1998–1999 Mendocino County Grand Jury Final Report

June 30, 1999

Eric Labowitz, Presiding Judge
Mendocino County Superior Court

The 1998-99 Mendocino County Grand Jury submits to you this final report as mandated by law. Our report is the culmination of study and work by a group of citizens who dedicated much of the past year to investigate public agency services, management, and use of funds within Mendocino County.

Many recommendations are similar to those of previous Grand Juries and we hope that the public and public servants will implement recommendations.

The final report is to be filed with the Mendocino County Clerk. We are submitting copies to each agency which is the subject of a report, all County department directors, and the libraries.

In September 1999, the Grand Jury and the County will publish a newsprint version of the final report, including agency responses. The Board of Supervisors would like to include the County response to the reports in this publication and have agreed to report within a 60-day time frame instead of the 90 days allowed by law. Other agencies who wish to have their responses included in the publication should also submit their responses to you within 60 days of release of this final report, August 30, 1999.

The final report and responses (as received) will also be available on the County web-site, www.co.mendocino.ca.us.

In addition to the investigative and oversight reports, we accomplished the following:

1. Originated a Grand Jury page and entered the 1997-98 Final Report on the County web-site.

2. Set up a protocol with the County Administrator's Office to do a mass publication of the final report with agency responses.

3. Received 52 citizen complaints and determined whether they should be investigated, rejected, or referred to next year's Grand Jury.

4. Upon order of the Board of Supervisors, studied the issue of compensation for Supervisors and presented the Board with a recommendation that reflects the full-time nature of the job.

5. Surveyed Grand Juries throughout the state regarding stipends and mileage reimbursement.
6. Worked with the Board of Supervisors to amend the County ordinance regarding Grand Jury stipends and mileage reimbursement.

We appreciate the cooperation we received from you, the Board of Supervisors, and the District Attorney in these actions.

The Court, especially Tania Ugrin-Copobianco, was instrumental in securing parking permits for all jurors, including Grand Jurors.

The Court has also been cooperative in updating the Grand Juror selection system, and we suggest (as did the 1993 Grand Jury) that the selection process begin earlier in the year.

We acknowledge the value of your role as advisor to the Grand Jury, and thank you for ordering Special Counsel when it was necessary due to conflicts of interest between County Counsel, the District Attorney's Office, and the agencies under investigation.

Respectfully,

Jo Ann Henrie, Foreman

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Preface

Several common themes emerged from Grand Jury investigations this year.

- Employee turnover and understaffing affects several departments, thus wasting scarce resources and depriving the most disenfranchised in our community of needed services; see, for example, the Jail reports.

- Training is inadequate in many agencies. Several reports indicate the need for training; see, for example, the report of the police shooting in Ukiah. It is easy to state that training is a goal, but much more difficult to provide the actual training. The Grand Jury is encouraged that a part of department directors evaluations will include their accomplishments of training their personnel.

- Both elected and appointed boards seem to have a problem functioning as they should. In some cases, the appointing bodies have not filled the positions. A May 1999 Board of Supervisors agenda listed 77 open positions. Boards lack adequate policies and procedures and members often lack training which can result in manipulation and intimidation by the very departments that they oversee; see for example the Mental Health Board report.

- County operations are centered inland. Coastal residents appear to have a more difficult time in obtaining services, and at the same time, the County does not adequately perform its oversight functions; see for example, the Transient Occupancy Tax and Environmental Health reports.

- Some departments do not have written policies and procedures; One department director stated that he does not have the staff necessary to write policies, but he also did not feel that written policies were necessary.

The Grand Jury, mandated to provide oversight to public agencies, has been described as a "watchdog with no teeth," since in most instances, the Grand Jury can only recommend solutions and there are no obvious penalties for an agency not responding or adopting recommendations.

However, the "teeth" can be 1) ensuring that information regarding agencies is public and 2) citizens informing officials and boards of concerns.

The State has mandated many public commissions and also firmly states that the public should be involved in the operation of public agencies. The Brown Act states:

> . . . .the public commissions, board and councils and the other public agencies in this State exist to aid in the conduct of the people's business. It is the intent of the law that their actions be taken openly and that their deliberations be conducted openly.
>
> The people of this State do not yield their sovereignty to the agencies which serve them. The people, in delegating authority, do not give their public servants the right to decide what is good for the people to know and what is not good for them to know. The people insist on remaining informed so that they may retain control over the instruments they have created.

Public agencies need to realize that they exist for the good of the public. Citizens need to realize that they can participate in the decision-making process.

Dog Licensing and Rabies Vaccinations

Two of the responsibilities of the Mendocino County Animal Control Department (Animal Control) are licensing and ensuring rabies vaccinations of dogs throughout the County.

Reason for Review

The Grand Jury received a complaint regarding penalty notices sent to dog owners based on veterinarian's reports of rabies vaccinations submitted to the Animal Control. While investigating the complaint, the Grand Jury found other problems within the administration of the department.

Method of Investigation

The Grand Jury interviewed the complainant and the Director of Animal Control. The Grand Jury reviewed licensing and notice documentation, a draft policy and procedure manual, the codes relating to licensing, and a newly instituted licensing procedure.

Dog Licensing Procedures

Findings

1. Dog owners are responsible for licensing their dogs within 10 days of the dog coming into their possession or 10 days after the dog reaches four months of age. Dog licenses can be purchased at the Animal Control Office in the Courthouse or at the Animal Shelter.

2. The Board of Supervisors in Resolution 96-106 established the license fees for a female or male dog is $20.00; an altered dog fee is $10.00/

3. The delinquent penalty fee is $15.00 for each individual dog license. Animal Control interprets this to mean that if a dog is not licensed for a period of two years, the penalty would be $30.00 plus two years license fees.

4. The Animal Control Director stated that a goal of the department is to license dogs and ensure rabies vaccinations, not collect penalty fees. He stated that he has no record of what penalty fees might be due the County.

Recommendation

The Board of Supervisors should institute an amnesty period during which all owners of unlicensed dogs can obtain licenses by meeting the rabies requirement and paying the current year fee only, waiving any past yearly fees or penalties.

"Penalty Notices"

Findings

1. When Animal Control receives a record of vaccination from veterinarians pursuant to Mendocino County Ordinance 10.16.030, staff checks to see if the dog has been licensed. If the dog is not licensed, a notice is sent to the dog owner stating the license fee that is due. The dog owner must obtain a license within 10 days. During 1997 and 1998, Animal Control sent out a variety of notices labeled "Payment Notice," "Late Notice," or "Penalty Notice." Many mistakes were made in sending these notices to owners of dogs that were licensed. The current form is now labeled "Pet License Statement."

2. The California Public Records Act (Govt. Code 6250) requires that the public have access to records, stating: "the Legislature finds and declares that access to information concerning the conduct of the people's business is a fundamental and necessary right of every person in this state."

   A citizen's group requested information regarding notices sent. The County Administrator informed the group that Animal Control would provide documentation, but when representatives met with Animal Control they were told that the information was in the computer and that a copy could not be printed. The Grand Jury requested and received the information.

   The Grand Jury is greatly disturbed that citizens were not able to access their public records.

3. The computer printout (provided by Animal Control) of notices sent during this time period indicates that all areas of the County received notices. It does not appear that any one area was targeted for "penalty notices."

Policy and Procedures Manual

Finding

The Grand Jury requested the Animal Control policy and procedures manual to verify procedures for licensing and rabies vaccination reporting. The Director provided a manual written in 1992, which he stated was a draft compiled by an intern. The Director stated that the department follows the State and County codes regarding licensing and that a manual was not necessary. However, even the County Code Section 10.12.010 does not reflect the current practice of licensing. On June 4, 1996, the Board of Supervisors authorized DMV style of licenses expiring on the dog's vaccination date but the County Code has not been revised, and after that date owners still received notices that their dog's licenses expired on the last day of the calendar year.

The "draft" manual contained a list of goals for Animal Control. Numbers one and two concerned licensing dogs and rabies vaccinations, yet no policies or procedures were in the manual concerning these two topics. The license section was a statement regarding kennel licensing.

Recommendations

1. The Department of Animal Control should develop and implement a policy and procedure manual that is consistent with County ordinances and State regulations.
2. The Board of Supervisors should order a report on licensing procedures from the Animal Control Director and amend the County Code.

Comment

The 1991 Grand Jury reported on the lack of a policy and procedures manual and recommended that one be written. The 1992 Grand Jury noted that Animal Control was in the process of developing a manual. It now appears that nothing has been done in regard to this manual since 1992.

"Advisory Committee"

Finding

County Code Section 10.04.030(4-7) establishes an "Animal Control Advisory Committee" but the duties outlined are those of a appeal and administrative hearing board.

Recommendation

The Board of Supervisors should amend the code to either specify duties of an advisory nature, or change the name of the committee to reflect its actual duties.

Final Recommendation

The Grand Jury finds that more time needs to be spent examining these issues. Either the Board of Supervisors or the Grand Jury should conduct both management and fiscal audits of Animal Control during 1999-2000.

Response Required

Mendocino County Board of Supervisors

Response Requested

Mendocino County Animal Control Director

Brooktrails Township Community Services District

Brooktrails is a seven-square-mile subdivision with 5,000 lots and 1,398 homes. The Brooktrails Township Community Services District (BTCSD), established in 1962 as the Brooktrails Resort Improvement District, has a five-member elected board, a full-time general manager, and staff. The board meets each month in the community center to act on matters pertaining to water/sewer service, fire protection, emergency services, recreation, and community planning. The BTCSD includes the fire department which has a full time chief and assistant chief.

Reason for Review

The Grand Jury received a citizen's complaint regarding the hazards abatement program.

Method of Investigation

The Grand Jury interviewed the complainant, BTCSD staff, made two on-site inspections of abated lots, attended a BTCSD board meeting, reviewed fire abatement lists for the last five years, abatement billings, BTCSD financial records, and contacted the California Department of Forestry (CDF).

Hazard Abatement Program

Findings

1. The Brooktrails Hazard Abatement Program started in 1991 as a response to the threat of rapidly spreading wildfires in the wake of the Oakland Hills fire, under the authority granted the BTCSD by California Government Code Sections 61623.4 and 61623.5.

2. All testimony supported the overall goals of the program: to reduce the risk of a large and fast moving fire through the Brooktrails area. Hazards on 1,000 to1,500 properties are cited and abated each year.

Program Implementation

Findings

1. In 1991, there was wall-to-wall brush and dead and dying debris throughout the steep hillsides of Brooktrails. BTCSD established standards in 1993, including removal of brush and trees under six inches in diameter at the base and thinning of trees to 10 to 12 feet apart. Clearing to this standard results in a park-like look. Natural regeneration requires periodic clearing to maintain this standard.

Recommendation

The Grand Jury encourages the BTCSD to involve property owners in a process which looks at the current abatement standards and determines whether these standards need to be maintained or refined.

2. Since 1993, almost every property has been on the abatement list once and many have been listed twice or more. Contrary to allegations in the complaint, the Grand Jury found no evidence of fraud or kick-backs or of selective enforcement in the abatement process. Non-resident owners were most often cleared through the BTCSD and the costs (plus fees) added to their tax bills.

3. The cost to property owners has ranged from $280 to $1,000 per lot (lots average 6,000 square feet in size). The BTCSD encourages land owners to contract privately for the work but in about 25% of the cases, work has been put up for public bid because nothing has been done.

Greenbelt Areas

Finding

The privately-owned lots have been cleared much more thoroughly than the commonly-owned greenbelt. (Over one-third of Brooktrails is greenbelt.) Only limited low-cost clearing in cooperation with the California Conservation Corps, CDF, and conservation camp inmates has been done in the greenbelt. Most areas where the Grand Jury observed the conditions that inspired the Hazard Abatement Program were on greenbelt properties.

Recommendation

The Grand Jury recommends that the BTSCD adopt a more systematic hazard removal program in the greenbelt area, allocating additional fire suppression funds if needed.

Response Required

Brooktrails Township Community Services District Board of Directors

Certification of Part-time Athletic Coaches in High Schools

The law requires that part-time athletic coaches have certain qualifications. They must have training; they must show negative results on tuberculosis tests (no more than four years old); and they must pass a background check for possible criminal history. School districts that fail to ensure that persons hired as part-time coaches meet those qualifications are exposed to liability in the event of preventable accidents, exposure to tuberculosis, or victimization of students through unlawful activity on the part of temporary coaches.

Reason for Review

The 1997-98 Grand Jury found deficiencies in the certification of part-time coaches in Mendocino County high schools and recommended that this year's Grand Jury do a follow-up survey.

Method of Investigation

The Grand Jury asked the principals of each of the nine high schools in the County to provide rosters and certified records of the qualifications of all of the part-time coaches they employed during the past academic year.

Legal Requirement

The California Code of Regulations, Title 5, Section 5592, sets out requirements for use of non-certificated temporary athletic team coaches; Section 5593 lists the required qualifications and competencies for those coaches.

Findings

1. High schools in Mendocino, Point Arena, Ukiah, and Willits provided rosters and complete certification forms.

2. Potter Valley High School provided a roster and certification forms, but one certification form was incomplete.

3. Anderson Valley High School did not submit a roster, but did provide certification forms.

4. Fort Bragg High School submitted no roster, but provided certification forms, not all of which were complete.

5. Laytonville High School submitted no roster and no certification forms, but sent a declaration stating that "Non-credentialed coaches receive regular supervision at practices and home games to assure proper practice and good game management." There was no mention of tuberculosis testing.

6. Round Valley High School submitted incomplete certification forms. There was no roster, only spotty documentation and no mention of tuberculosis testing.

7. There is no standard certification form being used by all districts.

Recommendations

1. Given the potential for injury or liability, district school boards must ensure that proper certification of part-time coaches takes place, including adequate documentation which is readily available.

Response Required

Anderson Valley Unified School District Board of Trustees
Fort Bragg Unified School District Board of Trustees
Laytonville Unified School District Board of Trustees
Potter Valley Unified School District Board of Trustees
Round Valley Unified School District Board of Trustees
Mendocino County District Attorney

2. The Mendocino County Superintendent of Schools should recommend to the district superintendents a standard, County-wide form for part-time coach certification and all high schools in the County should use it in the hiring process.

Response Required

Mendocino County Superintendent of Schools
Anderson Valley Unified School District Board of Trustees
Fort Bragg Unified School District Board of Trustees
Laytonville Unified School District Board of Trustees
Mendocino Unified School District Board of Trustees
Point Arena High School District Board of Trustees
Potter Valley Unified School District Board of Trustees
Round Valley Unified School District Board of Trustees
Ukiah Unified School District Board of Trustees
Willits Unified School District Board of Trustees

Mendocino County Public Defender

The Mendocino County Office of the Public Defender (Office) is charged with providing legal defense for persons lacking the resources to provide their own. Judges in criminal trials determine when defendants qualify for assignment of a public defender. The Public Defender (PD), ten Deputy Defenders, plus clerical staff make up the Office.

