



FESIA A. DAVENPORT  
Chief Executive Officer

## County of Los Angeles CHIEF EXECUTIVE OFFICE

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July 20, 2021

To: Supervisor Hilda L. Solis, Chair  
Supervisor Holly J. Mitchell  
Supervisor Sheila Kuehl  
Supervisor Janice Hahn  
Supervisor Kathryn Barger

From: Fesia A. Davenport  
Chief Executive Officer

Board of Supervisors  
HILDA L. SOLIS  
First District

HOLLY J. MITCHELL  
Second District

SHEILA KUEHL  
Third District

JANICE HAHN  
Fourth District

KATHRYN BARGER  
Fifth District

### **PUBLIC NOTIFICATION OF SEWAGE DISCHARGES (ITEM NO. 79-B, AGENDA OF JULY 13, 2021)**

On July 11, 2021, the Hyperion Reclamation Plant (the Plant), operated by the City of Los Angeles, discharged approximately 17 million gallons of untreated and/or partially treated sewage through the one-mile outfall into the Santa Monica Bay off the coast of Dockweiler State Beach. Although multiple agencies initiated a response to the discharge, including the Los Angeles County Department of Public Health, Environmental Health Division (Public Health), which is responsible for monitoring ocean water quality and is charged with taking appropriate action when untreated sewage enters an area where public health may be jeopardized, the public was not properly notified and the beach area affected by the spill remained open for approximately 16 hours following the discharge.

As a result, on July 13, 2021, the Board of Supervisor (Board) directed the Chief Executive Officer, in concert with Public Health, the County Fire Department, Department of Beaches and Harbors, Department of Public Works, and in consultation with LA Sanitation & Environment, to report back within seven days on the following:

1. Any and all issues, including but not limited to, the cause and extent of impacts related to the sewage spill and/or discharge that occurred the evening of July 11th off the coast of Dockweiler State Beach;

Each Supervisor  
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2. All necessary steps to protect the health and safety of Los Angeles County residents and provide timely public notification of environmental hazards, including but not limited to, dissemination of information, signage, and closures; and
3. A corrective action plan that would result in faster response, coordination, reporting and communication about future sewage discharges that may require timely beach closures to prevent public exposure.

In accordance with the Board's motion, CityGate Associates, LLC (CityGate) was contracted to perform an independent review to assess actions and impacts associated with the Hyperion sewage spill. CityGate conducted interviews, received related written correspondence and documentation, and reviewed communications from responding departments and agencies. Attached is a report that provides an incident summary, departmental roles and responsibilities, as well as recommendations and areas for improvement.

As a next step, CityGate will finalize a detailed after-action report and final recommendations, and conduct a multi-agency workshop and tabletop exercise to test new procedures. This additional work is expected to be complete by August 27, 2021.

Should you have any questions concerning this matter, please contact me Kevin McGowan at (323) 980-2261 or [kmcgowan@ceooem.lacounty.gov](mailto:kmcgowan@ceooem.lacounty.gov).

FAD:JMN:AC  
KM:EM:md

#### Attachment

c: Executive Office, Board of Supervisors  
County Counsel  
Beaches and Harbors  
Fire  
Public Health  
Public Works  
LA Sanitation & Environment



600 Coolidge Drive, Suite 150 ■ Folsom, CA 95630 ■ PH 916-458-5100 ■ FAX 916-983-2090

July 19, 2021

Supervisor Hilda L. Solis, Chair  
Supervisor Holly J. Mitchell  
Supervisor Sheila Kuehl  
Supervisor Janice Hahn  
Supervisor Kathryn Barger

**RE: HYPERION PLANT EMERGENCY SEWAGE RELEASE – SEVEN-DAY REPORT MOTION  
“PUBLIC NOTIFICATION OF SEWAGE DISCHARGES”**

On July 11, 2021, as a result of unprecedented events, the City of Los Angeles Sanitation and Environment Department’s Hyperion Reclamation Plant (Plant) discharged approximately 17 million gallons of untreated sewage through the emergency one-mile outfall into the Santa Monica Bay off the coast of Dockweiler State Beach. Notification to the public and closure of likely affected beaches did not begin to occur until late morning on Monday, July 12. Full notifications and press releases were not completed until late afternoon on July 12.

