alameda County Board of Supervisors	3
In Memoriam	4
Grand Jury Foreperson’s Letter	6
Grand Jury Members	8
Grand Jury Officers, Legal Advisors, and Presiding Judges of the Superior Court	9
Grand Jury Committee Assignments	10
Grand Jury Photographs	11
Alameda County Mental Health System Too Complex to Navigate	13
Oakland Fails to Enforce Financial Disclosure Rules to Protect the Public	33
Alameda County Voters Can Count on Election Integrity	47
Probate Conservatorship Cries Out for Reform	53
Wide-Ranging Safety and Health Care Issues at Santa Rita Jail	77
Camp Wilmont Sweeney Inspection	113
Fremont Police Department Detention Facility Inspection	121
BART Is on the Wrong Track with Independent Oversight	125
Lack of Fire Inspections in Oakland Creates Unnecessary Risks	135
Management Failures at Planning and Building Department Cost Oakland Millions	149
Homeless Students Need More Help	163
About the Grand Jury	177
Citizen Complaint Guidelines	180
How to Respond to Findings and Recommendations	182

*Cover photo and photo on pg. 3 courtesy of juror David Sarber.
 Photos on pgs. 120, 134 & 176 courtesy of juror Jonathan Cohen.
 Photos on pgs. 7, 12 & 148 courtesy of grand jury staff.
 All jail photos taken by the Grand Jury.*



Alameda County
Grand Jury

1401 Lakeside Drive
Suite 1104
Oakland, California 94612

510.272.6259
fax 510.465.9647
www.acgov.org/grandjury

Hon. Charles A. Smiley, Presiding Judge
Alameda County Superior Court
1225 Fallon Street, Department One
Oakland, California 94512

Dear Judge Smiley,

The 2021-2022 Alameda County Civil Grand Jury is pleased to present a final report to the Superior Court and the people of Alameda County.

There was nothing ordinary about this year's Grand Jury experience. When we took the oath to serve, we wouldn't have anticipated several unprecedented challenges, including the departure of two jurors, the inclusion of an alternate juror, a transition in presiding judges, and working with three legal advisors. In addition, we faced the tragic loss of a colleague and partner, Assistant District Attorney Rob Warren. I can never express the pain I felt when I learned of Rob's passing, and his presence was missed throughout our term.

As a full panel, Grand Jury members never had the opportunity to meet in person, yet we continued to fulfill our charter. The Grand Jury investigated the operations of various officers, departments, and agencies in Alameda County. Members also participated in the local Logic and Accuracy Board to view the transparency of the voting process. The Grand Jury interviewed over 150 witnesses, reviewed tens of thousands of documents, and deliberated countless hours, rarely taking a day off. As civic-minded citizens, we worked together for a one-year period focusing on local governmental entities and the conduct of public officials, which resulted in over 65 findings and nearly 100 recommendations for improvements. We conducted 11 investigations and jail inspections that represent a broad range of entities, and their reports provide a glimpse into some of the work we performed.

I am grateful for the opportunity to serve as a change agent who relied on life experiences, dedication, and willingness to devote my time and energy to these matters of importance, and I look forward to hearing feedback from citizens on this final report.

Respectfully,

A handwritten signature in blue ink, appearing to read "Randolph E. Pico".

Randolph E. Pico
Foreperson
2021 – 2022 Alameda County Civil Grand Jury



Rene C. Davidson Superior Court, Oakland, CA

2021-2022 Alameda County Grand Jury Member Roster

Name	City
Rodger P. Allen	Hayward
Martha C. Benco	Oakland
Subrahmanya Y. Bhat	Union City
Michael R. Bracco	Oakland
Mary Margaret Bush	Oakland
Jonathan W. Cohen	Berkeley
John R. Eichel	Alameda
Diane Lewis^	San Leandro
Thomas E. Lorentzen	Castro Valley
Jo A.S. Loss**	Castro Valley
John A. Mangini	Piedmont
Rhonda Phillips	Oakland
Randolph E. Pico*	Livermore
Carole Salerno*	Pleasanton
David Sarber	Oakland
Paul Schwartz	Oakland
Sandra Smith^^	Oakland
Geoffrey Sylvester	Alameda
Charles L. Yu	Oakland
Mary Louise Zernicke	Berkeley

^ Withdrew October 2021

** Alternate Juror Seated October 2021

* Jurors held over for a 2nd term by Presiding Judge Tara Desautels

^^ Dismissed December 2021

**2021-2022 Alameda County Grand Jury
Officers and Legal Staff**



OFFICERS

Foreperson:	Randolph E. Pico
Foreperson Pro Tem:	Martha C. Benco
Secretary:	Michael R. Bracco
Secretary Pro Tem:	John R. Eichel
Sergeant at Arms:	Rodger P. Allen
Sergeant at Arms Pro Tem:	John A. Mangini

LEGAL ADVISORS

Alameda County District Attorney's Office
&
Alameda County Counsel's Office

PRESIDING JUDGES OF THE SUPERIOR COURT

Honorable Tara M. Desautels
November 19, 2019 – December 31, 2021

&

Honorable Charles A. Smiley
January 1, 2022 – Present

2021-2022 Alameda County Grand Jury Committee Assignments

GOVERNMENT

Geoffrey Sylvester - Chair
Subrahmanya Bhat
Michael R. Bracco
Mary Margaret Bush
Jonathan W. Cohen - *Chair Pro Tem*
Jo A.S. Loss
John A. Mangini - *Secretary Pro Tem*
Carole Salerno
David Sarber - *Secretary*

LAW & JUSTICE

Carole Salerno - Chair
Rodger P. Allen - *Secretary Pro Tem*
Martha C. Benco - *Secretary*
Subrahmanya Bhat
Michael R. Bracco
Jo A.S. Loss
John A. Mangini
David Sarber - *Chair Pro Tem*
Geoffrey Sylvester

HEALTH & SOCIAL SERVICES

Thomas E. Lorentzen - Chair
Martha C. Benco
Mary Margaret Bush - *Secretary Pro Tem*
John R. Eichel - *Secretary*
Rhonda Phillips
Paul Schwartz
Charles L. Yu - *Chair Pro Tem*
Mary Louise Zernicke

EDUCATION & ADMINISTRATION

Mary Louise Zernicke - Chair
Rodger P. Allen
Jonathan W. Cohen
John R. Eichel - *Secretary*
Thomas E. Lorentzen - *Chair Pro Tem*
Rhonda Phillips
Paul Schwartz
Charles L. Yu - *Secretary Pro Tem*

AD HOC COMMITTEE

Randolph E. Pico - Chair
Subrahmanya Bhat
Mary Margaret Bush
John A. Mangini
Carole Salerno
Paul Schwartz

EDIT COMMITTEE

John R. Eichel
John A. Mangini

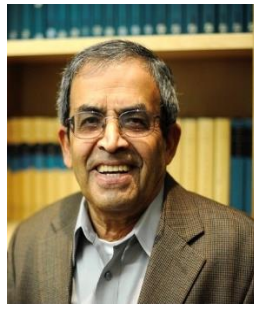
2021-2022 Alameda County Grand Jury Members



Rodger
Allen



Martha
Benco



Subrahmanya
Bhat



Michael
Bracco



Mary Margaret
Bush



Jonathan
Cohen



John
Eichel



Thomas
Lorentzen



Jo A.S.
Loss



John
Mangini



Rhonda
Phillips



Randolph
Pico



Carole
Salerno



David
Sarber



Paul
Schwartz



Geoffrey
Sylvester



Charles
Yu



Mary Louise
Zernicke



Ballena Bay Boat Harbor, Alameda, CA

ALAMEDA COUNTY MENTAL HEALTH SYSTEM TOO COMPLEX TO NAVIGATE

EXECUTIVE SUMMARY

The mental health system is supposed to provide a safety net for the thousands of homeless and near-homeless residents of Alameda County who struggle with serious mental illnesses. The current approach is missing the mark. Alameda County residents witness daily the inadequacies of our mental health system. The Grand Jury investigated the challenges faced by adult homeless and near-homeless people and their families as they try to navigate the mental health system to obtain care. Those in need of assistance complained that the system is fragmented and unresponsive. The Grand Jury found that the system is complex and difficult to navigate.

Alameda County's Behavioral Health Care Services department (ACBH) and a dedicated group of agencies and individuals struggle to offer seamless and holistic community care. With a budget of more half a billion dollars annually, ACBH is the center of care for mental health support for low-income residents of Alameda County. Within that budget, California Proposition 63 (Prop. 63), also known as the Mental Health Services Act (MHSA), provides around \$100 million annually to augment and enhance community-based care for the mentally ill through ACBH.

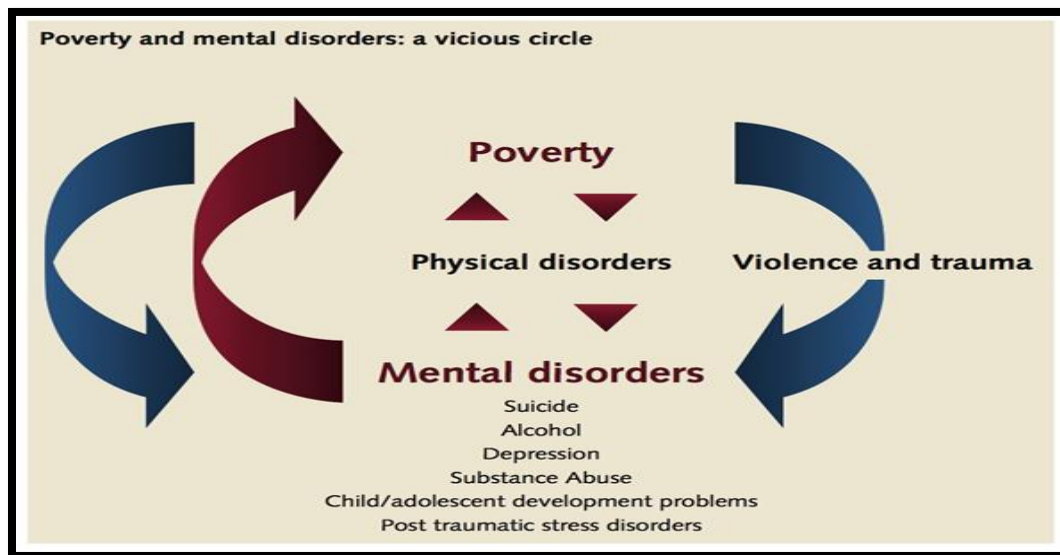
More needs to be done. The Grand Jury found that entry to the system needs to be streamlined, communication between ACBH and service providers must be improved, and technology should be updated to improve mental health services and tracking. Most importantly, the Grand Jury is recommending that ACBH conduct a county-wide needs and gaps in services assessment to ensure that funds are directed to services and service providers in the most beneficial and cost-effective way.



BACKGROUND

The Grand Jury investigated the intersection of two of Alameda County’s most serious social problems: 1) mental illness, particularly the stabilization and treatment of adults with severe mental illness (SMI, defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities) and 2) homelessness and near-homelessness among adults. Tragically, too many homeless adults with SMI, either on the brink of a mental health crisis or in crisis, populate Alameda County’s streets and open spaces. Homelessness among adults is frequently the result of SMI, as well as substance abuse. Those health issues, among other key factors, can lead to poverty, a direct cause of homelessness. And homelessness makes finding, stabilizing, and treating adults with SMI much more difficult. It’s a vicious cycle.

The Grand Jury focused its investigation more on SMI support, stabilization, and treatment than homelessness, but it’s important to acknowledge up front how interrelated the two issues are. The following chart illustrates this relationship, with poverty serving as a proxy for homelessness.



Locating, Stabilizing, and Treating Homeless Adults with Severe Mental Illness in Alameda County

Though homeless individuals with SMI are clearly visible by observation and through witness testimony, the Grand Jury found it difficult to find good data on the scope of the issues of locating, stabilizing, and treating homeless adults with SMI in Alameda County, which is part of the problem in itself. Therefore, the Grand Jury had to rely on broader California data to help illustrate the scope of this issue.

Estimates on the percentage of homeless adults in California who have SMI range from about 30% to over 75%. Many of the homeless with SMI end up cycling in and out of emergency rooms and jails; close to a third of California jail inmates have a documented mental illness. Most researchers agree that the connection between homelessness and SMI is a complicated, two-way relationship. Homelessness can exacerbate an existing mental illness, and individuals with SMI may find themselves homeless, primarily due to lack of income and housing. Rates of contact with the criminal justice system are higher among unhoused SMI, and SMI individuals are more likely to be the victim of a crime. (bbrfoundation.org)

A Brief History of Alameda County’s Current Mental Health System

California began to reform its mental health care system starting in the 1950s. But, prior to 1967, Alameda County’s mental health system looked very different than it does now. Many more individuals with SMI lived in state hospitals and large facilities, often for long periods of their lives. Then California passed the Lanterman-Petris-Short (LPS) Act. The LPS Act sought to, “end the inappropriate, indefinite, and involuntary commitment of persons with mental health disorders.” The Act in effect ended all hospital commitments by the judiciary system, except in the case of criminal sentencing, *e.g.*, convicted sexual offenders, and those who were "gravely disabled", defined as unable to obtain food, clothing, or housing. It did not, however, impede the right of voluntary commitments. It expanded the evaluative power of psychiatrists and created provisions and criteria for psychiatric holds (5150s).

Most mental health services are now delivered within the community by what are known as community-based organizations (CBOs).

Since the passage of the Act, there have been major changes in how mental health support has been provided in California, including Alameda County, and currently few people with SMI are involuntarily institutionalized. Most mental health services are now delivered within the community by what are known as community-based organizations (CBOs).

Also, in 1999, the U.S. Supreme Court held in *Olmstead v. L.C.* that unjustified segregation of persons with disabilities constitutes discrimination in violation of Title II of the Americans with Disabilities Act (ADA). The Court held that public entities must provide community-based services to persons with disabilities when 1) such services are appropriate, 2) the affected persons do not oppose community-based treatment, and 3) community-based services can be reasonably accommodated.

Licensed board and cares, including Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs), have long served as important housing options for SMI, disabled, and aging populations by providing safe residences when other housing options are

The core continuum of care for mental health includes a variety of services with different levels of intensity that should be available and easily accessible to all individuals. ACBH supports “upstream” behavioral health services—it considers the social, economic, and environmental origins of health problems that manifest at the population level, not just the “downstream” symptoms or end effects that manifest at the individual level.

The core continuum of care includes:

- Prevention and wellness services.
- Outpatient services.
- Peer and recovery services delivered in the community.
- Community supports, including flexible services designed to enable individuals to remain in their homes and participate in their communities, such as supportive housing, case management, supported employment, and supported education.
- Residential treatment provided on a short-term basis to divert individuals from or as a step-down from intensive services.
- Crisis services such as call centers, mobile crisis services, and crisis residential services.
- Intensive treatment services that are provided in structured, facility-based settings to individuals who require 24-hour/7-days-per-week care, including inpatient psychiatric treatment and clinically managed inpatient services.

Acute Crisis Care Evaluation for System-wide Service (ACCESS) - the Designated Entry Point for ACBH Services

ACCESS is the system-wide point of contact for information, screening, and referrals for mental health and substance use services and treatment for Alameda County residents. The ACCESS line (800-491-9099) is a state requirement, dating from when county behavioral health departments became carve-out mental health plans in the 1990s. The intent of ACCESS is a one-stop entry point, with “no wrong door,” that can provide services using a person-centered approach, reducing, in theory, the number of barriers for accessing services. A centralized team is responsible for linking beneficiaries to appropriate, medically necessary services. ACCESS is a portal telephone service staffed during the day by licensed clinical social workers (LCSWs), who determine eligibility for specialty mental health services after screening for symptomology and program qualifications, including verification of health plan eligibility. Referrals are based on clinical need and provider availability.

ACCESS is the system-wide point of contact for information, screening, and referrals for mental health and substance use services and treatment for Alameda County residents. The ACCESS line is 800-491-9099.

The ACCESS line is not staffed by a live person after 5 p.m. on Mondays through Fridays or on weekends. Although there is a phone line answered by a local mental health provider during hours when ACCESS is not staffed, emergency mental health intervention or referral services for low-income seriously mentally ill individuals are not offered 24-7. There is no crisis referral line or alternative to jail or 5150 holds for immediate care for the seriously mentally ill when ACCESS is closed.

The substance abuse line is not staffed by a live person after 9 p.m. There is no place for law enforcement or others to call for mental health referral support during evening hours, so psychiatric emergency services or jail become the only option for law enforcement by default. To obtain care, the client needs to be on the line unless they are experiencing an active psychotic episode. To be called back, a client must have phone access, which can be problematic for someone homeless. ACBH's website is rich in some information but difficult to navigate. After-hours calls are answered by Crisis Support Services of Alameda County, which offers phone support from non-professional crisis counselors. ACCESS is not a crisis line; **Alameda County's 24-7 crisis line is 800-273-8255.** (crisissupport.org)

Mental Health Services Act (MHSA) - Prop. 63

One key area of funding for ACBH is the MHSA, also known as Prop. 63. Prop. 63, passed in 2004, includes a 1% tax on individual incomes over \$1 million. At least 51% of the funds must be spent on community services and support for children and adults with or at risk of developing mental illness.

Services funded by MHSA must be voluntary. None of the funds are to be used for programs with existing fund allocations, unless it is for a new element or expansion in those existing programs.

Prop. 63 income has increased significantly since its passage. Alameda County received \$91 million in fiscal year (FY) 2020-2021, and \$97.6 million in FY 2021-2022; MHSA currently provides approximately 25% of the ACBH budget. In addition, there have been significant carryover funds (exclusive of a \$14.5 million reserve). Alameda County in recent years has left a significant amount of its MHSA funds unspent; excess funds are at risk of being returned to the state if they remain unspent for over three years. To accomplish its objectives, the MHSA applies a specific portion of its funds to each of six system-building components:

1. Community services and supports (CSS) (45%)
2. Prevention and early intervention (20%)
3. Community program planning and administration (10%)
4. Capital (buildings) and information technology (IT) (10%)
5. Education and training (human resources) (10%)
6. Innovation (5%)

A Community Program Planning Process is required every three years whereby the MHSA meaningfully engages its stakeholder community and creates a three year plan, with annual updates.

A Mental Health Advisory Board (MHAB) is mandated by Prop. 63. Roles of the Alameda County MHAB include education and advocacy, as well as review and evaluation of the county’s mental health system. Three-year plans and annual updates are developed by ACBH with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. (ACBH 2020-2023 Highlights)

The Courts, Alameda County, and Alameda County Behavioral Health Care Services

Behavioral Health Court (BHC)

BHC is a collaboration between the Alameda County Superior Court, the District Attorney’s Office, the Public Defender’s Office, and ACBH. Its mission is to promote public safety and assist SMI persons who commit non-violent crimes by diverting them away from the criminal justice system. Judges, lawyers, and mental health professionals work in partnership with the court’s client, aka “partner,” to develop a treatment plan for the “partner,” who has been charged with a non-violent crime. The program diverts those who qualify for the program out of Santa Rita Jail and into a one to two-year treatment program with an Alameda County-based mental health provider. The “partner” is closely monitored by the court, and upon successful completion of their treatment plan, the “partner’s” pending criminal case and associated arrest record are sealed.

The MHSA funds many of the treatment providers and the clinical team that staffs the BHC program. The lawyers and judges are funded by their respective departments.

Civil Rights Lawsuit

Alameda County has been the subject of a class action civil rights lawsuit, Babu v. Ahern and a Department of Justice inquiry into mental health conditions and services at Santa Rita jail. The parties agreed that Alameda County has violated the civil rights of people with SMI by failing to provide adequate care and allowing them to go into crises, ending up in the county jail, where violations of their rights occurred.

A Mental Health Advisory Board (MHAB) is mandated by Prop. 63. Roles of the Alameda County MHAB include education and advocacy, as well as review and evaluation of the county’s mental health system.

The Consent Decree from the Babu lawsuit has been approved and will impact how ACBH will provide services. Among its stipulations are that Alameda County provide evidence-based community-based services in the most integrated setting, implement a comprehensive crisis-response system, implement a sufficient number of full service partnership (FSP, a comprehensive and intensive mental health program for adults with severe and persistent mental illness) teams that can provide sufficiently intensive community services to those who need them, implement a sufficient quantity of scattered-site, permanent supported housing slots, implement peer support services, and implement sufficient community-based services, including case management.

As a result of the lawsuit, the Alameda County Board of Supervisors (BOS) has made a public commitment to a shift in priorities: from incarcerating those with mental illness to providing effective, evidence-based mental health treatment options for SMI individuals who are at risk of incarceration. The BOS adopted a “Care First, Jails Last” Resolution in 2021. The “Care First, Jails Last” Resolution includes behavioral health and wrap-around services that reduce the number of people with mental illness, substance use, and co-occurring disorders in Santa Rita Jail. The same resolution states there will be no net cost to the county.

INVESTIGATION

The Grand Jury received a complaint that there was inadequate community-based support for the seriously mentally ill in Alameda County and that services were fragmented and siloed. The complaint also stated that families of people with SMI were unable to find appropriate care for their loved ones.

The Grand Jury interviewed staff and board members of numerous local CBOs that provide a variety of mental health services to low-income Alameda County residents. The Grand Jury also interviewed several staff from ACBH, and members of the MHAB. Grand jurors attended MHAB meetings and met with the Alameda County Sheriff’s Office.

Many reports, written materials, and internet resources, were studied including but not limited to:

- MHSA three-year plans and annual updates,
- 2015 Crisis Report from Resource Development Associates for ACBH,
- MHAB annual reports and background materials,
- MHSA requests for proposal (RFPs),
- ACBH contracts,
- Alameda County annual budgets,
- Strategic Implementation Framework, Justice Involved Mental Health Taskforce,
- FY2021-2022 Medi-Cal Specialty Behavioral Health External Quality Review,

- Rapid Examination of Jail Diversion Strategies and Services 2020, Justice Involved Mental Health Taskforce, and
- Unrecognized and Underutilized Potential: BHC of Alameda County, Urban Strategies Council.

Additional Alameda County reports and background materials, foundations' and cities' mental health reports, and data available from the state were among other materials reviewed.

The Grand Jury acknowledges that the field of mental health services and support is undergoing changes from new state CalAIM requirements and as a result of the Babu case. The Grand Jury also wishes to acknowledge the committed and knowledgeable staff from local non-profits and government it found during the investigation. But the Grand Jury also found common areas of concern from a variety of sources that gave support to the initial complaint that the system of support for SMI people is not functioning well. The Grand Jury focused on areas of improvement over which ACBH has some control and that address the initial complaint.

Community Needs Assessments and Strategic Plans

The MHSA, which represents approximately 25% of total funding to ACBH, mandates the collection of outcome data for the programs it funds, primarily CSS and FSPs. That data includes:

- 7-day and 30-day hospital recidivism
- 7-day and 30-day follow-up care for hospital discharge
- 7-day and 30-day crisis stabilization unit recidivism
- 7-day and 30-day follow-up care for crisis stabilization discharge
- Housing status at admission and discharge
- Primary care utilization
- Reduction in incarceration days

However, there is not a recent broad-based, Alameda County mental health needs/gaps assessment that explores where in the county there are service needs, equity disparities, successful interventions, and that reviews current best practices and gaps in service availability, both inside MHSA and outside MHSA. One witness described funding choices by ACBH as “shooting in the dark.” The Grand Jury understands that a large-scale community needs assessment and strategic plan has not been completed since 2015, which was a crisis planning report completed by consultants *Resource Development Associates* for ACBH.

The Grand Jury reviewed many sources of information in addition to the annual MHSA reports, such as the External Quality Review, Alameda County Office of Homeless Care and

Coordination data and plans, various city agencies' reports and plans, Emergency Medical Services statistics, the Rapid Examination of Jail Diversion Strategies and Services Report, MHSA Integration Evaluation 2020-2021, and Santa Rita Jail data.

To summarize, Alameda County does not currently know if it is currently meeting the needs of its residents struggling with SMI.

Absence of Data

The lack of quality data integration and analysis was a concern for almost all witnesses, who came to this issue from a variety of perspectives. The Grand Jury agrees with this concern. The Grand Jury's investigation of many aspects of service needs and delivery was impeded by the unavailability of useful and coordinated data. There is no available data that reviews local CBO performance (outside data noted earlier in this report required by MHSA), or that compares success rates by agency, intervention, and diagnosis. There is no data documenting whether callers to ACCESS receive appropriate, or any, care. There is no integration of data from different organizations that follows a single individual and their outcomes. There is no data that explores reasons for failed outcomes for clients. Because waiting lists for services are not kept by all agencies, the actual need for individual interventions is unknown.

The Grand Jury's investigation of many aspects of service needs and delivery was impeded by the unavailability of useful coordinated data.

As an example, Assisted Outpatient Treatment (AOT) is a well-regarded MHSA program. It has a total of 30 slots in Alameda County and is chronically at capacity. Witnesses suggested that demand-based AOT capacity might be closer to 160 slots. It is unclear why this program has a cap of 30 while other MHSA-funded programs remain below capacity. Isn't AOT a "best practice" that should be rewarded, replicated, and expanded? Better data could help drive the decision.

It is unclear if there is equity in funding and services for AOT or other ACBH services. More information than just the race and gender of recipients is needed. The Grand Jury could not find data that compared services by geographic location. Nor could the Grand Jury find data that showed rates of funding or services compared with rates of disease for various population groups. There are many competing needs for mental health funding support. Better data and better data transparency would greatly clarify those needs for service providers and the community at large.

ACCESS: A Misnomer?

The Grand Jury found that ACCESS as a single point of entry to mental health help can be useful at certain hours, but those hours are limited. The phone number is only staffed by ACBH from 8:30 a.m. to 5 p.m. Monday through Friday; after-hours and weekend calls get referred to Alameda County Crisis Support Services, where nonprofessionals provide telephone support, with a call back from ACBH the next day. This makes ACCESS useless during immediate crises at night, when police report the majority of their need for help, or on weekends. While ACCESS may not have been intended as a crisis line, there is currently no county-wide alternative to jail or 5150s (involuntary holds in a psychiatric institution for up to 72 hours) when psychiatric events require an immediate response. Some cities are trying to create their own models for crisis response, such as the new Mobile Assistance Community Responders of Oakland (MACRO) pilot program.

Also, witnesses explained that the police do not have time to stay on the phone with a client and help complete a referral form—a form that requires clinical information. In addition, since ACCESS is a phone service, calls back the following day require access to a phone at the time of the call. And there is no follow-up with people who interact with this service, beyond the initial callback. Also, although loved ones and friends may call for information, the client must be on the call and participate willingly to initiate a service referral. Also of note, the new state budget includes proposed Medi-Cal eligibility for crisis intervention services and those services will be required to be provided 24-7.

ACCESS can be valuable as an information and assistance service, as it is staffed with LCSWs. But outreach is extremely limited, even to police and mental health providers. Witnesses from ACBH were not aware of any instances of any recent outreach efforts for either professionals or consumers. Of the approximately 2,300 calls that come into ACCESS monthly, fewer than 50 calls come from crisis management teams and law enforcement combined. And only about 10% of calls come from family members. Someone must know enough about the Alameda County mental health system, or be able to type the correct key words into a web search engine, to get to the ACBH or MHSA websites to find the ACCESS phone number.

Nonprofit programs describe a disconnect between ACCESS data and their true capacity. For example, witnesses noted that ACCESS often refers clients to their programs when the programs are already at capacity. Programs sometimes call ACCESS to ask about program availability for their clients but do not get accurate information. There is no current technology linking real time program capacity with ACCESS, although the Grand Jury was told there is a list updated daily to reflect service capacity.

Behavioral Health Court—Underutilized Resource?

Witnesses universally spoke highly of BHC. While a state statutory requirement (SB215) requires diversion opportunity for low-level mental health offenders, each county makes its own standards. However, no data is available to the public regarding the success or failures of BHC. For example, graduation rates are available for Collaborative Courts, but there's no public data for BHC graduation rates. The only publicly available data is that for the CBOs funded by FSPs through ACBH. Additional data was unavailable to corroborate witnesses' perception that BHC is a major asset to Alameda County. However, limited data from 2015-2016 indicates that BHC improves public safety, improves psychiatric outcomes for the participant, and lowers public costs. San Francisco BHC, which has similar rigorous criteria for enrollment, provides public data that indicates BHC reduces incarceration and violent behavior. The Grand Jury could find no available data that assesses why people drop out of BHC or don't follow through. There is also no available data that looks at whether the program provides racial and geographic equity.

ACBH needs to provide more flexibility in service delivery rules to ensure treatment and delivery of services work together to support client needs.

Alameda County allows 30 people in BHC at one time and a maximum of 100 people. There is only one BHC site in Alameda County—in Oakland. Witnesses stated that there are waiting lists for referral to BHC. By comparison, San Francisco has a BHC cap of 300 people annually for a population less than half of Alameda County's. Witnesses stated that expansion of BHC necessitates expansion of ACBH staff involvement, but more importantly, there is insufficient community-based treatment infrastructure.

Mental Health Services Act (MHSA)—Good Funding Source, Limited Guidance

ACBH provides information to MHSA CBO stakeholders on a regular basis, but does not extend those stakeholders structured opportunities to offer feedback or participate in a bidirectional communication process with ACBH. Witnesses from local CBOs expressed frustration with some aspects of the MHSA funding and contracting processes, particularly how funding choices are made and the limitations within the contracts, calling them inflexible and the process as opaque compared with other counties. A Grand Jury review of MHSA contracts confirmed that they are exacting in their expectations and that the timeline for new RFPs and contracts is not on a disclosed schedule.

ACBH needs to provide more flexibility in service delivery rules to ensure treatment and delivery of services work together to support client needs. Contracts are currently fee-for-service, where separate services are paid for individually, instead of performance-based, which set targets for measurable performance requirements and quality standards in

developing statements of work. Witnesses also complained that their FSP contracts are capped, and they are not allowed to over-serve. Reimbursement for these contracts is from MHSA and Medi-Cal funding, so additional services are at no cost to the county. County staff noted that agencies can make a request for additional funds if over-service is anticipated.

The Grand Jury also learned that not all MHSA funds are spent down annually. In FY 2021-2022, MHSA had \$64 million in unspent funds from prior years, and anticipated carryover funds of almost \$26 million, excluding the prudent reserve.

Equity of MHSA funding should be made more transparent. MHSA plans highlight groups that are undeserved by the system, but the Grand Jury is not aware of any systematized racial or geographic equity lens regarding funding allocations for services.

MHSA paperwork is a problem—FSP CBO contracts include substantial paperwork. One provider told the Grand Jury it no longer accepts funding for FSPs because the paperwork took 60% of staff time. Another provider called the paperwork “overwhelming.” Some of the paperwork is unavoidable due to state and Medicaid requirements, but providers state that the paperwork can be significantly streamlined.

Medical record access is challenging—providers discussed their challenges in providing integrated care without adequate access to medical records. None of the providers who met with the Grand Jury have full interoperability of medical records with other FSP providers, which would allow timely and secure access, integration, and use of electronic health data so that it can be used to optimize health outcomes for individuals and populations. Some service providers are connected to some parts of the overall support system but not others. This contributes to the sense of fragmentation of the system felt by clients and their families. ACBH acknowledged this challenge.

Mental Health Advisory Board (MHAB)—Well-Meaning Watchdog with Limited Bite

MHAB meetings are open to the public and written materials are posted on its website. Part of the MHAB’s charge is to advise the BOS on mental health issues. The BOS has a representative at MHAB meetings and ACBH attends the meetings regularly. The MHAB has written thoughtful letters to the BOS over the last several years about relevant issues, such as the Santa Rita Jail issues and the need for more transparent data, but the BOS has not responded to those letters nor invited members to present at a BOS meeting. Thoughtful communication deserves a response. And there are MHAB vacancies to be filled. There are 16 available positions on the MHAB, all appointed by the BOS, and only 10 are currently filled. MHAB members can enrich mental health service delivery and provide outside expertise and perspective.

CONCLUSION

Through its investigation, the Grand Jury found and verified that Alameda County's mental health system is very complex and challenging to navigate, particularly for the SMI individuals and their families and friends for whom it should be primarily designed to serve. Based on its findings and through its recommendations, the Grand Jury seeks to help simplify this complex system for those trying to use it, and to help facilitate needed improvements for those attempting to maintain and manage it.

The Grand Jury wants to make clear that the problems it identified through its investigation lie largely with the system itself, not the people working within it. Despite questionable allocations of resources and the high personal and financial costs and stresses of working in the San Francisco Bay Area, the Grand Jury found dedicated groups of individuals committed to serving Alameda County's mental health needs. The following findings and recommendations are focused on helping these noble mental health service providers and the people they serve.



FINDINGS

Finding 1:

A county-wide needs/gaps assessment (broader than what the Mental Health Services Act mandates) has not been completed since 2015. A current strategic plan for Alameda County Behavioral Health is missing.

Finding 2:

Alameda County mental health data is not well developed, organized, shared, or distributed by Alameda County Behavioral Health Care Services. Outside of mandatory Mental Health Services Act annual and three-year plans required by the state, integrated data is unavailable to the general public and local advocates. Because of this lack of transparency, Alameda County Behavioral Health outsiders suspect that funds are not properly directed to community service gaps and needs.

Finding 3:

Alameda County Behavioral Health service contracts are inflexible. Alameda County Behavioral Health's switch to fee-for-service contracts from performance-based contracts has likely resulted in reduced services available to Alameda County residents.

Finding 4:

The mental health record systems of county mental health service providers cannot connect with each other. Lack of interoperability of medical records for Mental Health Services Act providers limits needed communication and consistent information capacity between service providers.

Finding 5:

Most Alameda County residents have limited knowledge of the ACCESS phone line and its role.

Finding 6:

Although there is a phone line answered by a volunteer from a local mental health provider during hours when ACCESS is not staffed, emergency mental health services for low-income seriously mentally ill individuals are not offered 24-7. There is no crisis referral line or alternative to jail or 5150 for immediate care for the seriously mentally ill when ACCESS is closed.

Finding 7:

Behavioral Health Court works. That's the unanimous verdict of the Grand Jury's witnesses. But it's not adequately supported and funded. Alameda County Behavioral Health and the courts have not provided adequate data to determine that the well-regarded Behavioral Health Court is effective and is racially and geographically equitable so it can attract more funding.

Finding 8:

The Mental Health Advisory Board, which has strong, knowledgeable, and experienced members and generates excellent ideas, is not used effectively by the Board of Supervisors.

RECOMMENDATIONS

Recommendation 1:

Alameda County Behavioral Health should develop a community-wide needs/gaps assessment, beyond the scope of what the Mental Health Services Act requires, to guide funding and ensure equity in service delivery. This can help Alameda County Behavioral Health develop a strategic plan to ensure that Alameda County's current approach to mental health services and funding is fully in sync with "Care First, Jail Last" and Alameda County's current needs.

Recommendation 2:

Alameda County Behavioral Health should invest in and improve its data development, organization, sharing, and distribution capabilities. Accurate and complete data-driven analysis and evaluation should direct Alameda County mental health service and funding choices.

Recommendation 3:

Alameda County Behavioral Health should lift contract caps for providers who are over-serving their contracts, or at least provide clear protocols for how and when to lift those caps during contract negotiations with service providers.

Recommendation 4:

Alameda County Behavioral Health must develop technology that allows uniform interoperability between multiple provider agencies for sharing of medical records.

Recommendation 5:

Alameda County Behavioral Health should add outreach in multiple ways, languages, and venues, including directing materials to law enforcement, health care, social services, and to the general public to instruct them appropriately about ACCESS as both a resource line and a referral line.

Recommendation 6:

The ACCESS number should be more widely distributed by Alameda County Behavioral Health to the professional and consumer communities. If the ACCESS line is an information and referral line, there should be corresponding easily accessible resource information about mental health programs on ACBH's website and outside of the website, available to the public.

Recommendation 7:

Alameda County Behavioral Health should provide a mental health support/crisis line that is staffed 24-7 as a referral alternative to jail or psychiatric holds.

Recommendation 8:

Alameda County Behavioral Health must develop enough program slots to meet current needs.

Recommendation 9:

Alameda County Behavioral Health must improve/expand upon its coordination between service providers and ACCESS staff regarding available slots for service by developing appropriate technology to assess available program slots in real time.

Recommendation 10:

Alameda County Behavioral Health must provide more transparency in its reporting on Behavioral Health Court and make results of Behavioral Health Court available, including graduation rates, recidivism, and reasons for lack of completion.

Recommendation 11:

Alameda County Behavioral Health, in collaboration with the courts, should increase the capacity of Behavioral Health Court, based on findings above, to support the “Care First, Jails Last” Board of Supervisors resolution.

Recommendation 12:

Alameda County Behavioral Health, in collaboration with the courts, needs to provide data that ensures that Behavioral Health Court is racially and geographically equitable.

Recommendation 13:

The Alameda County Board of Supervisors should better utilize the expertise and skills of the Mental Health Advisory Board. Regular, scheduled Advisory Board presentations to the Board of Supervisors would be useful.

Recommendation 14:

The Alameda County Board of Supervisors should fill the vacant Mental Health Advisory Board positions that the Board of Supervisors is supposed to appoint.

REQUEST FOR RESPONSES

Pursuant to California Penal Code sections 933 and 933.05, the Grand Jury requests each entity or individual named below to respond to the enumerated Findings and Recommendations within specific statutory guidelines, no later than 90 days from the public release date of this report.

Responses to Findings shall be either:

- The respondent agrees with the finding.
- The respondent disagrees wholly or partially with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reasons therefor.

Responses to Recommendations shall be one of the following:

- The recommendation has been implemented, with a summary regarding the implemented action.
- The recommendation has not yet been implemented, but will be implemented in the future, with a time frame for implementation.
- The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or study, and a time frame for the matter to be prepared for discussion by the officer or head of the agency or department being investigated or reviewed, including the governing body of the public agency where applicable. This time frame shall not exceed six months from the date of publication of the Grand Jury report.
- The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation therefor.

RESPONSES REQUIRED

Director, Alameda County Behavioral Health Care	Findings 1 through 7 Recommendations 1 through 12
Alameda County Board of Supervisors	Finding 8 Recommendations 13 & 14

Glossary

- 5150—Involuntary hold in psychiatric institution for up to 72 hours
- ACBH—Alameda County Behavioral Health
- ACCESS—Acute Crisis Care Evaluation for System-wide Service, ACBH’s primary phone portal for access to county mental health services
- ACHCSA—Alameda County Health Care Services Agency, where ACBH resides
- ARF—Adult Residential Facility
- BHC—Behavioral Health Court
- BOS—Board of Supervisors
- CalAIM—California Advancing and Innovating Medi-Cal, a long-term commitment by the state to transform and strengthen Medi-Cal, aiming to offer Californians a more equitable, coordinated, and person-centered approach to maximize their health and life trajectory.
- CBO—Community-Based Organization, the primary providers for mental health services in Alameda County
- CSS—Community Services and Support
- FSP—Full-Service Partnership, a comprehensive and intensive mental health program for adults with severe and persistent mental illness
- LCSW—Licensed Clinical Social Worker
- MHAB—Mental Health Advisory Board
- MHSA—Mental Health Services Act, Prop. 63
- Medicaid/Medi-Cal—Medi-Cal is California’s version of Medicaid, which provides medical services to low-income people at little or no cost.
- RCFE—Residential Care Facility for the Elderly
- SMI—Seriously mentally ill

WHERE CAN I GO TO GET MENTAL HEALTH SERVICES IF I AM LOW INCOME?

1) **Mild to Moderate Symptoms:** Call your managed care plan for a referral. They will provide in-office services or refer you to an outside mental health specialist if the condition is outside their scope of practice.