Reason for Review

The Grand Jury received a complaint.

Method of Investigation

The Grand Jury interviewed the complainant, past and present employees of the Office, the PD, the County Administrative Officer, Risk Manager, Personnel Director, a Judge, a probation officer, a Mental Health Department worker, and personnel from the Sheriff's Department. The Grand Jury also made an on-site visit to the Office facility in Ukiah.

Staff Turnover

Findings

1. All of the Deputy Defenders employed at the time of the present PD's appointment have either been dismissed, quit, or have transferred to other County departments.

2. When the independent Alternate Public Defenders Office began in 1997, several Deputy Defenders chose to move to that office.

3. One Deputy Defender went out on disability and some took higher paying jobs in other counties.

4. Two of the former Deputy Defenders are now working in the District Attorney's office.

Staff Morale

Findings

1. Former employees interviewed commented on unhappiness and low morale among staff members under direction of the new PD. They complained of verbal attacks by the Public Defender as well as lack of teamwork and support within the office.

2. The PD is looked on by current staff as very qualified, knowledgeable in law, with good connections. He is praised for having modernized the office, using technology in a way which allows attorneys to immediately access case law.

3. The Grand Jury found considerable dissatisfaction among both past and present employees with management of the Office. There are current complaints of overbearing management styles of the PD and the Assistant PD. These complaints include the micro-managing of staff and the lack of teamwork from the top down. With some exceptions, staff morale in the Office is low, and there is an indication that a good number of the incumbents, while not seeking other employment, would leave if an opportunity came up. There is concern that Deputy Defenders are treated as "less than professional" by supervisors.

Recommendation

The County Personnel Office should conduct a teamwork/leadership sensitivity workshop for all Office personnel to address management style and the morale issues in the Office.

Possible Misuse of County Funds

Findings

1. The PD, at County expense and with the assistance of department staff, prepared, copied and mailed an friend of the court brief to the U.S. Supreme Court involving a case which did not originate in Mendocino County. The PD traveled to Washington, D.C., to take part in hearings on the case. The PD testified that he felt that his involvement was justified because the outcome of the case would have an impact on all counties, including Mendocino. Expenses associated with the Supreme Court appearance were paid for by the California Public Defenders Association and the travel was authorized by the Board of Supervisors.

2. The PD prepares and distributes to deputies and to attendees at training sessions material - under the title "Law Notes" - on various cases which come from other publications.

3. Two former Deputy Defenders told the Grand Jury that the "Law Notes" material is easily accessed in its original venues and that republication of the material is an unnecessary use of County resources.

4. The PD told the Grand Jury that the material makes up a useful adjunct to the training sessions and to seminars he holds from time to time and that it includes articles culled from other sources which have direct bearing on topics under discussion.

5. Funds collected for attendance at the seminars go to an account which pays costs involved in preparation of the seminar materials.

Recommendation

The PD has a responsibility to avoid the appearance of impropriety in the expenditure of public funds. The PD and/or the County Auditor-Controller should provide an accounting, including staff time, of expenses associated with seminars or other activities

having no direct bearing on County business. This information should be made available to the Office staff and the public.

Response Required

Mendocino County Auditor-Controller

Working Environment

The complainant commented that the physical office was dirty and crowded and that boxes and other materials blocked aisles and posed an unsafe environment for employees.

Findings

1. The Grand Jury toured the offices of the Public Defender and found them in a generally clean and adequately-maintained condition.

2. The Grand Jury found that there are numerous boxes of files on the floor and in some of the aisles. File shelves appear to be overloaded and could cause safety problems. However, archived files are being removed from the work area for storage in the basement of the building. That should reduce some of the potential hazard. The PD commented that he does not have funding his budget to obtain a newer, more secure filing system.

3. The rear staircase to the second floor is narrow and could be a problem in case of fire. At the time of the interview with the PD, there had been no fire or other safety drills conducted to train staff on proper exit procedures or to determine if the rear staircase is in fact a hazard. The PD said that he will initiate fire and safety training and drills.

4. The entryway area has a counter, but no other means of protecting clerical staff from risks associated with angry or hostile clients entering the facility.

Recommendations

1. The County Safety Officer should work with the PD to identify health or safety issues and take corrective action where needed, with particular attention to the filing arrangement and to staff training for emergencies.

2. The PD should look into the need for better security at the entryway counter.

Workers Compensation Claim

Findings

1. The PD filed a Workers Compensation claim on behalf of an injured employee without that employee's knowledge.

2. The employee was denied access to and the opportunity to review information in the workers compensation file. However, according to County Counsel's September 15, 1998 Opinion, employees are not allowed access to their Workers Compensation files (Workers Compensation Act as codified in Labor Code Section 3200).

3. According to a September 15, 1998 opinion from County Counsel, the claim filing was not permissible as an injured party must be notified of rights and benefits accorded by California Labor Code Section 5402, be provided with the proper forms, and personally sign the claim.

Recommendation

1. The PD must comply with all relevant Labor Code requirements.

2. The District Attorney should investigate the improper filing of workers compensation claims by the PD.

Overtime Requirements

Findings

1. Most Deputy Defenders are exempt employees and do not qualify for extra payment for overtime, though they are sometimes required to work overtime. Most overtime occurs when the Deputy Defender is involved in court proceedings and has no control over the court's schedule. In such cases, the employee is there at the will of the court and must remain on duty past scheduled work hours. The employee has no way of knowing when that might happen and the PD does not have the advance awareness necessary to authorize the overtime.

2. Deputy Defenders are also required to work unpaid overtime when attending weekend seminars put on from time to time by the PD.

3. Testimony supports the fact that the PD instructed deputies not to record overtime on their time sheets; however the County does not require entry of overtime hours for exempt employees.

4. The Office has a flex-time policy which allows employees to take time off, by arrangement, to compensate for extra time worked. The County does not have a flex time policy; department heads establish their own policies.

Recommendations

1. The Office should keep a record of all overtime hours worked.

2. The BOS should establish a policy allowing conditional approval of overtime in situations, such as court proceedings, where employees have no control over work schedules.

3. The BOS should establish a uniform flex-time policy.

Potential Conflict of Interest

Findings

1. The County established an Alternate Public Defender in 1997 to handle cases in which the PD has a conflict of interest.

2. The PD has no control over the Alternate Public Defenders Office in regard to personnel or operations. The Public Defender however, prepares and presents the Alternate Public Defenders' budget for the Board of Supervisors. This budgetary control presents the possibility for a conflict of interest.

Comment

The County must maintain the current separation between the Public Defender and the Alternate Public Defender.

Response Required

Mendocino County Board of Supervisors
Mendocino County District Attorney
Mendocino County Auditor-Controller

Response Requested

Mendocino County Public Defender
Mendocino County Chief Administrative Officer
Mendocino County Personnel Director

Citizen Complaint of the Environmental Health Division

The Environmental Health Division (EHD) is a division of the Public Health Department (PHD). The EHD stated mission is to safeguard the public from diseases, health hazards and lack of well-being related to air, water, food, sewage, hazardous materials, solid waste and other environmental factors. It does this by investigating and reporting on violations, real or alleged, which come to its attention. Violations can be corrected by the authority the Division has and if necessary through court action by the County Counsel and or District Attorney.

The stated vision of the EHD is that the public understands and supports environmental compliance. In order to do this, there must be a fully staffed division functioning as a team. This team relies on education and/or its power of legal enforcement in order to protect the health and well-being of the citizens of Mendocino County. Where observed violations lie outside the purview of the Division, they are obligated to refer the problem to appropriate agencies.

Reason for Review

The Grand Jury investigated the complaint resolution process of the EHD as a result of receiving a complaint from numerous individuals in a neighborhood.

Method of Investigation

In order to determine the effectiveness of the complaint handling procedures utilized by the EHD the Grand Jury focused its inquiry on complaints involving liquid waste which are representative of all complaints. Interviews were conducted with the Environmental Health Director, Environmental Health Specialist (EHS), and the complainants. Liquid waste complaints received by the EHD for the years 1978 through 1998 were reviewed. With a detailed review of unresolved complaints for the year 1997 and through October 1998.

The Grand Jury reviewed working documents of the Public Resources Council (PRC) relating to the proposed county wide standard complaint process for public health and safety issues.

The Grand Jury conducted four site inspections in Fort Bragg and Willits.

EHD and Citizen Complaints

During 1997 and through October 1998, the EHD received a total of 908 citizen complaints, 226 remain open, uncompleted and unresolved. Of this total 197 complaints involved liquid waste and 49 remain open. Many complaints remain unresolved, one for as long as ten years and another one for over 20 years. In each of these two instances, there is documentary evidence in the files of activity as recently as 1998.

Findings

1. The EHD lacks written policies and procedures or guidelines for resolving citizen complaints. Without guidelines, each EHS interprets state and local statutes and department policy. This

results in infrequent, inadequate, and unlawful conduct regarding complaint resolution in citizen complaints.

2. The EHD lacks written policies and procedures or guidelines for ongoing review of the citizen complaint process, thus perpetuating and exacerbating the current poor practices.

3. EHD states that its policy requires that the complainant conduct a follow up inspection within ten days and report back. If the complainant does not report in ten days the complaint is considered closed. Many of the specialists interviewed were unaware of or not clear regarding this "policy".

4. The Grand Jury's extensive review of complaint records revealed that of EHD does not adequately communicate with complainants.

5. Management review of complaints is cursory and inadequate. Complaints are left unresolved without adequate management attention being given to solve the problems satisfactorily. For example:

A complaint was filed in 1988 regarding open sewage standing in and/or flowing through neighborhood front and back yards. It took the EHD approximately four years to respond and then only after repeated complaints by the citizens living in the neighborhood. As of April 1, 1999 the EHD has failed to mitigate this health hazard.

The PHD made the following determinations on April 19, 1993 regarding this complaint:

a. "At that time I put dye in your toilet and determined that there was evidence that the ponding in your back yard contained sewage."
b. "The discharge of sewage to the surface of the ground is a threat to the health of visitors and neighbors."
c. "You are directed to take such action as necessary to discontinue the practice."
d. "The situation is worsened by the moderately heavy fly population. The flies can pick up the sewage on their bodies and transport to the foods of persons in the area"
e. "I have scheduled this for review on 31 May, 1993. At that time you should have made progress in correcting this situation."

The review on May 31, 1993 was not conducted and no further action was taken by the EHD until 1996.

In April 1996, the complainants further complained and then again in December 1996. After the December complaint the Supervising EHS requested a report , from the EHS, on the status of the complaint. That request was not complied with, the Supervising EHS did not follow up.

In January 1997, the following determination was made regarding the complaint.

a. "After inspection of the septic system at referenced property it was determined by this department that the system is not working properly, allowing sewage to back up into the residence."

b. "This constitutes a risk to health of the residents when this occurs."

In October 1998 the EHD responded to the complainants, but only after an investigation was begun by the Grand Jury. In its response the division stated "However, the Division of Environmental Health will not take legal action to improve drainage because we have no legal recourse." In addition it was recommended to the neighborhood that "Children and adults should be advised to not enter or play in the ponded water...".

On May 12, 1999, the Grand Jury requested a written response from the EHD to explain its failure to act, on this complaint, using enforcement authority under Penal Code Sections 370, 372, and 373a. On May 20, 1999, the EHD issued a Notice of Violation to the offending property owner citing Penal Code Sections 370, 372, and 373a as its legal authority.

Testimony supports the fact that EHD failed to act because doing so may cause a hardship on the offending property owner.

As a further example of inadequate complaint review, a complaint was filed in 1979 regarding sewage being discharged on the ground at a multi-family complex. A review of this complaint by the Grand Jury revealed that the complaint is still unresolved and that the engineering consulting firm engaged by the owner to design a septic system made misleading statements to both the EHD and the Community Housing Development Commission in an apparent attempt to gain favorable determinations by these two regulating agencies. A report stating the true condition of the septic system was, however, provided by the consultants to the property owner and the EHD.

On May 14, 1999, the EHD conducted an inspection of the septic system and noted that repairs were being undertaken. The report failed to note that the required County permits had not been obtained for these repairs.

The lack of policies and guidelines directly contributes to the inability of the EHD to correct this situation.

6. California Penal Code Section 370 provides the authority for the EHD to abate a public nuisance. Staff testified that they were unaware of their authority to abate public nuisances. Penal Code Section 372 states that "...anyone who willfully omits to perform any legal duty relating to the removal of a public nuisance, is guilty of a misdemeanor."

7. The EHD fails to complete and/or resolve 25% of citizen complaints. The EHD claims 16% are uncompleted but is unable to substantiate this claim. Whichever figure is accepted, 25% or 16%, that is unacceptable performance by any reasonable community standard.

8, The Public Resources Council has submitted recommendations regarding compliant response to department managers and the Board of Supervisors. These have not been implemented.

Recommendation

Unresolved complaints should not merely be noticed and flagged. They should be thoroughly settled, within a specific time frame because of possible threats to the public health and potential liability to the County. Written policies and procedures must be put in place to ensure at a minimum:

1. Timely acknowledgment of complaints.
2. Progress reports to the complainant and PHD management.
3. Complaint management escalation with complaint age.
4. Resolve all complaints in 90 days or less.

Additionally, the uneven and inconsistent application of local and state statutes leaves any attempt at enforcement easily challenged and leaves the County vulnerable to litigation.

Environmental Health Specialist

The EHD relies upon two Environmental Health Specialists (EHS), six Registered Environmental Health Specialists (REHS) one of whom is a supervisor. The job description for each of these positions states that they receive "...supervision within a broad framework of standard policies and procedures." The EHS and REHS are assigned to a specific geographical area of the county. According to the EHD their activities include oversight of permitted uses such as building, construction and food handling concerning public health matters. They are also responsible for the inspection, follow-up, and resolution of the citizen complaints, including legal action if warranted, in their assigned geographical area.

Findings

1. The Grand Jury is impressed by the dedication and commitment of the EHS and REHS in working with a sometimes hostile public.

2. The EHS do not receive any organized training in building and construction, food handling, quarantine procedures for rabid animals, and investigating citizen complaints concerning public health matters to insure consistency in the application of their day to day responsibilities. Training consists of on-the-job training by more senior EHS and, according to testimony, lacks a central theme or objective. On-the-job training is not consistent, frequently does not occur and more often than not promulgates inadequate and unlawful work practices relating to citizen complaints. Training records are not maintained.

3. In the absence of written policies and procedures each EHS must make up policy, a practice which further ensures that 25% of all complaints remain uncompleted and/or unresolved and hazardous conditions continue, some for years. In addition, this results in uneven application of the law and leaves the county vulnerable to litigation. This was particularly evident during the interviews with the EHS and supported by the overwhelming lack of documented evidence.