As a result, on Tuesday, July 13, 2021, the Los Angeles County (County) Board of Supervisors (Board) passed a motion requiring the identified County agencies to investigate and report back to the Board in seven days as to the causation of the delayed response by County agencies and what a likely corrective action plan must contain to ensure faster response, coordination, reporting, and communication about future sewage discharges that may require timely beach closures to prevent public exposure.

Given the multiple agencies involved and to provide the integrity of a neutral third party review, the Chief Executive Office (CEO) on behalf of the Board, retained Citygate Associates, LLC (Citygate), the firm that conducted the Woolsey Fire After Action Review (AAR) and is still under contract to the CEO and Board to provide oversight on the implementation of the Woolsey Fire AAR recommendations. The Citygate team includes former emergency managers very familiar with the agencies and circumstances of the beach and oceanside areas and was able to immediately start a review of this incident.



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## **HOW THE SEVEN-DAY REVIEW WORK WAS CONDUCTED**

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Citygate began collecting publicly available information with the supportive help of the CEO and the Office of Emergency Management (OEM) and issued a request for interviews to all of the involved County agencies' key leadership and field teams on the incident plus the Plant's Executive Manager. Six lengthy interviews were conducted with the following agencies and individuals:

- ◆ Los Angeles County Fire Department Lifeguards
- ◆ Los Angeles County Department of Beaches and Harbors
- ◆ City of Los Angeles Hyperion Plant Executive Director
- ◆ Los Angeles County Department of Public Works
- ◆ Los Angeles County Department of Public Health Environmental Health Program
- ◆ Los Angeles County Office of Emergency Management

In all cases, the agencies provided access, without hesitation, to the current leaders and field personnel. In Citygate's experience with this type of work, such prompt response of key leaders can be difficult, but not in this case. Citygate also takes note that in every interview we were provided transparent full disclosure *without hesitation or the need to "get back to us."* In each interview we asked for supporting agency records, written and electronic, to verify oral recollections or to provide agency Standard Operating Procedures (SOPs). In no interview or follow-up did Citygate feel there was evasion or withholding of details. Each County agency and the Plant Executive Director were very serious and at times, apologetic, taking responsibility as needed and willing to come together in the weeks ahead for multi-agency coordination improvement within Citygate's forthcoming Hyperion Plant AAR recommendations.

This seven-day report provides the headlines. Citygate will next compare and deconflict the oral history with the agency records, review the agency current and legacy operating procedures, and conduct follow-up interviews, as needed, to first clarify the facts and then review our draft recommendations with the agencies to ensure the most effective outcome possible.

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## **HYPERION PLANT INCIDENT SEQUENCE SUMMARY**

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### **Hyperion Plant**

On Sunday, July 11, at approximately 2:00 pm in the afternoon, on an otherwise normal summer day without excessive sewage inflows, the Plant began to receive a very high volume of large trash pieces. The mechanical headwaters intake screens use mechanical rakes to remove normal debris allowing treatable materials into the facility. The large trash flow began to overwhelm the screens

and trash clearing tools. As clearing the debris became more and more difficult, Plant executive staff were called to the site. By late afternoon the debris flow had completely overwhelmed the headwaters building, requiring the evacuation of personnel due to increasingly life-threatening circumstances.

The Plant was designed with a secondary closed containment system of drains and an on-site retention area where the overflow can be pumped into the secondary treatment system for at least partial treatment, but not into the ocean. Inside the headwaters building, there is also a diversion plate that, if opened, can divert incoming sewage flow around the blocked screens to the secondary system. In this case, staff believed they could manage the problem without using this option. However, the excessive arriving debris flow accumulated too fast, resulting in rapidly rising water driving staff out of the building before the diversion bypass plate could be opened. The headwaters building massively flooded and then spilled into the Plant street system.