Medi-Cal Managed Care Plans

- **Alameda Alliance (Beacon Health Strategies): 855-856-0577**
- **Anthem Blue Cross: 888-831-2246**

2) **Moderate to Severe Symptoms:** Call **ACCESS (1-800-491-9099)** if symptoms seem moderate to severe. The ACCESS mental health clinician will conduct a triage screening to determine the level of severity of your client's condition. To meet the "moderate to severe" criteria for Specialty Mental Health services, your client's condition must be impairing their ability to function individually or in the community. If the clinician determines that your condition doesn't meet the specialty mental illness criteria, they will refer you to their PCP or connect you to Beacon Health Strategies.

ACCESS clinicians are available in English, Spanish, Mandarin, Cantonese, Vietnamese, and Cambodian. Additional languages available upon request.

- Asian Health Services for **Asian language speaking individuals: 510-735-3939**
 - La Clinica de La Raza for **Spanish Speaking individuals: 510-535-6200**
- Deaf Community Counseling Services, for **Deaf and Hard of Hearing individuals: 510-225-7013, video phone: 510-984-1654**

3) **Crisis:** Call 911 or the **Alameda County Crisis Response Hotline: 1-800-273-8255** if you or your client is posing a threat to others, themselves (suicidality) or are gravely disabled by their condition, call 911. If a mental health crisis isn't showing immediate danger, call the crisis hotline for evaluations, limited crisis intervention and brief treatment with case management following acute care for selected individuals without other resources. Referrals to Crisis Response are also made through ACCESS.

If you are in Berkeley, call **Berkeley Mental Health: (510) 981-5291**

OAKLAND FAILS TO ENFORCE FINANCIAL DISCLOSURE RULES TO PROTECT THE PUBLIC

EXECUTIVE SUMMARY

In 2014, the Oakland Public Ethics Commission (PEC) established a code of ethics to provide guidelines for the filing of Form 700, also known as a Statement of Economic Interests, as required by the California Fair Political Practices Commission (FPPC). A tool to provide transparency and accountability in government, [Form 700](#) enables the public to discover and monitor the personal finances of Oakland government officials, such as their investments, real property, income, loans, business positions, gifts, and travel payments. Form 700 information is a critical part of the vetting process by public partners or persons interested in a transaction with the city.

A person who is required to file a Form 700, called a designated filer, has a conflict of interest in a governmental decision if that decision could have a “material and foreseeable” financial impact on the designated filer’s financial interests. To avoid the risk of biased decision-making or the appearance of improprieties, public officials are prohibited from participating in decisions where they could personally benefit financially. A designated filer must file the Form 700 when assuming a decision-making position, annually while working in that position, and within 30 days of leaving that position.

The Form 700 is a monitoring tool and is only effective if the process of gathering financial information of decision-makers is centralized, publicized, and rigorously enforced. Local government benefits if the Form 700s either reveal or fail to reveal hidden financial conflicts of interest. A Form 700, signed under penalty of perjury, deters fraudulent behavior, since it can be used to prove fault if the required financial information is false or not provided.

Form 700s are essential to the work of Oakland’s PEC, whose mandate is to ensure compliance with the ethics laws that require reporting of personal financial information. The PEC serves as a quasi-judicial body that adjudicates enforcement matters. Failure to disclose an economic

A tool to provide transparency and accountability in government, Form 700 enables the public to discover and monitor the personal finances of Oakland government officials, such as their investments, real property, income, loans, business positions, gifts, and travel payments.

interest on a Form 700 is a serious violation of the ethics rules because it deprives both the public and the PEC of valuable information about public officials' financial conflicts of interests.

The Grand Jury investigated how the process of administering the Form 700s currently operates and how and why that process should be streamlined and enforced for the benefit of the city of Oakland and its residents.

BACKGROUND

In the wake of the Watergate scandal, California passed broad sweeping ethics rules, including the Political Reform Act (the Act). The stated goal of the Act was to “put an end to corruption in politics.” Approved by more than 70% of California voters, the new state law required every elected official, employee, and consultant in decision-making positions to file an economic disclosure statement, known as a Form 700.

To avoid the risk of biased decision-making or the appearance of improprieties, public officials are prohibited from participating in decisions where they could personally benefit financially.

The law prohibits all decision-makers at any level of local government from participating in making or influencing a governmental decision in which the decision-maker has a financial interest. These decision-makers must disclose all assets and sources of income so that a governmental agency can monitor compliance with the ethics rules. The process of completing a Form 700 reminds public officials of potential financial conflicts of interest so they can abstain from making decisions. Because the completed Form 700s are available for public scrutiny, the resulting transparency can help monitor the decision-making of public officials.

To support the ethics rules, the Act mandated that all government agencies adopt a financial conflict of interest code. Oakland's Conflict of Interest Code incorporated the state's entire conflict of interest code and all amendments. Any violation of Oakland's Conflict of Interest Code is also a violation of the Act.

The Oakland Conflict of Interest Code lists positions of persons in city government who are required to disclose financial information and the categories of disclosure. The list of designated positions includes all agency positions involved in making decisions that could have a material effect on any financial interest of the decision-maker. The detailed disclosure categories describe the types of financial interest that officials in one or more job classifications must disclose.

According to Oakland's Conflict of Interest Code, the City Clerk office's Filing Officer has the duty to administer the Form 700 filing process. The Filing Officer must supply a Form 700 to designated persons who have assuming, annual, and leaving office filing obligations, and notify

filers who fail to file or who are required to amend. To determine who is required to file, the Filing Officer reviews and updates the list of designated positions and makes enforcement referrals to the FPPC. Filing officers are required to report apparent violations of the Act to the FPPC. An apparent violation exists if the Filing Officer knows or has reason to believe a Form 700 disclosure contains material inaccuracies or omissions, or when a filer fails to file all or part of a Form 700 after reasonable notice has been provided.

Failure to disclose an economic interest on a Form 700 is a serious violation of the ethics rules.

The following are examples of ethics violations highlighting deficiencies in the Form 700 process which prompted this investigation:

1. A complaint to the 2021-2022 Grand Jury reported a financial conflict of interest investigated by Oakland's PEC. In 2019, a consultant working in the city's Housing Development Department participated in decisions to grant loans of public funds to a development company operated by the consultant's father-in-law. The PEC's investigation into this conduct revealed several ethics violations including the failure to file a Form 700 disclosing the relationship. A broader review of the complaint by the PEC suggested a systemic failure of departmental management to monitor conflicts of interest.
2. In September 2021, the PEC took final action against an inspector in the city's Planning and Building Department. In 2019 the city employee in this investigation used his position to arrange "pay to play/quid pro quo" deals with property owners despite conflicts with his city position and without reporting these interests and income to the city on a Form 700. The PEC assessed a \$309,600 penalty for 47 violations of the Oakland Government Ethics Act.
3. The November 2020 Enforcement Order by the PEC described Form 700 violations in 2015 and 2016 of another city inspector in the Planning and Building Department who worked in tandem with the employee who was the subject of the September 2021 action referenced in number 2 above. This second city inspector failed to report income on a Form 700, in violation of Oakland's ethics laws. In January 2021, the PEC assessed a \$55,000 fine.
4. In 2021, the FPPC reported to the PEC that a former City Council member failed to file his 2019 and 2020 Annual Form 700s. The City Clerk's office did not report this ethical breach to the PEC.

INVESTIGATION

The Grand Jury heard testimony from several city of Oakland officials, department heads, and the PEC. The Grand Jury reviewed extensive documents regarding the Form 700 process. The investigation involved substantial research and surveys of relevant state and city ethics rules. The Grand Jury used these sources of information to develop facts, findings, and recommendations.

Public Ethics Commission

The Oakland PEC is an independent commission charged with ensuring fairness, openness, honesty, and integrity in city government. The PEC's objective is to ensure that public officials and government decision-making processes operate fairly and in an unbiased manner, to support transparency in Oakland government, and to promote public trust.

The PEC has primary responsibility and power to investigate and enforce violations under the Act. Local law requires that the PEC oversee compliance with the Form 700 filing requirement and enforce the law as it relates to the content reported on the Form as well as conduct related

The City Clerk's office has responsibility for the Form 700 Filing Officer function while the PEC has responsibility for the Form 700 enforcement and training responsibilities. The Grand Jury learned that the City Clerk's office and the PEC rarely collaborate.

to any conflicts of interest. The PEC may order administrative fines, non-payment of which is a debt to the city. Oakland may file a civil action or pursue any other legal remedy to collect these debts, including costs and attorney's fees. The PEC urges designated filers to comply with ethics rules to "avoid potential criminal, civil or administrative penalties (fines and jail time)."

The PEC conducts investigations, holds public hearings, issues subpoenas, and imposes fines and penalties. The Commission also educates, advises, and issues formal opinions to increase public awareness of the city's ethics laws. And it investigates allegations of ethics violation in city government and enforces the ethics laws through administrative prosecution or civil litigation.

The separation of Form 700 responsibilities between the City Clerk's office filing duties and the PEC enforcement and training duties makes the PEC compliance responsibility more challenging. The City Clerk's office has responsibility for the Form 700 Filing Officer function while the PEC has responsibility for the Form 700 enforcement and training responsibilities.

The Grand Jury learned that the City Clerk's office and the PEC rarely collaborate. The City Clerk's office was unaware that the PEC has statutory responsibility for enforcement of the Form 700 filings. In fact, the City Clerk's office wrote to the PEC asking it to cease advising designated-

filers about Form 700 filing, alleging that the PEC was “confusing” communications from the City Clerk’s office.

The Filing Officer in the City Clerk’s office does not refer late or non-filing persons to the PEC and, in violation of the law, has not referred those persons to the FPPC since 2016. Consequently, the PEC typically identifies Form 700 ethics violations as part of a broader investigation of other allegations of ethics violations by city officials, employees, or contractors hired by the city. Because the Filing Officer does not refer non-filers to the FPPC or the PEC, Oakland does not have a means of fully enforcing its Conflict of Interest Code.

In addition to the absence of collaboration, there is a lack of timely or prompt responses by the City Clerk’s office. The PEC has encountered delays of weeks and, in some cases, months by the City Clerk’s office in response to PEC requests for Form 700s from the City Clerk’s office for investigative or compliance checking purposes.

The PEC offers annual ethics training for the city managers, new employees, and consultants. PEC staff provided training in 2021 to 781 participants, including elected officials and their staff, and new employees. Last year 129 persons attended trainings for Form 700 filers through the city’s online learning management system and four live trainings conducted by the PEC staff via Zoom. City staff supervisors (100 in total) received additional ethics training. The PEC has a YouTube channel with ethics training, including Form 700 and conflicts of interest.

The PEC offers annual ethics training for the city managers, new employees, and consultants. PEC staff provided training in 2021 to 781 participants, including elected officials and their staff, and new employees.

A Filing Officer has the responsibility to collect, review, and provide public access to ethics-related data. Since 2016, the PEC has had responsibility for the Filing Officer function for campaign finance. In 2018, the PEC also assumed responsibility for the lobbyist Filing Officer function. However, responsibility for the Form 700 Filing Officer function remains with the City Clerk’s office. The PEC has requested that the City Clerk’s office transfer the Form 700 filing function to the PEC and has sought such a transfer in its budget application, to no avail. Such a shift would allow the PEC to fully implement its mission to ensure compliance with Form 700 filing requirements. As the PEC stated in its recently published 2021 Annual Report, the Form 700 filings “are of high interest to the PEC in ensuring compliance with ethics laws that require reporting of personal financial information.”

The PEC has six full-time staffers. The fiscal year (FY) 2020-2021 approved PEC budget included a one-time augmentation of \$100,000 for election-related services in lieu of the additional two positions requested for investigations and policy functions. The PEC was able to hire a temporary

part-time investigator for seven months. However, the PEC was not able to hire a full-time investigator after the City Administrator announced in December 2021 a \$62 million shortfall as well as a hiring freezes on vacant positions and a moratorium on temporary employees among other budgetary constraints. The PEC FY 2021-2022 budget of \$1,411,407 included one additional full-time administrative support person for the PEC starting in July 2022.

City and county departments have used grant funding to provide resources for critical staffing needs. The Oakland Fire Department, the County Public Defender, and Legal Services for Seniors, a contractor providing probate conservatorship representation, are examples. This method of funding may be a viable funding source available to the agency providing Form 700 services in Oakland. This possibility would require funding of a grant writer position.

Oakland's City Charter requires that the City Council appropriately fund the PEC to fulfill its functions and duties. PEC staffing, established by the 2014 Charter amendment, was based on 2013 case levels.

Oakland's City Charter requires that the City Council appropriately fund the PEC to fulfill its functions and duties. PEC staffing, established by the 2014 Charter amendment, was based on 2013 case levels. Over the years, the number of public calls to the PEC for advice and assistance regarding ethics, including financial conflicts of interest, has increased dramatically, requiring more staff resources to meet the demand for assistance. Public calls to the PEC for assistance quadrupled from 96 calls in 2016 to 460 calls in 2020. The PEC had a caseload of 74 open cases of alleged ethics violations by the end of 2020, initiated 60 new complaints, and 38 investigations into ethics violations by city officials,

employees, and contractors. In spite of the pandemic and the staff working at home, in 2021 the PEC responded to 260 requests for assistance, almost half of which concerned conflicts of interest rules. By year end 2021, the PEC had 44 open investigations.

City Clerk

The Oakland City Clerk's office manages the City Council's agenda materials, and oversees the city's elections, political filings, administration of records, management services, and the Form 700 process. The City Clerk's office maintains records for five separate departments, each of which has grown in the past seven years.

The City Clerk's office is chronically understaffed. Based on current staffing, the City Clerk's office is not able to fulfill the duties regarding Form 700. One person performs the Form 700 Filing Officer duties on a part-time basis, 35-50% of work hours, depending on whether a time-consuming election conducted by the City Clerk's office is occurring at the same time as Form 700 filings are due. Occasionally the City Clerk, who assumed that position in March 2021 and

who manages four other areas of record-keeping while supervising 10 employees, assists the Filing Officer with Form 700 duties.

For the past three years, the Assistant City Clerk position has been filled by inexperienced persons for short periods, but the position has been largely unfilled since 2017. The city's list of candidates for the Assistant City Clerk position is three years old and stale because most persons on that list are no longer interested or available for the job. The City Clerk's office has encountered a delay in getting a replacement list of candidates from the city's Human Resources department. A hiring freeze was announced in Oakland government late last year. The City Clerk office's budget for FY 2021-2022 is \$378,828 and for FY 2022-23 is \$334,847. The two proposed hires for FY 2022-2023 are an Administrative Analyst to respond to increased demands for public records information and a Management Assistant to fill the sole fiscal position in the office. The federal relief funds used to cushion the impact of reduced city funds during the pandemic is due to expire next year. The City Clerk's office is also funded by \$260,000 in miscellaneous grants.

The City Clerk's office is chronically understaffed. Based on current staffing the City Clerk's office is not able to fulfill the duties regarding Form 700.

The chronic short staffing means the one part-time person performing City Clerk office's Form 700 duties has been stretched thin. Because the City Clerk's office has been short-staffed for years, the present Filing Officer has significant responsibilities other than those related to Form 700. These additional duties include the responsibilities of the acting management assistant, assistance with elections, residency verification, sole responsibility for the front desk, domestic partnerships, payroll, passports, accounts receivable, mail, answering emails, recruitment duties, and preparing intake/separation paperwork regarding the City Clerk's office for the city.

The City Clerk's office is responsible for ensuring that the NetFile account, which serves as the automatic filing system for Form 700 and for the campaign filing system in Oakland, is paid on time. Payments of the Netfile account by the City Clerk's office was two quarters in arrears as of July 2017, a quarter in arrears as of December 2018 and again as of February 2019, two quarters in arrears as of January 2020, two quarters in arrears as of July 2021, and three quarters in arrears as of November 2021. NetFile recently proposed billing annually to limit the time "chasing payments."

The City Clerk office's training to city employees regarding Form 700 consists of a brief statement at annual trainings conducted by the city's payroll/employee relations units identifying designated filer's obligations and suggests filers contact the City Clerk with questions. This limited training does not reach the persons required to participate in the Form 700 process.

Form 700 Process

Most persons required to file a Form 700 do so electronically using NetFile. Other filers, primarily but not exclusively seniors and disabled persons, do so by mail or in person at the City Clerk's office. The City Clerk Filing Officer receives the original Form 700s from designated filers who do not file electronically.

For in-person filings, the City Clerk's Filing Officer reviews the Form 700s to ensure that they are complete and then sorts the forms into piles for notices regarding follow-up amendments if the forms are incomplete or for scanning into the city's system, which requires additional handling.

Since 2016, the City Clerk Filing Officer has not reported annually to the FPPC apparent violations of the law including material inaccuracies or omissions, or failure to file the Form 700 after receiving delinquency notices from the Filing Officer.

The FPPC requires that the City Clerk Filing Officer review 20% of all on-time statements filed, half of which are selected on a random basis. The limited review is to determine whether the summary page is complete, the required schedules are attached, and the information is legible. The forms are not reviewed for accuracy of the information provided by the filer. In addition, the FPPC requires that the City Clerk Filing Officer review all the late-filed Form 700s to confirm the Form 700 summary page is accurate and complete, that all applicable schedules are attached and include all required descriptive information for each financial interest. However, the Grand Jury has learned that the City Clerk Filing Officer does not review all the late-filed Form 700s. Since 2016, the City Clerk Filing Officer has not reported annually to the FPPC apparent violations of the law including material inaccuracies or omissions, or failure to file the Form 700 after receiving delinquency notices from the Filing Officer.

The Conflict of Interest Code and the Form 700 are fundamental tools in ensuring that officials act in the public's best interest and not their own. It is critical that the Conflict of Interest Code reflects the current structure of each agency and that the city of Oakland correctly identifies all officials and employees who should file a Form 700. According to the FPPC, "it is essential and legally required that an agency's conflict of interest code remain current and accurate...Each agency must review its Conflict of Interest Code at least every other year." According to FPPC rules, Oakland is required to review its Conflict of Interest Code at least every even-numbered year.

With regard to the mandated review of Oakland's Conflict of Interest Code, the FPPC requires that the city review whether there have been any substantial changes in an organizational structure, whether positions have been eliminated or renamed since the current Conflict of Interest Code was adopted, whether any new positions have been added, and whether there have

been any substantial changes in duties or responsibilities for any position. Any affirmative findings by a city review may mean that the Conflict of Interest Code would need to be amended.

The City Clerk's office did not produce to the Grand Jury any documents regarding its Conflict of Interest Code for the past four years. The Filing Officer does not maintain the documents necessary to conduct the review stated in the preceding paragraph. Notices to file the Form 700 could not be sent to an updated list of persons and designated positions added or removed since the last completed review of the Conflict of Interest Code. If no updated Conflict of Interest Code exists, the list of positions will be incomplete; as such it could exclude filings of decision-makers who make financial decisions throughout the city as well as include persons who are no longer designated filers.

Once the City Clerk's office completes its review of the Conflict of Interest Code and it is approved by the City Administrator, the Filing Officer must communicate with all agencies to confirm which employees and contractors are currently in designated positions. The Filing Officer then gives notice of filing dates for Form 700s to all designated filers. The notice includes information about the filer's disclosure categories along with the form or link to a website to complete the form. To satisfy this duty, the Filing Officer must have an accurate list of employees' and consultants' job status and current and accurate contact information for all designated filers. The primary method of issuing notice to filers by the Filing Officer is automatic emails to persons already registered with NetFile. For persons who are not already registered with NetFile or who have a status change that requires them to file a Form 700, the City Clerk's office is required to send a letter or make a phone call to them.

Accurate and timely city records regarding Form 700s are a key part of ensuring that the public has a useful tool for monitoring government and saving funds from misappropriation.

The FPPC requires that the Form 700 Filing Officer use a Form 804 and Form 805 to track changes in positions of designated filers and disclosure requirements in the Conflict of Interest Code. City departments are required to send Forms 804 and 805 to the Form 700 Filing Officer. The Form 804 includes all of the information for a new Form 700 designated employee position and the Form 805 records information from consultants who are designated filers. The Filing Officer is required to keep these forms for tracking purposes and for use in reviewing filers for the Conflict of Interest list of designated positions and disclosures.

The regulations require that when a person is hired for a position not yet covered under a current Conflict of Interest Code, the person file a Form 700 if the person serves in a position that makes or participates in making governmental decisions, using the broadest disclosure category until the Conflict of Interest Code is amended to include this position.

With few exceptions, the Filing Officer did not receive these forms from city departments and did not enforce the requirements for these forms. This gap in the information flow directly impacts the process of amending Oakland's Conflict of Interest Code listing of designated filer positions and disclosure requirements for these positions. The City Clerk's Filing Officer is required to review and consider the information on Forms 804 and 805 when the Filing Officer is reviewing Conflict of Interest Code designations for possible amendments of the Conflict of Interest Code. Without these forms, the Filing Officer cannot review the information on them that is required as part of the state-mandated process of updating and amending the Conflict of Interest Code. Keeping current and accurate records of who is required to file a Form 700 is critical for the public to trust that decisions are not made by persons who financially benefit from those decisions.

While NetFile records who has filed a Form 700 electronically, it does not have a record of who should file. The City Clerk's office acknowledges it cannot determine which persons file late and which are non-filers. Since 2016, the Filing Officer has not referred non-filers to the FPPC as required by law because the Filing Officer is unable to determine the number of non-filers each year. If the Filing Officer had this required information, followed up with the city departments to confirm changes, and referred persons who failed to file a Form 700 to the FPPC, the city would move toward compliance with its statutory duties.

Oakland has a duty to ensure that Form 700 statements are complete, to send requests to designated filers for amendments, to assess or waive late fees, and to refer non-filers to the FPPC. Accurate and timely city records regarding Form 700s are a key part of ensuring that the public has a useful tool for monitoring government and saving funds from misappropriation.

The City Clerk's Filing Officer is required to keep originals of Form 700 statements for seven years, maintain a tracking log, and make the forms available on request. Instead, the Filing Officer uses a spreadsheet to keep track of Form 700s. The spreadsheet cannot be compared with the original Form 700 statements to ensure accuracy.

For Form 700 filers who use NetFile, the Filing Officer is responsible for keeping all filer information current, including information about assuming and leaving office and when Form 700s are due. The Filing Officer must receive from city departments changes in the employment status of mandated designated filers shortly after the change happens because these persons must file a Form 700 within 30 days of a status change. Information about departing, promoted, or new employees is required for the Filing Officer to trigger notices to all designated filers. However, the Filing Officer frequently receives this information from city departments after the Form 700 filing deadline has passed.

Oakland Code of Regulations section 18115 states that city departments are required:

- to send completed Form 700s to the Filing Officer within prescribed times and keep a copy of those statements;

- notify the Filing Officer of a vacancy in an office and any other event affecting filing obligations;
- notify the Filing Officer of the names and positions of every person whose statements must be forwarded to the Filing Officer; and
- maintain a current list of all statements forwarded to the Filing Officer.

This law is not enforced. In the current Form 700 system in Oakland, the Filing Officer must conduct considerable follow-up attempts to try to obtain this information from individual city departments, with limited success.

This system, which was intended to ensure complete information for the City Clerk's Filing Officer, must be enforced to be effective. City departments do not routinely comply with their responsibilities to provide the essential information on at least a monthly basis. The Filing Officer struggles with intermittent information from departments that an official, employee, or consultant has been hired or has left a position, only receiving infrequent information by telephone, email, or written notices from persons in the agencies. City departments also frequently provide the Filing Officer some information well past the Form 700 filing date. If the Filing Officer does not learn of a change in status as soon as the person is hired or leaves a designated filer position, the Filing Officer does not have current information for sending the required filing notices. If a designated filer leaves a city position and the filer's city email is no longer available for communication, the Filing Officer must locate the departed person by other time-consuming methods. This results in late notices, late filing, and extended follow-up.

There is no enforcement of the requirement that agencies notify the Filing Officer of personnel changes. There is no automated notification to the Filing Officer from agencies regarding either change of required filing status or hiring or separation of designated persons. Different departments may not have a designated person responsible for sending the required information to the Filing Officer, the designated person may fail to send timely information to the Filing Officer, or the designated person may leave the department and is not replaced in a timely manner. The Filing Officer occasionally solicits the information from some departments. If the information provided is incorrect or incomplete, the process begins again.

The Grand Jury learned that Oakland uses a shared electronic Human Resources platform and that upon hiring or promotion, Human Resources maintains a checklist of forms and activities that must be completed by the new employee. The city does not take advantage of this shared Human Resource platform or the new employee checklist to assist with the reporting of Form 700 related information to the Filing Officer.

The Filing Officer does not maintain a database of who is required to file by title or position. The Filing Officer does not know whether a person is still an employee but is no longer in a required filer position. Because the Filing Officer does not routinely receive notices of promotion or demotion, the Filing Officer does not know how to contact those persons after discovering the

status change. When a position goes from a filer to non-filer status, the Filing Officer must pull the person's account out of the NetFile system and deactivate it. The NeFile information may be incorrect due to human error or lack of communication. Netfile does not provide information of e-files on its system to the Filing Officer; the Filing Officer must log onto NetFile and do a search to discover the information. NetFile tracks reminders it sends to filers; it does not track communications the Filing Officer makes to filers.

The Payroll Department periodically sends the Filing Officer a list of new hires and terminations (but not promotions or demotions) and the Filing Officer has to manually review the list to determine the designated filers. The new Employee Orientation Department sends a list of Form 700 filers to the City Clerk's Office, but the list is not always timely or complete.

With regard to supervision of the Form 700 process, prior to June 2021 the Filing Officer had not provided the City Clerk with periodic information regarding non-filers so that the City Clerk could share this information with the City Administrator supervising the City Clerk department.

CONCLUSION

All of the designated filers are persons in positions of power with respect to governmental decisions in Oakland. Supporting the Form 700 process by accurately reporting financial facts regarding designated filers helps protect the public from self-serving financial decisions by public officials, creates trust, and provides a factual basis for recovering misappropriated funds.

FINDINGS

Finding 9:

The Oakland City Clerk's office is not meeting the minimum requirements of the Filing Officer under the Political Reform Act. The issues of non-compliance with the rules regarding Form 700s are long-standing and structural, resulting from inadequate funding, an inefficient system of communication of critical information to the Filing Officer, and limited staffing.

Finding 10:

A transfer of the Form 700 filing duties from the Oakland City Clerk's office to the Public Ethics Commission would require hiring an additional employee; an amendment of the City Ethics Act to identify the Public Ethics Commission as the Filing Officer for Form 700s; and the transfer of the function and payment of the City's contract with the online filing provider, NetFile, from the City Clerk's office to the Public Ethics Commission.

Finding 11:

Grant funding has been used to fund staffing to support critical services in the City of Oakland.

Finding 12:

The city of Oakland's shared electronic Human Resources platform is not used in the Form 700 process but could be customized to assist in the sharing of information between departments.

Finding 13:

The city of Oakland's new employee checklist does not include Form 700 filing requirements to the employee.

Finding 14:

The Grand Jury commends the hard work of those individuals within the Oakland City Clerk's office who are responsible for the Form 700 process. The problems with the Form 700 process are the result of structural limitations, limited staffing, and inadequate interdepartmental communication.

RECOMMENDATIONS

Recommendation 15:

The city of Oakland should transfer the Form 700 Filing Officer responsibility to the Public Ethics Commission.

Recommendation 16:

The city of Oakland should hire an experienced grant writer with knowledge of state and local funding streams to secure funding for Form 700 services.

Recommendation 17:

On its shared electronic Human Resources platform, the city of Oakland should add a field to the employee information section that indicates whether the employee is a required Form 700 filer and require that the field be updated upon hiring, promotion, demotion, or separation.

Recommendation 18:

The City of Oakland should ensure that the Filing Officer is able to access a current list of Form 700 designated employees through the shared electronic Human Resources platform.

Recommendation 19:

The City of Oakland should add the notification of Form 700 status on the new employee checklist.

REQUEST FOR RESPONSES

Pursuant to California Penal Code sections 933 and 933.05, the Grand Jury requests each entity or individual named below to respond to the enumerated Findings and Recommendations within specific statutory guidelines, no later than 90 days from the public release date of this report.

Responses to Findings shall be either:

- The respondent agrees with the finding.
- The respondent disagrees wholly or partially with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reasons therefor.

Responses to Recommendations shall be one of the following:

- The recommendation has been implemented, with a summary regarding the implemented action.
- The recommendation has not yet been implemented, but will be implemented in the future, with a time frame for implementation.
- The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or study, and a time frame for the matter to be prepared for discussion by the officer or head of the agency or department being investigated or reviewed, including the governing body of the public agency where applicable. This time frame shall not exceed six months from the date of publication of the Grand Jury report.
- The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation therefor.

RESPONSES REQUIRED

Mayor, City of Oakland	Findings 10 through 14 Recommendations 15 through 19
Oakland City Council	Finding 10 Recommendation 15
City Clerk, City of Oakland	Findings 9, 10, 12, 13 & 14 Recommendations 15, 17, 18 & 19
Public Ethics Commission	Finding 10 Recommendation 15

ALAMEDA COUNTY VOTERS CAN COUNT ON ELECTION INTEGRITY

EXECUTIVE SUMMARY

November 2020 represented the confluence of two historic events: the worst world-wide pandemic in over 100 years, at a time when COVID-19 vaccines weren't yet widely available, and a tightly contested U.S. national/presidential election held in a deeply divided and highly charged political atmosphere.

Either event by itself would have presented significant challenges for local election managers and processes. Distancing requirements and COVID-19 fears limited in-person voting and made it less attractive to voters. Therefore, absentee voting soared, and local governments enacted COVID-19-related regulations and restrictions, forcing local election officials to adapt and change plans rapidly to meet COVID-19 safety requirements. Meanwhile, voter interest, engagement, and turnout were high. And, after a presidential election that produced results that are still being challenged in certain circles, there were widespread allegations of election fraud in the U.S.

Serving in the wake of these events, with pandemic waves and election doubts still washing over the U.S., the Grand Jury investigated the election processes and procedures of its local election management agency, the Alameda County Registrar of Voters (ROV).

The Grand Jury focused on two key questions:

1. Did the ROV maintain the integrity of Alameda County's election procedures and processes in the face of these historic challenges?
2. Can voters in Alameda County count on the ROV to carry out its basic mandates—to ensure every registered voter within the county counts, and all votes cast by the county's registered voters are properly counted?

The management and implementation of the 2020 General Election in Alameda County (as well as statewide and nationally) confronted election officials with unprecedented challenges. Foremost was that it was held in the midst of a global pandemic, which created new needs and issues for voters and election workers alike.

The Grand Jury found sufficient evidence to answer “yes” to both questions. And the Grand Jury wishes to share those answers with the people of Alameda County, to provide reassurance that the county’s election processes and procedures are functioning properly at a time when many are casting doubt on the proficiency and integrity of election processes and officials.

BACKGROUND

Voting for government officials and/or laws, through the election process, is one of the cornerstones of democracy. It provides citizens with the power to determine who represents them and what laws govern them. Therefore, maintaining the integrity of the election process—including voter registration, ballot accessibility, polling place accessibility, and vote counting—is essential to facilitating government representation by and for the people.

Voting Management at the County and State Levels

At the county level in California, election processes and procedures are primarily managed by the county office of the registrar of voters. All services provided by the ROV are mandated by the California Elections Code, the California Government Code, and the California Constitution. These mandated services include voter registration, voter outreach, candidate services, and vote-by-mail services.

The ROV’s full responsibilities are detailed on its [website](#). Highlights and other key points include the following:

ROV’s Mission Statement

To seek better ways to provide services to encourage all eligible residents to exercise their right to vote; conduct elections in a fair, accurate and efficient manner; maintain a continuous professional level of service to the public; and develop new techniques to improve outreach services which acknowledge the diversity of Alameda County.

ROV’s Reporting Relationships with County and State Government

The ROV reports to the Alameda County Administrator, who in turn reports to the County Board of Supervisors. Though the ROV has significant control and oversight of all elections conducted within the county, particularly county and other local elections, it shares its oversight role with the California Secretary of State’s Elections Division (State Elections Division) for federal and state elections and is accountable to the State Elections Division on election matters.

The State Elections Division manages and coordinates election responsibilities on a statewide basis with the ROVs in all of the state’s 58 counties. It also manages voter registration statewide and tests and approves all voting equipment for security, accuracy, reliability, and accessibility to ensure that every vote is counted as it was cast. More information about the State Elections Division’s roles and responsibilities are detailed on its [website](#).

The 2020 General Election

The management and implementation of the 2020 General Election in Alameda County (as well as statewide and nationally) confronted election officials with unprecedented challenges. Foremost was that it was held in the midst of a global pandemic, which created new needs and issues for voters and election workers alike. Public health guidelines changed rapidly as new information and data were released about the evolving pandemic. Accordingly, the ROV had to respond to new needs with tight deadlines. Compounding these conditions was that it was a presidential election year, which resulted in record voter registrations and turnout.

Adding to the election year challenges were increased mail voting levels and new mandates for increased locations for mailed ballots to be deposited (if they were not mailed). New state laws and regulations required the number of drop box locations to be greatly expanded. The prior election required the ROV to have 28 drop box locations. Because of a new state law, [Senate Bill 423](#), passed just three months prior to the November 2020 election (August 6, 2020), the number of required drop box locations more than doubled to 66 (per Section 2 of SB 423). Because of the dramatic increase in demand, there was a short supply of drop boxes that could be purchased and that met state law requirements. At the same time, these drop box locations had to be secure and strategically placed to meet new state requirements.

The Grand Jury determined that it was a matter of public interest to assess and report the performance of the ROV during this “crisis management” situation. An added factor was concerns that were raised nationally about the management and integrity of the 2020 election.

INVESTIGATION

Because of the aforementioned background factors, the Grand Jury determined that it was important to assess and determine if the ROV managed the implementation of the 2020 General Election in a manner that met all federal, state, and local legal requirements. In addition, the Grand Jury determined that it was a matter of public interest to assess and report the performance of the ROV during this “crisis management” situation. An added factor was concerns that were raised nationally about the management and integrity of the

2020 election. Because of these factors, the Grand Jury concluded that the citizens of Alameda County deserved to have an unbiased assessment performed on their behalf.

In conducting the investigation, the Grand Jury interviewed ROV staff and submitted written questions to and received written answers from the ROV. In addition, the Grand Jury submitted written questions to and received written responses from the State Elections Division. The Grand Jury consulted with the State Elections Division to obtain a broader statewide regulatory perspective and an additional “check and balance” on the work performed by the ROV and the Grand Jury.

During the course of its investigation, the Grand Jury asked the following questions and compiled evidence that produced the following corresponding mostly affirmative answers:

Q1: Did the ROV comply with all federal, state, and local laws governing the election process?

A1: Yes, the ROV complied with all legal requirements from local, state, and federal election laws. There were no complaints filed with the ROV or the State Elections Division that indicated otherwise.

Q2: Did the ROV take appropriate steps to prepare for the November 2020 election?

A2: Yes, the ROV took appropriate steps to prepare for the November 2020 election. These steps included conducting required and appropriate training for election workers. In preparation for the November 2020 election, the ROV conducted 133 in-person training classes held at eight separate locations within the county. In addition, each training location provided one-on-one training at its labs before and after class hours for election workers. A total of 2,349 election workers were trained on voting technology and procedures with hands-on, in-person learning experiences, and “online” training. Topics covered included all aspects of the voting process, touchscreen voting, on-demand printers, E-Poll books (roster book), curbside voting, COVID-19 precautions and protocols, and new procedures based upon recently passed legislation prior to the election.

Q3: Did the ROV take appropriate actions to comply with emergency conditions caused by the COVID-19 pandemic?

A3: Yes, the ROV took appropriate steps to respond to emergency conditions caused by the COVID-19 pandemic. The ROV took appropriate steps to comply with COVID-19-related election laws and regulations issued in the immediate months before the election. When problems emerged, the ROV responded quickly to resolve them in a time-sensitive manner to protect the successful implementation of the election process. The ROV offered a “help desk” for the public to call as well as for election workers to use for problem-solving purposes.

Q4: Did the ROV conduct training for election workers, both full-time and temporary?

A4: Yes, the ROV, under challenging conditions, conducted training for all election workers in preparation for the November 2020 election. This included both full-time employees and temporary workers hired for the election. This included testing procedures to confirm the knowledge and capability of workers to the areas of responsibility where they were assigned. If a worker did not pass the test they were transferred to an area where their skills were compatible. The ROV also conducted extensive cross-training for election workers, seeking to have workers possess a full understanding of the entire election process. For permanent employees, there was an orientation for the program area within the ROV where they were hired. They were also cross-trained in other areas to maximize their knowledge and capabilities. Similar training was provided to temporary workers, which is updated after each election.

Q5: Did the ROV meet mandated requirements for providing alternative language ballots for voters upon request? If a problem emerged, was it quickly addressed to ensure that as many alternate language voters as possible could vote, and that their votes were counted?

A5: Yes, the ROV provided ballots (some on demand) in 14 different languages. The main five languages, based on the county's population, were English, Chinese, Spanish, Vietnamese, and Tagalog. These voters had printed bilingual voter guides and ballots available for them. Voters in the other nine languages could vote with facsimile/reference ballots in their language at 100 locations. The ROV posted notices at all voting locations in all 14 languages informing voters that they could request a facsimile/reference ballot on demand in any of these languages. Every election site had the capability of producing these ballots upon request. If a problem occurred at a voting location, there were established methods resolve the problem.

Q6: Did the ROV meet mandated requirements for the placement of election drop boxes for the November 2020 election? If not, were they corrected on a timely basis? Did the ROV meet all requirements at on-site "Accessible Voting Locations?"

A6: Prevailing conditions made this a difficult mandate to fulfill. New requirements were placed on the ROV (and other county ROVs across the state) as a result of legislation that was passed by the State Legislature and became effective August 6, 2020. A brief time frame of two months was provided to obtain and place the required number of drop boxes in strategically determined locations. In the preceding election, the ROV had 28 drop boxes in place. The new law required a total of 66 to be obtained, prepared, and established within two months. The ROV ordered 38 new drop boxes from its vendor on July 22, 2020 – two weeks before the new requirement became effective. The vendor and supplier had issues satisfying the sudden increase in demand because multiple counties needed them at the same time. Because there are limited vendors that can make these drop boxes to meet legal

requirements, the sudden demand made it impossible for the vendors to satisfy the demand before the deadlines. The ROV took immediate steps to address this shortage as soon as possible. The ROV also dedicated resources to working with city managers and city clerks to identify strategic locations to place the required drop boxes in the communities where they were needed. During this time frame, the ROV also communicated with community-based organizations, faith-based organizations, the League of Women Voters, local school districts, and the State Elections Division to prioritize placement of these boxes. The ROV decided that it was best to proceed with the deployment of these boxes as they came into their possession from the vendor rather than seek a waiver from the State Elections Division. This was done to maximize the number of boxes in designated locations to maximize their availability to voters as soon as possible.

Q7: Did the ROV demonstrate its ability to resolve problems if/when they occur?

A7: Yes. For example, when a problem emerged at the Mills College voting site in Oakland, it was resolved. It involved confusion about proper ballot filing after voting, which resulted in some voters taking their ballots home instead of placing them in the proper trolley to be counted. Upon learning of the problem, the ROV took immediate steps to resolve the mistake. The ROV reached out by phone, email, and regular mail to every Mills College voter who might have been affected. This action enabled the ROV to collect 34 ballots from these voters. The ROV also obtained a court order allowing it to count any touchscreen ballots received from these voters. This incident was an isolated one and is not reflective of any systemic problem. To prevent a reoccurrence the ROV has increased the size of the header on the ballot that states “THIS IS A BALLOT.” The Grand Jury believes the ROV handled this problem in a rapid and correct manner and has taken proper steps to prevent a reoccurrence.