Conclusion

The EHD is falling short of meeting its stated goals and vision. The Grand Jury is concerned that in regard to citizen complaints concerning liquid waste, the EHD does not adequately protect the public health. It does not adequately use its enforcement powers to protect the public when it clearly has the authority.

Citizen complaints of environmental hazards are, for the most part, processed in a haphazard and unfocused manner without any guidelines. This failure to adequately document, review and otherwise manage complaints prevents, for the most part, any follow up enforcement action. Furthermore the uneven and at times arbitrary application of law, ordinances or other regulations by the division leaves the County vulnerable to citizen lawsuits.

The EHS job descriptions do not accurately reflect the training and duties of the EHS. They must operate without any written guidelines and receive inadequate on-the-job training contrary to EHD stated policy and contrary the EHS job descriptions.

The Grand Jury was unable to find any significant evidence, written or in testimony, that the EHD measures its performance relative to its stated goals and vision or in any other way measures its performance.

Recommendations

1. The BOS should direct the Public Health Department to establish written Policy and Procedures for the processing of citizen complaints.

2. The BOS should direct the Public Health Department to establish written policy and procedures for training and continuing education of Environmental Health Specialists.

3. The BOS should direct the Public Health Department to establish written policy and procedures for the frequent review and reporting of the complaint process.

4. The BOS should direct the Public Health Department to conduct a third party audit, comprised of County representatives and citizen volunteers, of the complaint process within the Environmental Health Division of the Public Health Department.

5. The Grand Jury directs the District Attorney to investigate the Environmental Health Division complaint process.

6. The BOS should direct the Public Health Department to revise the position descriptions of Environmental Health Specialist I, II, and IV to more accurately reflect the responsibilities, duties and training as actually practiced by the division.

7. The BOS should direct the County Administrator to provide a written report, quarterly, on the status of citizen complaints filed by all County departments. This must be institutionalized by the BOS through policy and procedures, using the Public Resources Council recommended guidelines.

Response required	Response requested
Mendocino County Board of Supervisors	Mendocino County Public Health Department
Mendocino County District Attorney	Mendocino County Public Health Advisory Board

How to Build a 55-foot-high Hotel in a 35-foot-high Zone in Fort Bragg

On August 19, 1992, the City of Fort Bragg (City) approved the issuance of Coastal Permit 10-92 for demolition of an existing restaurant and the construction of a 40-unit resort hotel between Highway One and the Pacific Ocean adjacent to the north end of the Noyo River Bridge. The project site slopes steeply downward toward the Noyo River from the approximate level of Highway One at the north end of the site to approximately 55 feet below Highway One at the southern limit of construction. The elevation of the roof of the hotel as approved by the City in Coastal Permit 10-92 stepped down so as to follow the ground level. At its highest point, near the north end of the Noyo River Bridge, the hotel roof height was to be 55 feet above grade, 24 feet above Highway One. As approved in 1992, the southern most approximately 100 feet of the hotel was never to be more than 24 feet above grade and never above the level of the Noyo River Bridge.

In addition, on August 19, 1992, the City approved the issuance of a scenic corridor review permit No. 2-92 (Corridor Permit 2-92) which was required by the City's Local Coastal Plan (LCP) for projects in particularly sensitive view corridors. The project as approved in the corridor permit is identical to that approved in the coastal permit.

On February 14, 1996, upon request of the developer, the City approved an amendment to Corridor Permit 2-92. The project approved in Corridor Permit 2-96 was significantly different from that approved in Coastal Permit 10-92 and Corridor 2-92. The building plan was changed from the multilevel stepped plan to a more rectangular shape with a more uniform height. The height of the hotel roof on the southern end of the building was increased to 55 feet.

The hotel was constructed during 1997 and 1998. The finished hotel, however, did not comply with the terms of Coastal Permit 10-92.

Reason for Review

The Grand Jury reviewed this issue as one of significant importance confronting the citizenry.

Method of Review

The Grand Jury questioned past and present planning commissioners, board members, City Manager, and City Planner, either by interview or by letter. The Grand Jury reviewed much of the material contained in the chronology prepared by the Assistant City Manager. Interviews also included concerned citizens.

Findings

1. The Planning Director is expected to know the Codes and Regulations.

2. The past planning commission was inexperienced and too dependent on the City Planner.

3. The City Manager is responsible for the Planning Director.

4. The California Environmental Quality Act (CEQA) requires that decision makers review the project to see that it is in conformation with local law and publish a "Notice of Determination."

   a. The 1992 Fort Bragg Planning Commission never conducted the CEQA review. There was no notice, no hearing, and no opportunity for public review.

   b. The information on the CEQA "Notice of Determination" dated August 19, 1992, and filed with the County Clerk on September 1, 1992, is inaccurate and cannot be verified, yet it was relied upon during the permitting process.

5. No coastal development permit for changes in the project was requested by the applicant nor approved by the City.

6. The Coastal Commission never received notice of formal action on the coastal development permit from the City.

7. Chapter 18.26.004 of the City LCP states the maximum height for buildings within its jurisdiction is 35 feet.

8. The project does not conform with Section 18.72.050 of Fort Bragg Municipal Code: "The height of buildings and structures shall be measured vertically from the average ground level of the ground covered by the building to the highest point of the roof."

9. No variance was ever applied for to increase the height limitations.

10. Evidence is lacking that the past City Planning Commission knew the details of what it was approving: *ie*. height.

11. The 1996 hotel plans did not in any way resemble the original 1992 approved plans. There were also a new owner, a new architect, and different plans.

13. There was no easy way to read indication of height on the plans.

14. The architect for the project acknowledged in an open meeting that the project was at least 44 feet high; the architect has a responsibility to know the codes that would limit the height to 35 feet.

15. At least one member of the Planning Commission knew the same to be true. At least some past and present members of the City Council consider this "minutia" and have various rationalizations regarding the project.

16. Information supplied by the City Planning Director to various involved agencies was in many cases insufficient and inaccurate, thereby significantly contributing to the current maelstrom.

17. The Coastal Commission never reviewed the 1996 plans because the Planning Director decided the design change was "minor."

18. At least one planning commissioner believes they were intentionally "misled."

19. In May 1998 when problems with the project surfaced, the City Manager hesitated and did not issue a stop work order. Pressure from the developer is alleged.

20. The City Attorney July 8, 1998 memo to the developer noted problems and advised the developer that if he chose to continue construction, he would be liable for expenses.

21. It appears the original Coastal Permit 10-92 was in conformity with the City LCP.

22. The hotel as ultimately constructed is not in conformity with the City LCP.

Recommendations

1. The Fort Bragg City Council should order creation of a checklist of the review process for the Planning Commission to refer to in its reviews.

2. The Fort Bragg City Council should conduct an immediate performance evaluation of the Planning Director.

3. The City of Fort Bragg Planning Commission should conduct a self-evaluation.

4. The City of Fort Bragg planning and building regulations, codes, and laws should be equally applied and complied with or repealed.

5. The Grand Jury recommends that the building be modified to be brought into compliance with the LCP.

Response Required

Fort Bragg City Council

Response Requested

Fort Bragg Planning Commission

Grading Ordinance Requirements of the Mendocino County General Plan

California Government Code 65300 states that each planning agency shall prepare and the legislative body of each county and city shall adopt a comprehensive, long-term general plan for the physical development of the county or city, and any land outside its boundaries which in the planning agency's judgment bears relation to its planning. The Mendocino County Board of Supervisors adopted the General Plan in 1991 and amended it in 1993 (General Plan). Provisions are made in the plan for possible annual amendments. As a legislative act, the general plan's provisions are subject to the initiative and referendum processes.

Mendocino County does not have a grading ordinance.

Reason for Review

A review was conducted as the result of a complaint.

Method of Investigation

Interviews were conducted with the complainant, Planning Department staff, a member of the Board of Supervisors, and District Attorney staff. Documents reviewed included the General Plan, the Uniform Building Code, Chapter 70 (UBC 70), five-county salmon conservation consortium timelines, and an opinion from the District Attorney' Office

Findings

1. The Mendocino County General Plan adopted in 1991 and amended in 1993 states: "A grading ordinance, compatible with Chapter 70 of the Uniform Building Code and exempting regulated lands, shall be adopted and implemented."

2. Even though ordinances related to grading have been drafted by the Department of Planning and Building and have been considered by previous Boards of Supervisors, the County still does not have an ordinance which would give guidelines and regulations for the movement of soils.

   The County relies on the provision of UBC 70 to regulate grading activity in the County. However, the General Plan states: "Construction-related erosion is not regulated--Grading activities related to building come under the jurisdiction of Chapter 70 of the Uniform Building Code as part of the building permit process. The standards described are mainly engineering standards and do not address erosion prevention or water quality protection." There seems to be little enforcement of UBC 70 which states that a permit is necessary for the movement of more than two cubic yards of soil.

3. On June 22, 1998, the Mendocino County Board of Supervisors passed order 1/182, which states: "IT IS ORDERED that the Board of Supervisors directs county staff not to pursue a grading ordinance in light of the 5-county salmon conservation planning effort."

4. Two Mendocino County Supervisors and several County staff representatives have been participating in the 5-county meetings.

   Mendocino, Humboldt, Del Norte, Trinity, and Siskiyou Counties have been meeting during the past year to develop plans for protecting salmonid habitats.

   One of many issues the group is addressing is that of grading which affects fisheries.

   The timeline for the group indicated that a draft plan would be completed by May 1, 1999. In June 1999, the lead planner in the effort indicated that it would be at least six more months before the draft would be ready. The current strategy is that Trinity County prepare a grading ordinance and "test" it before a group decision is made. This process could go on indefinitely. Del Norte County is the only county in the group with a grading ordinance, and Humboldt County is developing its own grading ordinance.

5. The failure of the Board of Supervisors to enact a grading ordinance may leave the County vulnerable to citizen lawsuits.

Recommendation

Since the 5-County salmon conservation planning effort has fallen behind its timeline, and is now relying on at least one other county to develop its own grading ordinance before adopting 5-county recommendations, the Board of Supervisors should order the Department of Planning and Building to move forward on previous efforts to develop a proposed grading ordinance which the Board of Supervisors halted in 1998.

Comment

It will take courage for the Board of Supervisors to act in adopting a grading ordinance because there are many special interest groups that have blocked past efforts in this direction. Should the Board of Supervisors fail to take action on a grading ordinance, the citizens have the right to amend the General Plan through the initiative process.

Response required

Mendocino County Board of Supervisors.

Jail Staffing and Facilities

The Grand Jury's review of the Mendocino County Adult Detention Facilities (Jail) revealed continuing deficiencies in staffing levels, with consequences as noted.

Reason for Investigation

The Grand Jury conducted an oversight review of County detention facilities.

Method of Investigation

The Grand Jury interviewed personnel and conducted site visits of the Jail in Ukiah, Fort Bragg Sheriff's substation and holding facility at the Courthouse. The Grand Jury also interviewed members of the Sheriff's command staff, Corrections Deputies and supervisors and other County officials and reviewed Jail and Board of Corrections (BOC) documents, including Jail inspection reports.

Staffing

Findings

1. Jail staffing as of June 1999:

	Corrections Deputies	Meets minimum BOC requirements
Required by BOC	56.9	
County budget allocation 1999-2000	44	No
County budget funded 1999-2000	40	No
Actual	32	No

2. As shown above, staffing levels are too low and do not meet minimum State standards. Corrections Deputies are required to put in overtime and will soon be going on five-day, twelve-hour shifts. Field deputies are now being used for transport duty and the prospect is for loss of more Corrections Deputies with no replacements in sight. According to a January, 1999 BOC inspection, staffing is adequate for hourly checks of Jail areas, but is not at a level sufficient for close attention to inmate activities, periodic searches and maintenance of overall facility appearance.

3. Staff turnover remains high and is a significant problem. The 1997-98 Grand Jury noted that the County loses Corrections Deputies to jurisdictions which are able to pay higher salaries. As well, Corrections Deputies, in the interest of professional advancement, take advantage of opportunities to move into what they see as more challenging, regular law enforcement.

4. The 1997-1998 Grand Jury found that the County had to return $150,000 state grant because of Jail understaffing.

5. County administrative staff told the Grand Jury that the County doesn't allocate positions if there is little likelihood that they will be filled because to do so ties up funds for those positions.

6. A peace office with corrections experience told the Grand Jury that service as a Corrections Deputy is excellent training for officers who then go on to street duty, as it provides officers with experience in interacting face to face with often hostile persons and in dealing at times with ticklish situations where resorting to force might be inappropriate.

7. The 1998-1999 budget states "..the Sheriff and his staff remained committed to accomplishing the goal of filling all 39 funded Corrections Deputy positions, which was achieved on April 27,1998. The Sheriff and his staff continue to recruit and hire additional Corrections Deputies to meet staffing levels of 44 Corrections Deputies committed to by the Board of Supervisors during Fiscal Year 1997-98 and Fiscal Year 98-99." The commitments made by the Board of Supervisors (BOS) and the Sheriff appear to be nothing more than public posturing to placate critics. Instead of increasing staffing, the County has actually lost personnel, leaving staff at 32 Corrections Deputies.

Recommendations

1. The Board of Supervisors and the Sheriff have been unable or unwilling to address the staffing problems in a solutions orientated way. The lack of leadership has resulted in the Jail having fewer Correction Deputies this year than last year. The time has come to take bold and imaginative steps to deal with the chronic staffing problem at the Jail. The problem is at crisis level and can no longer be ignored. The BOS must establish a citizens blue-ribbon panel comprised of both citizens and Jail personnel and and utilizing professional resources develop and deliver no later than January 1, 2000, a meaningful, result-oriented plan to deal with this chronic staffing problem.

2. The Sheriff's Department should consider requiring newly hired officers to spend a minimum period working as corrections officers before "graduating" to street duty.

3. The Grand Jury recommends that the County allocate the required positions and take steps to enhance recruiting efforts, in the interest of assuring that grants applied for are not lost to the County on grounds of short staffing.

4. The Board of Supervisors and the Sheriff must publicly explain to the citizens of this County why they have not fulfilled their commitment and legal obligation to adequately staff the Jail. The continued excuse of higher salaries elsewhere is no longer an acceptable explanation.

Physical Plant

Findings

1. Jail personnel report that the electronic security control panel for communication and movement in the Jail is old and often breaks down. At the time of the Grand Jury's site visit, the main panel in the control room was only partially functional; the control room operator could receive indications that a prisoner in a cell needed to speak with an officer, but could not communicate directly with the individual inmate and had to send an officer into the module to check out the problem. The situation was unchanged at the time of a second site visit two weeks later. The Grand Jury learned that the control panel had been repaired and that funds for procurement of a new unit will be included in the 1999-2000 County budget.