Plant staff had prepared for this and quickly installed pre-configured filter screens on all storm drain inlets within the Plant to remove as many of the solids as possible. Effluent then continues to the secondary catchment area for pumping back into secondary treatment. However, by early evening the flows were so high that approximately 50 percent of the Plant had flooded and the secondary pump system was unable to keep up.

When that happened, the Plant team was between two outcomes, and neither was environmentally desirable. Either the incoming effluent would back up into the nearest public streets *and* the Plant surface runoff would flood past its perimeter onto the beach or the secondary containment pumping system could discharge the excess over what could be handled into the emergency one-mile offshore pipe.

At approximately 8:10 pm, when the use of the one-mile pipe was going to be needed, the Plant followed its regulatory requirements to first file a Hazardous Material Spill/Release Report with the 24-hour duty officer at the California Office of Emergency Services (Cal OES), providing notification that an untreated, off-site discharge was starting to occur. Because it takes time for the raw effluent overflow flow to fill the pipe to the point of the effluent actually entering open ocean, early notification provides time for the local agencies to understand and protect the public.

The following morning, the Plant also dispatched its own boats to conduct water sampling testing back of the surf line, at the one-mile and five-mile discharge pipe outlets.

### **Los Angeles County Department of Public Health – Environmental Health Program**

At 8:11 pm on Sunday, July 11, the Environmental Health (EH) Program received an email from Cal OES stating that a massive discharge had occurred from one manhole on Vista Del Mar Street. The email also stated that most material was contained on site and that “some” had been discharged into the one-mile outfall pipe.



At 8:24 pm the email was forwarded to the on-call “Strike Team” leader and two other team leaders requesting confirmation of receipt. Over the next 19 minutes multiple communications occur within the EH Program team but *none to or from the Plant*.

By approximately 9:30 and 9:35 pm two EH Program Inspectors arrive at the Plant and were briefed by the two shift supervisors. From this point up to 11:00 pm there are multiple interactions between the Plant, the inspectors, EH Program mid-managers, and others. By 9:48 pm it is clear to at least the inspectors on-site that a major incident was underway, the Plant was containing most of the effluent, but some had left the facility and was impacting the public street via a manhole or other type of grate outlet at Dockweiler Beach along with the one-mile emergency pipe being used. At this point, as Plant executive managers were in the midst of saving the Plant, some of the information from the Plant shift supervisors was inconsistent in details, but to anyone *familiar with the Plant*, an extraordinary event was underway, and the inspectors could see significance Plant flooding. The Plant supervisors did tell the inspectors the release was ongoing and would not stop until repairs (if successful) could occur about 4:00 am the next day when the sewage flow is at the daily minimum.

At 11:03 pm the inspectors called their team’s supervisor, reported in, and assured that nothing more at the Plant was needed from them. At 11:15 pm the inspectors went to Dockweiler Beach where they found both Hyperion Plant and Beaches and Harbor Department (B&H Department) private contractor vacuum trucks on-site cleaning up the manhole spill. The Dockweiler Beach security guard stated the spill began about 6:00 pm. The inspectors observed the spill was contained and had not reached the beach.

The inspectors during this period tried twice unsuccessfully to contact the manager for Recreation Waters, and then did check in with another Recreation Waters inspector at about 11:56 pm. In that call the inspectors on-site were told there was not more for them to do, but that this other inspector in Recreation Waters would handle it. Between midnight and 1:00 am there were several communications between the individuals activated so far and one generic *email* was sent up the EH Program chain of command.

The individual whom the inspectors reported to became ill and did not report for work Monday morning. As EH Program upper management started their work week with normal meetings and dozens of emails, there was only partial notice of the Plant incident. Not until late morning as more agencies contacted the EH Program, did Executive Management understand what occurred, at what magnitude.