FINDING

Based on its investigation, the Grand Jury finds that the ROV, in 2020 and 2021, maintained the integrity of Alameda County’s election procedures and processes in the face of historic challenges. There was no evidence of unresolved problems in the election processes under the ROV’s jurisdiction. And when particular problems emerged at specific sites, the ROV moved quickly to address them in a manner that ensured all votes cast were counted.

Voters in Alameda County can count on the ROV’s dedication and effort to fulfill its basic mandates—to ensure every registered voter within the county counts, and all votes cast by the county’s registered voters are properly counted.

FINDINGS	<i>None</i>
RECOMMENDATIONS	<i>None</i>
RESPONSES REQUIRED	<i>None</i>

PROBATE CONSERVATORSHIP CRIES OUT FOR REFORM

EXECUTIVE SUMMARY

Alameda County provides legal services for people who cannot take care of their basic personal and financial needs and cannot afford a private attorney. These individuals, depending on the degree of impairment, may be placed in a conservatorship, a legal proceeding in which the court appoints a person or agency to take care of the individual's needs and make decisions on their behalf. The legal services provided by two agencies, the Public Defender and Legal Assistance for Seniors (LAS), are the primary safeguard against a person being placed in a conservatorship that is unjustified or unnecessarily restrictive.

The Grand Jury investigated the performance of the Alameda County agencies that are intended to protect impaired adults from harm: the Public Defender, which represents individuals in conservatorships, and the Public Guardian, which is appointed by the court as conservator when no one else is willing and able. (*See the Glossary in Appendix A for definitions of key terms used in this report*).

To understand the scope and purpose of conservatorship legal services, the Grand Jury focused on the performance and practices of the three service providers, the funding supporting these services, and the checks and balances that are in place to protect Alameda County's most vulnerable residents and make the entire process more responsive and transparent. The findings of this investigation provide a solid basis for recommendations for substantive and practical modifications of the conservatorship process that would provide more safeguards, define best practices, and reduce chronic underfunding and understaffing.

BACKGROUND

How Conservatorship Works

A conservatorship is established through a legal process, supervised by a court, in which a conservator is appointed as a decision maker on behalf of an impaired adult. An interested party, such as a friend, family member, or governmental agency, may petition the court for appointment of a conservator to protect an adult who needs help managing their personal or financial affairs. Depending on the evidence of the adult's inability to take care of their own needs, the court may transfer some or all of the adult's decision-making powers, known as the seven powers of conservatorship, to the conservator.

These rights include:

1. choosing where to live,
2. entering into contracts,
3. accessing confidential records,
4. making medical decisions,
5. making educational decisions,
6. choosing who to have social and sexual relationships with, and
7. marrying.

The court will order the transfer of these powers if there is convincing evidence that there is no less-restrictive alternative available to protect the adult from harm.

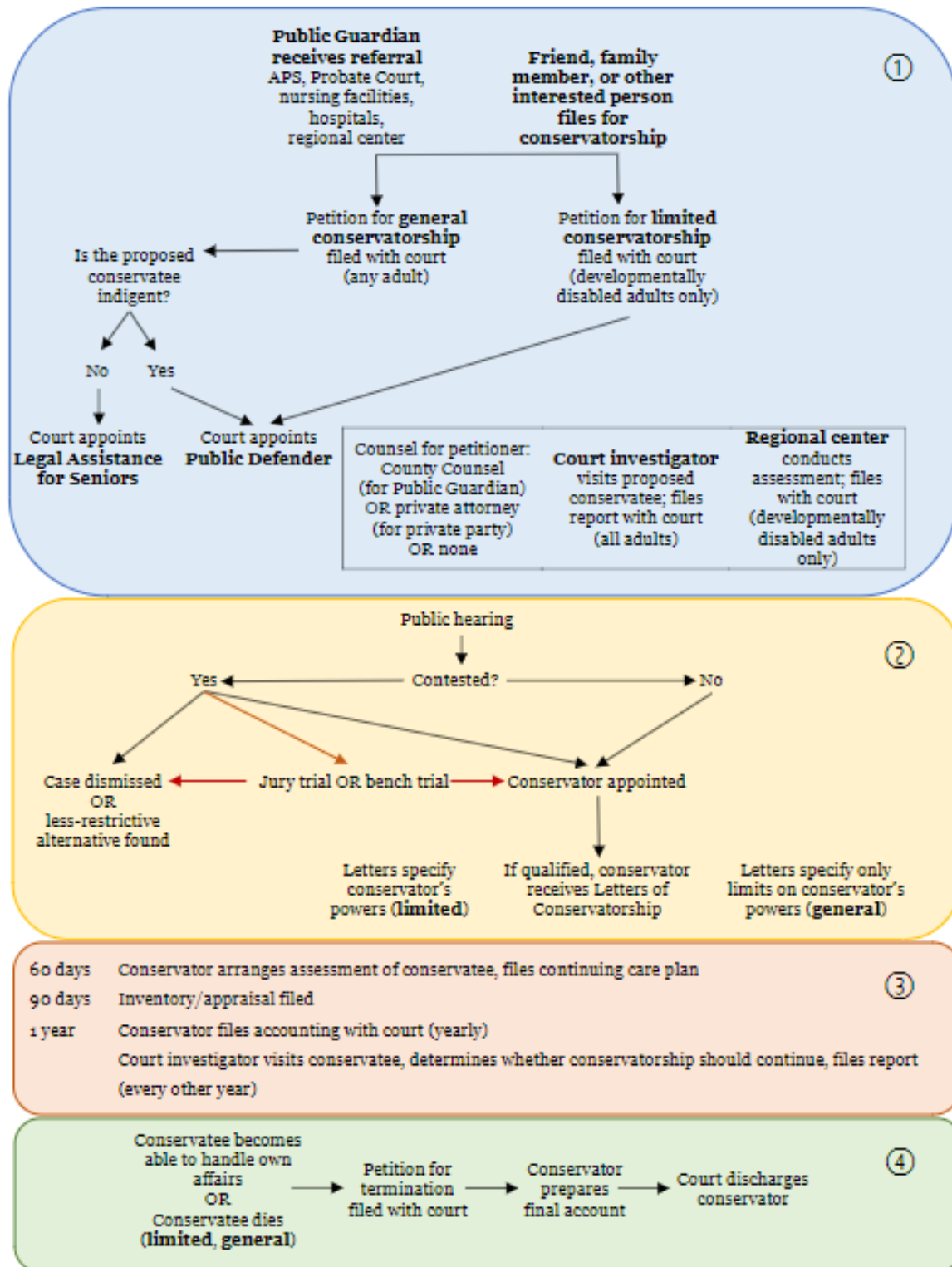
Types of Conservatorships

Several types of conservatorships exist. The two main categories are probate conservatorships, so named because they are handled in probate court, and LPS (or mental health) conservatorships, the most restrictive type, which aim to rehabilitate adults with severe mental illness and can be initiated only by a governmental agency; they expire after a year but can be renewed. Probate conservatorships, which are the focus of this report, can be divided into two subtypes, general and limited. General conservatorships are for any impaired adult, though most general conservatees are elderly and may have physical or cognitive disabilities (such as dementia). Limited conservatorships are only for developmentally disabled adults (of any age). Both general and limited conservatorships can last a lifetime.

A conservatorship is established through a legal process, supervised by a court, in which a conservator is appointed as a decision maker on behalf of an impaired adult. An interested party, such as a friend, family member, or governmental agency, may petition the court for appointment of a conservator to protect an adult who needs help managing their personal or financial affairs.

Conservatorship Process Summary

Here's a summary of the conservatorship process (see the figure on the following page): (1) Initiation of conservatorship proceedings. (2) The hearing and possible outcomes. The red arrows indicate options that have rarely (bench trials) or never (jury trials) been pursued in Alameda County within the past decade. (3) Court oversight of the conservatorship consists of annual accountings filed by the conservator and biannual reports filed by the court investigator. (4) Termination of the conservatorship. A conservatorship formally ends either when the conservatee successfully petitions the court to recognize that they are able to handle their own affairs or upon judicial recognition of the conservatee's death. The timeline data in part (3) are from the [*California Handbook for Conservators*](#).



In response to a petition to the court for a conservatorship, the proposed conservatee has a right to an attorney to present evidence on their behalf, to contest the proceeding, and to demand a jury trial. State statutes require counties to appoint attorneys in probate conservatorship proceedings and to provide or fund indigent legal defense services. According to [Local Rule of Court 7.820](#), the court will appoint a free Public Defender for all developmentally disabled and indigent adults, and it will appoint LAS for all other adults. Conservatees may also hire private attorneys, who must be approved by the court. State law requires the attorneys who perform these services to be licensed and to abide by the Rules of Professional Conduct.

The evidence presented at the hearing will determine whether the petition for conservatorship is approved. If so, the conservatee may lose the right to control where they live, to make decisions about their health care and medications, and to choose who to associate with, among other rights. For these reasons, a robust defense is essential. The attorney is obligated to protect a proposed conservatee's constitutional rights by carefully examining the client's capacity, cross-examining witnesses, considering the conservatee's placement and the extent of their powers, and determining who would best serve as a conservator.

State statutes require counties to appoint attorneys in probate conservatorship proceedings and to provide or fund indigent legal defense services.

Conservators and Their Role

If the petition is approved, the court appoints a conservator. For adults in both general and limited conservatorships, the court may appoint a conservator of the person, who is responsible for taking care of the conservatee's personal matters (such as food, shelter, and medical care), and/or a conservator of the estate, who is responsible for managing the conservatee's financial matters. These roles can be assigned to the same person or different ones.

A conservator may be a friend or family member of the impaired adult, a private fiduciary, or the Public Guardian. The Public Guardian is known as the conservator of last resort because it is appointed only when no other person is qualified or willing to act as conservator, or when the appointment of someone who is able and willing would not be in the conservatee's best interest (for instance, when a neutral party is needed because of a dispute among family members). In 2020, the Public Guardian acted as conservator in 17% of cases.

After a conservator is appointed, a court investigator conducts regular checks on the conservatee's living conditions and the conservator's actions, and reports its findings to the court. The conservatorship lasts until the conservatee dies or the court decides that the conservatorship is no longer necessary. When a petition for termination is filed, the conservator files a final accounting, and the court discharges the conservator.

Statewide Reforms: Adopted but Unfunded

In 2005, a series of articles by the *Los Angeles Times* exposed abusive treatment of conserved adults by for-profit conservators. Deficiencies in court oversight of these conservators prompted the California Legislature to pass the 2006 Omnibus Conservatorship and Guardianship Reform Act, which imposed licensing requirements on professional conservators and increased financial protections for conservatees.

At the same time, the California Supreme Court convened a task force to study how the probate conservatorship process could be improved. Its goals included the following:

- ensure that the conservatorship is the least restrictive alternative for the conservatee;
- ensure adequate access to information for all of the interested participants;
- make increased and better use of short- and long-term care plans;
- ensure that there is a system to prevent fraud and improper handling of conservatees' assets;
- ensure that the conservatee is being taken care of properly through personal visitation.

The final report of the Probate Conservatorship Task Force, published in 2007, called for systemic change. Its 85 recommendations covered aspects of the process ranging from attorney training to family relationship support to fraud detection. To help implement these reforms, the California Legislature approved a one-time payment to courts in fiscal year 2008-2009. In the wake of the 2008 financial crisis, however, the legislature eliminated funding for conservatorship reform from the state budget. It was never restored.

The Zealous Advocacy Law

The most important recent change in state law regarding representation of conservatees is the passage of AB 1194, known as the zealous advocacy law, in 2021. This law strengthens an individual's right to legal counsel in conservatorship proceedings and requires counsel to act as a zealous advocate, meaning that the attorney must advocate for what the client wants, rather than what the attorney (or anyone else) thinks is in the client's best interest. Among other reforms, it also requires professional conservators to be fully transparent about their fees and imposes heavy fines for misconduct.

The zealous advocacy law strengthens an individual's right to legal counsel in conservatorship proceedings and requires counsel to act as a zealous advocate, meaning that the attorney must advocate for what the client wants, rather than what the attorney (or anyone else) thinks is in the client's best interest.

As zealous advocates, attorneys are required to do everything reasonably within their means to help the client achieve the goals they articulate to their attorney at any point during the

proceeding. For people in involuntary conservatorship proceedings, the legal process is adversarial because their personal freedoms are at risk. The only hope for avoiding an unnecessary or too-restrictive conservatorship is a good defense attorney.

Public activists have advocated for years on behalf of vulnerable persons kept in conservatorships in which they are unable to make their own life decisions and/or are subject to potential abuse. The widely publicized Britney Spears case and two films, the 2018 documentary *The Guardians* and the 2020 feature *I Care A Lot*, led to a new wave of public interest and induced media outlets to take a critical look at conservatorships. These developments drew the attention of the Alameda County Board of Supervisors, which in 2021 conducted hearings on the subject of conservatorship.

The 2021–2022 Alameda County Civil Grand Jury received two requests to investigate probate conservatorship generally. These complaints, combined with the groundswell of public concern over alleged abuses of vulnerable people, prompted the jury to undertake this investigation.

INVESTIGATION

During its investigation, the Grand Jury conducted 10 witness interviews and received answers to emailed questions. Persons interviewed include employees of LAS, the Public Defender, the Division of Aging and Adult Protection, and the County Counsel Department. The Grand Jury also reviewed numerous documents, including reports by county and state agencies, manuals and standards of practice, conservatee asset records and case statistics, correspondence between county agencies, and the text of state laws and local rules of court.

Hundreds of new petitions for conservatorships are filed in Alameda County each year.

Conservatorship Defense Providers

Hundreds of new petitions for conservatorships are filed in Alameda County each year. The Public Defender represents approximately three-quarters of all (proposed) conservatees in Alameda County, and LAS represents most of the rest. LAS’s clients are primarily elderly adults in general conservatorships, whereas 80% of the Public Defender’s clients are developmentally disabled adults in limited conservatorships.

Despite being collectively responsible for representing several hundred conservatees per year, neither the Public Defender nor LAS has a written contract for services with Alameda County. As a result, there are no uniform guidelines or expectations for attorney training and evaluation, caseload, the scope of representation, or what constitutes zealous advocacy. The lack of guidelines means that the level of service clients receive is not consistent across these two agencies, but rather depends on the agency’s level of funding and staffing (see the table below for a summary).

This section of the report examines the conservatorship defense services provided by the Public Defender and LAS, with a focus on how they differ.

Summary of the Differences in Conservatorship Defense Services Provided by the Public Defender and Legal Assistance for Seniors

Aspect of Service	Public Defender	Legal Assistance for Seniors
Number of attorneys	1 full time	1.5 to 2 full-time equivalent
Support staff	1 shared legal secretary 1 shared clerical specialist	1 full-time equivalent
Caseload per attorney	Up to 362	Up to 50
Typical number of meetings with client	1	2 to 3
Training	2 weeks on-the-job training with outgoing attorney Self-directed continuing education	Work on conservatorship cases under supervision Conferences on elder abuse Community group trainings Ongoing continuing education
Track case outcomes?	No	Yes
Formal grievance procedure for clients?	No	Yes
Claim to practice zealous advocacy?	Yes	Yes

Training and Education

While the Public Defender employs more than 100 attorneys and 40 support staff across numerous practice areas, its probate conservatorship unit consists of a single attorney, with no dedicated support staff. For a newly hired attorney in this unit, training consists of one or two weeks of shadowing the departing attorney. There is no training checklist or manual.

After the initial training period, the attorney is responsible for self-educating to stay up to date on changes in the law and best practices. Continuing education consists of in-person seminars and recorded videos.

LAS was founded in 1976 and incorporated as a nonprofit organization in 1984. It is a much smaller agency than the Public Defender, with 35 employees providing legal, educational, and advocacy services in areas including elder abuse, minor guardianship, and conservatorship. A new conservatorship attorney at LAS is required to have experience working with older adults and to have worked a specified number of conservatorship cases, under supervision, from start to end. In addition to participating in continuing education seminars run by external agencies,

LAS conducts an annual conference on elder abuse as well as educational events within the community. A new hire at LAS has more thorough training, as well as more structured continuing education, than a new attorney at the Public Defender.

Caseload

The three attorneys at LAS who work on conservatorship part-time manage 40-50 cases each, not all of which are active. By contrast, between April and November 2021, the caseload of the Public Defender's probate conservatorship attorney ranged between 273 and 362 active cases, requiring significant evening and weekend work.

While the Public Defender employs more than 100 attorneys and 40 support staff across numerous practice areas, its probate conservatorship unit consists of a single attorney, with no dedicated support staff.

A heavy active caseload raises questions as to whether an attorney, regardless of skill or diligence, is able to act as a zealous advocate for each client. To mitigate this issue, the State Bar of California's *Guidelines on Indigent Services Delivery Systems*, published in 2006, recommend that attorneys practicing indigent defense prioritize their cases through "case weighting," which involves determining "the amount of work (in time) that is required to bring a case to a conclusion" (p. 27). To do so, attorneys should consider the complexity and specialized nature of the probate conservatorship process, their experience and training, reasonable preparation and study time for the task including the duty to research and investigate, and whether to consult with another professional in a related field. Despite this

recommendation, the Public Defender's probate conservatorship unit does not employ case weighting.

The *Guidelines* advise attorneys against taking on too many cases and caution that supervisors of overloaded attorneys are responsible for gaps in the legal services provided to conservatees. Specifically, the *Guidelines* cite an opinion by the American Council of Chief Defenders stating that:

When confronted with a prospective overloading of cases... the chief executive of a public defense agency is ethically required to refuse appointment to any and all such excess cases.

Refusing an increase in caseload is not an option for the Public Defender, as cases are assigned by the court and there is only one attorney to shoulder the workload. The consequence of chronic overloading of attorneys is insufficient legal services for conservatees.

Zealous Advocacy

In the absence of a contract between Alameda County and its conservatorship defense providers, the scope of attorney representation is unclear. Most importantly, according to [California Probate Code § 1800.3\(b\)](#), the court will not grant a conservatorship if a less-restrictive option is available, but the actions an attorney should take to pursue such options are not clearly defined.

The Grand Jury aimed to answer the following questions:

- How often do conservatorship defense attorneys meet with their clients?
- Do attorneys routinely arrange for clients to be evaluated by medical professionals and/or social workers? Should they?
- What role, if any, do attorneys have in communicating with a developmentally disabled client's regional center (described on page 62)?
- How often do conservatorship proceedings go to trial?
- After a conservatorship is established, does the attorney continue to monitor the case? If so, for how long?

As with attorney training, education, and caseload, in these areas the Grand Jury found significant differences between conservatorship defense providers.

Client Meetings

Most of the proposed conservatees represented by the Public Defender agree to the conservatorship. The Public Defender usually has one meeting with these clients (during the COVID-19 pandemic, this meeting often took place via video). For the small proportion of clients who object to the conservatorship, meetings are more frequent. LAS attorneys, by contrast, typically meet with their clients a minimum of two or three times, though in some complex cases there may be dozens of meetings over several years.

For the Public Defender, simple cases take three to five hours of attorney time. More complex cases, in which a client either objects to the proceeding or has a disability that impedes communication, can take up to 30 hours. If the client is unable to communicate their wishes, the Public Defender investigates their living situation and interviews their caretakers to determine what would be in the client's best interest.

Medical Evaluations

Whether a conservatorship defense provider should arrange for medical evaluations of proposed conservatees is subject to debate. The Grand Jury learned that there are conflicting opinions

about whether doing so should be considered part of the attorney's job, whether it should be delegated to support staff, or whether it should happen at all.

Neither the Public Defender nor LAS routinely arranges medical exams for clients. The rationale is that an exam might show that a client is more impaired than previously believed, which would not help their case. The Grand Jury acknowledges this concern but also notes that, in cases where the extent of a client's impairment is not clear, a thorough medical examination could help establish capacity, determine whether a treatable medical condition or a problem with medication or dosage is responsible for the impairment, or even bring to light a misdiagnosis.

Social Worker Evaluations

The Public Defender does not request evaluations by social workers, even though it employs five of them. A meeting with a trained social worker would provide valuable input and the ability to share observations. If feasible, such a meeting without the proposed conservator or family members present would provide an opportunity for the client to voice concerns about the proceedings, if so inclined and able.

Regional Center Involvement

Adults with developmental disabilities are frequently clients of regional centers, which are nonprofit agencies that offer assessments, access to services, and assistance with meeting educational and life goals. Regional centers play an important role in developing a client's individualized program plan (IPP), a document in which a client, in collaboration with their support system, sets forth their personal goals and how to achieve them. Depending on the client, an IPP can offer a blueprint for a less-restrictive alternative to conservatorship, such as supported decision-making, in which a client creates their own support network to help manage their personal and financial affairs. Such a document, assembled by a client with the help of people who know them and their capabilities well, would seem to be an invaluable resource for a conservatorship defense attorney.

Again, the Grand Jury heard conflicting testimony regarding whether (and to what extent) an attorney should communicate with a client's regional center, and whether doing so constitutes zealous advocacy or is outside the scope of representation. Most of LAS's clients are elderly adults in general conservatorships, so it has little contact with regional centers. Most of the Public Defender's, in contrast, are developmentally disabled adults in limited conservatorships who are regional center clients. The Public Defender routinely requests the most recent copy of a client's IPP from the client's family, but if none is provided, it does not follow up. IPPs are required by law to be updated at least every three years, but the Public Defender does not participate in this process and, therefore, does not receive or provide input.

By not participating in the IPP process, the Public Defender is forgoing an opportunity to assess changes in clients' capacity over time—changes that could result in a less-restrictive conservatorship or even termination. The Grand Jury learned that a developmentally disabled adult may be able to retain some of the seven powers of conservatorship and that capacity in each area can be assessed separately. For example, a person may be unable to make medical decisions or enter into contracts but may be capable of choosing where they would like to live or who to be friends with. Also, a conservatee's skills and abilities may develop to the extent that continuing the conservatorship is no longer necessary.

Trials

California Probate Code § 1827 grants conservatees the right to a bench trial or jury trial. In practice, however, bench trials in Alameda County are relatively rare and jury trials are nonexistent. Court records show that an average of 12 bench trials occurred each fiscal year from 2009-2010 to 2018-2019 and that there were zero jury trials in the same period. Notably, LAS was counsel for the proposed conservatee in the vast majority of the bench trials, despite representing fewer than half of all proposed conservatees in the county.

The Grand Jury learned that there are several explanations for the lack of jury trials, including their expense (for clients with the means to pay) and the unwillingness of many clients to air family disputes in open court. A jury trial is also very time-consuming, and an attorney with a high caseload would be hard pressed to see a trial through to completion.

Affirmative Outreach

Another aspect of zealous advocacy with no objective standard is whether (or for how long) an attorney should conduct affirmative outreach, or actively monitor a case, after conservatorship is established. The Public Defender usually withdraws as counsel after the petition for conservatorship is granted. If it becomes aware of a problem in an established conservatorship, it gets reappointed.

Follow-up generally consists of checking that the conservator is filing the required paperwork and that the court investigator is conducting a thorough review every two years, as required by law. If a case is scheduled for a status hearing and no problems have been reported, the Public Defender asks for the hearing to be taken off calendar to reduce caseload.

The court investigator plays an important role in conservatorship cases. The seven investigators employed by the Superior Court of Alameda County all work on conservatorship cases, and one is assigned to review accountings and fee requests. Aside from the biannual court investigator review, there is no other independent check on the conservator's performance throughout the life of the conservatorship. For this reason, it is crucial that the conservatorship defense provider conduct affirmative outreach to monitor the conservator's actions and ensure the conservatee's

well-being. In an effort to improve long-term follow-up, the Public Defender recently launched an affirmative outreach program that tasks interns with telephoning clients in long-established conservatorships to check on their status.

LAS conducts regular affirmative outreach for an average of a year after a conservatorship is established, but it withdraws as attorney of record by two years post-conservatorship. If LAS learns of a problem in an established conservatorship, it gets reappointed as counsel.

Quality Control

The Public Defender does not maintain an electronic database of its probate conservatorship cases. It does not track client demographics, case outcomes, or the rate at which conservatorships are terminated. In contrast, LAS maintains an electronic database of its conservatorship cases, allowing it to run reports on client demographics and case outcomes.

The Public Defender has no written complaint procedure to address the concerns of clients and their families. No audits of the Public Defender have occurred to determine compliance with probate rules designed to verify inventories and appraisals or accountings.

In the absence of an external assessment, a mechanism for analyzing case data, or a formal system for collecting client feedback, other quality control mechanisms are needed. The *Guidelines on Indigent Services Delivery Systems* emphasize the importance of attorney supervision and performance review, specifically:

a continuous, interactive system whereby mentors, supervisors and managers provide assessment, feedback, documentation, remediation and other functions to ensure that the quality of service being provided is assured... In general, newer employees ordinarily require considerable supervision as well as training to confirm quality assurance. However, the work product of more experienced employees should also be regularly or periodically assessed... To the maximum extent possible the performance measurements and standards should be in writing.

Contrary to these guidelines, the Public Defender does not have written performance standards for conservatorship proceedings, and no formal performance evaluations occur after the attorney's initial training period ends. Instead, supervision consists of weekly observation in court and informal discussions between the conservatorship attorney and their supervisor.

LAS does not represent indigent clients, so the *Guidelines* quoted above do not apply to it. Nevertheless, its procedures for attorney evaluation and client complaints are in line with zealous advocacy. To monitor attorney performance, LAS uses weekly case review meetings, regular

review by a supervising attorney, and client evaluation forms. If a client has a complaint, a written grievance procedure provides for two levels of review: a meeting with the legal director and, if the client is dissatisfied with that person’s response, a meeting with the executive director. Clients who wish to “appeal” the executive director’s decision are advised to bring their complaint to the Alameda County Area Agency on Aging, and a form for that purpose is available on the LAS website.

Funding and Fees

Fees charged to clients

In conservatorship proceedings, all requests for attorney fees are subject to court approval, and every party to a case (as well as any member of the public attending the court hearing) has an opportunity to object to a fee request. The court-approved hourly rate charged to clients by LAS is substantially lower than the county average. The Public Defender charges no hourly fees at all. Instead, it can claim a flat fee or a percentage of the estate of a conservatee whose assets have been liquidated. The percentage varies according to the value of the estate. The Public Defender requests fees only in general conservatorship cases, and only when the Public Guardian files a request for fees.

The court may deny any request for fees or reduce the amount to be paid. If a client of LAS cannot pay the fees, the county may be required to pay them instead.

How the agencies are funded

The Board of Supervisors approves each year’s funding for the Public Defender, and the Chief Public Defender is responsible for allocating funds among the various service areas. The office’s resources are devoted primarily to criminal defense; probate proceedings are not a priority for resources. There is no line item in the Public Defender’s budget for legal services in probate conservatorship proceedings.

By all accounts, the Public Defender is severely underfunded, and this problem is especially acute in the probate department. Of the numerous requests for funding submitted by the Public Defender to the County Administrator between 2018 and 2021, only one item (funds to support yearly probate training) relates to conservatorship defense. Despite the competing priorities for funds, the Grand Jury confirmed an urgent need for at least one additional attorney in the probate conservatorship unit.

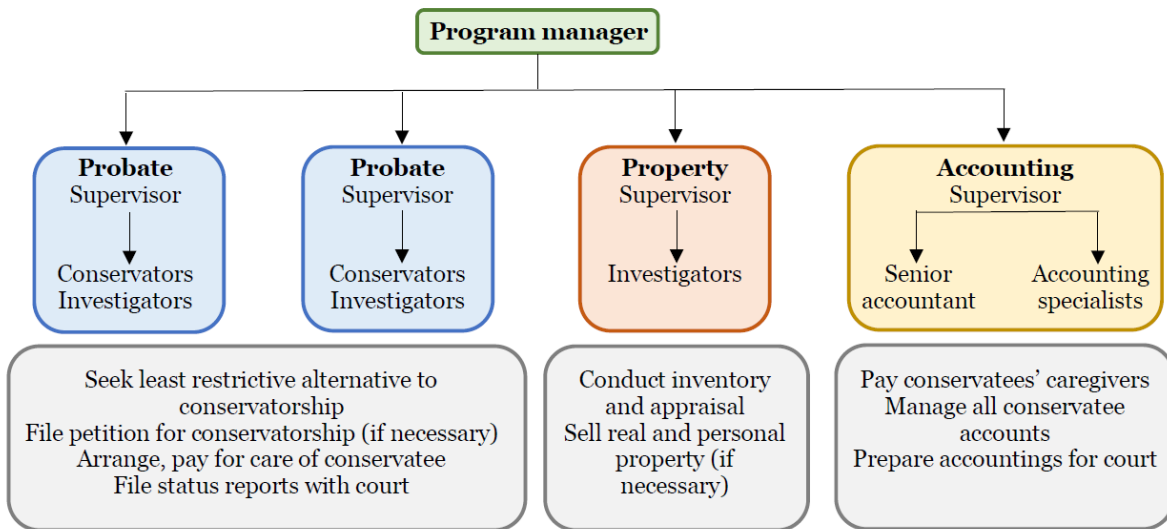
By all accounts, the Public Defender is severely underfunded, and this problem is especially acute in the probate department. Of the numerous requests for funding submitted by the Public Defender to the County Administrator between 2018 and 2021, only one item (funds to support yearly probate training) relates to conservatorship defense.

In contrast to the Public Defender, LAS receives no funds from the Board of Supervisors. With a budget of \$2.5 million, LAS’s operations are not self-sustaining, so it raises money through grants and individual donors. Most of its clients are low income. As a result, LAS charges clients on a sliding scale and sometimes writes off fees entirely if paying them would pose a hardship to the client.

Public Guardian

The Public Guardian-Conservator (Public Guardian) is a unit of the Department of Adult and Aging Services within the Alameda County Social Services Agency. The Public Guardian comprises conservators, investigators (not to be confused with court investigators), and accountants, along with support staff (see the below figure for a summary). It can be court-appointed as conservator in both LPS and probate conservatorships. In the latter, it can act as both conservator of the person and of the estate. County Counsel advises the Public Guardian and is responsible for drafting and reviewing all of its court filings.

Summary of the Staff and Duties of the Public Guardian in Probate Conservatorship Proceedings



The Public Guardian’s involvement in a conservatorship proceeding usually begins with a referral or an order by the court to initiate an investigation. Referrals may come from a hospital or nursing facility, Adult Protective Services, or a friend or relative of an impaired adult. Within five days of receiving a referral, a conservator meets with the proposed conservatee to learn about their needs, and an investigator begins researching whether a less-restrictive alternative is available.

In approximately two-thirds of cases, the investigation does not result in a petition for conservatorship (see the table below). If the Public Guardian does determine that conservatorship is necessary and appropriate, it will submit a petition to the court, usually within 20 days.

Sometimes, the court appoints the Public Guardian as conservator in a case it did not petition for. Such appointments are made when family members cannot agree on who should be conservator and it becomes necessary for a neutral party to arrange for the conservatee’s care and protect their assets.

Outcomes of Referrals for Probate Conservatorship Received by the Public Guardian for the Years 2018–2020 (as of November 2021)

Year	Referrals received	Conservatorships established (of person and of estate)	Cases pending	Terminated or deceased	Investigations closed/withdrawn or petition rejected
2018	86	24 (28%)	3 (3%)	2 (2%)	57 (66%)
2019	76	26 (34%)	1 (1%)	1 (1%)	48 (63%)
2020	89	17 (19%)	8 (9%)	2 (2%)	62 (70%)
Total	251	67 (27%)	12 (5%)	5 (2%)	167 (67%)

Data provided by the Public Guardian

Training and Education

The minimum qualifications for a probate conservator are a bachelor’s degree and previous experience with investigation or estate management. Probate conservators must also complete a four-year, 40-unit certification program by the California Association of Public Administrators, Public Guardians, and Public Conservators (CAPAPCPG); program participation is monitored by supervisors.

The Public Guardian has a detailed training manual and a guide to its case management software. In addition to the in-house and CAPAPCPG training, employees receive confidentiality and estate/trust management training from County Counsel as well as training in ethics, mental health, and aging.

Caseload

Ten probate conservators manage approximately 30 cases each, as conservators both of the estate and of the person. Witnesses stated that the unit is adequately staffed.

Quality Control and Oversight

Case management software allows the Public Guardian to track filing dates and task deadlines, as well as to analyze conservatee demographics, assets, and case outcomes. The Public Guardian pulls monthly reports to assess whether tasks are being completed in a timely fashion.

The Public Guardian's work is subject to several layers of review. Its accountings and status reports on conservatees are reviewed by County Counsel and the court investigator prior to approval by a judge. An external agency handles conservatees' tax returns, acting as a check on the Public Guardian's management of their estates.

A conservator of the estate can sell a conservatee's real or personal property to pay for ongoing care. If the Public Guardian determines that such a sale is necessary, it petitions the court for approval. Through their attorney, the conservatee can object to the sale.

Funding and Fees

The Public Guardian's funding comes from the county's general fund. Like the Public Defender, it can claim a flat fee or a variable percentage of the estate of a conservatee whose assets have been liquidated. However, if these funds are needed to pay for ongoing care, the Public Guardian does not request fees.

Optics and Liability

Appointing an attorney is a necessary accommodation under Title II of the Americans with Disabilities Act (ADA) to enable proposed conservatees to participate in a case. To ensure effective assistance of counsel, both the court and the county are obligated to adopt ADA compliance performance standards, require training of attorneys, and create methods to monitor attorneys' actual performance. Because there are no contracts between the probate conservatorship service providers and the county, ADA standards are not a part of any agreement to provide legal services.

The 2021 zealous advocacy law expands the risk of litigation by, or on behalf of, conservatees who are dissatisfied with the attorneys assigned by the county to represent their personal and financial legal interests. Alameda County's exposure to legal risk regarding probate conservatorships arises from the fact that the county does not keep track of how many and what type of probate cases are in the system; does not record what the outcomes actually are and what they should be; and does not audit the probate conservatorship system to examine its effectiveness, challenges, rate of improvement, and enforcement of probate conservatorship laws.

The significant understaffing and underfunding of the Public Defender likely contribute to the absence of jury trials and the rarity of court trials in conservatorship matters. With few trial

results for an appeals court to consider, there are virtually no appeals in which the appellate court could evaluate the procedures in probate conservatorships. Unlike constituencies with political power, adults in conservatorship proceedings are largely unable to lobby or influence the elected Board of Supervisors, the body responsible for funding decisions.

A Path Forward?

Alameda County's conservatorship defense providers rely on either funding from the Board of Supervisors, for which competition is fierce, or grants from foundations and individuals, which may not be reliable. However, other, more sustainable funding models exist. One such program, located outside California, has achieved good results for its clients and is financially self-sustaining.

The Legal Aid Center of Southern Nevada (located in Clark County) funds conservatorship defense through a fee appended to each document filed in the county recorder's office; its services are free to conservatees. Attorneys work with advocates and support staff to explore less-restrictive alternatives to conservatorship and to conduct affirmative outreach, which consists of twice-yearly, in-person visits with the conservatee to inspect their living conditions and assess their capacity. As a result of these efforts, in 2020 the Legal Aid Center closed almost as many conservatorship cases as it opened. In approximately 12% of its cases, either the petition for conservatorship was rejected or the existing conservatorship was terminated for cause. In other words, nearly one in eight conserved adults had their decision-making powers restored and their conservatorship proceedings dismissed.

Conservatorship defense providers in Alameda County would benefit from having a steady source of funding, employing advocates and legal assistants to monitor ongoing conservatorships, and having affirmative outreach built into the budget. Both conservatees and proposed conservatees would benefit from the proceedings being treated as a public service, with no fees or costs charged to their estates.

Under the current system, conservatees' estates can be quickly drained, despite court oversight. The main reasons are the costs of long-term care and fees paid to conservators and attorneys representing other parties (say, family members) whose hourly rates are not set by the court. The county is aware of this issue. In 2019, the Alameda County District Attorney investigated allegations that, among other things, probate court staff committed financial abuse and failed to protect conservatees' assets. The investigation found no evidence of criminal acts by probate

Conservatorship defense providers in Alameda County would benefit from having a steady source of funding, employing advocates and legal assistants to monitor ongoing conservatorships, and having affirmative outreach built into the budget. Under the current system, conservatees' estates can be quickly drained, despite court oversight.

court staff. It did, however, find that involuntary conservatorship proceedings are often very expensive for conservatees, especially those who are removed from their homes and placed in care facilities. The investigators offered the following recommendation to reduce or eliminate such costs for conservatees:

In situations where family members petitioned the court to be appointed conservator... and the Court finds conservatorship is not appropriate and eventually dismisses such petitions, the proposed conservatee should not be held accountable to pay for the costs of the legal process initiated by another person... [A]n analysis should be completed to identify alternate funding sources available through government agencies, including a voter approved initiative (tax) that can fund such expenses under limited and restricted circumstances.

The funding model used by the Legal Aid Center of Southern Nevada is one solution to this problem.

CONCLUSION

Through its investigation of conservatorship, the Grand Jury learned that there are numerous pitfalls in the system. The four findings and eight recommendations on the following pages aim to help conservatorship defense providers address these issues.

The Grand Jury recognizes that each case is unique and that attorneys have discretion in pursuing their clients' goals. The aim of this report is not to require attorneys to conform to a single, rigid standard but rather to clarify both the county's expectations of conservatorship defense providers and the duties of a zealous advocate. In the 2007 report conveying its recommendations to the Judicial Council, long before the funding intended to implement them was eliminated from the state budget, the Probate Conservatorship Task Force struck a hopeful note:

[M]any of the recommendations would require additional funding from outside sources and some recommendations would necessitate a substantial change in the culture and practice of superior courts and their justice partners. The task force did not want these factors to dictate whether a recommendation would be forwarded to the council; rather, the task force saw its charge as being one to make recommendations for the best possible system within which conservatees would have the greatest level of protection, resulting in a system that would warrant a high level of public trust and confidence.

The Grand Jury echoes these sentiments, with the hope that its findings and recommendations will lead to meaningful change for conserved adults in Alameda County. They have waited long enough.

FINDINGS

Finding 15:

The Public Defender's probate conservatorship unit is severely understaffed and overworked, meaning that proposed conservatees with means receive a far higher level of service than the indigent.

Finding 16:

The failure of the Public Defender to gather data on conservatorship case outcomes, implement formal training procedures, and establish a formal grievance process for clients, in addition to its reliance on paper files, hampers its ability to identify trends, stay up to date on best practices, and learn from past experience.

Finding 17:

The lack of a contract between Alameda County and its conservatorship defense providers that outlines the expected scope of representation means that not all proposed conservatees receive the same level of service and raises the risk of litigation against the county.

Finding 18:

Involuntary conservatorship proceedings can quickly drain proposed conservatees' estates, which would not occur under a recorder's fee- or grant-funded model.

RECOMMENDATIONS

Recommendation 20:

The Alameda County Board of Supervisors must transfer responsibility for conservatorship defense from the Alameda County Public Defender's Office to a separate agency.

Recommendation 21:

The Alameda County Board of Supervisors must establish a written contract with its conservatorship defense provider(s) outlining the standards to be met in order to receive county funding, as set forth in Recommendation 22.

Recommendation 22:

The Alameda County Board of Supervisors must include the following provisions in the written contract(s) named in Recommendation 21:

- a. actions required to establish zealous advocacy, including

- i. arranging an evaluation of proposed conservatees by a licensed medical professional and/or a social worker,
 - ii. working with regional centers to review individualized program plans (IPPs) for (proposed) conservatees who are regional center clients, to determine whether a less-restrictive alternative is available, and
 - iii. implementing a procedure to follow up with court investigators to ensure thorough and timely investigations,
- b. the length of time an attorney or support staff must perform affirmative outreach after letters of conservatorship are issued,
 - c. requirements that the conservatorship defense provider
 - i. establish written attorney training procedures,
 - ii. establish annual attorney performance evaluation procedures,
 - iii. review each case after the conservatorship ends and conduct an “exit interview” or survey with interested parties, and
 - iv. maintain a database of case outcomes.