2. The main Jail building is not maintained at a minimum acceptable level. An inspection by the BOC in January 1999, using 1980 and 1988 facility standards, found:

    - "The building shows a lack of cleanliness and maintenance which indicates a lack of staff presence in inmate housing and holding areas, and a lack of maintenance attention. Several areas are overdue for painting."

    - "Broken and inoperative plumbing fixtures (shower heads, drinking fountains, and toilet fixtures) were noted throughout the housing units. Rust has eaten completely through metal plating around several sinks in the housing units."

    - "The male intake area was dirty. Holes were observed in the corridor walls."

Recommendations

1. The Sheriff must request and the Board of Supervisors must provide sufficient funding to make the needed repairs to bring the facility into a condition that will be serviceable as well as funding that will allow General Services to assign a full-time maintenance person to the County detention facilities.

2. The Sheriff must assign responsibility for the cleanliness and maintenance of the facility to specific staff. This responsibility must be reflected in the position description and be part of the employee performance evaluation process.

3. The BOC inspection found that inmates were sleeping on mattresses on the floor, although there is sufficient bunk space for each inmate. This is contrary to Jail policy but condoned by Jail staff.

4. The BOC inspection report commented: “On duty staff indicated there were not enough personnel to conduct regular searches of cells and housing units.”

5. A County Health Department inspection found that water temperature of the dishwasher in the facility kitchen does not attain required temperatures. This has been an intermittent and continuing problem for some time. There are no plans at the present time to provide a permanent solution. Other kitchen problems reported include a questionable fire extinguishing system over the stove. Given the past problems, staff cannot be confident that the system will work in the event of a major fire. This is an extremely hazardous situation.

6. Staff is unable to adequately clean and sanitize kitchen shelving as it is presently arranged. While new shelves have been purchased which will resolve this problem and improve sanitation, there are no plans to install them. That is a misuse of scarce County resources as a result of inadequate management planning.

7. A site visit to the Fort Bragg detention facility found it to be in good condition: clean and well-maintained. The facility was found to be out of compliance with the California Welfare and Institutions Code and Title 15 in regard to the holding of minors at the facility. This is confirmed by a BOC inspection conducted in January 1999:

> There are no formal logs or procedures to ensure compliance with Welfare and Institutions Code Section 207.1(d), or minimum standards for minors held in a police building that contains a lockup (California Code of Regulations, Title 15, Section 1542).

Recommendation

The Sheriff must take immediate steps to correct the Welfare and Institutions Code and Title 15 violations and issue a public report no later than October 1, 1999.

8. There has been no progress in creating interview space in the holding facility at the County Courthouse. The 1997-98 Grand Jury report recommending that Courthouse space adjacent to the holding facility be used. The BOS response was "to consider this along with other criminal justice space needs as part of the comprehensive space study currently underway." A Jail official said they would discourage any arrangement which would require moving prisoners through public areas. Since the County must meet this requirement, there has to be some arrangement for doing so.

Recommendation

The Grand Jury insists that the County attain minimum Jail standards by providing adequate private space for attorney/inmate interviews.

Comments

1. The Grand Jury found Jail personnel at all levels to be cooperative and helpful. The Jail staff appears to be competent and generally well-trained. However, it is not acceptable for the Sheriff and the Board of Supervisors to operate a Jail which does not meet minimum standards for correctional institutions.

2. Understaffing is the cause of many of the problems found at the Jail. Understaffing creates a toll on correctional deputies, inmates, and the County as a whole, which no community can endure for long. It is time for the Sheriff and Board of Supervisors to take whatever steps are necessary to bring the Jail at least up to and preferably above minimal standards. Bringing staffing to full level would improve working conditions, reducing or eliminating mandatory overtime and stress, thus helping to eliminate staff turnover.

3 The Grand Jury is concerned that the Board of Supervisors, Sheriff, and CAO appear to use the budget as a public relations document to minimize public criticism of their failure to adequately staff the Jail. They quickly forget or choose to ignore commit-ments made to the citizens of Mendocino County. This conduct causes the Grand Jury to question their sincerity and commitment to achieving a solution to the staffing crisis.

4 The Grand Jury wishes to impress upon the Board of Supervisors and Sheriff that they have a responsibility to protect and maintain the citizens' property, in this instance, the Jail. To allow the Jail to deteriorate into its current condition makes the Grand Jury question if the Board of Supervisors and Sheriff fully understand this responsibility.

5 See separate report on medical care at the County's detention facilities.

Response Required

Mendocino County Board of Supervisors
Mendocino County Sheriff

Response Requested

General Services Director

Mendocino County Juvenile Hall Administrative Practices

Juvenile Hall, under the direction of the Department of Probation (DOP), provides for the physical and emotional care of incarcerated youth in Mendocino County pursuant to the California Code of Regulations, Juvenile Facilities (Title 15) and Building Standards (Title 24). The Grand Jury focused on certain administrative practices which affect the well-being of the youth held in that facility.

Reason for Review

The Grand Jury conducted an oversight investigation of the administration of Juvenile Hall.

Method of Investigation

Methods included site visits, interviews with the Chief Probation Officer, Superintendent of Juvenile Hall, staff, and a private consultant, as well as review of pertinent state regulations, reports, budgets, and policies.

Housing

Findings

1. Each youth is isolated in a 60-square-foot cell which has a concrete bed platform, toilet, and sink.

2. Throughout California, Juvenile Hall housing is provided in single, double-bunk rooms, or dormitories. In Humboldt County, youths on a suicide alert status are assigned roommates. In Santa Clara County, a youth must earn the privilege of having a single room.

Recommendation

In future construction, consideration should be given to the use of other than single-occupancy cells, both for space considerations and to avoid isolation.

Response required	Response requested
Board of Supervisors	Department of Probation

Classifications

Findings

1. In order to recognize special requirements and security risks for levels of supervision, allowed activities, and the participation of youths in programs, each youth is evaluated upon admission to Juvenile Hall. Youths are classified Code III upon admission if they are charged with committing a violent crime. Administration believes these youths are a higher security risk for attempted escapes and the safety of other youths and staff. Code I (maximum

security) includes youths who violate rules within Juvenile Hall. Code II (medium security) is a classification used to provide means for a youth to work back into full programming following a serious violation. Youths who do not meet one of these criteria do not have code classifications.

This is a discretionary policy and varies among counties. Humboldt County assigns special "alert status" classifications to youths according to their needs and behavior within Juvenile Hall; youths are not segregated or isolated from the general population unless their behavior in Juvenile Hall warrants it.

2. Code III status is reviewed monthly, or when charges are lessened. Code I is reviewed at daily shift changes.

Code III Isolation

Finding

Until September 21, 1998, Code III youth were kept locked in their cells 22 hours per day, including meals and schooling; during time outside the cell they were isolated from the general population. After that date, administration permitted attendance one-half day at school in a classroom segregated from the general population.

Recommendation

The amount of time these youths spend in isolated conditions is inappropriate. Studies illustrate the harmful effects of isolation on the human psyche. The Superintendent and DOP should look at the methods other counties use to prevent excessive isolation of youths.

Response required	Response requested
Board of Supervisors	Department of Probation

Comment

The new addition to Juvenile Hall has the potential to alleviate some of these problems, but it will be the responsibility of the administration to provide direction to these youths and not just detention.

Code III Recreation and Exercise

Finding

Typically, Code III youths participate in one hour of recreation and exercise per day, which denies them their statutory rights. Title 15, Section 1371 states: "Juvenile facilities shall provide the opportunity for recreation and exercise a minimum of three hours a day during the week and five hours a day each Saturday, Sunday or other non-school days."

Recommendation

Juvenile hall should provide the recreation and exercise mandated by Title 15.

Response required	Response requested
Board of Supervisors	Department of Probation

Educational and Productive Work Programs

Findings

1. Programs provided include Narcotics Anonymous/Alcoholics Anonymous, one time per week; Project Sanctuary, two times per month; girls aerobics, one night per week; and religious services on Sunday.

2. The only work program at this time is the maintenance of the internal grounds and cleaning the interior living spaces.

3. A vegetable garden program was discontinued.

4. Federal funding provides for foster grandparents.

5. In speaking with other counties, the Grand Jury found work programs that ranged from folding laundry and kitchen work to training dogs for the handicapped.

Recommendation

Juvenile Hall should implement productive, constructive, and educational programs.

Comment

The Grand Jury believes implementing productive work programs would benefit youths re-entering society.

Response required	Response requested
Board of Supervisors	Department of Probation

6. Title 15 Article 6 Section 1370 notes that the County Board of Education or the chief probation officer may provide classes in:
   a. victim awareness
   b. conflict resolution
   c. anger management
   d. parenting skills
   e. juvenile justice
   f. self-esteem building
   g. effective decision making skills; and
   h. vocational education and pre-vocational skills.

There are no specific classes offered by the school on these subjects though some are addressed peripherally.

Recommendation

These subjects should be addressed directly and in a proactive way.

Response required

Mendocino County Board of Education
County Superintendent of Schools
Board of Supervisors

Response requested

Department of Probation

Hair Care

Findings

1. Title 15, Section 1488 states: "Hair care services shall be available in all juvenile facilities. Minors shall receive hair care services monthly."

2. As of March 1999, no hair care services were provided in Juvenile Hall.

Recommendation

Juvenile Hall should provide hair care as mandated.

Comment

Juvenile Hall is negotiating with a private provider for hair care.

Response required

Board of Supervisors

Response requested

Department of Probation

Mental Health Services Funding

Findings

1. The Mental Health Department provides an on-site, half-time mental health clinician at Juvenile Hall at a cost to Juvenile Hall of $45,990 (Interdepartmental transfer of funds).

2. The Mental Health Department in Humboldt County does not charge Juvenile Hall for providing mental health services. These services are accepted as part of the Mental Health Department's overall responsibility.

Recommendation

The Mental Health Department should accept financial responsibility for providing mental health care to youths in Juvenile Hall.

Response required

Response requested

Board of Supervisors	Department of Probation Department of Mental Health

Comment

Adoption of the above recommendation, would make $45,990 available for Juvenile Hall to use for its own programs.

Pay Telephones

Findings

1. A provider contracts to install and maintain pay telephones to make automated collect local and long distance telephone calls for incarcerated youth. This contract pays the county a commission in the amount equal to 30% of gross revenue collected by the provider.

2. Policies state that profits are to be used directly for the benefit of the youth.

3. The $623.08 profit from 1997-98 was held in a trust account; $364.00 was used to purchase a ping-pong table; a service organization will reimburse the fund for the ping-pong table, leaving the total profit unused.

Recommendation

The telephone system should be changed to a non-profit system to lower fees for families.

Response required	Response requested
Board of Supervisors	Department of Probation

Comment

Youths should be able to be in contact with their families without their families being penalized by high telephone rates.

Inspection Reports

Title 15 Section 1313 requires that "on an annual basis, each juvenile facility administrator shall obtain a documented inspection and evaluation from the following:" (a) county building inspector (b) fire authority (c) health administrator (d) county superintendent of schools, and (e) Juvenile Justice Commission.

"(a) County building inspector or person designated by the Board of Supervisors to approve building safety;"

Findings

1. The 1997 inspection by the County Department of Planning and Building noted numerous items requiring correction and attached to that report was an inspection from 1988 that noted deficiencies still uncorrected in 1997. According to the Superintendent, no inspections were performed in 1995 or 1996.

2. Complaints were made that the Superintendent failed to follow through with recommendations made in the annual inspections and that it was a waste of time performing these.

3. After learning of building inspection discrepancies, the Chief Probation Officer met with representatives from Planning and Building and General Services Building and Grounds to establish guidelines.

Recommendations

1. A summary inspection should be made of Juvenile Hall to ascertain if all items from previous inspections have been corrected.

2. The Board of Supervisors should ensure coordination of inspection reports so that the Department of Planning and Building does the inspections and the report is shared with the County Department of General Services so that repairs may be made. A re-inspection should be done within 90 days to verify corrections.

3. In the event an inspection is not completed or a written report is not made available, the facility administrator should document the attempts to schedule the inspection and to obtain a written copy of the inspection report.

Response required	Response requested
Board of Supervisors	Department of Probation Department of Planning and Building Department of General Services

Comment

The coordination between departments to correct deficiencies has begun.

"(b) Fire authority having jurisdiction, including a fire clearance;"

Finding

The City of Ukiah Fire Marshall who has jurisdiction (and who would respond to fires) has refused to perform the inspections, instead the State Fire Marshall has done the inspections.

Recommendation

Juvenile Hall administration and the Ukiah Fire Department should cooperate and inspections should be done locally.

Response required	Response requested
Board of Supervisors	Department of Probation Ukiah Fire Department Department of Probation

"(c) Health administrator, inspection in accordance with Health & Safety Code, Section 101045;"

Finding

The 28-page 1998 inspection was performed by a Public Health Nurse and a Department of Environmental Health staff member.

"(d) County superintendent of schools on the adequacy of educational services and facilities;"

Finding

The County Superintendent of Schools has not done inspections at Juvenile Hall as mandated. Instead, each year the teacher at West Hills Court School (the Juvenile Hall school) inspects his own program.

Recommendation

The County Superintendent of Schools should carry out the mandate as per Title 15.

Comment

The Grand Jury feels it inappropriate that a teacher inspect his own program.

Response required	Response requested
Mendocino County Board of Education Mendocino County Superintendent of Schools	Department of Probation

"(e) Juvenile court and/or the Juvenile Justice Commission."

Finding

The Juvenile Justice Commission, a citizen review panel appointed by the Board of Supervisors, inspects Juvenile Hall annually and makes recommendations to the Board of Supervisors. The 1998 eight-page report covered internal programs offered, youth bilingual counselors, and the inadequacy of the existing physical plant.

Comment

The Grand Jury recognizes the necessity of inspections by both the Juvenile Justice Commission, and the Grand Jury, to ensure appropriate facilities for youths.

State Board of Corrections Inspection

Finding

The California Board of Corrections does an inspection every two years. An inspection was performed on October 14, 1997, and included the facility as well as a thorough examination of the facility's Policy and Procedure manual. Recommendations were included with the inspection report.

Staffing Problems

Findings

1. Juvenile Hall has 18 allotted counselor positions with one vacancy in March, 1999. The budget shows $70,000 allotted for extra help and $80,000 for overtime.

2. The main causes for staff turnover for counselors are promotion, transfer into probation work, and resignation for jobs in counties with higher pay.

3. Bilingual and male counselors are difficult to recruit. Low pay is a factor.

Recommendations

1. The Department of Probation should work with the local community colleges to train and recruit employees.

2. The Board of Supervisors should pay special attention to the Counselor position at Juvenile Hall when evaluating the county-wide compensation study.