By midday on Monday, July 12, the EH Program then began posting closure signs at the beach on Lifeguard Towers, without telling and using County Fire Department Lifeguards per longstanding practice, nor was there any effective public information until mid to late afternoon.

## **Los Angeles County Office of Emergency Management**

Cal OES sent an email spill notification to Los Angeles County OEM and multiple County, state, and federal agencies, including the County Public Health EH Program, within approximately two minutes of the Plant notifying Cal OES. OEM handled this first notification as an “awareness” notice since the actual regulatory and response agencies had been properly notified. Citygate has reviewed the notification form and there was insufficient information to portray the spillage as much more than a small event.

As the incident unfolded, OEM did not receive information from the Department of Public Health, which would have driven OEM to provide emergency management support and coordination. On the morning of Monday, July 12, OEM was fielding calls for information from Los Angeles County Fire, as well as trying to assess the severity of the situation. OEM was one of many County departments that did not get calls or emails returned from the Department of Public Health. When OEM was finally able to contact the Department of Public Health, OEM received incomplete or inaccurate information.

## **Los Angeles County Fire Department Lifeguards**

The Lifeguards were first alerted by a bicyclist about a sewer spill at about 8:55 am Monday morning. The Lifeguards started inquiring to all their partners but for hours could not obtain effective spill or response information. Their first real interaction with the EH Program team was an inspector placing “beach closed” signs on Lifeguard Towers at about 12:11 pm. Around mid-morning the Lifeguards sent a rescue boat out to the beach and to the Plant one-mile and five-mile outfall discharge locations and could not observe any sewage, debris, or odor anywhere.

The Lifeguards did find out from the B&H Department that the evening before the Department’s environmental contractors cleaned up a spill contained to the Dockweiler parking area. The Lifeguards and Fire Department Operations Command staff also checked with the City of Los Angeles, the City of El Segundo, and the United States Coast Guard, but no agency had any information Monday morning about a major Plant release into the ocean.

## **Los Angeles County Department of Beaches and Harbors**

An EH Program inspector notified the B&H Department’s duty officer about 7:00 pm on Sunday evening regarding the Dockweiler street and parking lot sewage spill. There was sewage overflowing from a “grate” into ice plant beds in the parking lot, not onto the beach. The B&H Department activated, per its SOPs, a pre-contracted environmental clean-up contractor. The Plant had sent at least two vacuum trucks mid-evening on Sunday to begin clean-up and the B&H Department contractor arrived by approximately 9:30 pm on Sunday. The spill was substantially remediated by 2:00 am Monday between the Plant, the County, and the City of Los Angeles resources. Between the hours of 9:30 pm and 2:00 am, normal SOPs were followed and were



effective even though at times it was difficult to get the Plant to answer a question. From the purview of the B&H Department, it had contained an isolated spill and remediated it with effective multi-party cooperation. However, as of this writing, it does not appear that B&H Department leadership knew Sunday evening that the parking lot incident was more than just a small, localized spill since they did not even notify the County Fire Lifeguards.

### **Los Angeles County Department of Public Works**

This Department was not part of the regulatory notifications Sunday evening, nor was a response for assistance ever made to them.

### **City of Los Angeles Emergency Management and Fire Departments**

As of this writing the oral history states that City of Los Angeles Emergency Management was contacted by OEM and the Los Angeles Fire Department was contacted by County Fire. However, neither City agency had any awareness of a problem at the Plant.