Recommendation 23:

The Alameda County Board of Supervisors must select a neutral third party to conduct an annual audit of a random sample of conservatorship defense cases to assess attorney performance and determine compliance with probate rules.

Recommendation 24:

Unless and until there has been a determination as to a new funding model, the Alameda County Board of Supervisors must approve funding for one experienced full-time attorney to be assigned exclusively to the Alameda County Public Defender’s probate conservatorship unit.

If the Alameda County Board of Supervisors finds it unmanageable to follow Recommendation 20, then it must ensure that the existing conservatorship defense providers meet the standards named in Recommendation 22 by implementing Recommendations 25, 26, and 27:

Recommendation 25:

The Alameda County Board of Supervisors must direct the Alameda County Public Defender to subscribe to an attorney training service upon hire and for continuing education in the area of probate conservatorship.

Recommendation 26:

The Alameda County Board of Supervisors must direct the Alameda County Public Defender to establish annual performance evaluation procedures for conservatorship attorneys.

Recommendation 27:

The Alameda County Board of Supervisors must direct the Alameda County Public Defender and Legal Assistance for Seniors to arrange for each client to be evaluated by a licensed medical professional and/or a social worker.

REQUEST FOR RESPONSES

Pursuant to California Penal Code sections 933 and 933.05, the Grand Jury requests each entity or individual named below to respond to the enumerated Findings and Recommendations within specific statutory guidelines, no later than 90 days from the public release date of this report.

Responses to Findings shall be either:

- The respondent agrees with the finding.
- The respondent disagrees wholly or partially with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reasons therefor.

Responses to Recommendations shall be one of the following:

- The recommendation has been implemented, with a summary regarding the implemented action.
- The recommendation has not yet been implemented, but will be implemented in the future, with a time frame for implementation.
- The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or study, and a time frame for the matter to be prepared for discussion by the officer or head of the agency or department being investigated or reviewed, including the governing body of the public agency where applicable. This time frame shall not exceed six months from the date of publication of the Grand Jury report.
- The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation therefor.

RESPONSES REQUIRED

Alameda County Board of Supervisors

Findings 15, 17 & 18
Recommendations 20 through 27

Alameda County Public Defender

Findings 15, 16 & 18
Recommendations 24, 25 & 26

APPENDIX A: GLOSSARY

Affirmative outreach: when an attorney proactively checks on a conservatee's well-being after conservatorship has been established, as opposed to taking no action unless a problem has been reported.

Capacity: a person's ability to perform a task (also referred to as competence).

Conservatee: an adult whom a court has determined is unable to manage their own personal and financial affairs because of physical illness, developmental disability, or conditions of old age.

Conservator: a person or organization approved by the court to manage and protect a conservatee's finances and assets (conservator of the estate); arrange for the conservatee's food, shelter, and/or medical care (conservator of the person); or both.

Court investigator: a person employed by the court who advises conservatees of their legal rights and visits them in person, assesses their living conditions, and reports back to the court on whether the conservatorship should continue. Court investigators are required to conduct a visit and file a report one year after a conservatorship is established and every two years thereafter.

General conservatorship: applies to any impaired adult, particularly those who cannot care for themselves or manage their finances, usually because of conditions associated with old age.

Indigent: refers to a person with few or no assets who is eligible for legal representation by the Public Defender.

Individualized program plan (IPP): a document assembled by a regional center client, in collaboration with their family, a regional center representative, and others, that describes the adult's personal goals and how to achieve them.

Limited conservatorship: applies only to adults with developmental disabilities. The conservator has limited authority, specified by the court, and the conservatee retains all other rights not specifically assigned to the conservator (see Seven powers of conservatorship).

LPS conservatorship (also known as mental health conservatorship): named for the Lanterman–Petris–Short Act of 1967, this type of conservatorship is the most restrictive, with the aim of rehabilitating adults with severe mental illness. Unlike a probate conservatorship, an LPS conservatorship must be initiated by a governmental agency. It is not the same as a 5150 hold, which lasts up 72 hours and does not involve a conservator.

Probate conservatorship: includes both limited and general conservatorships, which are administered in probate court (excludes LPS conservatorships). Probate conservatorships are the focus of this report.

Proposed conservatee: an individual for whom a petition for conservatorship has been filed but who has not yet been conserved by a court.

Regional center: a nonprofit agency that offers assessments, access to services, and case management for persons with disabilities.

Scope of representation: the legal services an attorney provides for a client.

Seven powers of conservatorship: the rights that a court can transfer from an impaired adult to a conservator (i.e., the rights to choose their place of residence, to access confidential records, to marry, to make medical decisions, to enter into contracts, to make educational decisions, and to choose who to have social and sexual relationships with).

Supported decision-making: a less-restrictive alternative to conservatorship in which developmentally disabled adults create their own support networks to help manage their personal and financial affairs.

Zealous advocacy: the requirement that attorneys advocate for what their clients want, rather than what they think is in their clients' best interest.

APPENDIX B: REFERENCES

Americans with Disabilities Act of 1990 (*ADA*), Title II, Subpart A, U.S.C. §§ 12131–12134

Cal. Prob. Code § 1800.3(b)

Cal. Prob. Code § 1827

Cal. R. Ct. Rule 7.820

Conservatorship, Stat. 2021, ch. 417 (AB 1194)

Judicial Council of California, *California Handbook for Conservators: 2016 Revised Edition*, 2016, <https://www.courts.ca.gov/documents/handbook.pdf>

Judicial Council of California, *Recommended Practices for Improving the Administration of Justice in Probate Conservatorship Cases: Final Report of the Probate Conservatorship Task Force*, September 2007, <https://www.courts.ca.gov/4039.htm>

Legal Aid Center of Southern Nevada, *2020 Report: Adult Guardianship Advocacy Program and Minor Guardianship Advocacy Program*, January 2021, <https://www.lacsn.org/images/2020-Guardianship-Advocacy-Program-mini-annual-report.pdf>

Omnibus Conservatorship and Guardianship Reform Act of 2006, Stat. 2006, ch. 493 (AB 1363)

State Bar of California, *Guidelines on Indigent Defense Service Delivery Systems*, December 2005, [https://www.calbar.ca.gov/Portals/o/documents/ethics/Indigent Defense Guidelines 2006.pdf](https://www.calbar.ca.gov/Portals/o/documents/ethics/Indigent%20Defense%20Guidelines%202006.pdf)

WIDE-RANGING SAFETY AND HEALTH CARE ISSUES AT SANTA RITA JAIL

EXECUTIVE SUMMARY

Santa Rita Jail is the primary adult detention facility in Alameda County. Built in 1989 on a 113-acre site in Dublin, Santa Rita was designed to hold 3,489 individuals, ranking it among the largest jails and prisons in the country. Eighteen separate housing units provide for minimum- to maximum-security incarceration of both male and female detainees. Santa Rita staff include approximately 1,200 county and contracted employees who support operations 24 hours per day, every day of the year.

Given the context of seven in-custody deaths during 2021, a multiple-year pattern of lawsuits concerning conditions at Santa Rita, and reported high levels of COVID-19 infection among inmates and staff, the Grand Jury conducted an extensive inspection of the facility and investigation of operations to provide the residents of Alameda County with a transparent, independent, and fact-based assessment of the facility.

Through four on-site inspections, analysis of more than 1,300 detainee grievances, interviews with senior leadership, and a targeted review of jail records, the Grand Jury completed a holistic assessment of Santa Rita. The findings and recommendations presented in this report involve issues of facility safety, detainment conditions, COVID-19 management, health care, and the process for grievance submission and investigation.

The Grand Jury acknowledges that Santa Rita represents a challenging environment to manage, especially in the context of a global pandemic, and that employees strive to meet rigorous expectations amid competing demands and limited resources. Nonetheless, the concerns identified in this report represent material health, safety, and financial risks and as such warrant urgent attention.

Through four on-site inspections, analysis of more than 1,300 detainee grievances, interviews with senior leadership, and a targeted review of jail records, the Grand Jury completed a holistic assessment of Santa Rita.

BACKGROUND

Santa Rita Jail, located in Dublin, is Alameda County's primary adult detention facility. Operated by the Alameda County Sheriff's Office (ACSO), the jail opened in 1989 with a design capacity for 3,489 detainees. As of February 12, 2022, Santa Rita was at 65% of capacity, with 2,263 detainees.

Conditions at Santa Rita are the frequent subject of critical news reports and litigation, which have cited deficiencies in health care, unsanitary living conditions, an ineffective response to the COVID-19 pandemic (COVID-19), poor-quality food, and a culture of disrespect and abuse directed toward detainees. These claims have persisted despite a robust independent inspection regime that includes annual reviews by the Alameda County Health Inspector, biennial reviews by the Board of State and Community Corrections (BSCC), and on-demand inspections by the Alameda County Civil Grand Jury. The most recent Grand Jury inspections of Santa Rita were conducted by the 2016–2017 and 2018–2019 juries and documented few areas of concern.

In contrast to the generally positive conclusions to recent periodic inspections, in April 2021 the U.S. Department of Justice provided the Alameda County Board of Supervisors with notice of:

*...alleged conditions that we have reasonable cause to believe **violate the Constitution and federal law**... After carefully reviewing the evidence, we conclude that there is reasonable cause to believe that Alameda County and the Alameda County Sheriff's Office... engage in a **pattern or practice of constitutional violations in the conditions at the Santa Rita Jail** [emphasis added].*

Similarly, in the February 7, 2022 resolution of a class action lawsuit filed against ACSO, a federal judge approved a consent decree that places Santa Rita under court supervision for a minimum of six years. In his comments on the testimony from 37 detainees who participated in a public hearing, U.S. Magistrate Nathanael Cousins stated:

Many spoke about inhumane conditions at the jail, citing minimal out-of-cell time, lack of access to mental health resources, an unresponsive grievance process, and unchecked uses of force... The Court agrees that these conditions are unconstitutional, and they demonstrate the need for the reforms mandated in the Consent Decree.

The widely divergent narratives on conditions at Santa Rita encouraged this Grand Jury to undertake an integrated inspection and investigation of jail operations.

The findings and recommendations contained in this report were developed following a comprehensive review of Santa Rita operations that took place between October 2021 and February 2022. Through this investigation, seven members of the Grand Jury participated in four on-site inspections and reviewed thousands of pages of records, including detainee grievances, contraband logs, violent incident reports, COVID-19 vaccination and testing records, outdoor access logs, the jail’s written policies and procedures, minutes of county Board of Supervisors meetings, contracts with major vendors, and material published on the ACSO website. In addition, jurors interacted with both staff and detainees during on-site inspections and conducted formal witness interviews.

The detainee population at Santa Rita includes individuals who have been arrested but not yet arraigned, individuals who have been arraigned on charges and are awaiting trial, and individuals who have been convicted of a misdemeanor or felony and are serving their sentence in county jail. While convicted prisoners represent a sizable fraction of the jail’s population, more than two-thirds of the detainees are not serving an imposed sentence but instead are being detained while awaiting adjudication of their case. The Grand Jury respects the principle that all individuals are entitled to a presumption of innocence until adjudicated guilty. In support of this presumption, the Grand Jury intentionally uses the term *detainee* throughout this report to describe the full range of individuals housed at Santa Rita.

The findings and recommendations contained in this report were developed following a comprehensive review of Santa Rita operations that took place between October 2021 and February 2022. Through this investigation, seven members of the Grand Jury participated in four on-site inspections and reviewed thousands of pages of records...

The Grand Jury recognizes that all detainees at Santa Rita are entitled to full protection of their safety, preservation of their health, and respectful treatment throughout detention. Consideration of these detainees’ rights, alongside the rights of Santa Rita staff to a safe and healthy workplace, served as the central frame of reference for this investigation.

INVESTIGATION

Facility Safety

Safety Code Violations

Santa Rita was designed to support the daily activities of more than 4,000 people, and has been in continuous operation for almost 33 years. With a 24 × 7 × 365 operations schedule and a critical public safety mission, an effective maintenance and repair program is essential

to ensure a smoothly functioning facility and the well-being of detainees and staff. While the facility is owned by Alameda County, its day-to-day operations are the responsibility of ACSO, which is led by the elected sheriff. Alameda County provides comprehensive property management support for Santa Rita through the General Services Agency (GSA). The GSA is responsible for preventive maintenance, repairs, and management of most capital projects within the facility.

The GSA has dedicated on-site staff and management to provide facility support. GSA employees skilled in the construction trades provide the first line of support for the infrastructure, and contracted providers are engaged for projects that are large in scope or require specialized skills. GSA and ACSO staff jointly access an online property management system that allows users to schedule preventive maintenance tasks and manage the submission and tracking of service requests related to the facility.

The Grand Jury visited Santa Rita on four separate dates. During these visits, members of the Grand Jury focused their inspection on the secured portions of the facility, including detainee housing units, security control rooms, the intake/transfer and release center, medical facilities, the kitchen, and the motor pool.

On each visit, the Grand Jury observed the facility to be fully operational and without significant disruption related to infrastructure. However, members of the Grand Jury identified aspects of building infrastructure and operating practices that appeared to be out of compliance with governing codes and presented material safety risks to both detainees and staff.

Items of concern observed by the Grand Jury include but are not limited to the following:

- High-voltage wiring within housing units supporting ovens and tablet-charging stations not installed in accordance with the governing electrical code.
- Unlabeled emergency-stop buttons on industrial equipment.
- Visibly damaged 110-volt outlets throughout the facility.
- Malfunctioning fire alarm sensor that continually reported a “triggered” status.
- Obstructed access to emergency eyewash station within the kitchen.
- Emergency eyewash station in the kitchen with out-of-date testing and maintenance.
- Inconsistent signage on hazardous waste disposal containers.
- Instances of missing temperature-monitoring data for food storage refrigerators.
- Damaged flooring in housing units that presented a tripping hazard.



Damaged electrical outlet in housing unit

Through a joint walk-through with on-site GSA management, the Grand Jury confirmed the presence of multiple violations of the California Building Standards Code and learned that, with a single exception, the issues identified by the Grand Jury had not previously been reported or entered into the facility management service request system. The Grand Jury believes that the issues observed and the absence of prior identification of these issues represent evidence of a material gap in the policy and procedures for ensuring that the facility is in compliance with safety

regulations.

The Grand Jury learned that jail maintenance relies on a combination of scheduled preventive maintenance activities and a reactive model for addressing emergent needs. In this environment, ACSO staff working within the facility have access to an online system for reporting any building-related issues. Similarly, GSA staff working in the facility can log support requests for issues they observe that need further attention. Support requests are routed to GSA supervisors and addressed with GSA or contracted resources, as appropriate. Facility issues identified by detainees may be relayed to jail staff for submission to GSA or submitted through the jail's formal grievance process. Issues submitted through the grievance process are reviewed first by Grievance Unit staff, who submit a work request to GSA when they believe a repair is needed.

GSA reported that the current model is generally effective in ensuring that repair and maintenance issues are addressed in a timely manner, noting that most requests are handled within one week of submission and that there is no significant backlog of outstanding support requests.

The Grand Jury believes the current model of service request-driven maintenance works well to identify and address problems that are disrupting operations. For example, a burned-out light or a nonfunctioning security door is likely to be noticed, reported, and addressed in a timely manner. However, as evidenced by the number of code violations identified during the Grand Jury's inspections, this model is less effective in identifying emergent issues, including those that present safety risks but have yet to result in a physical injury. An eyewash station with blocked access, unlabeled emergency-stop buttons on equipment, and noncompliant

Despite the GSA’s critical role in ensuring Santa Rita’s safety and functionality, GSA representatives do not directly participate in periodic facility inspections conducted by the BSCC and the Alameda County Health Inspector.

routing of high-voltage electrical wires are all examples of deficiencies that are likely to go unreported and unaddressed in the current model, with potentially serious consequences.

As a supplement to the current request-driven maintenance model, the Grand Jury believes there is a role for periodic, proactive reviews of facility conditions. Such reviews should be a joint exercise to include ACSO leadership, GSA management, and an expert on the health and safety codes that apply to the jail. Issues identified during these reviews would be recorded in the existing facility management system for prioritization and tracking.

The Grand Jury learned that, despite the GSA’s critical role in ensuring Santa Rita’s safety and functionality, GSA representatives do not directly participate in periodic facility inspections conducted by the BSCC and the Alameda County Health Inspector. The Grand Jury believes this lack of direct engagement results in a missed opportunity for valuable exchange between expert facility inspectors and the county staff most directly responsible for maintaining the facility.

Access and Contraband Control

The Grand Jury learned that Santa Rita staff view the entry of contraband, especially illicit drugs, as perhaps the most serious and persistent challenge faced by the jail.

In mid-2020, the Alameda County District Attorney announced the arrest of a member of Santa Rita staff on 10 felony counts related to smuggling methamphetamines and a cellphone into the jail. The arresting officers’ sworn declarations stated that the staff member was found in possession of drugs and confessed to the charges, which were alleged to have occurred over a six-month period. At the time of the arrest, the employee had been under investigation for two months, indicating that the illegal activity had begun at least four months before the investigation was initiated.

Over the course of the Grand Jury’s four inspections of Santa Rita Jail, the seven jurors who participated in on-site inspections physically entered the facility a total of 13 times. During these entries, jurors crossed the secure perimeter, spent time in detainee housing units, and spoke directly with detainees. Santa Rita policy requires all jail visitors to present government-issued photo identification prior to entry to the facility. Notwithstanding this policy, across the 13 entries, with only a single exception, jurors were permitted to enter the jail through doors restricted to staff and administrative visitors without being requested to present their Grand Jury credentials or any other form of government-issued identification.

Santa Rita’s internal reports confirm that the entry of drugs and weapons into the facility is a persistent problem and that this contraband has resulted in harm to both staff and detainees. Despite this risk, the Grand Jury noted a near absence of controls to protect against the entry of contraband by staff or administrative visitors. The controls experienced by the Grand Jury were limited to a verbal inquiry during the initial visit. At no point were jurors requested to pass through a metal detector, have their bags X-rayed, or undergo a physical search.

In addition to their direct experience, over the course of the investigation jurors observed dozens of jail staff enter the facility from outside and cross the secure perimeter. None of the jurors observed the deployment of controls that would protect against the introduction of contraband by members of jail staff. The Grand Jury confirmed that current policies and procedures permit jail staff to enter the facility with personal items, including electronics and bags, and that these personal effects are not subject to routine examination by X-ray, metal detectors, or direct search.

The Grand Jury learned that some members of the Santa Rita staff have concerns about the possibility that employees and contractors can enter the secure perimeter with unscreened personal items. A proposed set of changes was developed to address these concerns, but to date ACSO has not adopted any changes in policies or procedures to mitigate this risk.

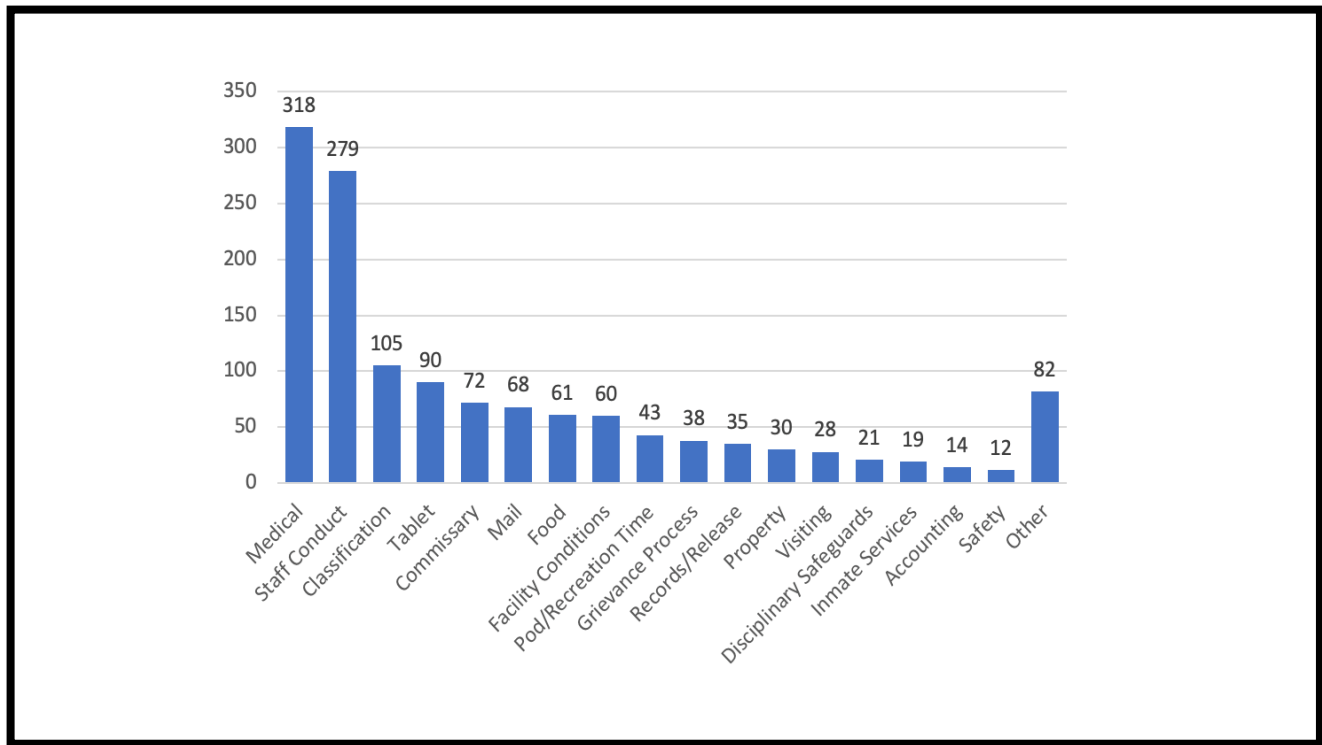
The Grand Jury confirmed that current policies and procedures permit jail staff to enter the facility with personal items, including electronics and bags, and that these personal effects are not subject to routine examination by X-ray, metal detectors, or direct search.

Detainment Conditions

When a detainee enters custody at Santa Rita, Alameda County assumes responsibility for that detainee’s health and well-being. That responsibility is a legal duty and persists regardless of the emotional or mental state of the detainee, the offense with which they are charged, budget pressures within the county, or even the presence of a global pandemic.

The Grand Jury’s investigation of detainment conditions was conducted in response to complaints of unacceptable detainment conditions reported in the media and allegations raised in civil lawsuits filed against ACSO. The investigation was conducted by reviewing more than 1,300 grievances filed by detainees, physically inspecting jail conditions during the on-site visits, and discussing focused areas of interest with staff and detainees.

**Breakdown of Santa Rita Detainee Grievances Filed
(August through October 2021)**



Analysis of grievances by category (August through October 2021). Concerns about medical care and staff conduct each represent more than 20% of filed grievances.

Among the 1,375 grievances filed by detainees during the three-month period between August 1, 2021 and October 31, 2021, medical services and staff conduct were the most frequent categories of concern, with each representing more than 20% of filed grievances. Concerns around housing classification, jail-issued tablets, the commissary, and mail were the next most common, each being responsible for 5% or more of filed grievances.

Many of the complaints about detainment conditions reported by the media and alleged in lawsuits were not substantiated during this investigation. The jury did, however, identify concerns regarding medical services, outdoor access, sanitation of temporary holding cells, and cleanliness of common spaces within the housing units. Each is documented below.

Medical Services

While detainees’ concerns about medical services varied widely, delayed access to care and challenges with ensuring continuity of medication were recurring themes.

Health care at Santa Rita is provided under contract by Wellpath, a for-profit medical services provider. The Grand Jury inspected the primary medical facility at Santa Rita and found it clean, well-supplied, and active with patient care. The medical staff on duty presented as

professional and knowledgeable and appeared to be practicing appropriate COVID-19 prevention protocols.

The Grand Jury confirmed that demand for medical services exceeded available capacity, often causing long wait times for appointments. The Grand Jury also learned that appointment delays and cancellations (for instance, to attend a court hearing) contributed to issues with continuity of medication for some patients. The Grand Jury was unable to confirm the root cause of this imbalance between supply and demand and concludes that it warrants a coordinated review by Wellpath and Santa Rita leadership.

The Grand Jury confirmed that demand for medical services exceeded available capacity, often causing long wait times for appointments.

Santa Rita recently initiated monthly, independent quality assessments of health care provided to detainees. The Grand Jury reviewed the resulting Monthly Quality Dashboard delivered in March 2022 and noted that it found examples of incomplete and inaccurate information in medical records as well as operational procedures that interfered with care delivery.

Although reported quality levels were far below established standards, the Grand Jury was impressed with the rigor of the audit, the quality of the recommendations, and the jail commander's personal participation in the monthly review meeting. Obtaining accurate information on the scope and nature of operational issues is a critical first step in addressing the problem, and the Grand Jury believes that the introduction of this process will be useful in monitoring not only access to care but also the quality of care.

The contract between Wellpath and ACSO includes requirements that Wellpath ensure minimum staffing by job function and maintain a low error rate across quality audits. The contract provides for monetary penalties for each understaffed shift and each occurrence of below-goal quality delivery. The Grand Jury understands that historically no penalties have been levied against Wellpath for understaffing or inadequate levels of quality. The Grand Jury believes these monetary penalties are an important tool to ensure that Wellpath delivers on its contractual obligations. The Grand Jury also encourages ACSO to actively pursue these penalties in each instance when contract requirements are not met.

In reviewing the history of the Wellpath-Santa Rita relationship, the Grand Jury learned that the former medical director for the jail, a Wellpath employee who worked at Santa Rita for five years, had her employment terminated in August 2020 for improper use of jail prescription pads to self-prescribe medication. At the time of the termination, Wellpath submitted a complaint to the Medical Board of California that documented concerns about self-prescription activity and that the physician had been practicing medicine while impaired.

On August 18, 2021, the Medical Board of California ordered a two-year suspension of the former Wellpath employee's license to practice.

The Grand Jury learned that Santa Rita Jail officials were first notified of the planned termination of the medical director less than 24 hours before it occurred. Santa Rita management did not materially engage around the personnel change, and prior to the Grand Jury's inquiry, Santa Rita leadership was unaware that Wellpath had observed performance issues and had been concerned about the physician practicing medicine while impaired.

The contract between ACSO and Wellpath includes the requirement for a drug-free workplace and prohibits the unlawful manufacture, distribution, possession, or use of controlled substances at any county facility. The contract also requires Wellpath to notify ACSO within five days of any instance of employee conviction or no-contest plea to a criminal drug statute violation occurring at a county facility. Failure to notify is deemed a material breach of the agreement. The circumstances involving the former medical director do not appear to have been covered by this notification clause, as the issue was addressed through the state medical review board rather than a criminal prosecution.

In reviewing the major vendor contracts for Santa Rita, the Grand Jury observed that while the health care provider and food service provider contracts shared common language regarding the core responsibilities of the contractor, the agreement for food service included a set of additional provisions specific to Santa Rita. These provisions addressed contraband, compliance, safety, and security and provided that key personnel could not be changed without the consent of ACSO. These requirements are notably absent from the Wellpath agreement.

Despite the extended time frame of the substance abuse by a senior medical provider at the jail, the use of jail resources to obtain fraudulent prescriptions, and Wellpath's concerns that its employee had been practicing medicine while impaired, a timely and transparent communication between Wellpath and Santa Rita on this issue did not take place. The lack of effective communication between Wellpath and ACSO on such an important topic is concerning to the Grand Jury, as is ACSO's failure to independently detect a period of on-the-job, illicit drug use by a senior member of the Santa Rita medical care team. Also of concern is that, once learning of the issue, ACSO failed to investigate and to assess Wellpath's response to this situation as part of its management oversight of Wellpath.

Outdoor Access

Santa Rita's primary structure is a two-story concrete building with 980,000 square feet of interior space containing 18 independent housing units, a medical facility, and supporting functions. The sprawling facility was designed with several large outdoor yards in the spaces

between housing units as well as multiple secure outdoor “mini-yards” directly adjacent to the maximum-security sections of the jail.

Despite its extensive outdoor space, the Grand Jury observed almost no use of either the large yards or the mini-yards by detainees. This observation was particularly surprising given COVID-19 mitigation recommendations that encourage social distancing and increased access to fresh air and sunlight.

On inquiry, jail staff reported to the Grand Jury that detainees were offered the opportunity of one hour of outdoor access per day. This assertion was countered by detainees’ reports of being offered a one-hour opportunity per week, subject to the weather and conditional on the detainee not being otherwise scheduled for court, medical, or other appointments.

The Grand Jury investigated the level of outdoor access permitted to detainees by requesting and reviewing the handwritten housing unit logs maintained by the deputies on duty. These logs supported the detainees’ reports of outdoor access being offered, on average, once per week for a single one-hour block of time. Despite the clear documentary evidence, several jail staff continued to assert that detainees were provided daily outdoor access which the Grand Jury did not find to be accurate.

The Grand Jury believes that regular access to fresh air and sunlight is crucial to the health and well-being of detainees and that that the current limit on this access to a single hour per week is inconsistent with the county’s responsibility for the detainees in its custody.



Aerial View of Santa Rita Jail by Jesstess87

(CC BY 4.0; <https://creativecommons.org/licenses/by-sa/4.0/deed.en>).

Source: https://commons.wikimedia.org/wiki/File:Aerial_view_of_Santa_Rita_Jail.jpg.

Sanitation of Temporary Occupancy Cells

Santa Rita contains several areas where detainees may be held in cells designed for temporary occupancy. Examples include:

- **Safety cells**, unfurnished and padded rooms with a floor drain; most frequently used for detainees who are considered at risk of self-harm.
- **Sobering cells**, rooms within the intake/transfer and release center occupied by incoming detainees who are found to be under the influence of alcohol or drugs.

The Grand Jury inspected several temporary holding cells during its four inspection tours. On multiple occasions, jurors noted foul odors and/or evidence of feces in these rooms. On inquiry, jail staff confirmed that the rooms being examined were considered available for immediate use. The presence of feces smeared on walls and foul odors in several cells described as being available for immediate occupancy suggests to the Grand Jury a systemic issue with the quality of cleaning and sanitation of temporary occupancy cells.

Cleanliness of Housing Unit Common Space

During its inspections, the Grand Jury observed varying levels of cleanliness in the facility. While most areas of the jail appeared freshly cleaned and well kept, the level of cleanliness in housing units and attached mini-yards was less consistent. Most housing units were maintained in a manner similar to the common areas of the jail and presented as clean, odor-free, and with all garbage disposed of in the provided trash cans. Several housing units were observed in a different state. In these units, jurors observed a combination of debris, dirty floors, and in one instance, a clogged commode.

Detainees reported to the Grand Jury seeing and hearing mice in their housing pods at night and being bitten by insects while sleeping. Rodent and insect traps were visible in several areas; however, the Grand Jury did not directly observe vermin during its visits.

Santa Rita policy places the responsibility for maintaining the cleanliness and sanitation of housing unit common spaces on the detainees who have access to that space. Detainees are provided access to cleaning supplies and determine their own cleaning schedule.

The Grand Jury understands and supports the intention underlying the delegation of cleaning responsibilities to the primary users of the space; however, in some instances this model fails to result in a clean living environment. In those situations, jail staff's failure to ensure the timely remediation of unacceptable conditions risks impairing the health and well-being of those who reside in the housing unit.

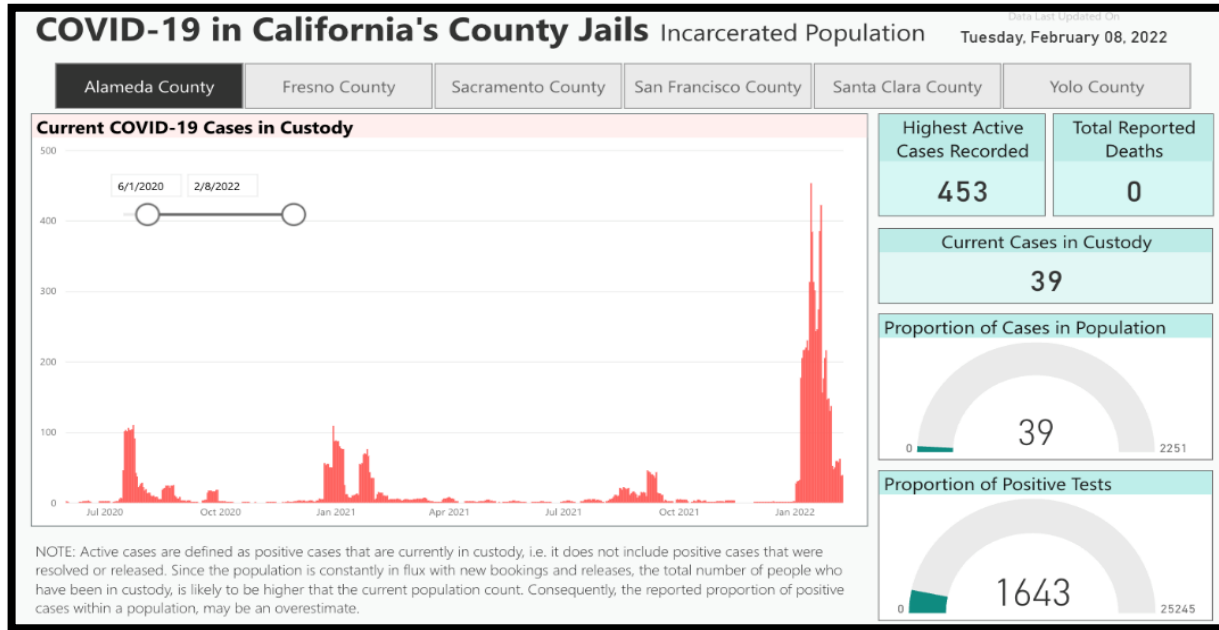
COVID-19 Management

On March 11, 2020, the World Health Organization declared the COVID-19 outbreak a global pandemic. Just five days later, the Alameda County Health Officer issued its first shelter-in-place order, prohibiting all nonessential gatherings and travel within the county. During the past two years, the Health Officer has regularly updated COVID-19-related orders and guidance to help ensure the health and well-being of all people in the county.

Correctional facilities like Santa Rita face unique challenges in managing the risk of contagious disease, given the communal living conditions, the difficulty of social distancing, and an ever-changing population of detainees housed at the facility. ACSO has taken its responsibility for managing the risk of COVID-19 infection to detainees and staff seriously, implementing a broad spectrum of policy and procedure changes to reduce COVID-19 risk and adjusting those policies and procedures as the understanding of that risk evolved. According to ACSO data, since the beginning of the pandemic only two detainees have been hospitalized with COVID-19, and none has died.

Correctional facilities like Santa Rita face unique challenges in managing the risk of contagious disease, given the communal living conditions, the difficulty of social distancing, and an ever-changing population of detainees housed at the facility.

In response to complaints by detainees, attorneys, and activists about ACSO's alleged failure to adhere to Alameda County's COVID-19 protocols for testing, physical distancing, and disinfection/cleaning, Sabot Consulting was engaged to perform an independent COVID-19-focused inspection of Santa Rita. Sabot's report on the inspection, published in mid-2020, concluded that while there were no systemic problems that materially undermined the efforts to manage the spread of COVID-19, there were "a number of opportunities for process improvements that should be addressed." Sabot also stated that "there must be a process in place going forward to detect and correct these problems, so they do not become systemic." In a follow-up to the report, Sabot praised ACSO's efforts to manage COVID-19 risk by complying with the majority of the report's recommendations but noted that two other recommendations had not been implemented. The inspector cautioned that he had observed "a few lapses in enforcement that could very well result in an outbreak of the virus within the secure perimeter and result in serious illness and/or death of staff and inmates if allowed to continue."



Presentation of data published by ACSO (source: covidincustody.org).

During 2021–2022, COVID-19 infections among detainees at Santa Rita spiked to unprecedented levels, with 20% of detainees testing positive for COVID-19 at the peak of a January 2022 outbreak. Using the Sabot report’s findings as a reference, the Grand Jury sought to answer the following questions:

- Do staff consistently adhere to ACSO’s and Alameda County’s COVID-19 policies?
- Do staff clearly and effectively communicate the policies and procedures to detainees?
- Has Santa Rita’s COVID-19 policy led to a sustained reduction in the number of infections among staff and detainees?

Entry Screening

On arrival at Santa Rita, detainees undergo COVID-19 screening, consisting of a temperature check and symptom questionnaire, prior to entering the jail for intake processing. The Grand Jury was informed that all detainees are offered a COVID-19 test within 48 hours of their booking and again on the fifth day of their detention.

Detainees who are symptomatic or who test positive for COVID-19 during intake are placed in an isolation room to complete their intake processing, then transferred to the medical unit. Detainees who are symptom-free are placed in temporary housing for a 14-day quarantine period. During this time, detainees who enter the jail on the same date are co-housed and monitored for symptoms while remaining isolated from other populations in the jail. If a

detainee becomes symptomatic after being placed in their housing, they are moved to an isolation cell and visited by a nurse, who assesses the detainee's symptoms and offers a COVID-19 test. The nurse relays the detainee's symptoms to the medical unit for follow-up, and the quarantine status of the previous housing unit is updated to reflect the potential virus contact.

Santa Rita's COVID-19 protocol requires visitors to undergo a temperature and symptom check outdoors before entering the facility. The outdoor COVID-19 screening center for visitors is staffed by a sworn deputy rather than a medical professional. The Grand Jury observed that while temperature checks were universal for visitors, the checkpoint attendant did not seek information on potential COVID-19 symptoms or exposures, as required by ACSO policy. Consistent with the screening observed for jail visitors, jurors participating in facility inspections underwent a temperature check but no symptom or exposure review, nor were jurors asked to provide documentation of vaccine or testing status prior to entry.



Medical supplies and symptom questionnaires at the COVID-19 screening area

Following screening, visitors are provided a sticker to wear that serves as a visual confirmation that they had been successfully cleared at the COVID-19 screening checkpoint.

The Grand Jury notes that a May 2021 Alameda County Public Health Department guidance states:

*The Centers for Disease Control and Prevention (CDC) recommends asking **both** COVID-19 screening questions **and** measuring temperatures upon arrival for... personnel, visitors, and persons confined to correctional/detention facilities. [emphasis in original].*

As reported by Sabot Consulting in 2020, ACSO constructed a dedicated staff screening kiosk outside the main staff entrance. Activity at this kiosk is designed to mirror the visitor screening checkpoint, with each staff member having their temperature checked and answering COVID-19 symptom questions prior to entry. Jurors did not directly observe operation of this checkpoint but were informed by jail staff that it operated in a manner consistent with the visitor screening checkpoint.

The Grand Jury notes that ACSO has made a meaningful investment in infrastructure and processes to create exterior COVID-19 screening checkpoints for detainees, staff, and visitors.

However, lapses in the execution of established screening procedures, specifically the absence of verbal questioning about symptoms and potential exposures, degrade the value of this investment. Furthermore, the Alameda County Public Health Department guidance issued in May 2021, and reiterated in CDC guidance for congregate facilities issued in February 2022, makes it clear that symptom screening should be considered a supporting rather than a primary control for preventing outbreaks:

Screening for COVID-19 symptoms (including temperature checks) and asking about recent exposure can help identify staff members or visitors who should be excluded from a facility before entry... Symptom screening alone will not prevent all transmission, since it is largely based on voluntary self-report and will not identify people with asymptomatic infection.