Response required	Response requested
Board of Supervisors	Department of Probation
Mendocino-Lake Community College Board of Trustees	
College of the Redwoods Board of Trustees	

Department of Probation Billing

Finding

DOP bills an average of $5,000 per month ($10 per day per child); in 1997-98, $13,083 was collected. Parents' abilities to pay those costs hamper collections efforts.

Recommendation

The Grand Jury feels every effort should be made to obtain reimbursement for the expenses of each incarcerated youth. DOP needs to be more aggressive in collecting this lost revenue.

Computer Systems

Findings

1. The JALAN computer program links Juvenile Hall with all the departments in the County criminal justice system and enables them to share information and statistics. The County offices that have the system available are: District Attorney, Courts, Sheriff/Jail, Public Defender/Alternate Defender, DOP, and Juvenile Hall.

2. From 1995 to 1998, JALAN cost the Juvenile Hall $10,080.00. This program was not being used at Juvenile Hall except for partial booking information. Due to staff turn-over and lack of training for new staff, the information was inaccessible for other uses.

3. The County contracted with a private provider to provide computer support services. In response to County departments' complaints, an audit of the provider was conducted by the California State University, Chico. In response to the audit, the County created a County position, Director of Information Services.

4. In 1998, the DOP sent two Juvenile Hall staff for JALAN training at a cost of $1,349.12.

5. As of March 1999, Juvenile Hall staff was more capable of using JALAN, but not up to its full capacity.

Comment

The Grand Jury finds it a poor use of both a costly computer program and support contract for Juvenile Hall to have been unable to access JALAN for four years.

Final Comments

Based on projections of an increase in violent offenders, a new Intake Center with a special isolation cell, medical examination room, visiting and interview rooms, and a 12-bed wing for serious violent offenders is under construction. Two double-bunk rooms will be included in the new Intake Center.

Ground breaking occurred in December, 1998, with completion scheduled for November, 1999. As part of a violent-offender grant, the State Department of Corrections provided $1,572.345 from federal funding and the County provided $174,705 for the facility expansion based on projections of increases in juvenile arrests between 1990 and 1997. Between 1988 and 1997 violent crimes (assault, rape, robbery, and murder) increased from 29 to 74 per year while bookings remained fairly constant during the same period, 586 to 546 per year.

The County needs to have effective outreach programs to give youth a proper direction in life.

It is clear we will need a new Juvenile Hall facility for the future that will provide space for comprehensive internal programs. Juvenile Hall should offer more than just detention.

Recommendation

The 1999-2000 Grand Jury should conduct an investigation of juvenile crime and incarceration in Mendocino County.

Mendocino County Library System

The voters of Mendocino County established the County Library in 1964. The Mendocino County Library has fiscal support from the County general fund supplemented by grant funding from the State Public Library Fund and funds raised by the Friends of Library in the County through three branches - Ukiah, Fort Bragg and Willits - and two stations, Point Arena and Covelo, and the Bookmobile.

The Bookmobile visits Laytonville, Branscomb, Redwood Valley, Parlin Fork, Wesport, Chamberlain Creek, Ridgewood, Covelo, Dos Rios, Potter Valley, South Leggett, Leggett School, Piercy, Comptche (2 sites), Floodgate, Philo, Boonville, Stewarts Point, Sea Ranch, Gualala, Anchor Bay, Point Arena, Manchester, Elk (2 sites), Albion, Mendocino, Yorkville, Hopland, Talmage, and Calpella on a regular schedule.

The system employs 22 workers, 12 of whom are full-time, and benefits from the efforts of 40 to 50 volunteers at each branch and 30 to 40 volunteers at each station.

The Friends of the Library are support groups of dedicated volunteers who raise funds for the library.

Reason for Review

The Grand Jury has a responsibility to review library operations. The most recent review by any Grand Jury was in 1989.

Method of Investigation

The Grand Jury interviewed the County Library Director about the operation, problems, financing and goals of the Library system. In addition, the Grand Jury interviewed a library volunteer who serves on the Library Advisory Board and is an officer with the Ukiah Friends of the Library

Library Funding

Finding

After several years of budgetary problems, the Library is now receiving increased funding, both from the County and the State, and based on a commitment from the Board of Supervisors (BOS), expects to receive the same higher level of County funding for at least five years.

Recommendation

The Grand Jury recommends the BOS continue increased library funding.

Diversity of Materials

Findings

1. As part of meeting the Library's goal of providing and improving "accessibility to information through a variety of means for all library users" (Library Mission Statement), the Library has

a Spanish language collection amounting to some 5% of the total number of books available and a fairly large collection of Native American materials, which is housed in Covelo.

2. Many residents throughout the County may not be aware of the availability of library services, especially of the Spanish language and Native American collections and how to access them.

Recommendation

The Library should emphasize outreach programs to make County residents, especially the Spanish-speaking community and those interested in Native American materials, aware of the resources available and how to access them.

Comments

1. Information technology is changing rapidly, posing a challenge for traditional library operations. Electronic devices are replacing not only the old 3X5 card file systems, but printed books as well. The County Library Director is aware of the issue.

2. The Grand Jury commends the BOS for increasing the funding of the Library.

3. The Grand Jury is impressed with the direction the Library is going and the efforts of the Director, staff, and volunteers.

Response Required

Mendocino County Board of Supervisors

Medical Services at the Mendocino County Adult Detention Facility

The law requires counties to provide medical, dental and mental health care services to the inmates of adult detention facilities (Jails). The County has a ten-year contract with a private firm (Contractor) to provide these services according to California Medical Association (CMA) Standards.. That contract, which expires in 2001, will pay the Contractor $700,000 in 1998-99 out of which Contractor must pay for all equipment, supplies and services provided, retaining the remainder as profit.

Reason for Review

The Grand Jury received complaints about medical and mental health care at the Jail. The Grand Jury investigated these and reviewed Contractor's performance as part of a review of Jail operations.

Method of Investigation

The Grand Jury reviewed documents from the State, the Sheriff's office, the California Medical Association (CMA), the Board of Supervisors, inmate and former inmate jail files and material from interested citizens' groups. The Grand Jury interviewed Contractor principals and medical staff, corrections personnel, inmates, County Health Department personnel and interested citizens. The Grand Jury also made several visits to observe Jail operations..

Contractor Staffing

Finding

1. Contractor provides a program manager who is a Registered Nurse (RN) 40 hours per week, 24-hour coverage by a Licensed Vocational Nurse (LVN), a psychiatric technician for 20 hours per week, a physician for12 hours per week (on call 24 hours per day) and a psychiatrist (on call 24 hours per day).

2. Contractor staffing is adequate to meet requirements of the contract and, according to professional standards, the staff is qualified. The work load varies from relatively light to heavy but does not, according to respondents, become overwhelming.

3. The 1997-98 Grand Jury report called for an increase in physician coverage from three to five days a week, to meet CMA standards. Since then, CMA standards for physician coverage have been reduced. Contractor meets the new standard. However, Sheriff's Department and Public Health Department officials have recommended that coverage be increased.

4. Interviews of Contractor staff indicate that morale appears to be good and the individual workers are pleased with the jobs they do.

Medications

Finding

Questions arise about medication. Procedures are in place which would seem to ensure that prisoners needing medication do, in fact, get what they need, but prisoners continue to complain about the lack of or delays in receiving medication. Contractor gives assurances that they make all possible efforts to determine what medications prisoners require, either by noting what they have on their person when booked, by contacting personal physicians or by calling pharmacies. Contractor does comply with legal restrictions on delivery of certain drugs to known drug abusers, assuming the possibility of potential abuse or use of the drugs as currency; that is possibly a factor in some of the complaints received.

Recommendation

The Public Health Department should closely monitor provision of medication to ensure that medication is timely, adequate and appropriate.

Reports

Contractor is required to provide monthly statistical reports of activities to the County and an annual report summarizing those monthly reports**.**

The 1997-98 Grand Jury found that the contractually required annual "reviewed financial report" of the cost of the health services provided "specifically to Mendocino County under this agreement," had not been submitted since 1993 and 1994. At that time, only those reports, unaudited, had been submitted "in the last seven years.

Findings

1. The Grand Jury determined that County Counsel has issued an opinion nullifying the need for the financial report on grounds that such information is "Proprietary," and need not be made available to the County.

2. According to the County Administrator's office, the Board of Supervisors signs and the Sheriff's office manages Contractor's contract.

3. The monthly statistical reports go to the Jail Commander who keeps them on file.

Recommendations

1. As public money is involved, there should be oversight by the Sheriff and BOS of the financial arrangements of the contract. Financial reports should be made available to the BOS without regard to any alleged proprietary interest. The public should know the

details of how much is being spent for medical services.
2. The monthly statistical reports should get wider circulation.

Mental Health Care

Contractor is responsible for mental health care as well as medical care. An inmate who expresses a need for mental health services will see a psychiatric technician, who will, in turn, refer the inmate to the contract psychiatrist. The psychiatrist makes decisions about treatment or medication. Inmates may speak with their own physicians if those physicians are willing to come to the Jail or to treat by telephone. Inmates who are acting out in ways that appear to threaten themselves or others may be sent to the County Psychiatric Health Facility.

Findings

1. There have been questions about the adequacy of psychiatric coverage. According to professional standards, the four hours weekly that the staff psychiatrist is on site, (24 hour on-call status) and 20 hour a week coverage by a psychiatric technician, meets minimum CMA standards. As with medical coverage, the Sheriff's Department and Public Health Department officials recommend increased coverage.

2. Most indications of medication problems involved persons suffering mental illness. Letters to Contractor from friends and relatives of mentally ill incarcerated persons, made available to the Grand Jury, suggest a breakdown in the recognition of the need for such drugs and their provision in a timely manner. Observations at the jail and conversations with concerned individuals outside the jail suggest that the medication issue has seen improvement within the past year. A private psychiatrist described experience with the medication issue as "mixed," with patients sometimes waiting anywhere from hours to "a day or two" before getting medications.

Timeliness of Mental Health Intervention

Finding

Records indicate the psychiatric technician commonly delays from two to five days after receiving a request before seeing an inmate.

Recommendation

Given the risks to themselves, to medical and corrections staff and to other inmates associated with persons suffering from mental illness, medical personnel must honor any request for mental health evaluation or intervention as soon as possible and within 24 hours. Jail procedures must allow for that to happen.

Contractual Remuneration

The Grand Jury finds that contracts that reward service providers for minimizing services are not in the best interest of the County.

Recommendation

The next County Medical Provider Contract should specify the standard of care, and not be guided solely by CMA. The Board of Supervisors should direct the County Administrative Office to begin work on a new request for bid for the future contract specifying care levels and performance standards, such as psychiatric technician coverage within 12 hours of request. The Grand Jury recommends that in the next bidding process local providers be given equal consideration.

Comment

The Grand Jury reviewed a report from the Public Health Officer, "Response to the Board of Supervisors' Jail Ad Hoc Committee." The report made several observations about Contractor performance and recommended options for the Ad Hoc Committee's consideration. In spite of the fact that the Ad Hoc Committee originially asked for the report and straff dedicated time and resources to its preparation, the Ad Hoc Committee never acted on it.

Response Required

Mendocino County Board of Supervisors
Mendocino County Sheriff

Mendocino Coast Health Care District

The Mendocino Coast Health Care District (District) was created by voters in 1967. Its boundaries encompass the Fort Bragg Unified and Mendocino Unified School Districts, stretching from Bear Harbor to Elk as far east as Orr Springs. It is governed by an elected five-person Board of Directors (Board). The District owns and operates the 51-bed Mendocino Coast District Hospital (Hospital) which opened in 1971. With nearly 300 employees, the District is one of the largest employers in the County.

Reason for Review

The Grand Jury investigated the District as part of its oversight responsibility.

Methodology

The Grand Jury interviewed past and present Board members, past and present Hospital administrators, Hospital staff, and community members. The Grand Jury observed Board meetings in person and on videotape, attended community forums, examined financial records, contracts, policy and procedure manuals, and other documents.

Employee Strike in July 1998

The unionized employees of the Hospital, represented by the United Food and Commercial Workers Union, negotiates contracts regularly with the Hospital. The 1998 negotiations were unsuccessful; employees rejected the Board's final offer 155 to 0 and went on strike July 16, 1998. The strike ended July 29 after the Board reopened negotiations with union representatives and agreed to a new contract.

Findings

1. The strike happened because
   a. Board members misjudged the level of employee morale.
   b. Board members thought employees would not actually walk out.
   c. Board members were not well-advised on the employee union's probable response to a proposed health care benefit give-back.

2. From the employees' point of view, the strike was about respect.

3. Hospital administrators felt betrayed by the Board's "flip-flop" on resuming negotiations

4. The strike had a positive, cathartic effect.
   a. Nearly all the administrative management left after the strike ended.
   b. Employee morale improved immediately.
   c. A new CEO started work February 1999.

3. The strike cost the District about $500,000 in contract termination costs, temporary labor costs, and lost patient revenue.

Board Responsibilities

Findings

1. Four out of five Board members (prior to the November 1998 election) had been on the Board for 12 years or more.

2. Voters have consistently chosen a Board with a health care background. Hospital employees cannot be on the Board, but former employees and members of the medical staff have served on a regular basis.

3. Board procedure for resolving of conflict-of-interest questions is inadequate. Clear guidelines for Board discussion of conflict situations do not exist.

4. The Grand Jury reviewed the Fair Political Practices Act filings for the past seven years of all current and past Board members. The Grand Jury finds that the two most recent physician members have not reported their property ownership, medical practices, partnerships, or contracts with the District on their State required conflict-of-interest forms. Other Board members appear to be in compliance.

Recommendation

Given the importance of the conflict-of-interest question, the Grand Jury urges the Board to formally discuss its policy and upgrade it. Members not complying with State and Board rules should be censured by the Board.

5. Board members described a reluctance to confront other Board members over conflict-of-interest, day-to-day meddling, or other troublesome issues.

Recommendation

Board members should listen aggressively and ask questions. The question and answer process is an important way of developing feedback and encourages everyone to do a better job. It also serves the public by bringing out more information. The Board should encourage a diversity of views, presented respectfully, in pursuit of the Board's common goals.

6. The Grand Jury finds the Board members inadequately trained in their responsibilities and obligations.

Recommendation

The Grand Jury endorses the following definition of a board's role and responsibility, adapted from the Community College League of California Trustee Handbook: a board as a unit, sets the policy direction, monitors institutional performance, employs a chief executive officer as institutional leader, acts as community bridge and buffer, establishes the climate in which community health goals are accomplished, assures the fiscal health and stability of the District, defines standards for good personnel relations, and serves as a positive agent for change. The Board should improve its training regarding the Board's role and make this training an annual requirement.

7. Public Board meetings do not convey the thought processes behind Board decisions. Votes are taken without sufficient discussion for members of the public to understand the course of action.

