

SANTA BARBARA COUNTY CORONER

FACILITY AND EQUIPMENT

A Hazardous Environment

SUMMARY

The existing, outdated, and deteriorating Coroner facility is a detriment to the profession and poses a significant health risk to the members of the Coroner's Bureau.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

INTRODUCTION

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

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

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

METHODOLOGY

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

OBSERVATIONS

Coroner Facility

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

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

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

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

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

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

Photo of Second Autopsy Suite

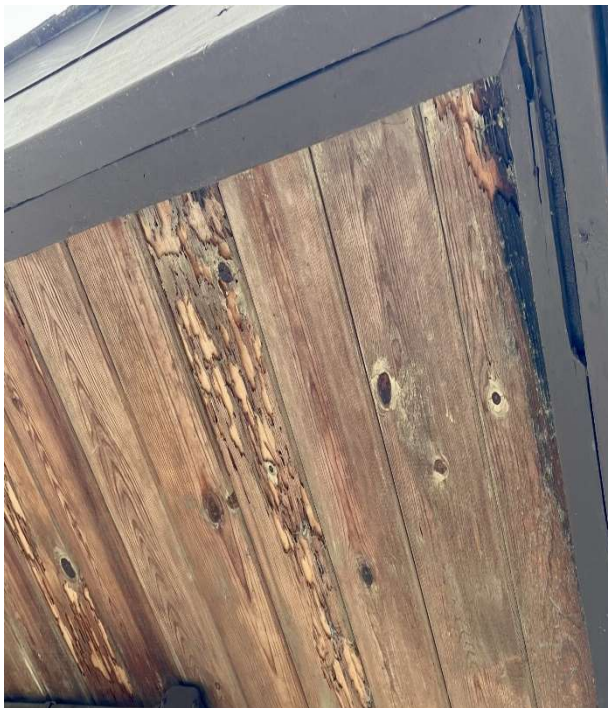


Empty Lot between Bldg. 1 and Bldg. 2

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

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

Photos of Coroner Facility – Building 1



Termite damage and wood rot (Bldg. 1)



View of the bathroom ceiling in Bldg. 1



Another view of the bathroom in Bldg. 1

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

Photos of Coroner Facility – Building 2



Rotted handrail outside Bldg. 2



Evidence of water intrusion and possible mold in Bldg.2



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

A History of Remission and Deferred Maintenance

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

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

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

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

Coroner's Equipment

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

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

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

CONCLUSION

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

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

FINDINGS AND RECOMMENDATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Requirements for Responses:

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

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

Finding(s): 1,2, 3

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

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

Finding(s): 1,2, 4

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

Responses to Findings shall be either:

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

Responses to Recommendations shall be one of the following:

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