Detainees and COVID-19 Prevention

The Grand Jury was informed that each new detainee receives soap and sanitizing wipes on arrival and that these supplies are resupplied upon request. Jurors observed that sanitation supplies and surgical masks were available within the intake/transfer and release center and the inspected housing units. While masks were readily available to detainees, most of the detainees observed by jurors were not wearing masks or were wearing a mask that did not fully cover the nose and mouth. The level of detainee mask use is concerning, given the low level of COVID-19 vaccination within the detainee population.



A fact sheet about COVID-19 symptoms; a CDC flier about handwashing (in English and Spanish); and vaccine information posted in a housing pod.

Information about COVID-19 symptoms and the availability of vaccines is conspicuously posted throughout the facility, including in each housing unit. Information on Santa Rita's COVID-19 prevention policies is also available to detainees electronically via jail-issued tablet. The Grand Jury confirmed with multiple detainees that they believe that information on the jail's COVID-19 policies and on the availability of testing and vaccinations is easily accessible.

Housing units are color-coded according to their current level of COVID-19 risk and exposure. Housing units and isolation rooms within the medical unit are conspicuously labeled with colored sheets of paper indicating the status of the detainees housed, and staff

take care not to let the color-coded groups interact. As a result of this mitigation step, outdoor yard access is limited to a single color-coded unit at a time and transit vehicles are restricted from transporting detainees from different color-coded units together.

Transport vehicles, both large and small, have been modified to accommodate fewer detainees with greater physical distancing and are operating at approximately one-third capacity. Staff reported to the Grand Jury that transit vehicles are thoroughly cleaned after each trip using a bleach solution and an electrostatic spraying machine similar to the type used to sanitize aircraft. The Grand Jury noted, however, that motor pool staff were unable to locate the sanitizing sprayer when requested.

Detainees have been assigned the responsibility of cleaning their cells and housing unit common areas. Cleaning supplies, personal protective equipment (PPE), and refills of hygiene products are, by policy, available on request. The Grand Jury observed soap and sanitizer in the bathrooms and sink areas of most of the housing units inspected, and when a juror pointed out a lack of soap and sanitizer, a staff member was able to immediately retrieve some from a storage closet.

Staff Use of Face Coverings

The Grand Jury observed a high but not universal level of face covering by jail staff. All employees who accompanied the Grand Jury on its inspection wore masks at all times. However, workers in housing unit observation rooms did not wear masks, even though multiple employees occupy these enclosed workspaces throughout the day. The Grand Jury also observed several administrative staff members working together in low-partition cubicles outside the jail's secure perimeter with their masks pulled down. Given the close proximity of the staff to one another and the open concept nature of the workspace, this behavior appeared to the Grand Jury to be out of compliance with then-current Alameda County and ACSO masking policies. Importantly, this lack of compliance was observed in an area adjacent to offices occupied by senior leadership, raising questions about whether leadership provides sufficient oversight of masking requirements.

Testing and Vaccination

Staff

As of February 2022, the only group of Santa Rita employees or contractors who are subject to a vaccination mandate is the medical staff, all of whom were reported to the Grand Jury as being fully vaccinated by October 8, 2021.

The vaccination rate among Santa Rita's nonmedical staff is much lower: Only 62% of custodial staff were documented as being fully vaccinated as of January 13, 2022. This level

compares unfavorably to that of the surrounding community; 81% of eligible individuals in Alameda County were fully vaccinated as of the same date.

ACSO's website presents weekly summaries of detainee vaccination rates and COVID-19 testing results for staff and detainees, among other COVID-19-related data, but information on the vaccination rate among jail staff is notably absent from this public reporting. Given the importance of vaccination in preventing the spread of COVID-19 and the real risk of transmission posed by asymptomatic individuals, the Grand Jury believes that the community deserves accurate and timely information concerning the aggregate vaccination level of Santa Rita staff.

ACSO's website presents weekly summaries of detainee vaccination rates and COVID-19 testing results for staff and detainees, among other COVID-19-related data, but information on the vaccination rate among jail staff is notably absent from this public reporting.

Santa Rita's Human Resources Department keeps track of documentation on staff vaccinations and shares this information with the Compliance Department to support its execution of COVID-19 policies. Santa Rita employees who are not fully vaccinated are required to undergo weekly testing that confirms their COVID-19-negative status to work at the facility. Consequences for delays in testing are modest, and the Grand Jury learned that they have not been uniformly enforced. The Grand Jury was informed that as of October 30, 2021, eight employees were out of compliance with the testing requirement while working at the facility.

According to current CDC guidance, a robust testing program, including both diagnostic and screening testing, is a critical component of an effective COVID-19 protection program for a corrections facility. The guidance further states that diagnostic testing should be performed for *"anyone who shows signs or symptoms of COVID-19 and for anyone who has been potentially exposed or identified as a close contact of someone with COVID-19, regardless of COVID-19 vaccination and booster status."*

The number of COVID-19 tests completed among staff dropped significantly between August 2021 and February 2022 despite a significant surge in COVID-19 cases both within the jail and in the broader community. According to ACSO data, in the week ending August 21, 2021, 958 staff tests were performed; in the week ending November 27, 2021, the number was 369; and in the week ending February 5, 2022, it was 229. The Grand Jury understands these counts to include both screening and diagnostic tests for staff. This level of weekly testing appears to be insufficient to include weekly testing of all unvaccinated staff and the level of recommended diagnostic screening for staff who have had close contact with someone who has contracted COVID-19.

Detainees

Since May 2021, the vaccination rate among detainees has ranged between 25% and 30%. In the context of such low vaccine penetration, ubiquitous use of alternative prevention measures, including masks, social distancing, and sanitizing, is essential to prevent widespread illness. While prevention measures are critical, increasing the vaccination rate for detainees offers the best opportunity to protect the health of both detainees and staff. ACSO recognizes the challenge presented by the low vaccination rate among detainees and actively encourages vaccination through posted flyers throughout the facility. Despite the availability of vaccination appointments and the efforts at education, the vaccination rate has remained essentially unchanged over the past year as in-custody vaccinations are offset by inflows of new detainees with lower vaccination levels.

In the week ending February 5, 2022, 10% of Santa Rita's detainee population was tested for COVID-19, which suggests that approximately two-thirds of detainees were both unvaccinated and untested that week. Despite the January 2022 wave of infections within Santa Rita, testing rates have not exceeded 20% since mid-January, while the test positivity rate has fluctuated widely in the range of 9% to 100%. The Grand Jury recognizes that Santa Rita staff cannot compel detainees to be tested or vaccinated; nevertheless, the low rates of both metrics are concerning, and the Grand Jury encourages ACSO to redouble its efforts to raise the testing and vaccination levels of detainees.

The Grand Jury commends ACSO for the following elements of its COVID-19 response:

- The development and maintenance of a comprehensive COVID-19 response plan, which was most recently updated on February 3, 2022.
- Regular meetings and consultations with representatives of the Alameda County Public Health Department.
- Availability and promotion of on-site COVID-19 tests and vaccinations.
- Availability of PPE and sanitation supplies.
- Publication of daily updates on COVID-19 quarantines, testing results, and detainee vaccinations through the ACSO website.

While there are many positive elements to note about Santa Rita's COVID-19 response, the Grand Jury also observed issues that likely compromise its overall effectiveness. In an intentional echo of the conclusions of the Sabot report, the Grand Jury notes that gaps in the program and lapses in execution risk contributing to further outbreaks.

Detainee Grievances

In accordance with California Penal Code § 6030 and California Code of Regulations, Title 15, § 1073, Santa Rita is required to maintain policies and procedures that enable detainees to

submit grievances relating to any condition of detainment. Procedures are required to include:

- a grievance form or instructions for registering a grievance,
- resolution of the grievance at the lowest appropriate staff level,
- appeal to the next level of review,
- written reasons for the denial of grievance at each level of review that acts on the grievance,
- a provision for response within a reasonable time limit, and
- a provision for resolving questions of jurisdiction within the facility.

Public statements by detainees and lawsuits filed against ACSO, as well as detainee reports to the Grand Jury, have claimed that the grievance process at Santa Rita is ineffective. Specific complaints include a slow average response time, a high rate of grievance denials, inadequate investigation of complaints, and retaliation by jail staff.

The Grand Jury investigation of the grievance process included an analysis of all grievances submitted in August, September, and October of 2021, a review of the complete Grievance Unit investigation files for a subset of those grievances, discussions with detainees about their experiences with the grievance process, and witness testimony by jail staff.

Filing

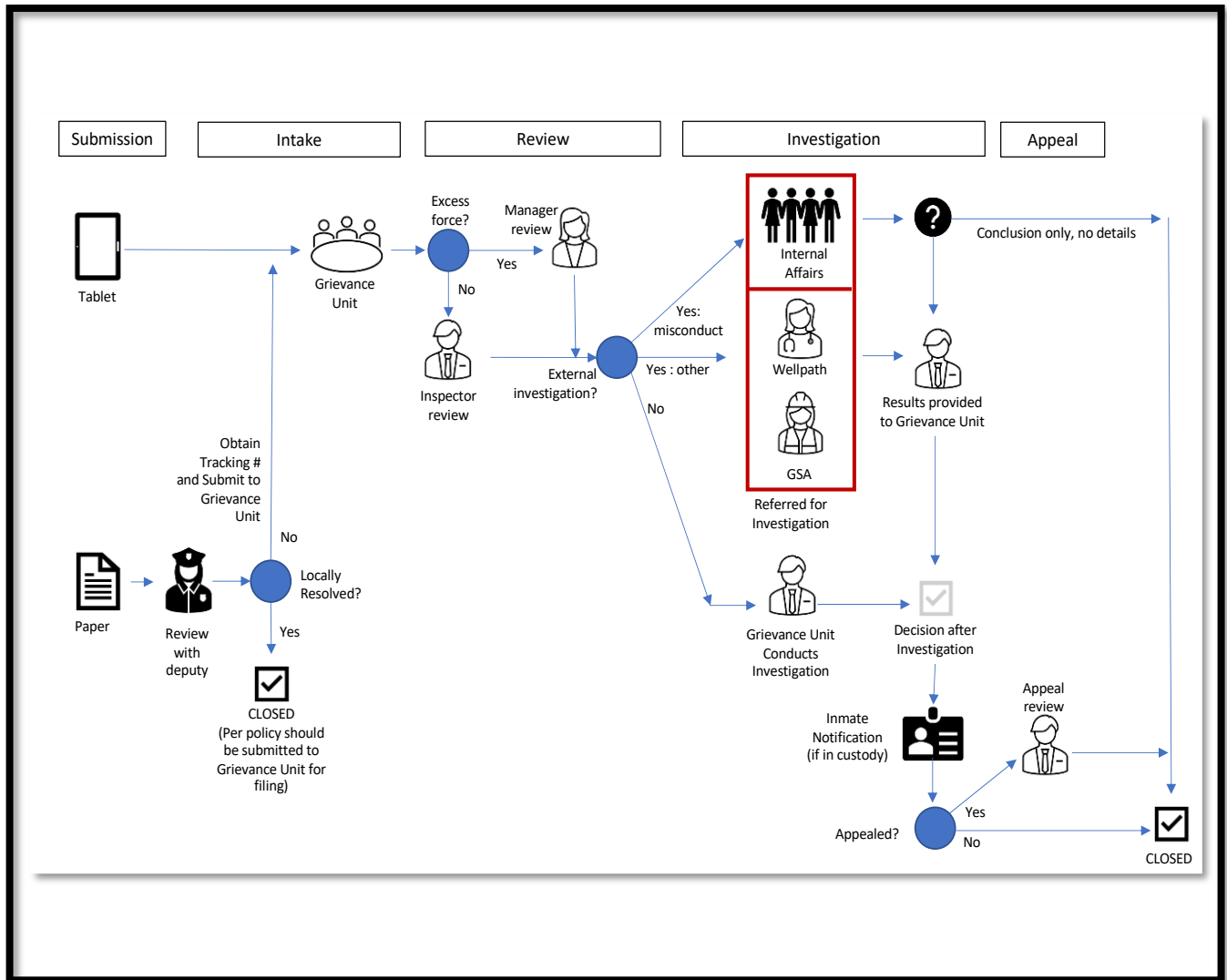
At intake, all detainees receive a copy of Santa Rita's grievance procedures, which form part of the Inmate Rules and Information Handbook. Two types of grievances exist:

1. **Standard grievances**, used to report problems in detainment conditions.
2. **Emergency grievances**, used to report harassment or sexual assault in accordance with the Prison Rape Elimination Act of 2003 (PREA).

Standard grievances may be submitted either on paper or electronically via jail-issued tablet. When filing on paper, detainees must request an official grievance form and a grievance tracking number from a deputy. While there is no limit on the number of paper grievances a detainee may file, electronic grievances are limited to four per detainee per month.

In an effort to streamline the grievance process and provide detainees with a way to submit grievances without needing to engage with a deputy who may be the subject of a grievance, Santa Rita introduced the electronic submission option in 2019. Although many detainees successfully submit electronic grievances, others reported that filing electronically is confusing and does not work as intended. Staff appeared unaware of the problems detainees were experiencing with tablet-based submissions.

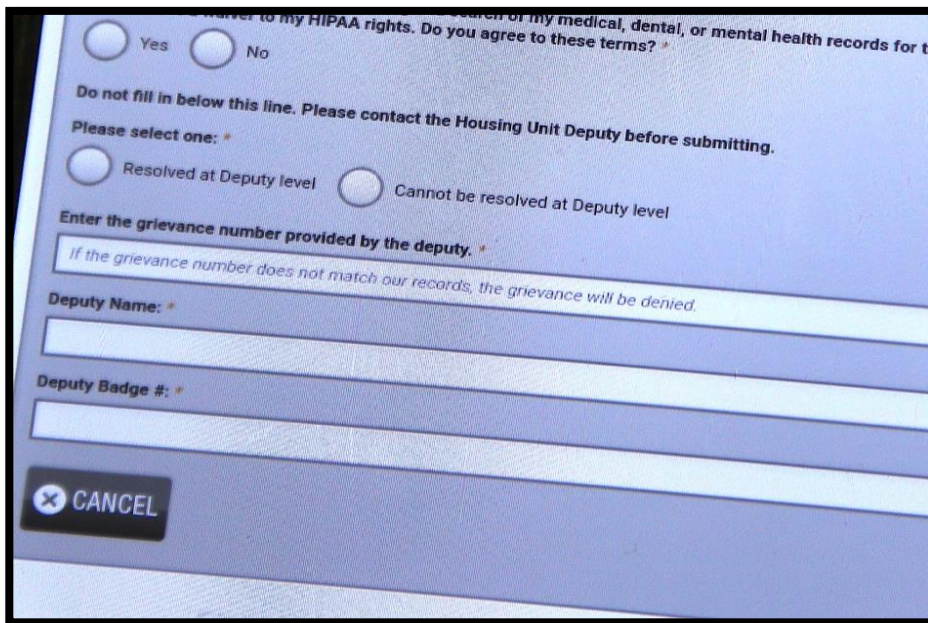
Overview of the Grievance Filing and Investigation Process



One critical issue highlighted by detainees involves the continued need to engage with a deputy to obtain a grievance tracking number for electronic submissions. While staff had informed the Grand Jury that this was not a required step for tablet submissions, detainees demonstrated to the Grand Jury that the tablet submission form shows the tracking number field as “required,” warns users about consequences for submissions with inaccurate information and displays an error message on attempts to submit grievances with the field unfilled. The Grievance Unit’s response to these observations was that the requirement for including an accurate grievance tracking number had previously been eliminated and detainees could insert any number into that field to enable a submission. The detainees with whom the Grand Jury spoke were unaware of this authorized bypass and, given the limited number of submissions permitted per month and the warnings about consequences for inaccurate submissions, were understandably reluctant to follow the suggested work-around.

Further complicating the use of placeholder tracking numbers is that detainees who used this approach reported inconsistency in receiving confirmation that their grievance was successfully submitted and delays in being notified of the actual tracking number once assigned.

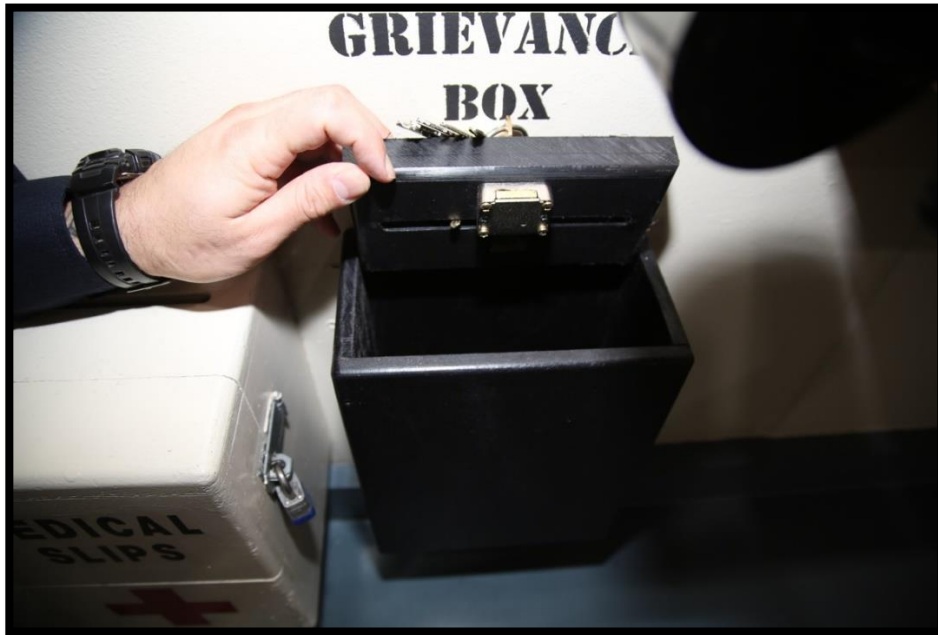
The Grand Jury believes that the implementation of a tablet-based option for grievance submissions improved the mechanism through which detainees can draw attention to concerns about detainment conditions. However, the flawed software implementation and inconsistent communication with detainees significantly reduce the value of this tool.



A blank electronic grievance form. The field labeled “Enter the grievance number provided by the deputy” is marked as mandatory by a red asterisk. The default text states: “If the grievance number does not match our records, the grievance will be denied.”

Emergency Grievances

Emergency grievances are intended primarily for reporting sexual assault or harassment, in accordance with PREA requirements. Given the nature of these issues, the jail provides each housing unit with a lockbox to allow confidential and third-party submissions. By policy, lockboxes are checked daily, and the Grievance Unit assigns emergency grievances a high priority. The Grand Jury observed the presence of a lockbox in each housing unit visited and confirmed that, consistent with policy, the on-duty deputy did not have the ability to unlock the box.



An emergency grievance box in a minimum/medium-security housing unit.

Grievance Investigations

The first attempt to resolve a standard grievance occurs before it is formally submitted. By policy, when a detainee approaches a deputy to request a tracking number, the deputy attempts to resolve the issue directly. If the complaint is not resolved on the spot, the deputy obtains a tracking number from Grievance Unit staff, adds that information to the detainee's completed form, gives the detainee a copy, and submits the original to the Grievance Unit through internal mail.

The Grievance Unit is staffed by three deputies and three non-sworn technicians who are responsible for the initial investigation of all grievances. On receipt, paper grievances are scanned and converted into an electronic record, as all the Grievance Unit's work is managed through an online case management system. Each day, a technician reviews that day's newly filed grievances and assigns them to the investigators.

Investigations typically involve interviewing staff members named in the grievance, reviewing jail policies, and viewing bodycam footage as appropriate. The Grand Jury learned that detainees are not routinely contacted as part of the investigation of their grievance, and several reported receiving no update on the status for weeks after submission.

The Grievance Unit refers and transfers investigation responsibility for several categories of grievances to other departments or contracted service providers. These include medical grievances, which are forwarded to Wellpath; facility issues, which are forwarded to GSA; and investigations of certain excessive use of force claims, which are forwarded to Internal Affairs (IA). These referrals are deemed necessary because the Grievance Unit has no access to detainee medical records, does not have the expertise required to address facility issues, and is prohibited from investigating the conduct of jail staff.

Grievances alleging excessive use of force by a deputy are initially reviewed by the Grievance Unit manager to determine whether a full investigation is warranted by IA. If the manager does not believe the grievance warrants IA review, it is typically concluded with a finding of “Denied.”

When a grievance has been referred to another department within the jail for investigation, the Grievance Unit suspends its tracking of investigation activities, as these steps are now being performed by a different department. As a result, some investigation steps conducted by other departments are not routinely captured in the case management system, and the Grievance Unit effectively cedes responsibility for the timely investigation of the grievance to the other department.

The Grand Jury learned that once a grievance is referred to another department, the Grievance Unit awaits direction from that department before taking further action. There does not appear to be a consistent process within the Grievance Unit for checking the status of referred grievances that remain open for an extended period of time, nor is there regular reporting on open grievance investigations that have exceeded target turnaround times. The Grand Jury noted that many detainee complaints about the grievance process involved extended timelines for investigations and that referred investigations take, on average, longer to reach determination than those handled entirely within the Grievance Unit.

Findings of Grievance Investigations

When an investigation is concluded, the detainee receives an explanation of the determination. The Grand Jury confirmed detainee complaints that, at times, the determination communication was limited to a statement that the grievance was Resolved or Denied, lacking any detail on why that determination had been reached or how it had been addressed.

Detainees are requested to acknowledge the findings of the investigation in writing. The acknowledgement paperwork notifies the detainee of a right to appeal, and the Grievance Unit reported that cases in which a detainee refuses to sign the acknowledgment are automatically appealed.

The Grievance Unit prepares monthly reports on trends in the volume of grievance submissions. It does not, however, analyze data within the case management system to identify common

themes, emerging patterns, or jail staff most frequently named in grievances. The Grievance Unit also does not take advantage of the available data to track operational metrics around the time required to complete investigations, the distribution of resolution status, or the percentage of initial findings that result in appeal.

Grievance Data Analysis

The Grand Jury reviewed a report of all grievances filed between August 1, 2021, and October 31, 2021, and analyzed these data to assess operations of the Grievance Unit. During the grievance review period, the jail population fluctuated daily as detainees were booked and released from the facility. Over these three months, a total of 2,900 individuals were detained and 1,375 grievances were submitted by those detainees.

The Grand Jury determined that only a minority of detainees used the grievance process, as under 20% of the population (474) submitted a grievance and 80% of those detainees submitted just a single grievance. While there were a few prolific grievance submitters, only 5% of filers submitted grievances at a rate of more than one per week. The combination of the low overall utilization rate of the grievance process and the high rate of single grievance submissions for those who did participate supports the view that most detainees are using the process in a measured manner to address concerns about their detainment conditions.

The Grand Jury's analysis identified medical services and staff conduct as the most frequent subjects of grievances. Each accounted for more than 20% of the total number of grievances. The Grand Jury's analysis also found that 55 of the staff-conduct grievances involved concerns about the behavior of individual deputies, and that three specific deputies, each mentioned in four or more grievances, accounted for 31% of that total.

The Grand Jury believes that thoughtful analysis of aggregate grievance data would provide information helpful for the management of jail operations and could serve as an early warning indicator of areas that present future material risks. The concentration of grievances pertaining to the behavior of three specific deputies is one such example of a data analytics finding that warrants attention by senior leadership.

Investigation Turnaround Time

The Grand Jury found that completion of a grievance investigation took on average a full month from submission to detainee notification of the investigation results. While this metric varied somewhat by the category of grievance, in no case was the average less than 19 days, and most high-volume categories were in the range of 30 to 35 days.

Grievances that were open and resolved over the three-month window took on average 31 days to resolve, with specific topics ranging from 19 to 40 days

Days to Resolve for Completed Grievances

<u>Subject</u>	<u>Avg Days</u>	<u>Subject</u>	<u>Avg Days</u>
Telephone	19	Television	31
Sexual Abuse/Harassment	23	Professional Staff	32
Accounting	25	Pod/Recreation Time	32
Other	25	Search Process	32
Tablet	25	Psychiatric	32
Safety	26	Medical Services	33
Records/Release	26	Medical Staff Conduct	33
Sergeant's Abuse	27	Sworn Staff Conduct	34
Disciplinary Safeguards	27	Facility Conditions	34
Visiting	27	Food	37
Inmate Services	28	Dental	37
Pro-Per	28	Sanitation	37
Title 15	29	Mail	37
Grievance Process	30	Hygiene	39
Property	30	Laundry	40
Commissary	30		
Classification	30	All Resolved	31

Time to disposition of grievances. Data from August through October 2021.

Appeals

After investigation, approximately 25% of grievances are reported as having been addressed, and the remaining 75% are reported as Denied. Following the return of these results to the detainees, 78% of the decisions were appealed. This high appeal rate suggests that detainees are generally dissatisfied with the investigation results and that many of the grievances considered resolved by the Grievance Unit were not considered resolved by the submitter.

On appeal, fewer than 2% of grievances were “Affirmed” in support of the detainee’s position, suggesting little difference between findings in the initial investigation and appeal stages.

Investigation File Review

The Grand Jury reviewed the full investigation files of a random sampling of grievances. While the sample size prevented the jury from drawing statistically significant conclusions about the investigative process, it did highlight several areas of concern that merit additional review by jail leadership. Specific concerns include the following:

- **Examples of disqualifying a grievance and returning a “Denied” finding in the absence of any investigative action.** The Grand Jury identified this outcome in the context of a staff-conduct grievance about actions directed against a detainee who was not

the submitter. The Grievance Unit disqualified the grievance, stating that only actions directly affecting the submitter were eligible. The Grand Jury believes this position ignores the potential impact that witnessing abusive behavior by a staff member has on the well-being of all who observe this behavior.

- **Examples of denying grievances after examining only evidence provided by the staff member named in the grievance.** The Grand Jury identified this outcome in the context of a grievance concerning retaliatory behavior where the only documented investigative step was interviewing the named deputy, who denied the allegation. The investigative file documented no steps taken to confirm the accuracy of the alternative narrative and cited the deputy's denial as the sole reason for closing and denying the detainee's grievance.

CONCLUSION

The 2021–2022 Alameda County Civil Grand Jury conducted a broad-based inspection and investigation into the operations of the Alameda County's Santa Rita Jail. This investigation resulted in the identification of 22 findings and 28 recommendations encompassing four domains:

1. facility infrastructure,
2. detainment conditions,
3. COVID-19 management, and
4. the grievance process.

The Grand Jury concludes that many of these findings present continuing risks to the health and safety of the staff and detainees who occupy the facility as well as a financial risk to Alameda County, which is ultimately responsible for the damages that may arise from conditions at the jail.

The Grand Jury gratefully acknowledges the support and assistance of the many Santa Rita staff members who accompanied jurors on their inspections, located documents and data, and explained processes and procedures. While not all personnel interactions were positive, the few instances in which staff engaged in a manner that the Grand Jury experienced as adversarial or unprofessional were addressed during the investigation and did not impair the completeness or accuracy of this report.

FINDINGS

Facility Safety

Finding 19:

High-risk safety code violations exist within the Santa Rita Jail. These include:

- High-voltage electrical wiring not installed in accordance with code.
- Obstruction of access to emergency safety equipment.
- Emergency safety equipment for which testing and maintenance are out of date.
- Unlabeled emergency-stop controls on industrial equipment.
- Inconsistent signage on hazardous waste disposal containers.
- Instances of missing temperature-monitoring data for food storage refrigerators.

Finding 20:

The absence of periodic, proactive reviews of the Santa Rita Jail facility's condition increases the risk that critical issues will be undetected and unaddressed until they result in an injury or operational disruption.

Finding 21:

Inspections of the Santa Rita Jail facility conducted by the Board of State and Community Corrections do not include participation of Alameda County General Services Agency staff responsible for the condition and maintenance of the jail facility, resulting in a missed opportunity for valuable exchange between inspectors and county staff and potentially unnecessary delays in addressing issues identified during inspections.

Finding 22:

Controls to protect against weapons, drugs, and other contraband being brought into Santa Rita Jail by staff and administrative visitors are weak, placing staff and detainees at risk.

Detainment Conditions

Finding 23:

Access to the outdoors for detainees at Santa Rita Jail is severely limited, with most inmates having a single one-hour opportunity per week, weather permitting, for access to fresh air and sunlight.

Finding 24:

Safety and sobering cells at Santa Rita Jail are not universally cleaned and sanitized after each use, indicating a systemic issue with maintaining cleanliness standards.

Finding 25:

The level of cleanliness in common areas and recreation yards at Santa Rita Jail is highly variable across housing units, with jail staff disavowing responsibility for ensuring a minimal standard of hygiene in areas cleaned by inmates.

Finding 26:

The level of engagement and oversight by the Alameda County Sheriff's Office of Wellpath's operational activities is insufficient to ensure that health care is being delivered in a timely manner with high quality.

COVID-19 Management

Finding 27:

COVID-19 screening procedures at points of entry at Santa Rita Jail are inconsistent with both stated Alameda County Sheriff's Office policy and current recommended best practices.

Finding 28:

The Alameda County Sheriff's Office has failed to follow local and national recommendations that all staff working at correctional facilities be vaccinated for COVID-19, posing an unnecessary hazard to detainees.

Finding 29:

The rate of COVID-19 vaccination among Santa Rita Jail staff is materially below the community average.

Finding 30:

The consequences for Alameda County Sheriff's Office staff who are not in compliance with COVID-19 test mandates are insufficient to ensure that up-to-date testing is performed.

Finding 31:

The Alameda County Sheriff's Office fails to provide full transparency by including weekly staff COVID-19 vaccination statistics on its website alongside detainee vaccination data and staff/detainee testing data.

Finding 32:

The Alameda County Sheriff's Office does not ensure that Santa Rita staff consistently adhere to Alameda County's indoor mask mandate, placing both staff and detainees at greater risk of COVID-19 infection.

Finding 33:

The Alameda County Sheriff's Office's efforts to promote detainee COVID-19 vaccination have been unsuccessful in materially improving the rate of vaccination in the detainee population.

Grievance Process

Finding 34:

The Santa Rita Jail Grievance Unit has failed to provide an electronic grievance submission system that eliminates the need for detainees to engage with the local housing unit deputy.

Finding 35:

Medical issues raised by detainees at Santa Rita Jail through the grievance process are not investigated and resolved in a timely manner.

Finding 36:

The current grievance process at Santa Rita Jail inadequately tracks and follows up on the status of investigations transferred to other departments, leaving grievances open for extended time periods and forgoing the opportunity to learn from patterns and trends.

Finding 37:

The Santa Rita Jail Grievance Unit fails to take advantage of the opportunity to analyze grievance submission data to identify trends in complaints, root causes, and resolutions.

Finding 38:

The current grievance process at Santa Rita Jail is a suboptimal mechanism for addressing facility safety and maintenance issues identified by detainees.

Finding 39:

The grievance process at Santa Rita Jail inappropriately disqualifies and denies grievances in which a third-party observes and is impacted by the treatment of another detainee.

Finding 40:

The current grievance investigation process at Santa Rita Jail fails to adequately engage the grievance submitter in the investigative process.

RECOMMENDATIONS

Facility Safety

Recommendation 28:

The Alameda County Sheriff's Office must remediate the following issues and verify full compliance with applicable codes:

- Electrical connection to ovens and tablet-charging stations within housing units.
- Provide permanent floor marking to demarcate area that must be kept clear around eyewash station in kitchen.

- Bring current the testing and maintenance for eyewash station in kitchen and incorporate the necessary periodic reviews into preventive maintenance scheduling system.
- Ensure presence and readability of all emergency-stop controls in kitchen.
- Attach signage for PPE/hazardous waste disposal to disposal containers.

Recommendation 29:

The Alameda County Sheriff's Office must conduct a facility-wide audit for health and safety code issues to be led by a subject matter expert and review results with the jail commander and the Alameda County General Services Agency (GSA) manager on completion.

Recommendation 30:

The Alameda County Sheriff's Office must incorporate into the Santa Rita Jail facility operation procedures a requirement for a semiannual facility-wide safety inspection to include the jail commander, the GSA facility manager, and a facility health and safety code expert. Document these results in a written report and add any issues identified to the facility's maintenance issue tracking system.

Recommendation 31:

The Alameda County Sheriff's Office must inform GSA of all Santa Rita Jail inspections by the Board of State and Community Corrections or any other third-party entities.

Recommendation 32:

The Alameda County General Services Agency must require a GSA facility manager be present during all Board of State and Community Corrections and other Santa Rita Jail facility inspections.

Recommendation 33:

The Alameda County Sheriff's Office must ensure that all entrants into the secure portion of the Santa Rita Jail facility are positively identified via government-issued identification in advance of entry.

Recommendation 34:

The Alameda County Sheriff's Office must implement access control procedures to reduce the risk of contraband being introduced into Santa Rita Jail by staff and administrative visitors. Controls should, at a minimum, place limits on the nature and number of personal effects that may be brought into the secure perimeter and establish protocols for screening those permitted personal effects for contraband.

Detainment Conditions

Recommendation 35:

The Alameda County Sheriff's Office must establish policies and procedures to ensure that each Santa Rita Jail detainee is provided an opportunity for access to outdoor space on at least three days per week for at least one hour per opportunity.

Recommendation 36:

The Alameda County Sheriff's Office must establish policies and procedures to ensure that each temporary access cell at Santa Rita Jail is removed from service until it is cleaned and sanitized.

Recommendation 37:

The Alameda County Sheriff's Office must establish policies and procedures that codify both the minimum acceptable levels of cleanliness at Santa Rita Jail in areas designated as being the cleaning responsibility of detainees and the responsibility of jail staff when those minimum levels are not maintained.

Recommendation 38:

The Alameda County Sheriff's Office must augment existing quality reviews to incorporate assessment of the timeliness of health care delivery at Santa Rita Jail.

Recommendation 39:

The Alameda County Sheriff's Office must institute monthly senior-level meetings of Santa Rita leadership, the on-site medical director, and Wellpath's service delivery leadership to review quality assessment reporting and any emerging operational issues related to health care delivery at Santa Rita Jail.

Recommendation 40:

During the next amendment to the Wellpath contract, the Alameda County Sheriff's Office must negotiate for the addition of jail-specific provisions requiring that the Sheriff's Office be allowed to explicitly consent to personnel changes in key roles proposed by Wellpath.

COVID-19 Management

Recommendation 41:

The Alameda County sheriff's Office must implement a visitor screening procedure for Santa Rita Jail that is consistent with current Alameda County Public Health Department and the Centers for Disease Control (CDC) guidance for congregate settings.

Recommendation 42:

The Alameda County Sheriff's Office must adopt a requirement that all Santa Rita employees be fully up to date with state and CDC-recommended COVID-19 vaccinations within congregate settings.

Recommendation 43:

The Alameda County Sheriff's Office must implement a procedure for discipline, up to and including removal, for employees who do not fully comply with Alameda County's COVID-19 protocols for county employees.

Recommendation 44:

The Alameda County Sheriff's Office must provide and maintain accurate weekly reporting of staff COVID-19 vaccination statistics on the Sheriff's Office website.

Recommendation 45:

The Alameda County Sheriff's Office must direct all Santa Rita staff (both Sheriff's Office employees and contractors) to fully comply with Alameda County's indoor masking recommendations.

Recommendation 46:

The Alameda County Sheriff's Office must develop a program that supplements COVID-19 education with targeted and compelling incentives for Santa Rita Jail detainees to become vaccinated.

Grievance Process

Recommendation 47:

The Alameda County Sheriff's Office must inform Santa Rita Jail detainees, in writing, that electronic grievances may be submitted by using a placeholder tracking number.

Recommendation 48:

The Alameda County Sheriff's Office must update the electronic grievance submission system at Santa Rita Jail to make clear to all users that there is no requirement for deputy involvement in a grievance submission.

Recommendation 49:

The Alameda County Sheriff's Office must modify procedures for the review, referral, and management of medical-related grievances at Santa Rita Jail to achieve a target of 100% engagement with medical grievance submitters within 72 hours, and resolution of 95% of medical-related grievance within seven days of submission.

Recommendation 50:

The Alameda County Sheriff's Office must implement policy and procedure changes necessary to ensure that the Santa Rita Jail Grievance Unit actively tracks the status of grievances referred to all external departments and contracted service providers, and that these changes include a mechanism for follow-up and escalation should a grievance not be resolved within a predefined period of time.

Recommendations 51:

The Alameda County Sheriff's Office must complete an analytical review of grievances received over the preceding 12 months that name individual Santa Rita Jail deputies.

Recommendation 52:

The Alameda County Sheriff's Office must adopt procedures that result in the delivery of a holistic analysis of grievance submission data on a quarterly schedule to the Santa Rita Jail commander.

Recommendation 53:

The Alameda County Sheriff's Office must adopt a mechanism for Santa Rita Jail detainees to alert jail administration to building safety and maintenance issues in a manner that is distinct from the filing of personal grievances.

Recommendation 54:

The Alameda County Sheriff's Office must adopt policies to acknowledge that the observation or knowledge of abuse or mistreatment of other detainees at Santa Rita Jail represents a potential grievance-qualifying harm requiring investigation.

Recommendation 55:

The Alameda County Sheriff's Office must modify Grievance Unit policies at Santa Rita Jail to acknowledge the value of seeking clarifications and direct testimony from submitters as an integral step in the investigative process.

REQUEST FOR RESPONSES

Pursuant to California Penal Code sections 933 and 933.05, the Grand Jury requests each entity or individual named below to respond to the enumerated Findings and Recommendations within specific statutory guidelines, no later than 90 days from the public release date of this report.

Responses to Findings shall be either:

- The respondent agrees with the finding.
- The respondent disagrees wholly or partially with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reasons therefor.

Responses to Recommendations shall be one of the following:

- The recommendation has been implemented, with a summary regarding the implemented action.
- The recommendation has not yet been implemented, but will be implemented in the future, with a time frame for implementation.
- The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or study, and a time frame for the matter to be prepared for discussion by the officer or head of the agency or department being investigated or reviewed, including the governing body of the public agency where applicable. This time frame shall not exceed six months from the date of publication of the Grand Jury report.
- The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation therefor.

RESPONSES REQUIRED

Sheriff, Alameda County Sheriff's Office	Findings 19 through 40 Recommendations 28 through 55
Director, Alameda County General Services Agency	Findings 19, 20, & 21 Recommendations 28 through 32

APPENDIX A: REFERENCES

Alameda County Public Health Department, *COVID-19 Screening Guidance for Businesses and Organizations*, May 2021, <https://covid-19.acgov.org/covid19-assets/docs/recovery/screening-guidance-for-businesses-and-organizations-eng-2021.05.07.pdf>

Alameda County Public Health Department, *Order of the Health Officer of the County of Alameda Directing All Individuals Living in the County to Shelter at Their Place of Residence*, March 2020, <https://www.acgov.org/documents/Final-Order-to-Shelter-In-Place.pdf>

Babu v. Ahern, No. 18-cv-07677-NC (N.D. Cal. Feb. 22, 2022)

Cal. Code Regs., tit. 15, § 1073 (1998)

Cal. Code Regs., tit. 24 (2019)

Cal. Penal Code § 6030 (2017)

Centers for Disease Control and Prevention, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, February 2022, <https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html>

Sabot Consulting, *Covid19 Inspection of the Santa Rita Jail Facility by the Joint Neutral Monitor*, June 2020, <https://www.alamedacountysheriff.org/home/showpublisheddocument/24/637520274653100000>

CAMP WILMONT SWEENEY INSPECTION

On October 5, 2021, members of the Grand Jury inspected Camp Wilmont Sweeney (Camp Sweeney), a compulsory minimum-security residential program for incarcerated young men ranging in age from 15 to 19. Camp Sweeney uses a rehabilitative approach with goals to educate and foster personal, social, and professional development through a variety of programs, services, and activities, as well as family reunification. Detainees are referred to Camp Sweeney by the Juvenile Court and the Alameda County Probation Department (ACPD). On average, youth serve a seven-month term intended to prepare them for reentry into the community. At the time of the Grand Jury's inspection, there were only nine youth residents, but the facility can hold up to 60.