Recommendation

The Board, as individuals, should take the time to explain their reasoning before adopting resolutions. More meeting time should be devoted to discussion, deliberation, and debate rather than simply listening to reports.

8. Board members are active and very dedicated to the Hospital's success and survival as an independent entity.

9. The Board gave itself very low marks in its 1997 self-evaluation, especially in the areas of Board knowledge, Board review and evaluation of itself and the CEO, Board meeting effectiveness, and Board teamwork. No self-evaluation was conducted in 1998.

Board and Administration

Findings

1. The Grand Jury found substantial evidence that individual Board members were at times deeply involved in the day to day administration of the hospital.

Recommendation

The Board should establish policies eliminating intrusive behavior by individual Board members. The Board should deal with the CEO only and only as a Board.

2. The Board did not set clear and specific goals and objectives for the CEO.

3. The Board evaluation of the CEO was not conducted in a timely manner.

Recommendation

The Board should establish clear parameters and expectations for the Hospital CEO, and evaluate the CEO annually against these standards.

4. The Grand Jury heard testimony that the Board tolerated abuse of leave and training programs by Hospital administrators.

5. The strategic planning process stalled in recent years and needs to get a new start. Without an agreed upon plan, the Board can neither reach its goals nor give competent direction to the Administrator. The Planning Committee consists of one Board member, the CEO, the chief of medical staff, and one community member.

Recommendation

The Board should adopt a focused and detailed strategic plan for the Hospital and the District. The Grand Jury urges broader participation through a larger Planning Committee with increased community participation.

Board and Doctors

Findings

1. By statute, the Board has little control over the doctors who use the Hospital.

2. The Grand Jury identified several problem areas with conflict or potential conflict between the District and the medical community:
   a. physician on-call responsibility
   b. direct competition between Hospital clinics and programs and doctor-provided services
   c. doctors' role as patient advocates versus Hospital need to conform to strict mandated diagnostic and length of stay restrictions

   Specific examples from recent history include:
   a. The OB/Gyn clinic was established because local doctors withdrew service but now doctors are upset because the Hospital is competing with them.
   b. Some doctors are taking patients to other hospitals because of perceived problems with staffing, training, and administration.
   c. Some doctors are using their own x-ray equipment for private-paying patients but sending Medi-Cal patients to the Hospital for x-rays.

3. The District offers incentives for physicians to come to the area; sometimes including loans and income guarantees. In a few specialties, doctors have actively discouraged newcomers, leaving the hospital without necessary physician on-call support.

4. The Hospital contracts with some individual doctors for specific services and programs. Conflict exists between doctors with Hospital contracts and those without.

5. The Grand Jury finds that the Board needs to take an active role in encouraging the Medical staff to support the Hospital and its mission.

Recommendation

The Board should develop, as a high priority, a plan which involves the medical community in a combined effort towards addressing these common concerns and towards creating solutions to the problems.

Board and Hospital Employees

Findings

1. The proposed contract gave employees, community members, and at least one Board member, the feeling that the Board wanted to have employees bear the brunt of financial cuts.

2. Most nurses prefer to work part-time; 87 registered nurses on the payroll fill the equivalent of 42 full-time positions. There is no local nurses' registry and there is a shortage of nursing staff willing to work full-time. The Hopistal imports temporary employees to fill the shortage which is an expensive solution.

3. The Grand Jury finds that employees are very devoted to the Hospital and its mission.

Recommendation

The Board should set a positive climate for collective bargaining and dispute resolution, and should establish policies ensuring that Hospital employees at all levels are involved in developing new solutions to problems, especially in areas of staffing and health insurance.

Board and Community

Findings

1. The Grand Jury finds that the Board has not effectively educated its constituents about the issues facing the District. This past winter's League of Women Voters town meetings filled the void.

2. Board meetings appear to be expedited for the convenience of its members. Board members do not explain their positions and decisions.

Recommendation

District Board meetings should be the forum for discussing the issues facing the Hospital and the District. The Board should set policies that include:

a. informed discussion of issues prior to action.
b. expression of the rationale for positions taken.
c. time for meaningful public input and Board response.

3. The Board feels that the community needs to come to Board meetings to express concerns and needs. The Grand Jury believes, rather, that the Board should actively solicit input from the community.

Recommendation

The Board should establish procedures which focus on its role as the link between the Hospital and the community. The Board must be responsive as it represents the community to the Hospital and it must also be the advocate of the Hospital in the community.

4. The controversies regarding contract services, on-call payments, and income guarantees have been a public relations problem, in part, because the Board has done an inadequate job of explaining itself to the community.

5. Community use of the Hospital could improve. A Board Planning Committee survey showed many in the community traveled out the area for medical services that could have been performed locally. The Board has not developed a program to encourage greater use of the Hospital.

Recommendation

The Board should take as a priority the need for increased utilization of the Hospital facilities and services, and develop a plan to encourage greater use.

6. The Mendocino Coast Hospital Foundation, an independent fund raiser for the District, has done an excellent job of raising large sums of money for special Hospital capital projects. Most of this money is now raised from sources outside the District.

Hospital Services

Since the opening of the Hospital in 1971, the Hospital has added many services, including anesthesiology, cardiac stress testing, prenatal clinic, diabetes care, physical therapy, radiology, and a pulmonary diagnostic lab. The Hospital bought the ambulance service, previously operated by a local mortuary, because the level of care was sub-standard; it established an OB/gyn clinic because the local physicians were planning to terminate obstetric services. There has been discussion of increasing services to the aging, both through a clinic and a skilled nursing facility.

Finances

Findings

1. The Hospital, like all small, rural hospitals, is under increasing financial strain resulting from decreasing payments from Medicare, Medi-Cal, and private insurers. A sub-stantial part of the Hospital's services are provided at no cost to those without the means to pay. A much larger burden occurs when payments from government programs fail to cover the costs of providing the services it covers. 51% of Hospital revenue comes from Medicare and these payments cover only about 94% of the actual cost. 10% of Hospital revenue comes from Medi-Cal and their reimbursement covers 64% of actual cost. A hospital which has an average daily census of 15 to 25 patients has a heavy overhead in facilities and staff.

2. The Hospital has had an operating loss for five of the past six years.

3. The District's investment income and tax support has meant that the District as a whole has shown overall net surpluses in all six years. For the current year, the District anticipates a loss.

4. The bond issue which supported the original construction of the Hospital has been paid off.

5. Current tax support comes from property owners in the District. Excluding debt service, which is no longer collected, this amounted to $358,217 for the year ended June 30, 1996, $371,136 for the year ended June 30, 1997, and $376,546 for the year ended June 30, 1998.

6. The District's largest single financial drain comes from running the ambulance service. The deficit for the year ending June 30, 1996 was $217,750; for the year ending June 30, 1997 it was $304,610; and for the year ending June 30, 1998 it was $394,081.

7. District expenses are over $20 million per year. The District has a balance in its unrestricted fund ($11,055,241 as of June 30, 1998). This is its total reserves for building upgrades, equipment replacement, and unexpected expenses.

8. The Grand Jury finds that the District is not in immediate financial peril because its current reserves, investment income, and tax support are adequate in the short term.

Recommendation

Given the trend of decreasing revenues, the reality of an aging building needing substantial modernization, and the overwhelming need for a community-based hospital, the Grand Jury supports an increase in the pro-rata tax rate to provide additional revenue for the District. An additional one-hundredth of one percent tax on the assessed property value in the District, about the amount collected for debt service previously, would raise an additional $140,000 annually. Any tax increase would have to be approved in an election by two-thirds of the voters.

Response Required

Mendocino Coast Health Care District Board of Directors

Mendocino-Lake Community College

The Mendocino-Lake Community College (College) is a community college serving Mendocino and Lake Counties.

Reason for Review

The Grand Jury received a complaint about possible violations of freedom of speech based on the status of the student newspaper, *The Eagle*., being forced to change from a volunteer student activity to one under the direct control of the English Department.

Method of Investigation

The Grand Jury interviewed two former faculty advisors of *The Eagle*, two members of the College Board of Trustees (Board), the President of the College as well as the complainant. The Grand Jury also interviewed a citizen interested in the operation of the College and several members of the staff at the College.

Freedom of Expression

Findings

1. As mandated by California Education Code, Section 76120-76121, the Board adopted Board Policies 509 and 524, which established a comprehensive policy protecting First Amendment rights throughout the campus.

2. Students were involved in the publication of *The Eagle* on a voluntary basis, loosely guided by a faculty advisor(s). The College administration provided assistance to the project in the form of a $200.00 monthly stipend for the advisor(s), space for the work and use of College equipment. At some point *The Eagle* established a link to the College's web site with no objection from the administration.

3. In late 1997, *The Eagle* received anonymously and published a confidential memo-randum concerning personnel issues involving administrative evaluations of a Dean of Instruction. The memorandum also included charges of improper hiring procedures for a specific administrative position and improper use of certain categorical funds.

4. Following the publication of the memorandum, the Administration took three actions regarding *The Eagle*:

   First, the Administration cut the previously condoned link between *The Eagle* and the college web site on the stated grounds that such linkage, without official college approval, was unlawful. The "hot link" to *The Eagle* web site was removed within 36 hours of the posting of *The Eagle Extra* in October 1997.

Second, the Administration then terminated the existing arrangement of the publi-cation of *The Eagle*. The exact date of termination is difficult to determine because there was no official notice.

Third, the Administration moved the publication of *The Eagle* into a newly created journalism class within the English Department. The newly hired instructor of the journalism class is also the advisor to the presently operating student newspaper.

5. The journalism teacher/faculty advisor has stated a commitment to ensuring that the publication meets high standards for quality journalism and to the free expression of ideas and non-interference in what appears in the newspaper.

Recommendations

1. The Grand Jury recommends vigilance on the part of students and faculty alike to ensure that the established policies of the College and the First Amendment rights receive strict adherence.

2. The Grand Jury recommends that the College Administration make no further changes in the status of *The Eagle* which might again give the impression of retaliatory restriction on free speech rights. *The Eagle* must be free to publish any information, with due regard for libel and obscenity rules, without fear of administrative interference or retaliation. The College Administration should reactivate a link between *The Eagle* and the College web site.

3. *The Eagle* should publish the official policies of the College in order that everyone can be familiar with the College's official, established policy regarding free inquiry and expression.

4. The Board should institute a colloquium including Board, Administration, faculty, and student body concerning freedom of expression on the College campus, including cyberspace issues.

Freedom of Communication

Finding

An administrative official told some staff members that some information "should not be included" in a departmental status report to the Board. The accuracy, or inaccuracy, of the information was not given as the reason for eliminating parts of the report.

Recommendations

1. The Board must establish a "whistle-blower protection" policy in order to make certain that all points of view are available to members of the Board. A wide breadth of information about the College is necessary in order to enable the Trustees to make decisions based on a full awareness of all the conditions.

2. All points of view from various constituent groups must be readily available to the Board because the Board needs to have complete, unfiltered (and unfettered) information about all the conditions of the College.

3. The members of the Board must not micro-manage the College. However, they need to open conduits of information from the entire College in order that their confidence in the Administration is confirmed. The Board must have an assured flow of vital information about the College for which they alone bear ultimate responsibility.

Response Required

Mendocino-Lake Community College Board of Trustees

Mendocino County Mental Health Board 1997–1998

The California Legislature passed the Bronzan-McCorquodale Act of 1986 which provides for the authorization and financing of community mental health services for the mentally disordered in every county through locally administered and locally controlled community mental health programs. The act further mandates that a Mental Health Board be established. The Mendocino County Mental Health Board (MH Board) is a public body that is designed to provide local oversight of the County's mental health programs through oversight of the Mental Health Department. (MH Department)

Mendocino County has established a 15-citizen MH Board plus a Board of Supervisors (BOS) representative. The diversity of the MH Board is mandated by the Welfare and Institution Code Section 5604. The Board consists of citizens from a diverse cross section of the county's population and represent Consumer-Direct, Consumer-Family, and Public Interest segments of the population.

The Mendocino County MH Department is locally administered. However, the BOS, and MH Board which are jointly responsible have not provided the essential mechanisms needed for local control of the mental health system. This has been the situation for several years. The MH Board has failed in its responsibility to the citizens of Mendocino County to provide citizen oversight of the MH Department. The Mendocino County MH Board has not been in compliance with state statutes and its own bylaws. In addition, the previous Chairperson attended only two of seven meetings in 1998 leaving the MH Board leaderless, unable to conduct lawful business, and vulnerable to manipulation.

In September 1998, a new Chairperson was elected. This new leadership is seen to be aggressively implementing many of the necessary steps to correct the problems revealed by this investigation. After several years of neglect, some time will be needed to assess the results and permanency of the new leadership's bold revitalization of the MH Board. This revitalization effort will require the support of the community and the BOS.

Reason for Review

As part of its oversight responsibility the Grand Jury investigated the operation and functioning of the Mendocino County MH Board.

Method of Investigation

In an effort to ascertain the extent of citizen participation and oversight provided by the MH Board, the Grand Jury interviewed MH Department members, MH Board members, care providers, consumers, consumer families and community mental health care advocates. The Grand Jury also attended MH Board meetings as well as community mental health advocates' meetings and reviewed MH Board, MH Department, BOS and State Department of Mental Health records for the years 1997 and 1998.

MH Board Responsibilities

The MH Board meets on the third Wednesday of each month except for the month of August. The meetings are held in Fort Bragg, Willits and Ukiah. An agenda is prepared and publicly distributed prior to each meeting.

Finding 1

The stated goals of the MH Board are:

- To promote quality care and attention for people with emotional problems.

- To obtain community input regarding mental health needs.
- To shape, in collaboration with County MH Department staff, the long term values and goals for the mental health care in the County.
- To monitor changes in County, State and Federal law, regulations and funding that can affect mental health care in the County.
- To educate the community about emotional problems and mental health services. There is a specific educational goal regarding the reduction of the stigma associated with mental health problems and care.

The Grand Jury failed to find any evidence that any of the MH Board goals were realized or that any effort was made to achieve its stated goals.

Finding 2

Between January 1997 and July 1998, MH Board members did not regularly attend meetings.

- Only four meetings had a quorum (nine members).
- Overall average MH Board attendance was 34%.
- Only three of 15 MH Board members were present at the January 1998 meeting. January is the month for the election of officers.

Finding 3

Under new leadership between September 1998 and December 1998, members of the MH Board regularly attended board meetings. Meetings were conducted in a business-like manner and conformed to the published agenda.

- All MH Board meetings had a quorum.
- Overall average MH Board attendance was 77%.

Board Autonomy

The MH Board has a history of being manipulated and intimidated by the MH Department. There were attempts to manipulate and mislead the Grand Jury's oversight investigation. The MH Department provided fabricated documents to the Grand Jury and failed to fully disclose essential information relating to this investigation.