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### ***CITYGATE'S INITIAL SUMMARY FINDINGS AND RECOMMENDATIONS***

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- Finding #1:** The EH Program has had recent mid-manager retirements and has lacked succession planning, training, updated SOPs, and checklists. The person receiving the after-hours call from the field inspectors was a second- or third-level choice, was not trained enough for that role, and then was absent for critical hours. All late notifications to County partner agencies and the public stem from this “single point of failure” due to vacancies, old SOPs, and outdated call lists that did not provide contact information for the best trained personnel for a major incident.
- Finding #2:** The EH Program relies too heavily on email and lacks operational imperative policies to separate the small occurrence “FYI” from the major occurrence that requires “all hands on deck.”
- Finding #3:** The EH Program Deputy Director (newer to the Program and Los Angeles County), stated they *take full responsibility for this cascade of events, and apologizes to your Board and the community.* They are already undertaking immediate steps to improve notification of and reaction time by Program leadership. Their entire team stated without prompting, “this was an immediate closure event.”
- Finding #4:** In listening to the EH Program team and reviewing the Cal OES-generated report, the Plant made the required notification to the state. The off-Plant response and the protection of the public is conducted by local government. As possible, the Plant’s vacuum trucks assisted with the Dockweiler cleanup. They were trying to save the



Plant and lessen ocean damage and believed they had coordinated to the degree needed with the County's EH Program units.

**Finding #5:** The overall lessons learned include siloed operations; single points of failure without backup; stale procedures; no effective public information plan; and no central point of command and coordination, use of the Incident Command System, or Departmental Operations Center.

**Finding #6:** The Plant notification process needs to be improved so that direct notification is sent to local city and County stakeholders at the same time the required notice is sent to Cal OES. Once County departments are engaged, an incident response should be established using the principles of the Incident Command System.

**Finding #7:** The EH Program did not engage with urgency and did not use the Incident Command System. An emergency incident should have been started with Unified Command at the Plant, which would initiate Countywide systems and processes to effectively coordinate and support response functions based on size and the proportionality of response.

### **CONCLUDING OPINION**

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The handling of this release and the necessary public notification were failures. What should be noted is that in Citygate's and in the Plant's Executive Director's description, this was a "once in a career event." The fact that the Plant staff saved their Plant, with limited ocean damage and that no water samples the day of or afterward detected contamination in the waters the community used is due to current Plant design and what the Plant staff did under extraordinary circumstances and pressure. Next time, however, it may not be enough.

This incident is a warning, as the Plant had a "dry season" debris flow. The Plant and its partners need to learn from this "near miss" and if this could be a new normal, agencies must establish faster, better procedures. In addition, the Board of Supervisors, the Los Angeles City Council, and contract cities in the Plant's system should redouble public education efforts to keep debris out of the sanitary sewer system. To allow otherwise, places the public at as much risk as a loss of electric power or drinking water. These plants are essential to modern urban society. They take their environmental responsibility seriously and the public must as well.

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### **WORKING MACRO RECOMMENDATIONS**

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The Citygate team already has 12–16 specific actionable recommendations that need further refinement. They can be grouped into the following themes:

1. The notification process needs a tiered alert system to denote severity and must include active communication as opposed to the mere issuance of an email.
2. SOPs need to be updated to prevent a single point of failure by one person or technology notification system.
3. The agencies need to come together in the next four weeks and quickly establish a new intra-agency SOP for major plant emergencies.
4. County departments need to fully implement the Incident Command System. In addition, based on the proportional needs of the incident, the County may utilize the County’s emergency management system, including the activation of the County’s Emergency Operations Center, if necessary.

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### **NEAR-TERM WORK PLAN**

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We understand the Board may desire a more complete AAR and final recommendations. Given the scope of what we understand within seven days, Citygate suggests:

1. Citygate complete:
  - Deconflicting essential points in the evidence
  - Conducting follow inquires as needed
  - Reviewing existing agency SOPs
  - Publishing a more detailed AAR within four weeks after the Board receiving this report.
2. If the CEO and the applicable agencies desire, before final new SOPs are drafted, conduct a multi-agency workshop to refine the lessons learned and have the agencies cross collaborate on procedures for joint alert and response, to include not only the Hyperion Plant team, but also the other City of Los Angeles departments that would respond when something leaves the perimeter of Hyperion Plant. The last step would be to test the new procedures in a multi-agency tabletop exercise.