The Grand Jury inspected all areas of the camp and met with members of the ACPD and a program manager from the Alameda County Public Library. There are 29 probation department employees assigned to Camp Sweeney, including administrators, probation officers, and support staff who provide oversight and services 24 hours a day.

Youth admitted into Camp Sweeney undergo a comprehensive assessment to determine a myriad of needs, including but not limited to physical and mental health screenings and social and academic success factors. Youth are evaluated by a physician to determine if there are immediate health needs or mental health conditions that may require further assessment and accommodation. Youth are also evaluated for high-risk behaviors (e.g., undesirable actions resulting in serious consequence and poor decision-making) that may have resulted in their incarceration. Alcohol or drug use and abuse, family dynamics, and social influences are assessed and discussed. Where there are opportunities for positive change, a program plan is designed with the tools and resources needed for a successful transition and reentry into the community.

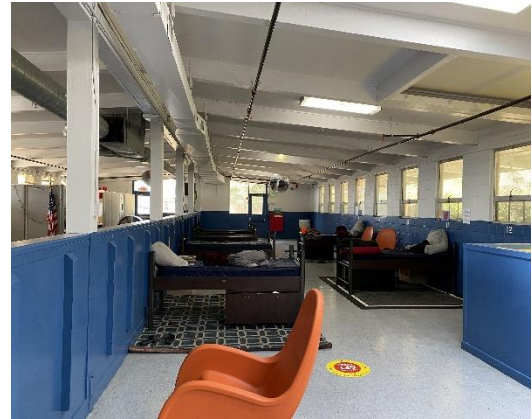
At the time of the Grand Jury's inspection, there were only nine youth residents, but the facility can hold up to 60.

Facilities

Camp Sweeney is managed by the ACPD, set on a 10-acre site in the San Leandro foothills and adjacent to the Juvenile Justice Center (JJC). The buildings at Camp Sweeney were built in the 1950s, and while the exteriors are dated and worn, the interiors are well maintained and, in some cases, include modern amenities. In general, the grounds are void of landscaping and in need of regular maintenance (e.g., clearing the overgrown foliage and weeds, filling the cement cracks, and repairing the asphalt). In particular, the Grand Jury noted several areas of uneven, cracked,

or missing pieces of cement and asphalt. There are no ramps at building entrances, and some areas can be traversed only by stairs. These circumstances would pose a particular challenge for anyone using a wheelchair or other ambulatory assistance device. It's possible that they could not be safely or reasonably accommodated.

Youth are housed in a dormitory-style setting, a large, open environment divided into four wings. Due to the low occupancy, one of the four dormitory sections was converted to a leisure area where youth have access to board games, a small library, television, and movies. Youth are issued individual lockers where they can store their camp-issued clothing, personal hygiene products, coursework and related materials, and some personal effects. Effective March 2020, religious services are live streamed to the youth, who also are offered telephonic access to one-on-one (noncontact) religious counseling.



Camp Sweeney Dormitory

The dormitory also includes showers and toilet facilities, and a laundry area. Required bedding and camp clothing are provided to the youth, with support staff furnishing laundry services. At the time of the inspection, the dormitory, showers, toilets, and laundry area were in a clean and orderly condition and the Grand Jury noted no deficiencies.



Camp Sweeney Dining Hall

Camp Sweeney has a dining hall with a large commercial-sized kitchen. Youth receive three meals a day and can purchase snacks from a small on-site commissary. Those requiring special diets are also accommodated. The meals and snacks are prepared by a third-party vendor who services both Camp Sweeney and neighboring JJC. Every Sunday, the staff host a barbecue and cook for both staff and youth residents. At the time of the inspection, the dining hall and the kitchen were in a clean and orderly condition and the Grand Jury noted no deficiencies.

Security

Camp Sweeney is a minimum-security facility with chain-link fences around the perimeter. The perimeter fencing serves as a barrier but is not practical for keeping youth from leaving the property unsupervised or from keeping uninvited visitors from entering without permission. Twenty-four-hour video surveillance cameras are present at the entrance and at

various locations throughout the camp with large signs to indicate their presence. Through an internet-based system, authorized personnel can monitor the site from anywhere at any time. The lack of a video surveillance system was highlighted in the 2014-2015 Grand Jury Final Report, resulting in the current system being put into place. At the time of the inspection, the surveillance system appeared to be in working order and the Grand Jury noted no deficiencies.

Health Care and COVID-19 Protocols

Within the Administration Building is a designated room for medical care and evaluations where a nurse is on-site during regular hours, Monday to Friday, to administer care. If a youth becomes ill, immediate medical attention is provided by the Camp Sweeney nurse or at the JJC, depending on the time, day, and or/seriousness of the illness. Additional health care (i.e., medical, dental, prescription drugs) is available and can be performed by the JJC through its partnership with UCSF Benioff Children's Hospital in Oakland.

Guided by the Alameda County Public Health Department and the Centers for Disease Control, Camp Sweeney follows COVID-19 precautions and protocols. Anyone entering Camp Sweeney, including the Grand Jury, must have their body temperature taken and complete a symptom checker via a series of COVID-19 related questions. Posters with reminders and instructions to wear masks, wash hands, and be physically distant are visible throughout the campus. The Grand Jury noted that hand sanitizer is readily available at building entries and exits and in several other locations throughout the campus. The Grand Jury observed staff and youth wearing masks and maintaining appropriate physical distancing and noted that other COVID-19 precautions and protocols are satisfactorily administered and followed.

Guided by the Alameda County Public Health Department and the Centers for Disease Control, Camp Sweeney follows COVID-19 precautions and protocols ... COVID-19 precautions and protocols are satisfactorily administered and followed.

Policies and Procedures

Staff, youth, and a parent or guardian are provided with written policies and procedures, which include, but are not limited to:

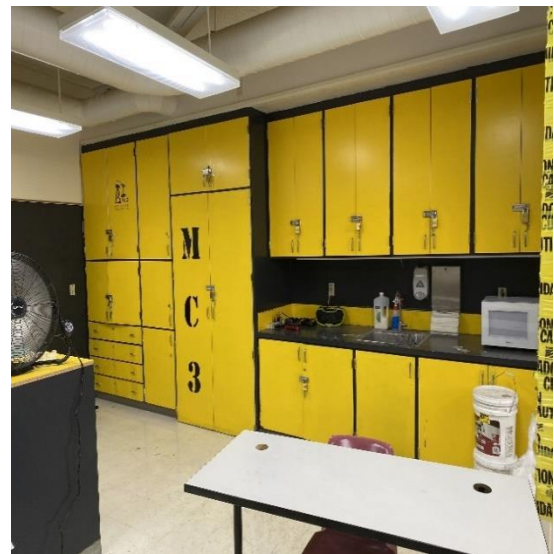
1. *Alameda County Camp Wilmont Sweeney Success Handbook*. Issued to incoming youth, it provides detailed information about the facility, programs offered, disciplinary requirements, recognition and rewards systems, and conduct expectations, to name a few topics.

2. *Alameda County Probation Department, Camp Wilmont Sweeney, Parent Handbook.* Each parent or guardian is issued a copy of this handbook, which details the programming the youth will engage in and parent/guardian participation, contributions, and responsibilities to support the success of the youth.
3. *Camp Sweeney Program Guide for Staff.* The Program Guide details the program goals and objectives, and the procedures, operations, and resources for program administration and oversight.

Education and Rehabilitation

Camp Sweeney offers a number of resources to assist youth while in custody that are designed to provide structure for the transition from incarceration back to the community.

Multi-Craft Core Curriculum (MC3) is a comprehensive construction pre-apprenticeship vocational training program that aims to prepare youth for employment in the construction trades. Led by three staff members, youth receive training and instruction including training in job site mechanics and math, and they can receive OSHA 10, First Aid, and CPR certifications. Weekly, each youth can complete a personal MC3-related project for up to eight hours. Another vocational training program offered at the camp is food preparation. Participants learn the basics of cooking and baking, including meal preparation and cleaning, proper food storage, and food safety. Upon successful completion of the program, a Food Handler Certificate is issued.



MC3 Classroom

Camp Sweeney offers a number of resources to assist youth while in custody that are designed to provide structure for the transition from incarceration back to the community.

The Alameda County Office of Education oversees the Sweeney Academic Center, which provides instruction, teachers and tutors, and special education services. A primary goal for youth is to earn a high school diploma if they do not already have one. Classes are conducted Monday to Friday, with most instruction on-site, but some off-site college classes, usually held at Chabot Community College, are also available. Camp Sweeney also offers opportunities within the community to gain on-the-job experience and training.

A literacy specialist employed full time by the Alameda County Public Library is on-site Monday through Thursday and tutors each youth individually. The literacy specialist oversees the Write to Read educational program, which provides opportunities to improve literacy skills and build confidence in reading and writing. In this transformative approach aimed at creating positive change and encouraging self-expression, youth are encouraged to examine personal, social, economic, and political topics through reading and writing. Some of the writing assignments are published for future reading, and also presented to peers, staff, and family members and friends.



Camp Sweeney Library

In addition to the programs already mentioned, the Grand Jury received information about several other programs and services offered at Camp Sweeney, as noted below:

1. *Restorative Justice Program.* Group discussions, personal reflection, and coursework intended to study restorative practices, social justice, civic engagement, and increase awareness of personal and community safety.
2. *Parent education and support groups.* An integrated approach that includes a parent or guardian for the youth's treatment program. It promotes counseling and open communication, including regular visitation, phone calls, and writing. An extension of the integrated approach is the Temporary Releases/Home Visits program. Youth earn the privilege to temporarily leave the Camp Sweeney premises, return to their communities, and stay with family. The program focuses on developing positive relationships between youth and their families, other support resources, and their communities, which can lead to higher success once permanently released.
3. *Drug and alcohol treatment and education programs.* These substance use and abuse programs focus on changing behaviors and making better choices through intensive counseling and by providing information and education about the effects of drugs and alcohol.

A literacy specialist employed full time by the Alameda County Public Library is on-site Monday through Thursday and tutors each youth individually.

4. *Off-grounds activities.* Youth are offered supervised educational activities including excursions to museums and aquariums.

Recreation and Social Activities

There are several recreational opportunities for youth both on and off campus.

There is a gym with new, clean, and well-maintained equipment including cardio machines and free weights. A small recreation room in the administration building has video games and a telephone. Youth are provided a minimum of four free telephone calls per week, excluding calls to attorneys. Long-distance calls are paid for by the receiving party. A recording studio where youth can listen to or record their own music and learn from a sound engineer who teaches sound technology and sound recording is one of the more favored activities.

Visits from family members are encouraged and such visits are individually approved by a deputy probation officer (DPO). Visitor passes are issued to children under the age of 18, who must be accompanied by an adult in possession of a valid picture identification and a valid visiting pass. Visitation with more than three people must be prearranged with the youth's assigned DPO. During COVID-19, increased video visitation is being offered through Microsoft Teams. An assigned DPO is required to approve all guests using video visitation.



Camp Sweeney Classroom

Outdoors, the youth have a number of on-site and off-site options. The facility is equipped with a large field that can be used for a variety of sports such as soccer and baseball. The youth created some of their own leisure undertakings through the construction of a small car racetrack, a well-designed golf putting green, and a vegetable garden. Supervised off-site activities such as golf and hiking are also available.

CONCLUSION

The interiors of Camp Sweeney were clean, orderly, and well maintained and, in some cases, include modern features and conveniences. However, the buildings are outdated, and the grounds are void of landscaping and in need of regular maintenance. Moreover, the condition of the grounds (e.g., uneven, cracked or missing cement and asphalt, access by stairs only, and no

ramps at building entrances) poses challenges for anyone utilizing a wheelchair or other ambulatory assistance device. Those individuals cannot be safely or reasonably accommodated. In addition, perimeter fencing should be more secure and restrictive. The fencing presents ample opportunity for youth to leave the premises without supervision and uninvited visitors to enter without permission. Plans to build a new Camp Sweeney were scheduled for completion in 2020. However due to the low occupancy and construction costs, the county changed direction and now has no plans to build a new campus in the near future.

FINDINGS	<i>None</i>
RECOMMENDATIONS	<i>None</i>
RESPONSES REQUIRED	<i>None</i>



Oakland City Hall, Oakland, CA

FREMONT POLICE DEPARTMENT DETENTION FACILITY INSPECTION

On October 19, 2021, members of the Grand Jury inspected the Fremont Police Department Detention Facility (Fremont Jail). The inspection focused on the condition of the facility, whether policies and procedures were in place and correctly implemented, and COVID-19 protocols. The Grand Jury also reviewed services available to detainees while in custody. Significant changes have been made that affect many facets of the facility’s current operations. Effective July 1, 2021, the Fremont Jail ceased operations as a Type I facility. With the Type I classification, the jail was used for detention after booking, and arrestees were housed for not more than 96 hours (excluding holidays).

Effective July 1, 2021, the Fremont Police Department Detention Facility ceased operating as a Type I facility. Currently, [it] operates as a temporary holding facility.

Currently the Fremont Jail operates as a temporary holding facility in accordance with California Code of Regulations Title 15, § 1010(d) Applicable Standards, and California Code of Regulations Title 24, §13-102 Minimum Standards for the Design and Construction of Local Detention Facilities. The definition of a local detention facility is one that was “constructed after January 1, 1978, and is used for the confinement of adult detainees for 24 hours or less, pending their release, transfer to another facility, or appearance in court.”

Introduction



Fremont Jail Housing Unit and Cells

The Fremont Jail has four holding cells, three detoxification cells, and one safety cell. The detoxification cells have no telephone, bench, or bed, requiring the detainee to sit and sleep on the floor. It does have a functioning toilet and sink. The safety cell is identical to the detoxification cell but holds a detainee who is uncooperative or could be harmful to others.

At the time of the Grand Jury’s inspection, no detainees were in custody at the facility. COVID-19 restrictions have resulted in a limited number of arrestees being housed daily. The average number of detainees was 10 per day when the jail was classified as a Type I facility. Currently

the average is two per day, with a maximum of 10 on any day in 2021.

The facility is open 20 hours per day and closed from 2:00 a.m. to 6:00 a.m. Arrests during this time are booked at Santa Rita Jail in Dublin. Arrestees at the Fremont Jail are detained in the temporary intake areas only. The Type I housing units are no longer utilized and are being used for storage. The storage areas were observed to be clean and well maintained.

The facility currently provides detention services for the city of Fremont only. Previously, when it was a Type I facility, other local agencies could utilize its services, but they now take their arrestees to Santa Rita Jail. As a temporary holding facility, the Fremont Jail continues to meet and maintain the requirements of Type I status. If modifications are needed in the future, a requalifying process would be needed to reacquire Type I status. Such a process would require a petition to, and review and approval by, the California Board of State and Community Corrections.



Fremont Jail Booking/Intake Area

Three Fremont police employees (one sworn officer and two non-sworn officers) were present during the Grand Jury's inspection. Janitorial staff from a third-party vendor was also present. Sixteen employees are needed to cover staffing seven days a week, 20 hours per day, with four current vacancies that are on hold for hiring due to staffing needs that have diminished since the change from a Type I facility. Should an emergency arise, additional personnel from the adjacent Fremont Police Department can respond immediately.

When the facility is open, a technician monitors holding cells, and other areas inside and outside the facility from an in-site video center. One screen displays the images from all interior cameras, and one displays the exterior cameras.

COVID-19 Protocols

The Fremont Jail follows the COVID-19 protocols outlined by Governor Newsom's Executive Order, the Alameda County Public Health Department, the city of Fremont, and the Centers for Disease Control and Prevention. Prior to entering the jail, staff is screened for body temperature and completes a symptom screening questionnaire. Hand sanitizer and face masks were readily available at the facility and utilized appropriately by staff. All jail personnel are required to be fully COVID-19 vaccinated.

Facility Procedures

All detainees are screened by staff for basic health care needs prior to entrance. Staff are trained in basic first aid and cardiopulmonary resuscitation. First aid kits and automated external defibrillators are readily available. A detainee requiring immediate medical care is transported by ambulance to Washington Hospital in Fremont or John George Psychiatric Pavilion in San Leandro. No health care providers are on-site. Interpreter services are available by telephone and on demand and some staff members speak Spanish.

As part of the booking process, a detainee's personal items are inventoried in the presence of the detainee, and they are provided with a written receipt. The detainee's items are stored in a secured location for the length of their stay. The booking process includes the utilization of a "transfer room" that contains a metal detector.

There are three types of rooms at the facility's entry point, known as the booking area:

1. an interview room, which contains a table and chairs,
2. a room equipped with a breath-analyzer machine used by officers when conducting breathalyzer tests on arrestees (Union City and Newark police officers utilize this room at their own agencies' cost), and
3. temporary holding rooms that are available for detainees.

Each detainee is offered a clean change of clothes upon entry to the facility, and staff launders detainee's clothing upon request. Detainees do not often take advantage of this offer, or of the shower facility.

In addition to the detoxification and safety cells, the facility has four holding cells. These cells are located away from the intake area in a separate space behind an individual closed door. Each holding cell has a toilet, washbasin, drinking fountain, television, and an emergency call button. Enclosed showers are available in an area outside the holding cells. Due to construction at a nearby building, water was shut off at the time of the Grand Jury's inspection. Therefore, the Grand Jury was unable to determine if all plumbing was functional.

Visitation booths are available and are equipped with a handset and a glass partition to separate the detainees from visitors. Phones are placed in accessible areas, including holding cells. Up to 15 minutes of local calls are free for detainees. The receiving person is responsible for the cost of longer local or any long- distance calls.

A detainee requiring immediate medical care is transported by ambulance to Washington Hospital in Fremont or John George Psychiatric Pavilion in San Leandro.

A service company delivers prepared meals for detainees that are stored on-site and served upon a detainee's request. A small commercial kitchen contains a range, ovens, and a refrigerator for food preparation and storage. The Grand Jury noted cereal on a shelf in the kitchen past its expiration date, and staff stated that it would be disposed of. The kitchen area was clean and neat.

Only indoor recreation is available for the detainees, and the area was clean and well maintained. Books are available for reading.

A complaint process is in place, starting with a complaint form. The complaint form is delivered to the detention facility manager, who determines whether an investigation is needed. Any investigations are conducted by the Internal Affairs Division of the Fremont Police Department. No complaints from detainees were received in 2021.

CONCLUSION

The transition of the Fremont Jail from a Type I facility to a temporary holding facility has resulted in unused space, a reduction in the number of detainees, and a change in operational requirements. The Grand Jury learned that assessments are currently underway to determine whether the facility remains viable or if the site could be better utilized. The Grand Jury found the Fremont Jail to be professionally managed and clean.

FINDINGS	<i>None</i>
RECOMMENDATIONS	<i>None</i>
RESPONSES REQUIRED	<i>None</i>

BART IS ON THE WRONG TRACK WITH INDEPENDENT OVERSIGHT

EXECUTIVE SUMMARY

BART, the San Francisco Bay Area’s largest and geographically broadest rapid transit system, is governed by an elected board of directors whose members serve four-year terms and are drawn from nine districts representing portions of the area served. A board-appointed general manager is the chief executive officer.

A successful 2018 regional ballot measure in nine Bay Area counties activated [Senate Bill 595](#) which dedicated \$1 billion in bridge toll revenue to BART capital projects. It also created an independent Office of the Inspector General (OIG) to provide oversight and accountability of BART’s operations and finances. The first and current Inspector General (IG) was selected by California Governor Gavin Newsom in 2019 from three candidates put forward by BART’s board.

The Grand Jury found that from the beginning, both BART’s board and management impeded the IG’s efforts to conduct independent oversight. In addition, board members and management supported union efforts to limit OIG access to their members, which stymied OIG independence and the confidentiality of investigations.

At a time when ridership is down due to the lingering effects of the pandemic, and BART is more dependent than ever on public funding, independent oversight should be strengthened, not sidelined. This public agency, with a \$2.4 billion annual budget, lacks proper financial structures and oversight. It has a treasurer/controller, an internal auditor, a general counsel, and an external auditor, but none of these are independent of BART’s board or management.

When compared with other urban transit agencies, BART’s OIG is significantly underfunded and unable to fulfill its mission of uncovering waste, fraud, and abuse. At its current level of funding, the OIG has a backlog of urgent investigations that it does not have the resources to undertake. As one BART director stated at a recent public hearing, “Without this oversight, we don’t know what we don’t know.” Despite this, some BART directors have publicly refused to support efforts to find funding to adequately support the OIG.

A textbook example of the need for independent oversight was revealed in April 2022 when the OIG found an apparent conflict of interest between a senior BART manager and a construction management firm now working on a \$40 million BART contract. The BART manager, who helped

This public agency, with a \$2.4 billion annual budget, lacks proper financial structures and oversight.

write the contract, did not disclose that the construction firm employs the manager's spouse and sibling. On its face, this is an apparent violation of state and federal guidelines that eluded BART's internal controls for two years. With \$1.5 billion in annual capital expenditures, most of it contracted to private companies, how is the public to know how many other such conflicts have gone undiscovered?

BACKGROUND

In 2018, nine Bay area counties, including four not served by BART, were willing to raise their bridge tolls to help fund BART with the expectation of improving transportation and reducing congestion throughout the region. Once this ballot measure passed, the enabling legislation, California Public Utility Code sections 28840-28845 went into effect, providing initial seed money of \$1 million per year from tolls collected by the Bay Area Toll Authority (BATA) with the provision that the budget could be adjusted annually.

In March 2020, BART's ridership suddenly plunged 94% due to COVID-19. As of the writing of this report (April 2022), it was still below 50% of pre-pandemic levels. An agency that had previously been funded mostly from the farebox now needed substantially more public money. To supplement lost income while avoiding layoffs, BART received \$328 million in Federal CARES Act funding and \$57 million in Federal Coronavirus Response and Relief funds. Now that the system relies primarily on public funding it has more responsibility than ever to be accountable.

What Is an Inspector General?

Nationally, the Inspector General Act of 1978 (IG Act) created OIGs to be independent and objective units that conduct audits and investigations to promote economy, efficiency, and effectiveness of their agencies' programs and operations. Their purpose is to prevent and detect waste, fraud, and abuse. OIGs are operationally independent from their agencies. Supervision of the IGs themselves is strictly limited and there are safeguards against their removal. The IG Act guarantees OIG independence to ensure the objectivity of their work.

It is the norm nationally for publicly supported urban transit agencies to have OIGs. Across the country, these watchdogs have uncovered fraud and saved their transit systems millions of dollars.

It is the norm nationally for publicly supported urban transit agencies to have OIGs. Across the country, these watchdogs have uncovered fraud and saved their transit systems millions of dollars. As the chart on page 129 shows, peer transit agency OIGs are far better funded than BART's OIG.

Typically, IGs report only to their agency heads, in this case, BART's elected board. Employees, even chief executives, do not direct the activities of IGs. This independence limits the potential for conflicts of interest that could exist if an IG were supervised by an official whose programs were being reviewed.

Specifically, the California Public Utility Code legislation states:

*There is hereby created in the district an **independent** (emphasis added) Office of the BART Inspector General to ensure that the district makes effective use of bridge toll revenue and other revenue and operates efficiently, effectively, and in compliance with applicable federal and state laws.*

The legislation goes on to define the duties and responsibilities of the BART OIG to include, among other things, examining the operating practices of the district to identify fraud, waste, and opportunities for efficiencies in the administration of programs and operations.

California Government Code Section 1236 requires special district personnel that conduct audits to adhere to “standards prescribed by the Institute of Internal Auditors, or the Government Auditing Standards issued by the Comptroller General of the United States,” and moreover, that “Auditors should be independent of the activities they audit.”

INVESTIGATION

The Grand Jury interviewed members of BART’s elected board and senior BART officials. The Grand Jury reviewed the board’s public meeting agendas, minutes, and meeting videos as well as applicable laws, internal emails, budget documents, national auditing standards, and news reports.

A Pattern of Obstruction

From the beginning, the Grand Jury learned that BART’s board, management, and unions demonstrated an unwillingness to support an independent OIG and erected roadblocks to its function. Instances of attempted interference include the following:

- Unlike comparable transit agencies across the country, BART had never had an IG. The enabling legislation offered little guidance, so a charter was needed to clarify roles and insure sufficient independence between the OIG and BART’s management. The IG presented such a charter at a January 2020 board meeting. At the meeting, the board directed the IG to consult with BART’s unions before the board would consider adopting the charter. Subsequently, a heavily modified version of the charter was produced by union attorneys. The modified charter would have required the IG to provide 48 hours’ notice of any interview with a represented employee, no matter what the subject. Since the vast majority of BART employees are union-represented, it is necessary for the OIG to hear about issues directly from employees. While employees are entitled to union representation in disciplinary matters (Weingarten rights), such a provision applicable to non-disciplinary matters where employees are merely witnesses and not themselves the subject of an inquiry would needlessly destroy the confidentiality of investigations. IGs

should have direct access to all employees, whether they're union or not, and employees should be able to bypass management or union representatives to talk directly with IGs on whistleblowing matters if employees so choose.

- One of the core responsibilities of an OIG is to conduct a risk assessment. A risk assessment is the ranked identification of risks that could negatively impact a complex organization's ability to conduct its mission. It identifies areas most vulnerable to waste, fraud, and abuse and looks for opportunities to improve programs, operations, and service delivery. As such it is a roadmap and work plan for the OIG. But the BART Audit Committee directed the OIG not to move forward with the risk assessment until concerns expressed by BART's general manager were resolved.

BART management went so far as to instruct staff not to cooperate with the OIG until the scope of the risk assessment was altered to management's satisfaction.

In the summer of 2020, the OIG produced an outline of the proposed risk assessment for BART. In a series of emails during August and September 2020, BART's management sought to insert itself into the process by identifying areas of risk assessment that it wanted to be off limits to the OIG. BART management sought to restrict the OIG from investigating such areas as potential cost savings and controls, revenues, performance metrics for project and program activities, maintenance and engineering, environmental sustainability and equipment delivery—all seemingly vital areas to

the operation of a transit agency. BART management went so far as to instruct staff not to cooperate with the OIG until the scope of the risk assessment was altered to management's satisfaction. Ultimately, the risk assessment was carried out by an independent consultant.

- In a July 30, 2020, letter to BART's general counsel, the IG identified examples of obstruction:
 - Physical evidence was withheld because a BART employee did not understand the OIG's right to access all information.
 - Management made misleading responses to investigations.
 - Management withheld documentary evidence to quantify the cost of a decision to terminate a contract.
 - Management did not respond to an OIG investigation pertaining to a vendor credit for an overcharge.
 - IG described instances of employees fearing retaliation for contact with the OIG.
 - BART general manager insisted on being the conduit through which all communication between the OIG and employees is filtered.

An Underfunded Watchdog

The enabling legislation set an initial OIG budget of \$1 million for the first year, from an allocation of bridge toll revenue from BATA. It states:

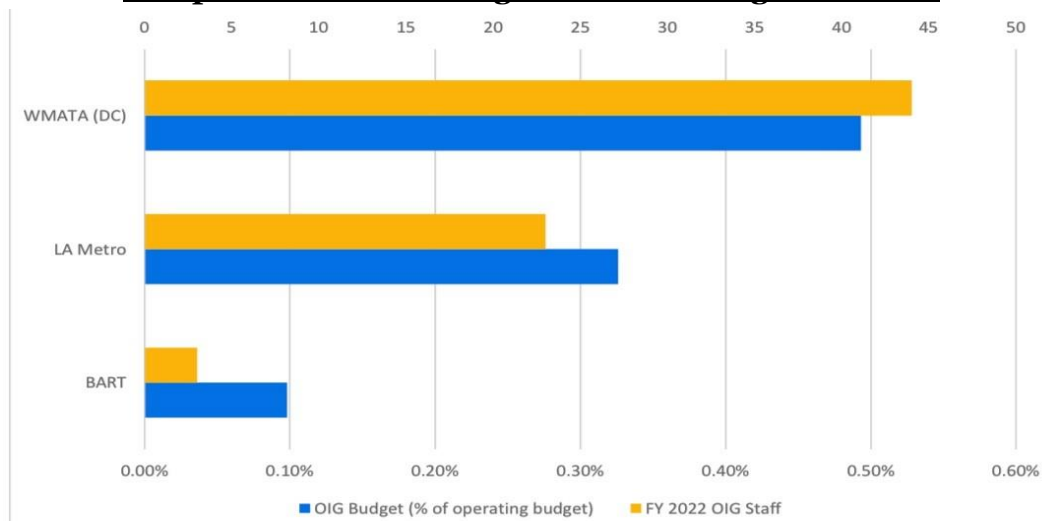
“In the second and subsequent years of operation of the office, the authority may increase the amount of funding allocated for this purpose to the extent funds are requested and justified by the office and can be accommodated in the authority’s budget.”

When compared to other urban transit agencies, BART’s OIG is significantly underfunded and unable to fulfill its mission of uncovering waste, fraud, and abuse.

No second or subsequent requests for additional funding have been made by BART’s board. In March 2020, BART’s general manager and BATA’s executive director entered into a funding agreement for the BART OIG. With regard to annual adjustments to the OIG budget as provided for in the law, the agreement states that any increase in the OIG budget is subject to “BATA’s sole reasonable discretion.” Further, it stipulates that the OIG will be charged for overhead. Overhead, not mentioned in the legislation, is not defined but can be as much as 50% of direct labor expenses. Such a charge reduces the OIG’s already paltry budget by as much as 25%. The Grand Jury found no evidence that this agreement was ever discussed or voted on by BART’s board.

In a December 2021 letter from the IG to the executive director of BATA, a supplementary budget request pursuant to the enabling legislation was made. It proposed an annual budget of approximately \$2.7 million to hire staff and pay for independent legal advice and experts to conduct complex and time-consuming audits. This letter was never answered. After prompting from BART directors, the IG was asked to present this budget request to BART’s Audit Committee and ultimately to BART’s full board in January 2022. At that meeting, some BART directors refused to even consider looking for additional funding for the OIG.

Comparison of Transit Agencies’ OIG Budget and Staff



In February 2022, California [Senate Bill 1488](#) was introduced – an amendment that would update and expand the lean text of the original legislation approved by Bay Area voters in 2018. It would spell out the relationship between the OIG and BART staff in a way that that the defeated charter sought to do. However, BART’s general manager recommended that the board oppose the bill. On April 14, 2022, the BART board voted 6-3 to “oppose the bill unless amended.”

The bill, if enacted, would, among other things:

1. Authorize the OIG to engage in fraud prevention as well as detection.
2. Stipulate that the OIG has the independence necessary to conduct audits and investigations in conformance with national standards.
3. Give the OIG the authority to examine all records and documents.
4. Give the OIG the authority to confidentially interview employees.
5. Give the OIG subpoena power.
6. Require the general manager to respond to all OIG findings and recommendation within 10 days.

Unearthing a Conflict of Interest

On April 8, 2022, the OIG reported an apparent conflict of interest between a BART senior manager and a construction management firm, under contract with BART for a \$40 million project, that employs the BART manager’s spouse and sibling. The report alleges that neither the firm nor the BART manager met its responsibilities to disclose the potential conflict of interest in compliance with BART’s Codes of Conduct, or California Government Code Section 1090 that prohibits government employees from having a role in making contracts in which they have a financial interest. The report also alleges noncompliance with the even more stringent requirements of the Federal Transit Administration (the construction project is partially funded by the federal government).

Public records say that the BART manager in question stated that the family relationships were common knowledge and that “everyone knew.” Regardless of whether the BART employee gained financially from the contract, the fact remains that well-established BART rules as well as state and federal guidelines were alleged to have been ignored. The OIG recommended that the contract be voided to protect BART from possibly more damaging financial and legal consequences going forward. Some of the nine recommended actions were implemented, and at an April 14, 2022, joint meeting with its Audit Committee, BART’s board discussed the need for independent counsel to advise whether or not the contract should be voided.

CONCLUSION

Four years after the voters spoke, some members of BART’s board and management continue to resist the independence of the OIG mandated by voters and the legislature. There is still no charter that enshrines this independence or spells out roles and relationships within BART.

Recent allegations of a previously unreported conflict-of-interest involving a \$40 million construction contract demonstrates that BART management's own internal controls aren't performing well and makes the case for an independent OIG to review and report on BART's financial operations. Now largely funded by the public, BART needs to step up its accountability.

The OIG's existing, arbitrary \$1 million per year budget is inadequate. BART must work together with other government entities to fully fund the OIG, at least to the level of \$2.7 million per year required to execute the planned audits and investigations for 2022 and 2023.

FINDINGS

Finding 41:

BART's board and management interfered with the Office of the Inspector General's performance of its duties.

Finding 42:

BART's board and general manager hampered the approval and implementation of a charter for the Office of the Inspector General, resulting in a lack of understanding within the organization that the Inspector General is independent.

Finding 43:

BART's board and management supported the labor unions representing BART employees to try to limit the independence of the Office of the Inspector General investigations by setting unreasonable conditions for engagement of employee witnesses or complainants.

Finding 44:

BART's Office of the Inspector General does not have access to independent counsel, administrative staff, and records storage systems as is considered best practice nationally.

Finding 45:

BART's Office of the Inspector General's budget, set at an initial \$1 million per year in 2018 by PUC Section 28842, is much lower than the budgets of comparable transit agencies' Office of Inspector Generals adjusted for size. A mechanism for increasing the budget annually in the enabling legislation has not been used.

Finding 46:

A potential serious conflict of interest exists between a BART senior manager and a construction management firm now under contract that employs the manager's spouse and sibling.

RECOMMENDATIONS

Recommendation 56:

BART's Board of Directors must adopt written policies that acknowledge California Government Code 1236 and require compliance with standards prescribed by the Institute of Internal Auditors or the Government Auditing Standards issued by the Comptroller General of the United States (known as the "Yellow Book.").

Recommendation 57:

BART's Board of Directors must adopt an Office of the Inspector General charter that expands on the spare language of PUC 28840 – 28845 such that the independence of the Inspector General is clearly acknowledged, and the roles and relationships are clearly defined between the Inspector General and senior BART staff such as general manager, general counsel, treasurer/controller, and internal auditor.

Recommendation 58:

BART's Board of Directors must give the Office of the Inspector General unencumbered and confidential access to all of BART's resources, information, and employees, while respecting the "Weingarten" right of employees to representation during an investigatory interview if requested by the employee.

Recommendation 59:

BART's Board of Directors must provide the Office of the Inspector General independent access to counsel, administrative staff, and records storage systems.

Recommendation 60:

BART's Board of Directors must increase funding for the Office of the Inspector General to the level of peer transit agencies such as LA Metro and WMATA, expressed as a percentage of overall operating budget.

Recommendation 61:

BART's Board of Directors must update BART's Code of Conduct, last revised in 2013, to make reporting of potential conflicts of interest more internally consistent and aligned with federal and state regulations.

REQUEST FOR RESPONSES

Pursuant to California Penal Code sections 933 and 933.05, the Grand Jury requests each entity or individual named below to respond to the enumerated Findings and Recommendations within specific statutory guidelines, no later than 90 days from the public release date of this report.

Responses to Findings shall be either:

- The respondent agrees with the finding.
- The respondent disagrees wholly or partially with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reasons therefor.

Responses to Recommendations shall be one of the following:

- The recommendation has been implemented, with a summary regarding the implemented action.
- The recommendation has not yet been implemented, but will be implemented in the future, with a time frame for implementation.
- The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or study, and a time frame for the matter to be prepared for discussion by the officer or head of the agency or department being investigated or reviewed, including the governing body of the public agency where applicable. This time frame shall not exceed six months from the date of publication of the Grand Jury report.
- The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation therefor.

RESPONSES REQUIRED

BART Board of Directors

Findings 41 through 46
Recommendations 56 through 61



McLaughlin Eastshore State Park, Berkeley, CA

LACK OF FIRE INSPECTIONS IN OAKLAND CREATES UNNECESSARY RISKS

EXECUTIVE SUMMARY

Uncontrolled fires can be devastating for communities, the environment, buildings, and homes; not only to the structures they destroy but also to the mental and physical well-being of people. Most of us take common-sense actions every day to minimize and prevent fires: we turn off the stove, do not leave candles burning unattended, or store flammable liquids in hot places. Just as individuals can take action to minimize fire risk, California requires owners of apartment buildings, high-rise dwellings, schools, and meeting places to meet fire safety codes, laws, and regulations. Local fire departments are mandated to inspect these spaces, yet the city of Oakland has not met its requirement. The Oakland Fire Department (OFD) and the city's leaders bear responsibility for unsafe environments for citizens by failing to complete state-mandated fire inspections. The lack of completed fire inspections is the focus of this report.

Since 2018, California Health and Safety Code sections 13146.2 and 13146.3 require every fire department in the state to annually inspect all buildings used as a public or private school, a hotel or motel, a lodging house, or an apartment house. Oakland has suffered a continuously low rate of completing these inspections. Data shows that the Fire Prevention Bureau (FPB) of the OFD inspected, on average over the last six years, only 25% of the buildings requiring state-mandated fire safety inspections.

The Health and Safety Code requires every fire department to annually report to its administering authority (in this case, Oakland's mayor and city council) its compliance with the annual inspection requirement. The code also requires the mayor and city council to formally acknowledge receipt of the fire department's compliance report. This part of the code helps to hold policy makers accountable for progress on fire prevention resources and funding.

State-mandated inspections are vital to the safety of the Oakland community and should be a high priority for every resident. The barriers and hurdles to completing state-mandated inspections must be removed and fire prevention and life safety should become a priority for all.

State-mandated inspections are vital to the safety of the Oakland community and should be a high priority for every resident.

BACKGROUND

In the recent past, Oakland has suffered deadly fires resulting in demands for improved fire inspections. There have been incidents where people were unable to safely exit a building, where fire sprinkler systems did not work, where smoke alarms were not present, or where fire extinguishers were not readily available or in working order. These dangers exist for any inhabited structure but are more dangerous in densely populated buildings such as schools, assembly halls, high-rise buildings, hotels, and apartment buildings.

In November 2017, Oakland’s mayor and then-city administrator announced changes to OFD’s FPB, including hiring six additional fire inspectors. Following the mayor’s executive order, a Fire Safety Task Force was formed with four subcommittees:

1. data,
2. fire budget and staffing,
3. inspection and displacement protocols, and
4. zoning and building changes.

This task force was charged with improving safety.