Finding 1

The MH Board is forced to rely on the MH Department for administrative support. This support is inadequate and for the most part confined to providing a mail drop and transcribing monthly MH Board meeting minutes.

- The mailing address for the MH Board is the MH Department, it is common practice for the MH Department to open mail addressed to the MH Board.
- Documents maintained by the MH Department on behalf of the MH Board number less than 30 for the 12 years the MH Board has been in existence.
- The MH Board must rely on the MH Department to transcribe MH Board meetings; these transcriptions are frequently lost, and often transcribed in a way that does not reflect the actual events or votes of a particular meeting. The MH Department lost the minutes of the particularly contentious September 1998 MH Board meeting regarding the selection criteria of the replacement MH Department Director.
- The MH Board does not have internet/e-mail resources with which to communicate with other MH Board resources or to do basic grant research or stay abreast of legislation affecting the County's delivery of mental health services.

- The MH Board does not have office space; its one file cabinet has been relegated to a hallway in the MH Department. The MH Board lacks any reasonable space with which to carry out its many administrative responsibilities.

Recommendations

1. The BOS should provide a modest annual budget for the MH Board. A budget at a minimum level of independence will provide many of the resources needed in order for the MH Board to function: outside transcription services to insure the timeliness and accuracy of MH Board meeting minutes, post office box for the exclusive use of the MH Board, letterhead stationary, and postal expenses.
2. The MH Department has access to numerous Departmental as well as County resources and has an ethical responsibility to share these resources. The BOS should insist that the MH Department provide an office for the exclusive use of the MH Board. This office should be secure and furnished as is customary for the MH Department. It should be equipped, at a minimum, with a telephone and computer with e-mail and internet capability.

Finding 2

In the past, the MH Board has not had sufficient independence from by the MH Department to fulfill its responsibilities properly.

Recommendations

1. The BOS must assure that citizen oversight of the MH Department is free from existing and future manipulation and interference by the MH Department.
2. The makeup of the MH Board is critical. Having a strong chair is essential to the MH Board functioning properly. To effect this the BOS must:
   a) recruit MH Board members who are able and willing to do the job for their full term. While this seems obvious, it appears this has not been done well enough in the past.
   b) regularly monitor the performance of the MH Board in general, and the relationship between the MH Board and the Mental Health Director specifically.
   c) ensure that the relationship does not revert to one where the MH Board is dominated by the MH Department Director and the MH Department staff.
   d) monitor this situation on a regular and continuing basis.

Mandated Advice

The Welfare and Institution Code and MH Board bylaws mandate that the local MH Board shall advise the BOS as well as the local mental health director as to any aspect of the local mental health program.

Finding

The Grand Jury found scant evidence that the MH Board is in compliance. The monthly MH Board meeting does provide for 15 minutes for a report from the MH Department Director. There are, however, no procedures in place that provide for mutual communications.

Recommendation

Procedures that foster and ensure communications with the BOS need to be established by MH Board. MH Board bylaws should establish procedures to keep the BOS informed as to the state of mental health services within the County.

Mandated Annual Report to Board of Supervisors

The Welfare and Institution Code and MH Board bylaws mandate that the local MH Board shall submit an annual report to the BOS on the needs and performance of the County's mental health system. This report is presented in January of the year following the report year.

Finding

The MH Board failed to submit a report for the year 1997. At the September 17, 1997 MH Board meeting, a MH Board member expressed concern that the annual report was due, and the MH Board took no action to ensure compliance.

Recommendation

The BOS should institutionalize a protocol which ensures and guarantees compliance. The MH Board should establish procedures for the preparation, editing, review and presentation of the annual report to the BOS in a timely manner.

Certification of Annual Mental Health Performance Contract

The MH Department attempted to mislead the BOS and to obstruct the Grand Jury's investigation of the MH Board by providing a fabricated document. The Welfare and Institution Code and MH Board bylaws provide that the proposed annual County mental health services performance contract shall include the assurance that the local mental health advisory board has reviewed and approved procedures ensuring citizen and professional involvement at all stages of the planning process. Records that would support the MH Board assurances were requested from the MH Department, BOS, MH Board, and the State Department of Mental Health.

Finding 1

The MH Board did not approve or certify the annual performance contract as required by statute. Testimony of MH Board members supports this finding that the MH Board did not review, certify or approve the contract as claimed by the MH Department.

Finding 2

The MH Department provided the Grand Jury with a copy of the annual performance contract along with a transmittal/cover document from the MH Board to the State Department of Mental Health. This document was signed by the Chair of the MH Board.

Finding 3

The Chair of the MH Board denies reviewing or signing the document. A cursory review of the signature supports the testimony of the MH Board Chair. The State Department of Mental Health denies receiving the subject document and provided a copy of the document which was actually received.

Recommendation

This matter has been referred to the Mendocino County District Attorney.

Mandated Evaluation of Community Mental Health Needs

The Welfare and Institution Code and MH Board bylaws mandate that the local MH Board shall review and evaluate the community's mental health needs, services, facilities, and special problems.

Finding

The Grand Jury was unable to locate any evidence, documented or in testimony, that this mandated requirement is being or has been complied with. The MH Board provides a 15-minute segment of their monthly meeting for public input. While well-intentioned, this 15 minutes is ineffective and infrequently used by the community.

Recommendations

1. The review and evaluation of this mandated activity needs to be formalized within the functioning of the MH Board within the committee process.
2. Outreach activities are essential if the mandate requiring community input is to be achieved. These outreach activities must be part of a much broader program to facilitate mutually beneficial communications, information, and education.
3. The MH Board should take a proactive stance towards the review and evaluation of the community's mental health needs, services, facilities, and special problems. A focused approach in conducting public outreach events utilizing resources of the media, schools, and community-based organizations will allow leveraging of limited MH Board resources. Outreach events are mandatory if the MH Board's stated goals and philosophies are to be realized.

Committee Responsibilities and Functioning

The MH Board cannot be effective if it endeavors to handle everything by the MH Board as a whole. Therefore, the accomplishments of the MH Board depend, for the most part, upon the work of its committees. MH Board bylaws provide for the establishment and functioning of committees, established to reflect program elements within the MH Department: Administrative Support, Acute Services, Adult Services, and Children's Services. In addition there is a Legislative Committee which is not actively involved with the MH Department. Each committee plays a vital and necessary role in ensuring citizen participation and oversight in the delivery of mental health services to insure that community needs are being met. Each committee is charged with meeting on a regular basis and providing written progress reports annually to the MH Board Chair. In addition, each committee is charged with presenting interim progress reports at each MH Board meeting.

Finding 1

Between January 1997 and July 1998, only the Acute Services Committee (of the five committees) was functioning, meeting 15 times. That committee and particularly its Chair, is to be commended for the way that the committee accepted its responsibilities, providing ongoing liaison with the MH Department and regular progress reports to the MH Board. The change of

leadership on the MH Board in July 1998 made dramatic improvements in the functioning of the other committees.

Recommendation

A training program must be implemented that ensures each MH Board member is aware of their individual responsibilities as well as the MH Board responsibilities. This training should include orientation that encompasses all aspects of the County mental health system including the effective functioning of the MH Board.

Annual Evaluation of MH Department Programs

Annual reports by the committees are indispensable elements in assuring that MH Department programs reflect the needs and priorities of the community. Each committee is charged with establishing a working relationship with the MH Department program under its oversight responsibility. Additionally, each committee is charged with conducting an annual evaluation of the program under its oversight responsibility.

Finding

There is no evidence to support that annual evaluations were conducted between January 1997 and December 1998.

Recommendation

The MH Board in collaboration with the MH Department must establish formal policies and procedures for the annual evaluation of MH Department programs. These policies and procedures must develop and implement, on an annual basis, the protocols for the obligatory annual evaluations.

Summary of Recommendations

1. The BOS must monitor the performance of the MH Board in general.
2. The BOS must establish procedures that foster and ensure communications between the BOS and the MH Board on a regular basis.
3. The MH Board must establish procedures that provide for the preparation, editing, review and presentation of the annual report to the BOS in a timely manner.
4. The MH Board in collaboration with the MH Department must establish formal policies and procedures to ensure the annual evaluation of MH Department programs as mandated by MH Board bylaws.
5. Outreach activities are essential if the mandate requiring community input is to be achieved. These must be part of a much broader program to facilitate mutually beneficial communications, information and education.
6. The MH Board must implement training programs to ensure that MH Board members are aware of their individual responsibilities as well as of MH Board responsibilities to the community.
7. The BOS must establish safeguards to assure that MH Board oversight of the MH Department is free from manipulation and interference in any form.
8. The BOS must provide a sufficient annual budget in addition to directing the MH Department to provide secure administrative facilities to the MH Board.

Response Required

Board of Supervisors

Millview Water District

The Millview Water District (District) was formed in 1956 under provisions of the California Water Code. The District is an independent governmental unit. It is governed by an elected five-member Board of Directors (Board).

The purpose of the District is to provide water services to residents and businesses within its boundaries. The District includes the Ukiah Valley from a line through Deerwood and south of Masonite to a point between The Forks and Calpella. The District has approximately 1425 water connections.

Reason for Review

The Grand Jury received a citizen's complaint.

Method of Investigation

The Grand Jury interviewed the complainant, the District manager, three members of the Board, a former Board member, the independent auditor hired to examine the District's financial condition in 1997 and 1998, and the County auditor charged with examining the financial condition of special districts. The Grand Jury attended Board meetings and reviewed documents relating to the Capital Reserve fund, ordinances establishing water rates, financial statements, audit reports for 1996, 1997, and 1998, the contract to sell water to the Calpella Water District, Board meeting minutes and available policy manuals.

Capital Improvement and Facilities Reserve Funds

Findings

1. Discussion of a possible rate increase began at a Board meeting July 2, 1991.

2. The Board requested that the district engineer develop a facilities needs assessment plan for the District. Three alternatives were presented in May 1994.

3. On July 11, 1994, the Board passed resolution #231 adopting a ten-year plan and setting rates to most customers of $1.97 per 1000 gallons plus a monthly meter charge based on meter size. They also passed a resolution that the Board's intent was that the increased revenues be used primarily for projects outlined in the ten-year plan.

4. The water charge of $1.97 per 1000 gallons was described in Ordinance 97-1 as $1.45 for operating expenses and $0.52 for capital projects. (As presented on the monthly billing, this information is confusing to customers.) The $0.52 fee together with the connection fee and interest income are restricted funds and are to be used only for capital projects.

5. The District has a separate bank account in which to hold funds allocated for capital improvement projects. The restricted funds balance on February 28, 1999, was $574,893.

6. There is no evidence of Board policies for accounting procedures of these restricted funds.

7. The District has relied on its auditor to reconcile the restricted funds during his annual audit rather than the District reconciling funds on an ongoing basis.

8. California Water Code Section 31007 mandates that the rates and charges collected by a district shall be established to yield an amount sufficient for the following:

   a. Provide for repairs and depreciation of works owned or operated by the district.
   b. Pay the interest on any bonded debt.
   c. So far as possible, provide a fund for the payment of the principal of the bonded debt as it becomes due.
   d. Pay the operating expenses of the district.

9. Water Code Section 60245 mandates, "The Board shall fix such rate or rates for the sale or exchange of water for replenishment purposes only as will result in revenues which will pay, insofar as practicable, the operating expenses of the district."

10. For several years, costs have exceeded $1.45 per thousand gallons.

Recommendations

1. The Board should explain clearly to its customers the rate structure. This should include a statement of the reasons behind the payment of various portions of the water charge and connection fee: normal operating expenses, plant expansion necessitated by increased demand, plant replacement because of wear, and system upgrading because of mandates.

2. The Board should establish policies concerning restricted funds, including a comprehensive policy for accounting and reporting on the restricted funds. The District should annually disclose the use of the Capital Improvement and Facilities Reserve Fund.

Comment

An issue was raised regarding California Government Code Section 66006(b) which requires that any fee imposed in connection with a development project must be deposited into a separate capital facilities account. This is to assure that fees are not commingled with other revenues and funds. The District asked its attorney for an opinion as to whether it was subject to this code in its handling of these funds. The opinion provided was that the code does not apply since neither the service connection fee or the water delivery fee are imposed "as a condition of approving a development project."

Insurance Payments

Findings

1. The previous manager worked without contract with the same rights and benefits as a regular District employee.

2. He had a work-related injury in February 1998, went on disability leave, never returned to work, and never resigned.

3. The District continued making health insurance payments for him and his family during his absence.

    a. District Policy 2160.40 concerning employee considerations are silent as to the accrual of health insurance payments while on disability leave.

    b. District Policies 2070.30 and 2070.31 state that an employee's service will not be broken by reason of industrial disability.

    c. A workers compensation attorney advised the District to continue health insurance payments.

4. The Board terminated his employment in May 1999, and the insurance premium payments have been discontinued.

Recommendation

District Policy 2160.40 should be amended to clarify provisions concerning the payment of health insurance premiums for employees while on disability leave.

Agricultural Customers

Findings

1. All District water is treated.

2. Three agricultural customers who were being supplied water at the time of the rate increase, are being charged $0.65 per 1000 gallons, while everyone else is charged $1.97 per 1000 gallons.

3. This rate structure violates Govt. Code 31007 by charging less than costs of pro-duction and delivery of the water.

4. These three customers are being subsidized by all District users.

Recommendation

The Board should adjust the rates of the three agricultural users so that no customer pays less, at a minimum, for water than its cost of production and delivery.

District Auditor's Reports

Finding

1. District audits done by a private auditor for the past three years have indicated many flaws in the District's accounting systems. Recommendations included:
   a. Establish administrative policies and procedures
   b. Establish an investment policy
   c. Maintain an adequate accounting that completely and at all times shows the financial condition of the District.

2. Some suggestions have been repeated for two to three years with no action taken.

Recommendation

The District should implement its auditor's recommendations.

Comment

Accurate and timely financial data are essential to the efficient operation of any business.

Board Consideration of the Public

California Government Code Section 54950 *et seq*. (Brown Act) states that "the people insist on remaining informed so that they may retain control over the instruments they have created" and also "the legislative body of a local agency shall not prohibit public criticism of the policies, procedures, programs, or services of the agency or of the acts or omissions of the legislative body."

Findings

1. A citizen sent a formal request for information concerning the capital reserve fund in a May 1, 1998, letter to the Board. The District replied in a letter dated February 9, 1999, over nine months after the initial request, but only after the Grand Jury began its investigation.

2. The only *legally* required public notice is the posting of the agenda in the District window.

3 Board minutes reflect that when the rate increase was being considered, a citizen expressed his dismay that users had not been notified. He was told that the Board meets on a regular basis each month at which the public is invited to participate. The Board, while legally meeting minimum requirements, did not appear to consider the impact an increase would have on its constituents and did not provide information to users.