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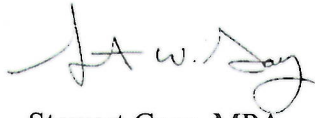
*Board of Supervisors*

*July 19, 2021*

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If you have any questions, please contact me at [sgary@citygateassociates.com](mailto:sgary@citygateassociates.com) or (916) 458-5100, extension 305.

Sincerely,



Stewart Gary, MPA

Public Safety Principal, Citygate Associates, LLC

Attachment: Hyperion Plant Statement

cc: Executive Office, Board of Supervisors  
County Counsel  
County Public Works  
County Public Health  
County Beaches and Harbors  
County Emergency Management  
County Fire

# **LA SANITATION HYPERION WATER RECLAMATION PLANT SUMMARY OF DISCHARGE OF UNTREATED WASTEWATER THROUGH THE 1- MILE OUTFALL ON JULY 11, 2021**

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The hard working and dedicated frontline staff of LA Sanitation and Environment consider themselves guardians of the Santa Monica Bay and Hyperion Water Reclamation Plant as their home. Just as they have done during rain or shine, 24 hours per day, 365 days per year, and even through a major pandemic, they put up a valiant struggle to save Hyperion and the Santa Monica Bay. Their heroic efforts averted a much larger catastrophe, and limited the discharge of untreated wastewater to 17 million gallons, which is a small fraction of the 260 million gallons per day that could have polluted Santa Monica Bay for days on end.

On the afternoon of Sunday July 11, 2021, the Hyperion Water Reclamation Plant became inundated with overwhelming quantities of debris, causing backup of the headworks facilities. The plant's relief system was triggered and wastewater overflows were controlled through use of the plant's one-mile outfall system at 7 pm which resulted in the discharge of untreated wastewater into Santa Monica Bay. Normally the discharge of secondary-treated effluent is through the five-mile outfall. During the over eight hours of discharge through the one-mile outfall, approximately 17 million gallons of wastewater (representing six percent of an average daily load) was discharged as an emergency measure to prevent the plant from going completely offline and discharging much more untreated wastewater.

Per established protocols, the State of California Office of Emergency Services (Cal OES) and the National Response Center were notified respectively at 8:10 pm and at 8:18 pm on July 11<sup>th</sup>. State Law requires that an unauthorized discharge of sewage [as defined in 23 California Code of Regulations (CCR) 2250 (b)] into or onto state waters must be reported to Cal OES. Cal OES will then immediately notify the appropriate Regional Water Quality Control Board, the local public health department, and the local office of environmental health. These offices are responsible for determining appropriate public and environmental safety measures.

Plant staff was onsite all night and resolved the issue early Monday morning. Overflow of wastewater from the plant headworks flowed through roadways within the plant, inundated multiple buildings on site, flooded underground pipe galleries, submerged equipment and caused significant damage. On Monday July 12<sup>th</sup> during low influent into the plant at around 4:30 am, a previously submerged metal plate was lifted to provide an opening for plant flows to bypass the barscreens and flow downstream into treatment processes.

Numerous improvements over the years, in partnership with several environmental groups, helped to mitigate the flow into the ocean, including reconfiguration of in-plant storm basins to pump sewage back into the plant in cases of emergency; installation of screens on all catch basins to prevent untreated debris from entering the storm drains and out to the ocean; and installation of a Headworks Bypass to prevent untreated wastewater from overflowing out of the Headworks building and into the plant streets.

Water quality sampling and testing of shoreline (beach) samples was conducted, and our monitoring vessel traveled to both outfalls to make observations and take samples for analyses following regulatory permit protocols. Two days of testing revealed normal bacteria levels, and the County Department of Public Health reopened the beaches on the evening of Wednesday July 11<sup>th</sup>. We are investigating the cause of the debris and are repairing damaged equipment.