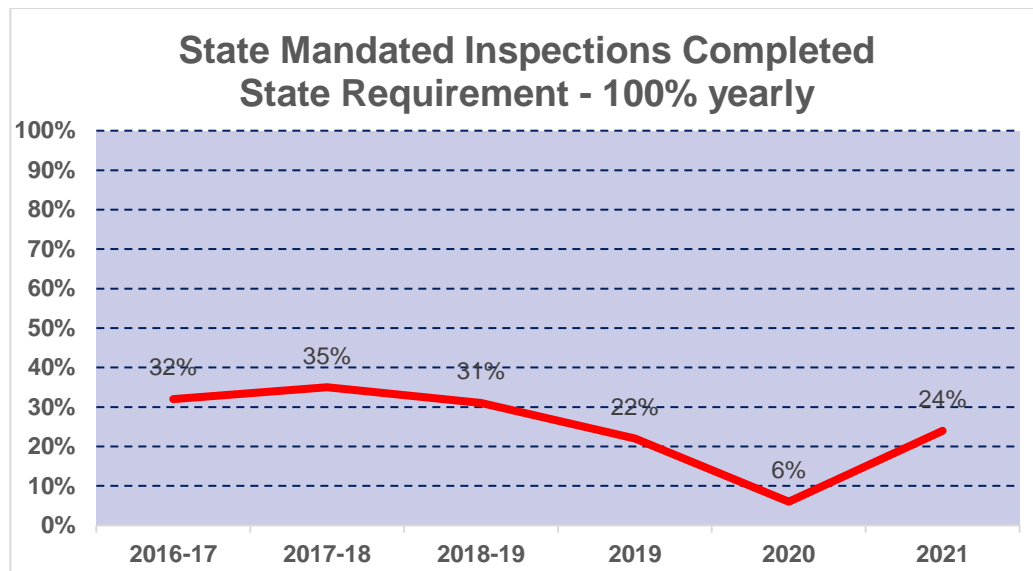
Three years later, in 2020, Oakland’s city auditor issued a report entitled, “Performance Audit of Oakland Fire Department’s Fire Prevention Bureau.” The report found that the FPB is not meeting its state-mandated inspection requirements. Thirty recommendations were issued to improve the performance of the FPB. The report noted, “After three years, a great deal of work remains for the city to accomplish the reforms outlined by the Mayor’s Task Force following the Ghost Ship Fire.”

The FPB is solely responsible for conducting state-mandated inspections and as of March 2022, had six fire inspectors and one supervisor dedicated to this work.

OFD has over 530 employees organized into six major divisions. The current fire chief has held this leadership position only since April 2021. Most of Oakland’s fire department personnel and resources reside in the fire-suppression divisions of the Field Operations Bureau and Support Services. These divisions include firefighters, emergency medical services, firefighting equipment, and communications.

The FPB is much smaller than the fire-suppression divisions. Fire protection engineers and fire code inspectors are assigned to this division. The FPB is responsible for fire safety education, inspection of high hazard occupancies, fire code enforcement, and vegetation management. The FPB is solely responsible for conducting state-mandated inspections and as of March 2022, had six fire inspectors and one supervisor dedicated to this work. There is currently an acting fire marshal who has led the division since January 2022. A national search is underway for a permanent fire marshal.

Fire inspections fall into several different categories. There are specialized inspections for flammable vegetation (such as in the East Bay hills), the cannabis industry, and buildings with hazardous materials. The Grand Jury focused on state-mandated inspections, which include mixed occupancy buildings, high-rises, multi-unit residential buildings, as well as assembly, educational, and institutional buildings. The FPB completed a high of 35% of state-mandated inspections in 2017-2018, to a low of 6% in 2020. Based on current data from January to March of 2022, the inspection rate, annualized, is still only 50%. The Grand Jury learned the current fire chief is aware of this issue and has improved performance in the first quarter of 2022, with a goal of meeting the state-mandated inspection requirements with 100% compliance by the end of 2022.



Historical State-Mandated Oakland Fire Inspection Data
by year and building type

Facility Type	Number to be Inspected+	2016-2017+	2017-2018+	2018-2019+	2019*	2020*	2021*	6-year Average
Assembly	1,202	120	149	173	178	71	142	
Educational	283	26	119	107	94	32	147	
Institutional	85	16	15	22	27	7	8	
Multi-Unit Residential	2,505	1,148	1,167	941	679	105	669	
High-Rise	121	31	34	39	32	56	107	
Total Inspected		1,341	1,484	1,282	1,010	271	1,073	
Total Buildings	4,196	4,196	4,196	4,196	4,559	4,559	4,559	
Percentage		32%	35%	31%	22%	6%	24%	25%

+ Data received from the Oakland Fire Department. The Performance Audit by the Oakland City Auditor published inspection data that reflected a lower rate of inspections. (September 30, 2020).

* Data received from the Oakland Fire Department February 23, 2022.

INVESTIGATION

The Grand Jury determined that to reach 100% compliance for state-mandated inspections, the following are needed:

- **Accurate Inventory**: Complete inventory of the buildings to be inspected—where are they, what are they used for, and who owns them. For example, the OFD’s inventory listed the Ghost Ship building as a nonresidential warehouse and therefore not requiring a state-mandated inspection.
- **Trained Inspectors**: Inspectors must be cross-trained in multiple inspection categories to maximize their efficiency. For example, high-rise buildings have different requirements than schools because fire codes differ depending on building use. The fire code manual also spans over 500 pages, and the job of fire inspector requires interpersonal skills and subject-matter expertise necessary to educate and work with building owners who are not always happy to be inspected or initially able to invest in fire safety.
- **Staffing**: Oakland needs a sufficient number of inspectors, supervisors, and resources to inspect the over 4,000 buildings requiring annual inspections. The Grand Jury was informed that at least 11 fire inspectors are needed to fully staff the FPB. The FPB currently has a number of staff on leave and has not been fully staffed for several years. The Grand Jury has learned that the FPB is in the process of onboarding six additional fire inspectors.
- **Standardized Procedures and Processes**: The inspection process must be standardized to track inspections, efficiently record needed corrective action, and take advantage of available automation. Expectations for inspector workload and productivity should also be established and monitored.

The 2020 Performance Audit noted that OFD does not have a complete inventory of buildings requiring fire inspections in Oakland.

- **Enforcement Coordination**: There must be consequences for building owners who do not comply with fire safety regulations. For example, a building owner stalled installation of a required fire alarm system for four years by ignoring re-inspection notices of noncompliance without repercussion.

City-wide Building Inventory

The 2020 Performance Audit noted that OFD does not have a complete inventory of buildings requiring fire inspections in Oakland. This is consistent with the message the Grand Jury received while interviewing witnesses. Such an inventory needs to be a current block-by-block, address-by-address, picture of the city that includes changes in use, new construction, and demolitions. The lack of an accurate

database of buildings impacts the ability to complete inspections because there is no way to gauge which buildings require inspections. For example, the Grand Jury learned it is not unusual for a building to be a church one year, and changed to a multifamily home the next, or become vacant entirely. These changes in use subsequently change the fire inspection requirements.

The data on completed state-mandated inspections per year compiled by OFD reflects the known number of facilities requiring inspections. The actual compliance rate cannot be known until there exists a reliable inventory of buildings. If an improved inventory existed, it would identify more buildings needing inspection, and consequently the actual inspection rates would be lower than currently published.

Historically, there appears to be too little interdepartmental coordination between OFD and other city agencies necessary to create and maintain an accurate building inventory. When buildings change use through the permit process, tax assessment, or building/planning changes, OFD must be notified of the change in building status. Implementation and use of a city-wide database has been sluggish and incomplete.

Accela is the cloud-based software solution that Oakland has adopted to accomplish both interdepartmental coordination, the creation and updating of building use inventory, and to automate the fire inspection process. This includes the use of handheld tablets and automated templates by fire inspectors to document inspection results and follow-up.

Accela offers fire inspectors standardized check-off templates suited for various building inspections, which, when completed, automatically create and upload completed inspection reports. Accela also notifies inspectors when re-inspections are needed and tracks the citation progress or other enforcement actions.

Accela and the use of tablets has previously been slow to implement within the FPB. Its adoption has also been sporadic throughout city departments, where its use is voluntary. Only one battalion of three in OFD was using Accela as of March 2022. The Grand Jury was pleased to learn that the OFD chief has succeeded in implementing Accela across the department as of May 1, 2022.

Accela currently has the ability to identify buildings requiring inspections by FPB. While OFD is making use of this, at this time, there has not been the inter-departmental coordination necessary for OFD to be able to take full advantage of the efficiencies provided by Accela.

The Grand Jury learned that there is a citywide Accela implantation task force that resides within Oakland's Department of Planning and Building. OFD has not been able to maximize the value and expertise of resources available from the task force. The task force exists to aid city departments in the transition to new software. To maximize the utility and value of Accela, OFD must provide:

- Subject matter expertise.

- Constant assessment and reassessment of how well new Accela programming fits the needs of OFD.
- Practical training for fire personnel on the use of Accela.
- A clear timeline for change.
- Support from executive management within OFD.

Importantly, there remains a disconnect between the Accela Solutions team and OFD on administrative access to Accela. OFD does not have administrative access to Accela, which slows OFD's ability to make immediate changes to the interface and functionality of the system that would streamline its workflow. This appears to be an additional barrier to full Accela implementation for the OFD.

Fire Inspector Training

The Grand Jury learned that historically, training offered to fire safety inspectors was haphazard, generally internal, and mainly consisted of on-the-job mentoring by experienced inspectors. External training was difficult to get approved and expensive to obtain. Some inspectors chose to use their own money to attend training classes rather than wait for the department to offer or authorize needed training.

Because training has been sporadic and uneven within the FPB, not all inspectors are certified to inspect all types of facilities. In recent years, this problem caused serious inefficiencies within the ranks of inspectors while hundreds of needed inspections went undone because the available inspectors lacked the skills to conduct the types of inspections needed.

The Grand Jury learned that the current chief is aware of these challenges, recognizes their seriousness, and has begun to address them in 2022. The Grand Jury's investigation has confirmed the chief's commitment to improving inspector training, and the Grand Jury has also learned that the current chief has put in place necessary changes to improve department-wide training.

Additionally, it is the responsibility of the leadership of OFD to build a culture that values and respects inspectors as equal partners with sworn firefighters. The Grand Jury learned that a perception may exist that uneven priority is given to these equally important vocations. Higher compensation or expanded training will assist with retention of fire inspectors, but until fire inspectors see a clear career path and feel they can earn higher status within OFD, it will be difficult to retain the best and most skilled inspectors. The current chief is aware of this issue and is working to address this perception within the department.

Insufficient Staff

New fire inspector applicants must be recruited for applicable skills and experience. The staff within the FPB needs to be highly qualified with a wide range of inspection certifications. The critical nature of their performance impacts the residents of Oakland as a whole. These positions should be filled as soon as possible for the overall safety of Oakland. Current city civil service procedures do not facilitate this process. The Grand Jury learned of numerous situations where the city's human resources procedures did not address the urgent needs of the OFD and its FPB.

The Grand Jury learned of repeated complaints about delays in hiring and the hiring of inspectors with little or no background in fire science. Delays in making an employment offer to qualified candidates is a very serious problem. Experienced candidates have employment options. They accept positions outside of Oakland because of delays in hiring. The Grand Jury understands that civil service requirements and labor contracts impact the hiring process. It is critical to expedite the hiring process by seeking to negotiate new terms in the existing labor contracts that would allow for a faster hiring process to fill these vital positions.

Oakland describes preferred candidates for fire inspectors in the official description of the position as follows:

The ideal candidate is a highly motivated, organized and detail-oriented person, who has experience in inspecting buildings, fire protection systems and/or fire code enforcement....

The Grand Jury believes that the OFD has hired some candidates without fire code experience, who require more time and money to train than equally qualified applicants with a background in fire science, as a consequence of delays in the hiring process. The Grand Jury urges Oakland's leaders to correct these issues within the hiring process.

Another staffing challenge is compensation and working conditions. High turnover has hampered efforts to complete inspections. As a large city, Oakland includes a complex array of buildings which presents challenging work for fire inspectors. Smaller surrounding cities offer competitive pay and, for some, more attractive working conditions. Therefore, inspectors often leave, especially once they have a year or two of training and experience. The unfortunate combination of significant recruiting delays, inexperienced hires, compensation that often does not make up for the more challenging and more complex work compared with other nearby communities, high turnover, and unequal status within OFD make it difficult for OFD leadership to staff a quality team of fire inspectors to protect Oakland citizens.

Internal Processes

Many of the recommendations from the 2020 Performance Audit focused on the need for the FPB to adopt standard operating procedures. The Grand Jury did not find evidence that this has been completed. All inspections, including state-mandated, were hampered by inconsistent use of devices, handwritten notes on inspection reports, and a troublesome database conversion from the prior software system One Step to the new Accela system. As of May 2022, One Step has been retired and its data is being migrated into the new Accela system, which is a large step in the right direction.

The lack of communication between departments also adds to a number of re-inspections, some of which result in a building inspected 5-6 times for the same violations. These re-inspections draw staff time away from first-time inspections of other structures.

The Grand Jury understands that the current fire chief has indicated that there will not be repeated re-inspections in 2022. The Grand Jury supports the fire chief's focus on inspecting more buildings rather than using resources for duplicate inspections. It is important to be transparent with the public about the number of buildings inspected each year and the number of buildings that fail inspections, as well as the number that eventually pass inspections once violations are corrected. This fire safety data should be easily available to city leaders and to the public on the OFD website.

Enforcement

The Grand Jury is concerned about the lack of legal action designed to ensure fire safety. The Grand Jury inquired about the number of legal actions taken by the Oakland City Attorney's Office against owners cited for fire safety violations. This inquiry revealed that the city attorney is not the primary initiator of these actions, and instead acts as legal support for the OFD for citations that have already been issued.

Existing Oakland Fire Code (Chapter 15.12) reads in part:

Failure to comply with any of the provisions of this Code, including failure to provide, obtain or maintain valid permits, certifications, tests, ...remove, ...unsafe materials, appliances, fixtures, equipment or other property; or failure to ...correct, unsafe or hazardous for egress or fire ...shall be and is declared to be prima facie evidence of an existing and continuing hazard to life or limb, property or public welfare.

Fire inspectors have the legal authority to cite owners for fire code violations. Generally, the FPB follows a policy of working with owners prior to citing, issuing a notice to repair and then allowing them time and flexibility to make the needed repairs or installations. Barring extraordinary circumstances an owner usually has 15 to 30 days to make corrections. One re-inspection is then

required. Owners who fail to make the necessary corrections can be issued a citation and/or fined, which can ultimately lead to a lien being placed on the building and a referral to the city attorney.

The Grand Jury found that citations are rarely issued for failure to meet inspection criteria. Many witnesses had trouble remembering the last time a citation or referral to the city attorney occurred, and the Grand Jury found one instance of confusion as to whether inspectors had the ability to issue citations. It is the responsibility of the fire chief and the fire marshal to

ensure that inspectors utilize all means, including citations, to achieve compliance with the fire code, and that OFD staff fully understands the enforcement options that are available.

The Grand Jury learned that the fire chief recognizes the need to support inspectors as they issue citations. The fire chief's expectation that citations are appropriate, within the authority of the fire inspectors, and will be used, has been shared with the FPB.

The enforcement process has not been used on educational facilities that fail inspections. The Grand Jury learned that 97% of Oakland schools failed compliance with state-mandated inspections one year, 90% the next year, and corrections have just begun after intervention by the current fire chief. These statistics for public schools have been supplied to the mayor, the city administrator, and the superintendent of the Oakland Unified School District. This is a troubling statistic concerning the safety of Oakland's students.

CONCLUSION

The Grand Jury concludes that, historically, the OFD and city leaders, by not-setting fire prevention as a priority, risked endangering the life and safety of Oakland citizens. The lack of attention to life-saving inspections and barriers to enforcement of fire code regulations falls on the city's leaders. This signified a lack of due diligence in performing their duties to the residents, workers, and visitors of Oakland.

The Grand Jury found that the current fire chief has instituted significant reforms and personnel changes that are moving OFD in a positive direction toward meeting its inspection requirements. The Grand Jury commends the fire chief and urges the department to continue its work to institute change that will increase fire safety in Oakland.

Oakland's leaders and agencies must explicitly state and demonstrate their commitment to focus on fire prevention by developing a plan to complete 100% of the annual required state-mandated fire inspections within the next 24 months. They must ensure that the effect is sustained year

The Grand Jury found that the current fire chief has instituted significant reforms and personnel changes that are moving OFD in a positive direction toward meeting its inspection requirements.

after year by annually approving the resources needed for the OFD's FPB to complete its responsibility for state-mandated inspections.

FINDINGS

Finding 47:

The Oakland City Council has no written plan or timetable for holding Oakland Fire Department accountable to annually complete all state-mandated fire inspections.

Finding 48:

The Oakland Fire Department does not have an up-to-date inventory of buildings that require state-mandated inspections.

Finding 49:

The slow, uncoordinated, and incomplete implementation of Accela, throughout Oakland's city departments including, but not limited to the Oakland Fire Department, has greatly reduced the ability of the Fire Prevention Bureau to complete state-mandated fire inspections.

Finding 50:

Historically, the Oakland Fire Department has not provided sufficient training for fire inspectors.

Finding 51:

The city of Oakland presents a uniquely challenging environment for inspections which has resulted in high turnover of inspectors.

Finding 52:

The city of Oakland's slow and inefficient recruitment process results in hiring delays and fails to hire candidates with relevant experience.

Finding 53:

The Oakland Fire Department has not used the citation process for fire safety violations in a manner that results in immediate and substantive improvements to fire safety.

Finding 54:

The Oakland Fire Department does not have sufficient administrative staff support for fire inspectors to aid in the citation process.

Finding 55:

The city of Oakland does not have fire inspection information readily available on its website for public review.

RECOMMENDATIONS

Recommendation 62:

The Oakland Fire Department shall report the status of state-mandated fire inspections to the Oakland City Council's Public Safety Committee quarterly for review and evaluation.

Recommendation 63:

Oakland's mayor must meet monthly with the Oakland Fire Department chief focusing on progress toward the goal of 100% compliance with state-mandated fire inspections.

Recommendation 64:

The city of Oakland must develop a dependable, cross-agency, up-to-date inventory of buildings needing state-mandated fire inspections.

Recommendation 65:

The Oakland Fire Department, in partnership with the Accela Task Force, must evaluate the Oakland Fire Department team and the work plan for the Oakland Fire Department's Accela implementation, including the possible addition of administrative permission for the Oakland Fire Department to allow the Oakland Fire Department Accela liaison to make direct changes to the Accela interface.

Recommendation 66:

The Oakland Fire Department executive staff must meet regularly with the Oakland Fire Department Accela liaison to evaluate the status of Accela implementation within the department, including the status of Accela's performance in aiding inspections.

Recommendation 67:

The Oakland Fire Chief must evaluate personnel assignments to ensure the appropriate liaison with systems and operational knowledge is in place for the critical implementation of Accela.

Recommendation 68:

The Oakland Fire Chief must evaluate the implementation of Accela support and training available for state-mandated inspectors.

Recommendation 69:

The Oakland Fire Department must assess its Accela working group to ensure that the fire department's automated needs in the Accela program are being met. This should include an automated online system for documenting all state-mandated inspections, the ability to document all follow-up inspections, and the ability to access data for statistical analysis of inspection results.

Recommendation 70:

The Oakland Fire Department must ensure that all fire inspection training meets or exceeds the standards provided by the California Office of the Fire Marshal, and that a sufficient number of staff are cross-trained to ensure that fire inspections are completed.

Recommendation 71:

The Oakland Fire Department must create a clear career path for professional advancement of fire inspectors.

Recommendation 72:

Oakland Fire Department leadership must work to raise the status of the Fire Prevention Bureau, so it is on par with the status and esteem afforded firefighters within the department.

Recommendation 73:

The Oakland Fire Department must establish clear expectations for the number of completed inspections on a daily/weekly basis to reach the 100% inspection goal.

Recommendation 74:

The Oakland Fire Chief must authorize a salary and job study to determine the placement of Fire Prevention Bureau personnel in comparison to other large cities. Results should be shared with the mayor, city council, and Oakland's human resources department.

Recommendation 75:

The city of Oakland must reform its hiring process to allow for more rapid filling of open positions in order to hire more experienced fire inspectors.

Recommendation 76:

The Oakland Fire Chief and Fire Prevention Bureau Fire Marshal must provide all inspectors with sufficient training that includes clear guidelines on how and when to cite violators. This must include a written policy that outlines specific actions and inspectors' authority when citing.

Recommendation 77:

The Oakland Fire Department must provide the Fire Prevention Bureau with administrative staff to support the fire inspectors to process noncompliance citations and prepare for court appearances if necessary.

Recommendation 78:

State-mandated fire inspection data should be easily accessible on the city of Oakland's public information web page.

REQUEST FOR RESPONSES

Pursuant to California Penal Code sections 933 and 933.05, the Grand Jury requests each entity or individual named below to respond to the enumerated Findings and Recommendations within specific statutory guidelines, no later than 90 days from the public release date of this report.

Responses to Findings shall be either:

- The respondent agrees with the finding.
- The respondent disagrees wholly or partially with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reasons therefor.

Responses to Recommendations shall be one of the following:

- The recommendation has been implemented, with a summary regarding the implemented action.
- The recommendation has not yet been implemented, but will be implemented in the future, with a time frame for implementation.
- The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or study, and a time frame for the matter to be prepared for discussion by the officer or head of the agency or department being investigated or reviewed, including the governing body of the public agency where applicable. This time frame shall not exceed six months from the date of publication of the Grand Jury report.
- The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation therefor.

RESPONSES REQUIRED

Mayor, City of Oakland	Findings 47, 49, 52 & 55 Recommendations 62 through 65, 74, 75 & 78
Oakland City Council	Findings 47, 49, 52 & 55 Recommendations 62, 65 & 78
Chief, Oakland Fire Department	Findings 48 through 51, 53, 54 & 55 Recommendations 62 through 78



Sunset Over Western Alameda County

MANAGEMENT FAILURES AT PLANNING AND BUILDING DEPARTMENT COST OAKLAND MILLIONS

EXECUTIVE SUMMARY

The city of Oakland's Planning and Building Department (PBD) has a long-standing practice of allowing building permit applicants to expedite their plan reviews by paying additional fees for reviews outside of normal business hours. Nearly 20 years ago, the 2002-2003 Alameda County Civil Grand Jury investigated PBD and the expedited plan checking service over concerns related to excessive overtime payments to plan check engineers. Their report concluded there was:

- *No evidence that hours reported are observed or verified.*
- *Little evidence to show that time sheets are actually checked.*
- *Perception of possible collusion or favoritism between the applicant and the plan checker.*

The 2002-2003 Grand Jury's report recommended eight changes to address these issues. Only three of these recommendations have been implemented.

Over the intervening years, complaints about delays in completing plan checks have persisted, and on multiple occasions media reports have identified a PBD plan checker as one of Oakland's highest-paid employees, who earned multiples of their salary in overtime compensation. These factors led the 2021-2022 Grand Jury to conduct a renewed investigation of PBD's plan check process, with a focus on the oversight of expedited plan checks and the overtime compensation it generates.

The current Grand Jury's investigation found that nearly all of the practices identified as problematic in 2003 continue to this day and that there has been an absence of management oversight around the expedited plan check process. These factors created an environment where unusually high levels of overtime compensation have been paid to PBD staff while the community members dependent on PBD to provide an efficient and transparent process for approving new construction and renovations have been underserved. Perhaps most troubling, management's failure to adequately oversee the process enabled a systemic under-billing of large project developers that persisted over many years, costing Oakland millions of dollars in uncollected revenues.

Perhaps most troubling, management's failure to adequately oversee the process enabled a systemic under-billing of large project developers that persisted over many years, costing Oakland millions of dollars in uncollected revenues.

In addition to reviewing operational management practices, the 2021-2022 Grand Jury investigated the financial management model and reasonableness of fees associated with the expedited service for plan checking. Proposition 26 requires that fees like those covered by this investigation are:

... not more than necessary to cover the reasonable costs of governmental activity, and that the manner in which those costs are allocated to a payor bear a fair or reasonable relationship to the payor's burdens on, or benefits received from the governmental activity.

The PBD oversees regulation of the city's growth and development. Through reviewing project plans, enforcing local ordinances, developing neighborhood plans, and responding to public concerns, its purpose is to create an environment that supports the health, safety, and economic vitality of Oakland.

The Grand Jury's investigation produced evidence that the current expedited service fees fail to meet this standard as they appear to be set at a level of three to five times the actual cost to provide the service. Of note, while the fees for expedited service are set in the city's master fee schedule and are supposed to apply equally to all projects, the Grand Jury found residential and small commercial projects were required to pay the full amount of these fees, while larger projects were often charged as little as 25% of the fees due to the city. This practice of differentiated fees for expedited service work is also inconsistent with Proposition 26.

The Grand Jury further found that the combination of an expedited service fee set materially above actual costs along with the segregated fund accounting model in place for PBD creates financial incentives for PBD management that are not fully aligned with the department's explicit goals and are not in the best interests of Oakland residents.

The Grand Jury's investigation resulted in six findings and 11 recommendations related to PBD's plan check function.

BACKGROUND

Planning and Building Department Function and Funding

The PBD oversees regulation of the city's growth and development. Through reviewing project plans, enforcing local ordinances, developing neighborhood plans, and responding to public concerns, its purpose is to create an environment that supports the health, safety, and economic vitality of Oakland.

As part of the adopted 2021-2023 policy budget, PBD described goals which include:

- Enhance customer service experience throughout the Planning and Building process by reducing wait time for responses.
- Strengthen the permit processing and coordination function in the Building Bureau to assist applicants in obtaining building permits.

Effective fiscal year (FY) 2006-2007, Oakland made a significant change to the funding mechanism for PBD by removing the organization from the general city budget and establishing the segregated *Development Services Fund* (2415) for managing the department’s revenues and expenses.

	Source of Funds	Use of Funds
2415 Development Service Fund	Licenses, fees, and permits from housing and commercial planning and construction-related activities	Planning and zoning services; construction inspections, construction permit approvals; building code enforcement; plan checks, engineering services

This segregated fund is intended to be self-supporting, and any revenues collected that exceed expenses must remain within the fund for future approved uses. Building permit fees and expedited plan checking service fees are two of the many revenue sources for the Development Services Fund. This fund’s revenues have exceeded expenses in recent years and Oakland forecasts that the fund will end FY 2021-2022 with an uncommitted balance of \$61.6 million. This level of surplus represents over 75% of the annual operating budget for the fund.

The Building Bureau is a component of PBD and is the sub-department responsible for conducting plan checks for all construction and renovation activity in the city. For FY 2021-2022, the bureau has an authorized staff of 97 employees and a budget of \$19 million. The PBD executive responsible for overseeing the Building Bureau is the chief building official. The chief building official position has been vacant since 2020, and the previous incumbent was in the role for just a single year prior to this vacancy.

The chief building official position has been vacant since 2020, and the previous incumbent was in the role for just a single year prior to this vacancy.

Permit and Plan Check Fees

The cost for applicants to obtain a building permit is determined by a fee schedule that has been reviewed and adopted by the city council. A project’s permit fee is determined by the size and nature of the project, with the value of the construction or renovation the primary factor used in calculating the fee. This basic building permit fee covers a broad range of services provided by PBD to applicants, including completing plan checks for the project.

Plan checks are generally assigned to staff and completed on a first-in, first-out basis. When demand exceeds capacity, a backlog results and applicants wait in a queue to receive service. Within the Building Bureau, plan check capacity has chronically been insufficient to meet demand and waits of up to two months are common to have a plan check engineer assigned to a project. The plan check assignment delays are a frequent source of complaints directed to PBD. In a

February 2021 memo to the public and the city council, Oakland’s vice mayor highlighted the negative impact that result from delays in permitting:

Many members of the public and stakeholders have complained about difficulty and slowness accessing our city’s permit process, which is impeding the building of housing, and the opening of businesses. This also reduces revenue available to fund vital services.

In December 2021, the plan check team had an authorized staff of 17 full-time equivalent positions. Only 11 of the 17 positions were filled, and the six remaining were open for recruitment. Staff available to assist with plan checks in December 2021 was down from October 2020 levels, when 14 of 16 authorized positions were filled.

As an alternative to accepting the typical weeks-long delay for assignment of a plan checker, PBD offers applicants the opportunity to request expedited service at an additional cost. Expedited requests are intended to be worked on after normal business hours by staff working overtime.

As an alternative to accepting the typical weeks-long delay for assignment of a plan checker, PBD offers applicants the opportunity to request expedited service at an additional cost. Selecting this option moves the request out of the normal queue for checker assignment and places it in a separate queue of expedited requests. Expedited requests are intended to be worked on after normal business hours by staff working overtime. While no commitments are made about turnaround time for expedited service, the expedited queue is intended to shorten wait times.

To request expedited service, the applicant must agree to pay the city an additional fee of \$465 for every hour of staff time spent on the plan check. This fee is neither capped nor estimated in advance. The hourly charge of \$465 is included in the city’s master fee schedule and is set at 1.5 times the city’s estimate for its cost to provide plan check services during normal business hours. The city has estimated that the cost to provide plan check

services during normal business hours is \$310 per hour. This cost is intended to include all related expenses, including both employee specific and department level overhead. The actual direct labor cost of the plan checkers is a small fraction of this amount as they typically earn a salary based on an hourly rate of \$60-\$80. It is important to note that the \$310 per hour cost estimate for plan checks completed during normal hours is never directly charged to applicants as these services are covered in the basic permit fee an applicant pays for a project.

The plan check engineers within the Building Bureau have the option to volunteer for overtime work and to receive assignments from the expedited service queue. Those who work overtime are compensated at 1.5 times their normal hourly wage. The plan check engineers working on expedited service projects are directed to track and report **all** of their hours working on that

project, not just those incurred outside of business hours. These total hours, as reported by the plan check engineer, are then billed to the applicant at the \$465 per hour rate.

The amount of overtime hours worked in support of expedited service varies widely across the PBD plan checkers. Many plan checkers do not regularly work any overtime, while one plan checker regularly reported working 15 hours per day and often working overtime seven days a week. This latter individual received overtime compensation that ranged up to 275% of their base pay in recent years and was employed by the department and earning significant overtime at the time of the time of the 2002-2003 Grand Jury's investigation of the department. This dynamic of high levels of overtime work and compensation is not limited to a single individual, as several other engineers have also received a multiple of their base pay in overtime compensation across a full year.

The work of plan check engineers is typically done by an individual, working alone with only minimal manager supervision. Once assigned to a project, engineers engage directly with the applicant to provide written comments on submitted plans, and the engineers have discretion to determine when the plan review is complete and when additional revisions by the applicant are required. Typically, an approval process will involve several cycles of comments, corrections, and resubmissions before the plans are fully approved. For plan checks which have requested expedited service, all time spent in these review cycles is intended to be billed to the applicant at the expedited service hourly rate.

Plan check engineers submit bi-weekly timecards as part of the city's standard payroll process. These timecards report hours of regular and overtime hours worked, as well as time off from work. Following submission of an engineer's timecard, it is forwarded electronically to their direct manager for review and approval and subsequently sent to the payroll department for processing. Given the solitary nature of the plan check work and the physical layout of the facility, managers are not typically positioned to directly observe the work of their team members.

The overtime reporting process for payroll and the process for recording hours to be billed to applicants for expedited service are not integrated, and there is no formal reconciliation process to ensure that overtime hours reported to payroll were authorized in advance and match the expedited service hours billed to applicants.

Long Term Case Study of Overtime Compensation and Oversight

When plan check overtime irregularities were investigated by the 2002-2003 Grand Jury, its report found that the

...plan checker who earned the most money reported working overtime every week during fiscal year 2001-2002 without exception. In the same time period, the city of Oakland reported one other plan checker had also worked a large amount of overtime. That employee reported 2,227.5 regular hours and 2,080.0 overtime hours for a fifteen-

month period. These two plan checkers accounted for nearly 75% of all overtime hours worked in the department.

In assessing the processes and controls related to overtime work the 2002-2003 Grand Jury concluded:

There is little evidence to show that timecards are actually checked. In reviewing the entire years' timecards which were pre-approved, there was not a single instance of correction based on reported hours worked.

The 2002-2003 Grand Jury's final report included the following eight recommendations:

1. Plan check supervisors must verify time sheets for accuracy.
2. Plan check supervisors must verify that overtime has actually been worked and accurately documented.
3. Plan checker overtime must be pre-approved. Post-approval must be limited and include documented reasons for such approval.
4. Hire additional plan checkers to reduce the amount of overtime.
5. The practice of allowing day-at-a-time vacation when combined with overtime must be discontinued.
6. Management must evaluate and plan for future staff requirements to eliminate the need for excessive overtime.
7. Eliminate the automobile allowance for employees who do not use automobiles as an integral part of their job.
8. Permanently change the plan check application form so that applicants can no longer designate a specific plan checker.

Media reports on high levels of compensation for workers within PBD's plan check function have appeared regularly in recent years. These reports were often timed around the public release of data on government employee compensation in California. An example of one of these reports, verified by the Grand Jury, is a May 14, 2017 article in the *San Francisco Chronicle* on Oakland's highest paid employee, which reported:

One plan checker's time cards show he worked all 366 days of the leap year, at times putting in 90-plus-hour workweeks. He worked so much that he quadrupled his salary. His regular compensation and overtime pay – including benefits, \$485,275 – made him the city's highest-paid worker and the fourth-highest overtime earner of California's 550,000 public employees in 2016.

The Grand Jury's review of public records show that the engineer who was the subject of these media reports received over \$2 million in overtime compensation between 2011 and 2020. Compensation from overtime was approximately double his base salary, and this plan checker alone accounted for more than half of all overtime paid to Oakland plan check engineers during this time frame.

The Grand Jury learned that this same plan checker throughout their career submitted internal reports of time worked for billing applicants that did not match the time records submitted for their own compensation. The time records submitted for billing of expedited service on larger projects were intentionally understated to average between just 25%-33% of the hours claimed for overtime compensation. The Grand Jury estimates that PBD management's failure to detect and address this individual's inaccurate reporting cost Oakland \$2 million to \$6 million in lost revenue over the past decade.

In December, 2020, after more than three decades of employment by the PBD, the plan check engineer who was routinely one of the highest-paid employees in Oakland retired from the department. The Grand Jury verified the individual received overtime compensation up through October 2020.

INVESTIGATION

In conducting its investigation, the Grand Jury interviewed seven witnesses and reviewed hundreds of documents, reports, and emails. Among other activities, the Grand Jury analyzed multi-year patterns of compensation within PBD and completed an independent assessment of the cost study used by Oakland in setting the fee level for expedited service on plan checks. Through this investigation, the Grand Jury is confident that it had access to adequate quantity and quality of data to develop an informed perspective on PBD's expedited service offering and to prepare meaningful recommendations to PBD.

Non-Expedited Plan Checks

In reviewing PBD processes, the Grand Jury learned that the department has established internal targets for turnaround time on plan checks that have not requested expedited servicing. The Grand Jury also learned that while these targets exist, the objective is not commonly understood within PBD, is not reported in internal management reports and does not appear to have been consistently achieved in recent history. In practice, while a service commitment level may exist, the reality for applicants is they have little reason for confidence that a non-expedited plan check will be processed on a predictable and reasonable time frame.

It is the Grand Jury's opinion that this failure to deliver a predictable and reasonable service level for plan checks is a primary driver of the demand for expedited service. Were the department to adequately staff and manage the plan check function in a manner that delivers on the established service goal, many of the requests for expedited service would be eliminated.

The Grand Jury believes that reducing the demand for expedited services by improving the service on non-expedited plans is both consistent with the stated goal of the department to reduce wait times and an obligation the department has to applicants that are already paying for this function in their project permit fees.

The Grand Jury believes that reducing the demand for expedited services by improving the service on non-expedited plans is both consistent with the stated goal of the department to reduce wait times and an obligation the department has to applicants that are already paying for this function in their project permit fees.

Expedited Service Process and Procedures

In reviewing processes and procedures associated with the expedited service for plan checks, the Grand Jury observed that five of the recommendations prepared by the 2002-2003 Grand Jury have **not** been adopted by PBD. They were recommendations that:

1. Staffing is adequate to support normal demand.
2. Supervisors verify time sheets for accuracy.
3. Overtime is pre-approved.
4. Supervisors verify that overtime has actually been worked and accurately documented.
5. Managers plan future staff requirements to eliminate the need for excessive overtime.

This Grand Jury believes these outstanding recommendations remain essential for effective management of the expedited service.

In addition to the outstanding recommendations, the Grand Jury identified five additional concerns with the expedited service process and procedures:

1. Overtime authorizations are routed to payroll without supervisor approval.
2. Overtime authorizations are not kept in a retrievable format and cannot be checked against timecards.
3. There is no process for comparing overtime hours authorized to overtime hours reported.
4. There is no systemic reconciliation of hours reported for expedited service billing and hours reported for expedited service overtime compensation.
5. There is no limit to the amount of overtime an individual can work by day, week, or year.

Investigation of an Irregularity

In 2019, a plan check manager within the Building Bureau noticed a material discrepancy between the overtime hours reported by an engineer to payroll and that same engineer's report of hours worked on expedited services that were billed to applicants. The net impact of this discrepancy was that many fewer hours were billed to applicants than were paid to the engineer in their overtime compensation. The Grand Jury learned the manager failed to take immediate steps to investigate, waiting at least several months before asking the engineer for an explanation and nearly a year before escalating to their supervisor.

As of April 2022, the internal investigation into this discrepancy has been underway for over two years and the Grand Jury understands that the investigation remains open. Despite a written acknowledgement by the engineer of intentionally misreporting hours worked for an extended period, the Grand Jury was unable to find any evidence that disciplinary actions were taken or that efforts were made to recover funds that might have been owed to the city from applicants for work performed that went unbilled or for overtime compensation that might have been paid but not earned.

It is the Grand Jury’s understanding that despite this recent example of a control gap which could result in applicants receiving expedited service without paying the mandated fees and/or engineers receiving overtime compensation for hours not actually worked, PBD has not yet implemented a control to ensure matching entries in the compensation and applicant billing systems.

Through its investigation, the Grand Jury learned there was an absence of a common understanding among PBD staff of the policies and procedures for providing the expedited service for plan checks.

Management and Senior Leadership Engagement

Through its investigation, the Grand Jury learned there was an absence of a common understanding among PBD staff of the policies and procedures for providing the expedited service for plan checks. The Grand Jury further learned that there was limited visibility of the economics and operational dynamics of this service outside of the Building Bureau.

The Grand Jury observed that management expressed little concern about the extended time frame required to complete plan checks as well as a lack of engagement on the underlying dynamics that were leading to a plan check engineer being frequently one of the city’s highest paid employees.

The Grand Jury noted a lack of urgency and accountability in PBD management’s investigation into the discrepancy between overtime hours paid and the hours billed to applicants for expedited service that was described earlier in this report.

The Grand Jury learned that several management positions within PBD have been vacant or filled on an acting basis for extended periods, and acting managers are often tasked with performing multiple jobs during their acting role period, which may limit their ability to be effective at either job. In particular, the Grand Jury is concerned that the role of chief building official, who serves as the primary interface between PBD senior leadership and the Building Bureau, has remained vacant since the end of 2020.

The Grand Jury believes that the combination of inadequate process controls and insufficient management engagement have contributed to creating an environment around plan checks where poor service levels are accepted as the norm and identified financial risks go unaddressed.

The Grand Jury views stronger leadership around these issues by senior executives within the Building Bureau and PBD as essential for improving the current situation.

Reasonableness of Fees

Local governments in California are empowered to establish and collect fees for certain services subject to the requirements of California Proposition 26 which states:

the local government bears the burden of proving by a preponderance of the evidence that a levy, charge, or other exaction is not a tax, that the amount is not more than necessary to cover the reasonable costs of governmental activity, and that the manner in which those costs are allocated to a payor bear a fair or reasonable relationship to the payor's burdens on, or benefits received from the governmental activity.

A common method for meeting this burden is through the commission of an independent analysis to estimate the government's cost to provide services. The study used in setting Oakland's current fee for expedited service processing was completed in 2015. This study's recommendations were documented in a 69-page report that addressed a broad range of services provided by PBD. The city council adopted the study's proposed recommendations for fee levels and incorporated them into the city's Master Fee Schedule.

Applicants requesting expedited plan checks at the time of this report are charged a fee of \$465 per hour of plan checker time engaged on their project. This hourly cost represents the fee of \$375 per hour recommended in the 2015 Cost Study with periodic increases for inflation and 14.75% in additional charges to support records management and technology enhancements.

The Grand Jury's analysis of the study used to set the fee for expedited service on plan checks identified several areas of analytical concern that when considered together represent strong evidence, in the Grand Jury's opinion, that the fee is likely not fully compliant with the requirements of Proposition 26. Specifically, the Grand Jury notes:

1. The study estimated the cost for plan checker activity during normal business hour was \$250 per hour. This amount was 3-4 times the direct compensation for plan checkers at the time of the study and is reflective of the fact that the \$250 per hour estimate was intended to be a fully loaded cost, inclusive of direct costs of the checker as well departmental overhead.
2. The cost study recommended that three services, including expedited plan checks, be charged on a per hour worked basis. For each of these services, the cost estimate for work completed outside of normal business hours was set at exactly 1.5 times the cost estimate

for work performed during normal working hours. In the case of expedited plan checks, this outside of normal hours fee was estimated to be \$375 per hour.

The Grand Jury notes that applying a 1.5 multiple to the fully loaded cost of performing a service during normal business to estimate the cost of performing that same service outside of working hours will inevitably overstate the actual cost. This is because a majority of costs included in this \$250 per hour amount are fixed or overhead expenses unimpacted by overtime work.

3. As previously covered in this report, applicants are not charged separately for plan checks that are not expedited. This is because the cost for completing plan checks during normal business hours is one of the core services that the applicant pays for through the basic building permit fee charged to all projects. When an applicant requests expedited review, the city is entitled to additional fees that reasonably align with the actual additional cost of providing the expedited service. In the case of work that is transferred from being conducted without overtime to being conducted with overtime, the incremental expense is properly calculated as the cost to conduct that activity during overtime less the cost it would have cost to conduct that activity during normal time.

By charging an applicant that requests expedited plan check services 1.5 times the hourly cost estimate for work on plan checks during working hours, the city fails to recognize that the cost for the service during working hours has already been paid by the applicant and that at most they should be charging the incremental amount of one half of the normal working hours rate, which was \$125 per hour at the time of the study.

Considered in aggregate, these three points of analytical concern with the 2015 cost study led the Grand Jury to conclude that the current hourly rate charged to applicants for expedited plan reviews is estimated to be three-to-five times the actual incremental cost to Oakland of providing the expedited service and hence out of compliance with Proposition 26.

FINDINGS

Finding 56:

The system in place for authorizing, assigning, checking, and verifying reported overtime for expedited plan checks in Oakland's Department of Planning and Building is ineffective.

Finding 57:

The extended vacancy of the deputy director/chief building official position in Oakland's Department of Planning and Building contributes to the undermanagement of the expedited plan check service.

Finding 58:

The fees currently charged by Oakland for expedited service of plan checks are likely inconsistent with the requirements of Proposition 26.

Finding 59:

The plan check function in Oakland's Department of Planning and Building does not actively monitor productivity within the plan check team and currently does not collect data on hours worked by project to enable this analysis.

Finding 60:

Supply of plan checking resources in Oakland's Department of Planning and building is not aligned with demand for those resources in part because there is no attempt to forecast anticipated supply and demand and provide decision makers with the information with sufficient lead time to address anticipated gaps.

Finding 61:

Exclusive reliance on internal resources for providing plan check services in Oakland's Department of Planning and Building limits the ability of the Planning and Building Department to ensure service commitments to applicants are consistently achieved.

RECOMMENDATIONS

Recommendation 79:

Oakland's Planning and Building Department shall integrate a comprehensive set of process controls to protect against the risk of fraud in the reporting of overtime.

Recommendation 80:

Oakland's Planning and Building Department shall establish and enforce a limit on the maximum annual number of hours of overtime for that can be worked by each plan checker.

Recommendation 81:

Oakland's Planning and Building Department shall establish a process for regularly reconciling Authorized Overtime, Paid Overtime, and Expediting Fees charged to applicants.

Recommendation 82:

Oakland's Planning and Building Department shall fill the currently vacant post of Deputy Director/Chief Building Official.

Recommendation 83:

Once the chief building official is hired, the director of Oakland's Planning and Building Department shall direct the chief building official to provide updates to Planning and Building Department senior leadership on the state of the plan check function and progress on implementing these recommendations on a quarterly basis during their first year in the role.

Recommendation 84:

In the next update to the Planning and Building Department cost study, Oakland's Planning and Building Department shall direct the independent consultants to address or respond to the cost estimate methodological issues identified in this report.

Recommendation 85:

With the next amendment to Oakland's Master Fee Schedule, the city council shall ensure the cost estimate methodological issues and the Proposition 26 compliance issues identified in this report have been addressed in fees set for expedited plan checks.

Recommendation 86:

Oakland's Planning and Building Department shall extend the practice of tracking plan checker activity to all projects not just those for which expedited Service has been requested.

Recommendation 87:

Oakland's Planning and Building Department shall establish and maintain forecasting models for plan checker supply and demand.

Recommendation 88:

Oakland's Planning and Building Department shall make use of forecast models of plan checker supply and demand in resource planning.

Recommendation 89:

Oakland's Planning and Building Department shall establish contracts with on-demand resources, such as third-party plan checkers, that can be utilized during periods in which internal resources are inadequate to meet applicant demand.

REQUEST FOR RESPONSES

Pursuant to California Penal Code sections 933 and 933.05, the Grand Jury requests each entity or individual named below to respond to the enumerated Findings and Recommendations within specific statutory guidelines, no later than 90 days from the public release date of this report.

Responses to Findings shall be either:

- The respondent agrees with the finding.
- The respondent disagrees wholly or partially with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reasons therefor.

Responses to Recommendations shall be one of the following:

- The recommendation has been implemented, with a summary regarding the implemented action.
- The recommendation has not yet been implemented, but will be implemented in the future, with a time frame for implementation.
- The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or study, and a time frame for the matter to be prepared for discussion by the officer or head of the agency or department being investigated or reviewed, including the governing body of the public agency where applicable. This time frame shall not exceed six months from the date of publication of the Grand Jury report.
- The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation therefor.

RESPONSES REQUIRED

Director, City of Oakland Panning and Building Department	Findings 56 through 61 Recommendations 79 through 89
Mayor, City of Oakland	Finding 58 Recommendation 85
Oakland City Council	Finding 58 Recommendation 85

HOMELESS STUDENTS NEED MORE HELP

EXECUTIVE SUMMARY

Homelessness is an issue of crucial importance to the residents of Alameda County. In the educational context, it presents complicated issues for schools and districts to identify and assist students (and their families) who lack stable housing. All children need a safe and stable home to flourish; homeless students have unique challenges that often interfere with their ability to fully participate in their education. It is vital that our educational institutions effectively support homeless students for a brighter future.

Thousands of Alameda County students are homeless. The true number of homeless students in the county is masked by inconsistent policies toward outreach and the inherent challenges of overcoming the social stigma of being identified as homeless. Homelessness results in a wide variety of negative outcomes in the educational realm. Before these outcomes can be addressed, homeless students must first be identified. But merely identifying homeless students does not end the challenge. Providing ongoing support for this vulnerable community is difficult. The persons charged with implementing the various school districts' outreach towards homeless students are designated as McKenney-Vento (MKV) liaisons (named after the federal legislation that outlines the rights afforded to homeless students throughout the U.S.). The Grand Jury found MKV liaisons are typically dedicated, hard-working staff members, yet they are often constrained in their ability to meet the needs of homeless students. This is because they are often buried in district organizational hierarchies and have other job duties that limit their focus on homeless students. Allowing MKV liaisons greater latitude to focus on issues related to student homelessness and increasing MKV visibility within educational organizations will greatly enhance the support systems for homeless students.

Thousands of Alameda County students are homeless. The true number of homeless students in the county is masked by inconsistent policies toward outreach and the inherent challenges of overcoming the social stigma of being identified as homeless.

Additionally, greater emphasis can be placed on offering wrap-around services in the same geographic location, in facilities such as family resource centers, where students and families can address other unmet needs, including housing, mental health support, food, and public assistance. Such resource centers are especially effective when students and families can obtain a variety of services in a single location. There are far too few of these family resource

centers in Alameda County, and more emphasis should be placed on the approach involving consolidated wrap-around services.

Greater emphasis can also be placed on assisting schools and/or districts to connect with Community-Based Organizations (CBOs). These organizations can provide a critical link with services needed by homeless students and their families. There is not a common approach to connecting school districts to CBOs. Under-resourced educators are left to identify and seek out potential partnerships. More assistance is needed to assist schools and districts with CBOs who can help homeless students and their families.

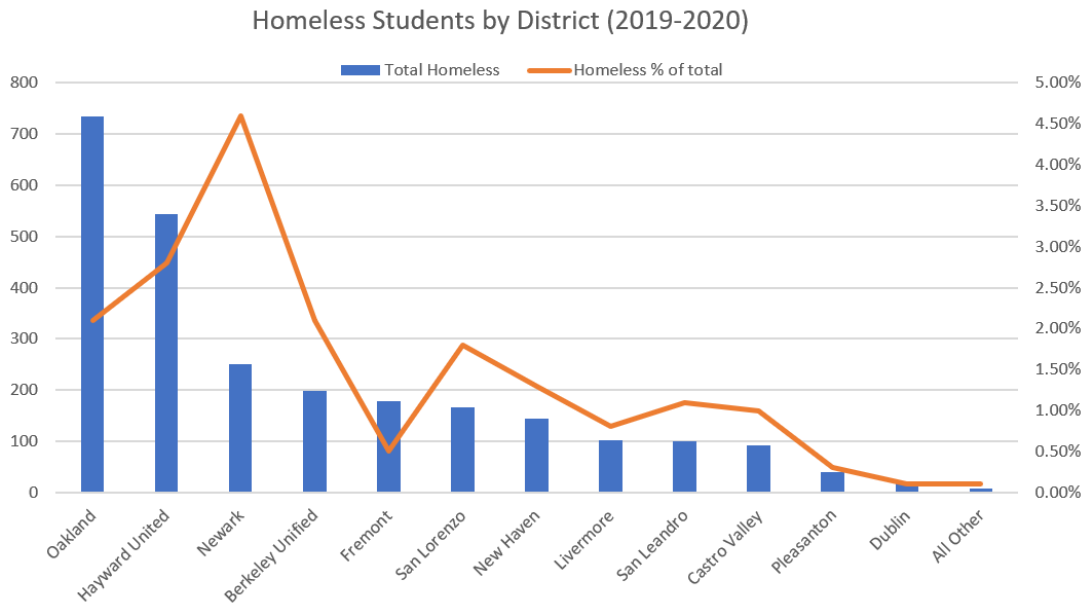
BACKGROUND

The McKinney-Vento Homeless Assistance Act of 1987 (MKV Act) defines a student experiencing homelessness as one who lacks fixed, regular, and adequate nighttime residence. This includes circumstances where students are:

MKV- Qualifying Homeless Circumstances
Sharing housing with others due to loss of housing, economic hardship or a similar reason
Staying in hotels, motels, trailer parks, or camping grounds due to a lack of alternative adequate housing
Staying in emergency or transitional shelters
Abandoned in hospitals
Staying in public or private places not designed for humans to live
Staying in cars, parks, bus or train stations, abandoned buildings, or substandard housing

The definition also includes migratory students who meet any of the homeless definition criteria. While the list of circumstances described in the MKV Act is not exhaustive, it helps educators determine which students are eligible for services.

In the 2019-2020 school year, the last school year for which data is available, 1.3 million students throughout America experienced homelessness. This represents 2.5% of all students enrolled in public schools. Seventy-eight percent were in doubled-up living situations, 11% were at shelters, and 4% were in fully unsheltered situations. Alameda County school districts reported 3,421 homeless students during the 2020-2021 school year. This amounts to 1.4% of the students enrolled in the county. Black/Latinx students make up only 45% of the overall enrollment of Alameda County students but more than 80% of the homeless students.



None of the witnesses interviewed by the Grand Jury believed that the reported numbers accurately represented the extent of student homelessness. As detailed in the next section, homeless students are chronically undercounted, meaning the true number of homelessness students far exceeds those currently estimated.

The numbers are likely to grow exponentially in the future. The county has enacted an eviction moratorium due to the COVID-19 pandemic that forbids any landlord from evicting a tenant who cannot pay rent because of pandemic-related financial difficulties. Once this moratorium expires, the number of homeless students is expected to proliferate.

Effects of Homelessness on Student Performance

Homelessness has devastating effects on students. Homeless students perform qualitatively worse in almost every metric compared with their stably housed peers. Homeless students tend to be chronically absent, as something that many families take for granted, merely getting children to school, is exponentially more difficult for homeless families. Homeless students are more likely to perform below grade level and are more likely to repeat a grade than housed students. As a result, homeless students graduate a far lower rate than their housed classmates. Moreover, unhoused students are disciplined at twice the rate as their peers. Homeless students are also at greater risk for victimization, trafficking, rape, assault, suicide, substance abuse, hunger, and bullying, among other risks.

Homeless students are also at a greater risk for victimization, trafficking, rape, assault, suicide, substance abuse, hunger, and bullying, among other risks.

Education plays a critical role in breaking the cycle of homelessness for these students. The most significant factor for young adults becoming homeless is the lack of a high school diploma or GED. Young adults are more than 300% more likely to become homeless if they do not graduate from high school, highlighting the critical importance education plays in providing a meaningful future for students.

Funding For Homeless Student Services

The MKV Act allocates federal money to the state, which in turn makes subgrants to school districts to provide services to students experiencing homelessness. The MKV Act requires public school districts to appoint an MKV liaison to ensure the identification of students experiencing homelessness in coordination with other school personnel and community agencies. MKV liaisons broadly reported that MKV funds were primarily used for homeless student transportation costs.

The most significant factor for young adults becoming homeless is the lack of a high school diploma or GED. Young adults are more than 300% more likely to become homeless if they do not graduate from high school.

The American Rescue Plan Act of 2021 specifically included \$800 million for the purposes of identifying students experiencing homelessness as well as for providing wrap-around services and assistance needed to enable students experiencing homelessness to attend school and participate fully in school activities. Students experiencing homelessness served by these funds will be reported mainly in briefs for school year (SY) 2021-22 through SY 2024-25.

School districts also receive funding for homeless student services through Title I, Part A of the Elementary and Secondary Education Act (ESEA). Under this program, Local Education Agencies (LEAs) receive allocated funds to hire MKV liaisons and for transportation costs for getting homeless students (and their families) to schools.

Additional funding is available to school districts via California's Local Control Funding Formula (LCFF). This program provides differentiated assistance funding to school districts to improve educational outcomes for indigent students, foster youth, and English learners. Homeless students are automatically eligible to receive services through the LCFF as indigent students.

Other sources of funding often referenced by Alameda County district personnel supporting homeless students are private grants and partnerships with CBOs. These sources are piecemeal, meaning schools and/or districts must seek out local CBOs and grant providers who provide assistance in the area. There is no platform within the county to identify and build CBO partnerships.

Services Provided for Identified Homeless Students

Once students meet the MKV Act’s definition of homelessness, they are afforded specific rights related to their education. These rights are conferred to ensure that homeless students have the same “equal access to the same free, appropriate public education,” as their stably housed classmates.

Homeless students have the right to remain in their school of origin or enroll in the local school where they are temporarily staying, based on what is in the students’ best interests. They are entitled to receive subsidized transportation to their school of origin. They should receive free school meals, as well as educational and related support. School supplies, academic support, and subsidized participation in after-school programs should also be provided to homeless students. Students and their families are also referred to outside agencies and CBOs for other forms of assistance, such as food, clothing, and medical care.

The best way to address student homelessness is to find stable housing for students and their families. MKV students and their families are eligible to receive vouchers for short-term housing assistance. A program in Oakland connects families with a volunteer and a local CBO to assist with securing housing. The program is helpful to those who actually qualify and receive housing, yet the need far exceeds the support. Only 25% of those who applied through the Oakland program received housing, a common theme among those looking for housing assistance in Alameda County.

Homeless students have the right to remain in their school of origin or enroll in the local school where they are temporarily staying, based on what is in the students’ best interests.

Homeless students can be assigned a social worker who can assist students with the myriad of issues that face homeless students. Sometimes this work is done by dedicated school personnel who are not licensed or credentialed. The work is crucial to identifying and addressing student needs.

INVESTIGATION

McKenney-Vento Liaisons

MKV liaisons are the backbone of outreach efforts to assist homeless students in the county. MKV liaisons train district personnel as to how to identify homeless students and then assist them once identified. This includes ensuring that there is wide understanding the MKV Act’s definition of homeless as well as the clues as to what might demonstrate that a student and/or their family is homeless. While on-site school personnel may be the eyes and ears of outreach efforts, those eyes

and ears depend heavily on training from MKV liaisons. The Alameda County Office of Education (ACOE) assists MKV liaisons through its Division of Student Programs and Services, meeting with MKV liaisons regularly and offering suggestions for best practices and other ways of providing service-provision.

MKV liaisons are also crucial service providers to the homeless students and families in each district. Once students are identified as homeless (or potentially homeless), MKV liaisons, working with on-site Family Service Support Specialists (FSSs) or Coordinated Service Teams (COSTs), assist families by helping them to register for classes, discussing particular needs for the students, and checking in regularly to see how students are performing at school, as well as anything else the families might need to respond better to the challenges of being homeless.

MKV liaisons have for the most part diligently and passionately tried to fulfill their responsibilities to homeless students. Their work, like that of so many in the education field, is tireless and their devotion to homeless students and their families is admirable.

MKV liaisons have for the most part diligently and passionately tried to fulfill their responsibilities to homeless students. Their work, like that of so many in the education field, is tireless, and their devotion to homeless students and their families is admirable. Predictably, their jobs have been made exponentially more difficult by the COVID-19 pandemic. As many government buildings were closed to the public, MKV liaisons reported meeting parents in parking lots to provide supplies and discuss school issues. Relationships between MKV liaisons and families have been further stifled as lack of access to vaccines, illness, and worsening economic conditions have kept families from meeting regularly with MKV support structures.

Even though MKV liaisons play such a critical role in serving the needs of homeless students, not all MKV liaisons are able to focus exclusively on those needs. MKV liaisons often “wear many hats” and have many other job duties that require attention such as tracking student attendance and other student welfare indicators. While some MKV liaisons in the county are 100% focused on homeless students, others have significant other job responsibilities. Some MKV liaisons reported only being able to spend 25% to 33% of their time on homelessness students and one MKV liaison reported only being able to spend 4-5 hours per week on homeless student issues. The constraints placed on MKV liaisons necessarily interfere with responsibilities to support homeless students and their families.

Another issue facing MKV liaisons is their visibility within their own organizations, the school districts. Often MKV liaisons report to individuals within a chain of command several layers below district decision-makers. This often results in a disconnect between those making decisions for school districts and those who are most intimately familiar with the difficulties associated with homeless student populations. This can lead to situations where district decision-makers do not understand their own MKV programs or how school policies can negatively impact homeless students. As an example, one district enacted a disciplinary policy automatically assigning any

student absent for three days in a given school week to Saturday school. This policy disproportionately impacted homeless students, as chronic absenteeism is one of the most common attributes of homeless students. While ACOE worked with the district to understand this unfair impact, such intervention may not have been necessary had decision-makers received regular feedback from MKV liaisons.

Identification Issues

Identifying students who are-or may be-homeless is a critical aspect of outreach efforts. The rights afforded to homeless students under the MKV Act necessarily require schools and districts to first identify students meeting the MKV Act's definition of homelessness. Efforts to identify students are most focused during class registration at the beginning of the school year, but school personnel also have an ongoing responsibility to identify homeless students during the school term through on-site engagement.

Identifying homeless students is challenging because many families do not want to be identified as homeless. Many parents fear negative consequences from self-identifying as homeless, worrying that government entities might take their children away from them. There is also stigma to being homeless, and many parents and/or children carry a sense of shame. Witnesses reported that overcoming this stigma is central to the proper identification of homeless students and this usually requires a strong sense of trust between the students, families and their first point of contact at the school. School personnel can begin to overcome this stigma when they can demonstrate to students and their families how they can benefit from being designated under the MKV Act.

Identifying homeless students who are-or may be-homeless is a critical aspect to outreach efforts.

This presents a challenge, as witnesses shared the difficulties of identifying homeless students. MKV liaisons are responsible for training school personnel on how to identify students that are or might be homeless. MKV liaisons typically reported training on-site personnel, such as schools' front desk workers, administrators, and student service directors, such as FSSs and COST members, as to signals that might indicate that a given student is homeless. There is also a training module for teachers that informs teachers how to identify students that are homeless to help the students receive the services they need. This training module is currently available but not required.

This training, however, is done in patchwork fashion throughout the county. Each school district in the county has a different system in place to train personnel on how to identify homeless students. These unaligned approaches lead to varying degrees of efficacy. Some schools and school districts are better than others at identifying homeless students. Whether

due to a district or school’s lack of urgency to identify these children or relying on ineffective systems to train school personnel in that identification, opportunities exist to improve training for those best situated to identify homeless students.

This has led to situations where school personnel were often not well-trained in identifying homeless students. Particularly, school personnel often did not identify students in shared housing situations as homeless. Shared housing is often temporary in nature and difficult to spot, even more so during the pandemic, where remote learning environments restrict school access to students and their lives.

There is a training module for teachers that informs teachers how to identify students that are homeless to help the students receive the services they need.

ACOE has established quarterly meetings between all the MKV liaisons in the county to identify best practices and assist underperforming districts with bettering their response to homeless students. This includes process-mapping for each district to standardize practices as much as possible and data analysis to understand the success of any given approach. As well-intentioned as this is, this support is relational, in that it requires that districts share their struggles with ACOE administrators and accept suggestions for improvement. These two-way relationships don’t always exist.

The Grand Jury is mindful that efforts to identify homeless students are further hampered by chronic absenteeism by school and district personnel. The pandemic has created a revolving door of those responsible for the county’s MKV response teams. Teachers, school staff and FSS/COST members have all had attendance challenges given COVID-19-related illnesses, making training extraordinarily difficult and outreach even harder. And this doesn’t even take into account the impact on the students themselves; homeless students who already have issues with chronic absenteeism have even greater challenges attending school in the COVID-19 era.

As a result, witnesses unanimously shared the belief that homeless students are significantly undercounted across the county. While the precise extent is unknown, there could be thousands of schoolchildren who are eligible to receive additional services but cannot do so because schools and the district have not yet identified them. Services provided under the MKV Act are dedicated for and essential to combatting the challenges homeless students face; adequately identifying affected students is the first step in this process.

Fragmentation of Services for Homeless Students and Their Families

Systems for addressing the needs for homeless students work best when they tightly integrate a wide array of services together. “One stop shopping” service centers, such as the Union City

Family Center, allow parents to access a wide array of programs to help address the multiple issues connected to homelessness. In an integrated service center, a family registering for school can immediately meet with an MKV liaison who can assist in filling out the proper paperwork. They can also meet with case managers/social workers who can assist with the challenges faced by the family. The family can also connect with food assistance programs to help with food scarcity, or technical support for technology-related issues. The more services offered at a geographical location, the more the needs for homeless students and their families can be met.

These wrap-around services more effectively and efficiently allow families to access the services they need by giving families all the help they need in one place. Time and/or transportation barriers may affect a family's ability to get the help they need, forcing prioritization as to what is most important, such as having to get food assistance at the expense of mental health treatment or tutoring for a student. Unfortunately, service centers are not widespread throughout the county, but their impact is being recognized. Union City Family Center reports that some 10 other LEAs have visited the center recently with aims to replicate the success found there. The Grand Jury is encouraged to learn that other educational jurisdictions are interested in creating family resource centers.

“One stop shopping” service centers, such as the Union City Family Center, allow parents to access a wide array of programs to help address the multiple issues connected to homelessness.

Other jurisdictions within the county certainly do not have the budget nor a geographical location where such wrap-around service providers is feasible. Yet, the effectiveness and importance of these types of service centers suggest that additional focus is warranted to see how wrap-around services might be provided in similar fashion outside of the family resource center setting. After all, such programs could not only offer assistance to MKV families, but to other families as well, like socio-economically disadvantaged families or those struggling with mental illness.

Support from Community-Based Organizations

Outreach to homeless students is largely a resource issue, and current funding is inadequate to address the challenges faced by homeless students. Schools and districts are already drastically underfunded. Budgets are stretched thin, and even with the influx of COVID-19-related monies from federal and state government, witnesses reported that adding more homeless services would likely trigger cuts in other service areas. And yet, other options exist for funding more extensive programs for homeless students. School districts across the county work with CBOs for a wide variety of projects. Additional effort could be made to work with CBOs to ensure further support for homeless students. The Union City Family Center is

an example of the successful partnerships with CBOs; the costs associated with building and staffing the center were largely covered by federal grant money.

Currently, each school district is left to its own devices to hunt down opportunities, each with its own unique geographical and program requirements. As it stands, some districts do this better than others, and it is ultimately the students who suffer in districts that do not find support from CBOs. This is often related to a district's base-level capacity, and the ability to dedicate staff for CBO relationships. This is particularly true in the area of student homelessness. Persons responsible for responding to student homelessness are often tasked with numerous other responsibilities.

It should be a goal of all school districts in Alameda County to work collaboratively with other agencies and CBOs to identify and help homeless students. ACOE can help districts identify and pursue partnerships with CBOs that would enhance services for homeless students.

FINDINGS

Finding 62:

McKenney-Vento liaisons face significant time restraints fulfilling their duty to assist homeless students in Alameda County.

Finding 63:

McKenney-Vento liaisons lack visibility within their organizations to effectively impact school districts' service for homeless students.

Finding 64:

Teachers in Alameda County are not required to be trained or certified to identify homeless students.

Finding 65:

Efforts to identify homeless students throughout Alameda County are inconsistent from district to district, including differences as to which school district employees receive training on identifying homeless students and how they are trained.

Finding 66:

Wrap-around services provided at a single geographical location, such as those provided at the Union City Family Center, offer tremendous value to homeless students and their families and are a critical component in assisting with the difficulties associated with homelessness.

Finding 67:

Partnerships with Community-Based Organizations are an effective way for school districts and schools to overcome funding deficiencies for the provision of services for homeless students.

RECOMMENDATIONS

Recommendation 90:

The Alameda County Office of Education should identify strategies for reducing the workloads for McKenney-Vento liaisons in Alameda County to provide greater focus on homeless student service provision.

Recommendation 91:

The Alameda County Office of Education should work with school districts to increase visibility for McKenney-Vento liaisons within their organizations, including making MKV liaisons cabinet-level positions for district superintendents.

Recommendation 92:

The Alameda County Office of Education should require, to the extent possible, that Alameda County teachers be certified that they have completed training on identifying homeless students.

Recommendation 93:

The Alameda County Office of Education should develop standards to identify which district/school personnel should complete training related to homeless students, as well as how that training should be conducted.

Recommendation 94:

The Alameda County Office of Education should assist districts within the county as to possibilities for wrap-around service centers and which services could be offered at such centers.

Recommendation 95:

The Alameda County Office of Education should create a clearinghouse to identify potential partnerships for districts in the county with appropriate Community-Based Organizations as well as assist districts in how to establish these partnerships.

REQUEST FOR RESPONSES

Pursuant to California Penal Code sections 933 and 933.05, the Grand Jury requests each entity or individual named below to respond to the enumerated Findings and Recommendations within specific statutory guidelines, no later than 90 days from the public release date of this report.

Responses to Findings shall be either:

- The respondent agrees with the finding.
- The respondent disagrees wholly or partially with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reasons therefor.

Responses to Recommendations shall be one of the following:

- The recommendation has been implemented, with a summary regarding the implemented action.
- The recommendation has not yet been implemented, but will be implemented in the future, with a time frame for implementation.
- The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or study, and a time frame for the matter to be prepared for discussion by the officer or head of the agency or department being investigated or reviewed, including the governing body of the public agency where applicable. This time frame shall not exceed six months from the date of publication of the Grand Jury report.
- The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation therefor.

RESPONSES REQUIRED

Alameda County Office of Education

Findings 62 through 67
Recommendations 90 through 95

INVITED RESPONSES

Superintendent, Alameda Unified School District
Superintendent, Albany Unified School District
Superintendent, Berkeley Unified School District
Superintendent, Castro Valley Unified School District
Superintendent, Dublin Unified School District
Superintendent, Emery Unified School District
Superintendent, Fremont Unified School District
Superintendent, Hayward Unified School District
Superintendent, Livermore Valley Joint Unified School District
Superintendent, New Haven Unified School District
Superintendent, Newark Unified School District
Superintendent, Oakland Unified School District
Superintendent, Piedmont Unified School District
Superintendent, Pleasanton Unified School District
Superintendent, San Leandro Unified School District
Superintendent, San Lorenzo Unified School District
Superintendent, Sunol Glen Unified School District

GLOSSARY

ACOE: Alameda County Office of Education

LEA: Local Education Agency. A public board of education or other public authority that maintains administrative control of public elementary or secondary schools in a city, county, township, school district

MKV: McKinney-Vento Homeless Assistance Act of 1987 is a federal law that provides federal money for homeless students

CBO: Community-Based Organization, typically a 501c3 organization



Lake Chabot, Castro Valley, CA

ABOUT THE ALAMEDA COUNTY GRAND JURY

The Alameda County Grand Jury is mandated by Article 1, Section 23 of the California Constitution. It operates under Title 4 of the California Penal Code, Sections 3060-3074 of the California Government Code, and Section 17006 of the California Welfare and Institutions Code. All 58 counties in California are required to have grand juries.

In California, grand juries have several functions:

1. to act as the public watchdog by investigating and reporting on the affairs of local government;
2. to make an annual examination of the operations, accounts and records of officers, departments or functions of the county, including any special districts;
3. to inquire into the condition and management of jails and prisons within the county;
4. to weigh allegations of misconduct against public officials and determine whether to present formal accusations requesting their removal from office; and
5. to weigh criminal charges and determine if indictments should be returned.

Additionally, the Grand Jury has the authority to investigate the following:

1. all public records within the county;
2. books and records of any incorporated city or joint powers authority located in the county;
3. certain housing authorities;
4. special purpose assessing or taxing agencies wholly or partly within the county;
5. nonprofit corporations established by or operated on behalf of a public entity;
6. all aspects of county and city government, including over 100 special districts; and
7. the books, records and financial expenditures of any government agency including cities, schools, boards, and commissions.

Many people have trouble distinguishing between the Grand Jury and a trial (or petit) jury. Trial juries are impaneled for the length of a single case. In California, most *civil* grand juries consist of 19 citizen volunteers who serve for one year and consider a number of issues. Most people are familiar with *criminal* grand juries, which only hear individual cases and whose mandate is to determine whether there is enough evidence to proceed with a trial.

This report was prepared by a *civil* Grand Jury whose role is to investigate all aspects of local government and municipalities to ensure government is being run efficiently, and that government monies are being handled appropriately. While these jurors are nominated by a Superior Court judge based on a review of applications, it is not necessary to know a judge in order to apply. From a pool of 25-30 accepted applications (an even number from each supervisorial district), 19 members are randomly selected to serve.

History of Grand Juries

One of the earliest concepts of a Grand Jury dates back to ancient Greece where the Athenians used an accusatory body. Others claim the Saxons initiated the Grand Jury system. By the year 1290, the accusing jury was given authority to inquire into the maintenance of bridges and highways, the defects of jails, and whether the sheriff had kept in jail anyone who should have been brought before the justices.

The Massachusetts Bay Colony impaneled the first American Grand Jury in 1635 to consider cases of murder, robbery, and wife beating. Colonial grand juries expressed their independence from the crown by refusing in 1765 to indict leaders of the Stamp Act or bring libel charges against the editors of the *Boston Gazette*. The union with other colonies to oppose British taxes was supported by a Philadelphia Grand Jury in 1770. By the end of the colonial period, the Grand Jury had become an indispensable adjunct of government.

Grand Jury Duties

The Alameda County Grand Jury is a constituent part of the Superior Court, created for the protection of society and the enforcement of law. It is not a separate political body or an individual entity of government, but is a part of the judicial system and, as such, each grand juror is an officer of the court. Much of the Grand Jury's effectiveness is derived from the fact that the viewpoint of its members is fresh and unencumbered by prior conceptions about government. With respect to the subjects it is authorized to investigate, the Grand Jury is free to follow its own inclinations in investigating local government affairs.

The Grand Jury may act only as a whole body. An individual grand juror has no more authority than any private citizen. Duties of the Grand Jury can generally be set forth, in part, as follows:

1. To inquire into all public offenses committed or triable within the county (Penal Code §917);
2. To inquire into the case of any person imprisoned and not indicted (Penal Code §919(a));
3. To inquire into the willful or corrupt misconduct in office of public officers of every description within the county (Penal Code §919(c));

4. To inquire into sales, transfers, and ownership of lands which might or should revert to the state by operation of law (Penal Code §920);
5. To examine, if it chooses, the books and records of a special purpose, assessing or taxing district located wholly or partly in the county and the methods or systems of performing the duties of such district or commission. (Penal Code §933.5);
6. To submit to the presiding judge of the superior court a final report of its findings and recommendations that pertain to the county government (Penal Code §933), with a copy transmitted to each member of the board of supervisors of the county (Penal Code §928); and,
7. To submit its findings on the operation of any public agency subject to its reviewing authority. The governing body of the public agency shall comment to the presiding judge of the superior court on the findings and recommendations pertaining to matters under the control of the governing body and every elective county officer or agency head for which the Grand Jury has responsibility (Penal Code §914.1) and shall comment within 60 days to the presiding judge of the superior court, with an information copy sent to the board of supervisors, on the findings and recommendations pertaining to matters under the control of that county officer or agency head and any agency or agencies which that officer or agency head supervises or controls. (Penal Code §933(c)).

Secrecy/Confidentiality

Members of the Grand Jury are sworn to secrecy and all Grand Jury proceedings are secret. This secrecy guards the public interest and protects the confidentiality of sources. The minutes and records of Grand Jury meetings cannot be subpoenaed or inspected by anyone.

Each grand juror must keep secret all evidence presented before the Grand Jury, anything said within the Grand Jury, or the manner in which any grand juror may have voted on a matter (Penal Code §924.1). *The grand juror's promise or oath of secrecy is binding for life.* It is a misdemeanor to violate the secrecy of the Grand Jury room. Successful performance of Grand Jury duties depends upon the secrecy of all proceedings. A grand juror must not divulge any information concerning the testimony of witnesses or comments made by other grand jurors. The confidentiality of interviewees and complainants is critical.

Legal Advisors

In the performance of its duties, the Grand Jury may ask the advice (including legal opinions) of the district attorney, the presiding judge of the superior court, or the county counsel. This can be done by telephone, in writing, or the person may be asked to attend a Grand Jury session. The district attorney may appear before the Grand Jury at all times for the purpose of giving information or advice.

Under Penal Code section 936, the California Attorney General may also be consulted when the Grand Jury's usual advisor is disqualified. The Grand Jury has no inherent investigatory powers beyond those granted by the legislature.

Annual Final Report

At the end of its year of service, a Grand Jury is required to submit a final report to the superior court. This report contains an account of its activities, together with findings and recommendations. The final report represents the investigations of the entire Grand Jury.

Citizen Complaints

As part of its civil function, the Grand Jury receives complaints from citizens alleging government inefficiencies, suspicion of misconduct or mistreatment by officials, or misuse of taxpayer money. Complaints are acknowledged and may be investigated for their validity. All complaints are confidential. If the situation warrants and corrective action falls within the jurisdiction of the Grand Jury, appropriate solutions are recommended.

The Grand Jury receives dozens of complaints each year. With many investigations and the time constraint of only one year, it is necessary for each Grand Jury to make difficult decisions as to what it wishes to investigate during its term. When the Grand Jury receives a complaint it must first decide whether or not an investigation is warranted. The Grand Jury is not required by law to accept or act on every complaint or request.

In order to maintain the confidentiality of complaints and investigations, the Alameda County Grand Jury only accepts complaints in writing. Complaints should include the name of the persons or agency in question, listing specific dates, incidents or violations. The names of any persons or agencies contacted should be included along with any documentation or responses received. Complainants should include their names and addresses in the event the Grand Jury wishes to contact them for further information. A complaint form can be obtained from the Grand Jury's [website](#). Complaints are accepted electronically via the website, by email (grandjury@acgov.org), or by US Mail.

Mail complaints to:
Alameda County Grand Jury
1401 Lakeside Drive, Suite 1104
Oakland, CA 94612

An acknowledgment letter is routinely sent within one week of receipt of a complaint.

How to Become a Grand Juror

Citizens who are qualified and able to provide one year of service, and who desire to be nominated for Grand Jury duty, may complete a Grand Jury application found on the Grand Jury website. Based on supervisorial districts, approximately six members from each district for a total of 30 nominees are assigned for Grand Jury selection. After the list of 30 nominees is completed, the selection of 19 jurors who will be impaneled to serve for the year are selected by a random drawing. This is done in late June before the jury begins its yearly term on July 1. To complete an online application, please visit: [Join us!](#)

Qualification of Jurors

Prospective grand jurors must possess the following qualifications pursuant to Penal Code section 893: be a citizen of the United States; at least 18 years of age; a resident of Alameda County for at least one year immediately before being selected; possess ordinary intelligence, sound judgement and fair character; and possess sufficient knowledge of the English language. Other desirable qualifications include: an open mind with concern for others' positions and views; the ability to work well with others in a group; an interest in community affairs; possession of investigative skills and the ability to write reports; and a general knowledge of the functions and responsibilities of county and city government.

A person may not serve on the Grand Jury if any of the following apply: the person is serving as a trial juror in any court in the state; the person has been discharged as a grand juror in any court of this state within one year; the person has been convicted of malfeasance in office or any felony or other high crime; or the person is serving as an elected public officer.

Commitment

Persons selected for Grand Jury service must make a commitment to serve a one-year term (July 1 through June 30). Grand jurors should be prepared, on average, to devote approximately 20-30 hours each week to Grand Jury work. Grand jurors are required to complete and file a Statement of Economic Interest as defined by the state's Fair Political Practices Commission, as well as a Conflict of Interest form. Grand jurors are paid \$15.00 per day for each day served, as well as a county mileage rate (currently 58 cents per mile) portal to portal, for personal vehicle usage.

Persons selected for Grand Jury duty are provided with an extensive, month-long orientation and training program in July. This training includes tours of county facilities and orientation by elected officials, county and department heads, and others. The orientation and training, as well as the weekly Grand Jury meetings, take place in Oakland. Selection for Grand Jury service is a great honor and one that offers an opportunity to be of value to the community.

HOW TO RESPOND TO FINDINGS & RECOMMENDATIONS IN THIS REPORT

Pursuant to the California Penal Code sections 933 and 933.05, the person or entity responding to each Grand Jury finding shall indicate one of the following:

- The respondent agrees with the finding.
- The respondent disagrees wholly or partially with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reasons therefor.

The person or entity responding to each Grand Jury recommendation shall report one of the following actions:

- The recommendation has been implemented, with a summary regarding the implemented action.
- The recommendation has not yet been implemented, but will be implemented in the future, with a time frame for implementation.
- The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or study, and a time frame for the matter to be prepared for discussion by the officer or head of the agency or department being investigated or reviewed, including the governing body of the public agency where applicable. This time frame shall not exceed six months from the date of publication of the Grand Jury report.
- The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation therefor.

SEND ALL RESPONSES TO:

Presiding Judge Charles A. Smiley
Alameda County Superior Court
1225 Fallon Street, Department One
Oakland, California 94612

A COPY MUST ALSO BE SENT TO:

Cassie Barner
c/o Alameda County Grand Jury
1401 Lakeside Drive, Suite 1104
Oakland, California 94612

All responses for the 2021-2022 Grand Jury Final Report must be submitted no later than 90 days after the public release of the report.