Recommendations

1. The Grand Jury encourages the District to be open, responsive, and timely with its customers and the public. When something occurs which might have a substantial impact on District customers, the Board should fully inform its customers in a manner which is easy to understand.

2. The District should inform customers annually, perhaps through a mailing, of the financial condition of the District. This should include income, operating expenses, and cost per unit of water delivered. This might be included in the annual report on water quality.

Brown Act Violation

Finding

January 20, 1999, the Board met at a private business facility which required attendees to sign in before being allowed on the premises.

The Brown Act states, " A member of the public can attend a meeting of a legislative body without having to register or give other information as a condition of attendance."

Recommendations

1. The Board must follow the Brown Act, including holding meetings at locations that do not require attendees to sign in.

2. The Board should require Brown Act training for all directors.

Board Training

Findings

1. The Board is inadequately trained.

2. The Board has no training policy.

3. Proposed Board Policy 40900 relating to "Training, Education, and Conferences" has never been adopted.

4. The Board members do not avail themselves of Association of California Water Agencies and the Special Districts Association training seminars which are presented regularly.

Recommendation

The Board should adopt a training and education policy which includes annual Board training for all directors.

Board Behavior

Finding

The Grand Jury has attended several Board meetings and observed discourteous behavior between Board members and between Board members and the public.

District policy is clear in this area. Policy 4050.20 states "Directors shall at all times conduct themselves with courtesy to each other, to staff and to members of the audience present at Board meetings."

Recommendation

The Board should follow its own policy.

Lack of Board Policies

Findings

1. The District had some unusable pipe (contained asbestos). It gave away the pipe on February 2, 1997. There is no District policy for surplus property.

2. Conflict exists about whether the District bidding and contracting procedures are fair. There is no District policy governing this area.

Recommendation

The Board should adopt clear policies and procedures regulating bidding, contracting and the disposal of surplus materials.

Comments

1. In December 1998, the Board approved the use of not more than $400 to have a dinner for employees and guests. The actual dinner cost about $314. The Grand Jury believes that this was an appropriate use of this much money.

2. Mendocino County's "Special District Handbook" has not been updated since 1984 and is not widely available. The Board of Supervisors should provide for the revision of the "Special Districts Handbook" and should sponsor a training day for all Special Districts in the County using the expertise available in the various departments.

Response required

Millview Water District Board of Directors

Mendocino County Board of Supervisors (regarding “Special District Handbook” and training)

An Investigation of a Police Shooting of a Mentally-ill Citizen

On July 16, 1998, a Ukiah Police Department (UPD) officer shot and fatally wounded a Conditional Release Program (CONREP) client of the Mendocino County Mental Health Department (MH Department). There were five primary elements considered in this investigation: (1) the MH Department client himself and his history of mental illness; (2) the MH Department and its involvement with the client; (3) the incident; (4) the police, their training and their actions; and (5) the legal document, California Welfare and Institutions Code Section 5150 (5150), that the police relied upon to authorize their confrontation of this mentally-ill man.

Reason for Review

The Grand Jury investigated this incident in response to citizens' complaints. One of the issues raised in the requests for this investigation was that of a racial bias.

Method of Investigation

The Grand Jury reviewed all documents and evidence held by the Mendocino County Sheriff's Office pertaining to its investigation of the incident; Policy and Procedure Manuals of UPD and the MH Department; the State Commission on Police Officers Standards and Training (POST) manuals pertinent to issues raised by this incident. The Grand Jury interviewed personnel from the UPD, Mendocino County Sheriff's Office, MH Department, Protection and Advocacy, and POST.

Historical Perspective of the Mentally-ill Client

The client had been found not guilty by reason of insanity for a 1981 felony false imprisonment and rape of his wife, with a special allegation of using a shotgun in the commission of a crime.

He was diagnosed a paranoid schizophrenic:chronic and served time in Napa and Atascadero State Hospitals before being released into the community July 18, 1986, as part of a CONREP, an outpatient treatment program administered locally by the MH Department.

According to Court records, the original felony act in 1981 was the only previous violent or criminal behavior exhibited by the client.

Mental Health Involvement

Findings

1. The client was under the care and supervision of MH Department for 12 years as a CONREP client and received multiple services including group and individual therapy sessions.

   CONREP requires participants to endorse and adhere to individualized plans and sets of conditions. These include attending individual and group therapy sessions, submitting to substance abuse screening, allowing home visits and collateral contacts, having periodic psychological assessments, and taking psychotropic medications as prescribed.

Failure to adhere to the terms and conditions set by CONREP can result in revocation of the community out-patient status.

The County received $134,169 in 1997-98 to provide services to CONREP clients released to the County. The 1997 budgeted cost of CONREP per patient, one of whom was this client, was $21,879.

2. MH Department is required to provide the Court with quarterly reports on CONREP clients. These reports demonstrate that this client:

   a. Remained on the same psychotropic medication in increasing dosages, finally receiving Haldol 150 mg., monthly;
   b. Exhibited the same symptoms of his mental illness; and
   c. Had the same therapeutic goals set each year.

3. There was no documented evidence of progress during the 12 years. Despite not attaining any of the goals set for him, mental health services were reduced on a predetermined time table.

4. In the 12 years between July 18, 1986 and his death July 16, 1998, the client was threatened three times with revocation of his out-patient status due to non-compliance with his medications. Each time, the revocation was rescinded with his renewed promises of compliance with the terms and conditions of his contract.

5. In 1990, a psychological assessment of the client recommended the continued structure of day treatment programs and ongoing supervision from the CONREP program or there was a "risk of engaging in violent behavior." Also noted in that report was that the client "suffers from serious problems in thinking. There is a concrete, immature quality to his thought processes that leads to faulty conceptualizations and poor judgment."

6. At the time of his death, the client was under additional emotional stress. He was to have a court hearing July 17, 1998, regarding his continued participation in CONREP and he had an upcoming hearing on his Social Security benefits. The MH Department documented increased symptoms of his mental illness and anxiety attacks.

Welfare and Institutions Code Section 5150

"When any person, as a result of mental disorder, is a danger to others, or to himself or herself, or gravely disabled, a peace officer, member of the attending staff, as defined by regulation, of an evaluation facility designated by the county, designated members of a mobile crisis team provided by Section 5651.7 or other professional person designated by the county may, upon probable cause, take or cause to be taken, the person into custody and place him or her in a facility designated by the county and approved by the State Department of Mental Health as a facility for 72-hour treatment and evaluation.

Such facility shall require an application in writing stating the circumstances under which the person's condition was called to the attention of the officer, member of the attending staff, or professional person has probable cause to believe that the person is, as a result of mental disorder, a danger to others, or to

himself or herself, or gravely disabled. If the probable cause is based on the statement of a person other than the officer, member of the attending staff, or professional person, such person shall be liable in a civil action for intentionally giving a statement which he or she knows to be false." (5150)

Findings

1. The MH Department rationale for instituting involuntary detention under a 5150 was that the client "had refused to come to the clinic for scheduled injection and appointments." This rationale uses non-compliance of the CONREP contract as the reason for the detention.

2 The client met the standard for revocation as he was in non-compliance. Revocation of his out-patient status under CONREP could have been initiated under Penal Code 1610 at the Court hearing scheduled the next day (July 17) or the Court could have ordered the client detained under Penal Code 1608. These provisions grant authority for detention of CONREP clients.

3. A MH Department supervisor stated in a UPD interview "safety may have been a factor but primarily it was the matter of compliance to get him into the hospital."

4. A review of his medical history reveals that the behavior noted to support a 5150 was behavior that the client had exhibited throughout his mental illness.

5. To support its contact of the client under 5150, police officers relied on a MH Department assessment rather than relying on their own judgment. However, police officers cannot be deprived of their authority in the field and cannot give up their own judgment. "In justifying particular intrusion, an officer must be able to point to specific and articulable facts which, taken together with rational inferences from those facts, reasonably warrant belief or suspicion" that the person is a danger to himself or others . *Peo. v. Triplett* 144 Cal. App. 3d 283 (1983)

6. When the client did actually exhibit aberrant behavior that would have supported use of 5150, the police viewed that behavior as being criminal and reacted to the client as a felon, not a mental patient.

The Incident

July 13, the client attended his scheduled, weekly individual therapy session and underwent a regularly-scheduled urine test. July 14, he did not keep his appointment for his scheduled monthly medication injection (Haldol 150 mg). July 15, he did not appear for the scheduled weekly CONREP group therapy session. On that day, MH Department attempted to contact him through a home visit, but he was not home. MH Department reached him by phone on July 16 at which time he indicated he would no longer comply with medication or appointments. That day at noon, MH Department decided to use 5150 for an involuntary detention of the client and to request Ukiah Police Department (UPD) to effect the detention.

July 16, 1998, 12:30 p.m. dispatch at the UPD received a call from a MH Department clinician requesting officer assistance in detaining the client under 5150. The officer of the day (OD) returned that call and obtained general background information on the client. He was given a brief history of the original crime in 1981, and told that the client might be dangerous. He was not told of the client's resistance to authority figures, his behavioral traits of bluster when anxious, or the "immature quality of his thought processes that leads to . . . poor judgment." The OD contacted two other officers on his team, one a K-9 unit and went to locate the client at his apartment. He was not home. Subsequently, one of the officers located the client at a fast food restaurant, spoke to him, obtained his identity, and then reported back to the OD that he had located the client.

At 1:07 p.m., all three uniformed officers and the canine entered the restaurant where the client was sitting at a table drinking a lemonade, waiting for his lunch. The OD approached the client and repeatedly requested that he accompany the officers outside the restaurant. The client refused each request and at 1:13 p.m. stood and withdrew a knife from the waistband of his shorts, again refusing to accompany the officers.

At this show of force, two officers drew their firearms and started yelling for the client to get down and for patrons in the restaurant to get out. The canine started barking. There was confusion in the restaurant. Some people with children began leaving. The client exited the restaurant still holding the knife. At 1:14 p.m., the officers were following the client down the sidewalk. One officer emptied his can of pepper spray with little effect. Another officer began to spray the client, determined the spray was not working, and then made attempts to use his baton to subdue the client. The police followed the client 220 yards, keeping a distance between the client and themselves to the door of the client's apartment building. There were no other attempts at take-down techniques nor was the canine released.

The client gained access to the stairwell to his apartment through a locked door and locked the police officers and the dog outside. The police gained entry and sent the dog after the client who was at the top of the stairwell. The client stabbed the dog once in the side as it approached him. The client, holding his knife, turned and was in a superior position above the officers. The canine's handler, who was closest to the top of the stairs and already had his weapon drawn, was ordered to "shoot" by the OD. The officer fired once and the client collapsed and subsequently died from the gun shot.

Before firing, police officers gave no warning. The Use of Force manual from POST (the State commission which establishes standards and policies, adopts regulations, and trains law enforcement officers) states: "Give warning where feasible 'the Court imposes a constitutional requirement that some warning be given prior to the use of lethal force where feasible,' Halt Police! Stop or I'll shoot."

Ukiah Police Department

The three officers involved in this incident had undergone background checks relative to their employment as officers, graduated from recognized police academies, and had good records as police officers. The three had been employed with UPD for 11 years, 5 years, and 5 months, respectively.

Finding

At no time did the racial issue surface.

Training

Findings

1. POST is only responsible for setting training standards for the hiring of police officers. Post requires and reimburses for 24 hours of training per officer every two years, but the specific courses taken and more hours per year are discretionary with each department.

2. POST will reimburse local districts for up to 80 hours of training per officer per year.

3. POST is currently conducting a study which may result in mandatory on-going training in certain "perishable skills," which includes use of a baton.

4. Other than basic training at academies, the officers had no additional training in dealing with the mentally ill, in edged-weapons defense, in negotiating with violent suspects, or in take-down techniques.

5. According to the POST training manual chapter, Controlling Force, "Peace officers must be ready and physically capable of control of a suspect if the suspect refuses to follow verbal commands, physically resists, or attempts to attack a peace officer during a detention or arrest."

6. "Ongoing training is critical for peace officers and is necessary to maintain proficiency with control holds...and takedown techniques."

Policies and Procedures

Findings

1. The UPD Policies and Procedures manual is grossly outdated and in need of revisions.

2. The UPD Policies and Procedures manual does not mention use of pepper spray. One of the pepper spray canisters emptied in the client's face was outdated and the manufacturer could not testify to the effectiveness of the contents. Pepper spray canisters must be shaken prior to use to mix the contents. UPD Policies and Procedures Manual does not contain instructions for use of pepper spray, proper maintenance, or have a procedure to turn in outdated canisters.

3. UPD Procedure No. PATROL 4.4 G 4, September 18, 1985, states: "Canine teams should not be used to apprehend anyone suspected to be under the influence of drugs or alcohol if no other crime is involved, or the mentally disturbed if no crime is involved."

4. Officers may use mental health personnel in their contacts with the mentally ill. UPD Procedure No. 10.4, September 5, 1975, states: "In a case where an officer feels the person contacted is mentally disturbed and there is no justification for an emergency commitment, the officer is authorized to notify the Watch Commander who will relay the information to the psychiatric unit at MH Department. Arrangements have been made by that agency to send a member of the psychiatric staff to confer with the person."

Tactical Decisions

Findings

The Grand Jury finds that the UPD officers decided:

1. not to report the client's location to MH Department or ask them to effect their own detention or to assist the police. (Without a mental health clinician present with the police officers, the ability of someone familiar to the client to negotiate was lost.)

2. to proceed in a 5150 detention based on the assessment provided by a mental health clinician rather than assessing under their own authority.

3. to proceed into taking the client into custody without delay. (A POST training officer stated that the first question the officers should have asked themselves was, "What would happen if he is not taken into custody?" The risk to the community must outweigh the value of his life.)

4. to use a canine team contrary to policies and procedures.

5. to confront the client in the restaurant and use all three officers and the canine.

6. to escalate to a show of lethal force by drawing weapons when the client produced a knife rather than viewing the action as verifying him as a mental health patient and attempting negotiations.

7. not to ask for mental health department assistance.

8. to continue the confrontation after the client returned to his apartment building.

9. to shoot him.

Recommendations

1. The Ukiah City Council should ensure that UPD officers receive immediate and comprehensive training in:

    a. Scope of their authority and civil liberties;

b. Dealing with the mentally ill;

c. Escalation in the use of force, with emphasis on process prior to drawing their weapons;

d. Techniques in negotiating with hostile suspects; and

e. Techniques in take-down procedures.

2. The Board of Supervisors should ensure immediate and comprehensive training for all appropriate MH Department workers in the proper use of 5150 and the civil liberties of the mentally ill.

3. There must be coordination and training between Mendocino County MH Department, Ukiah Police Department, and the Mendocino County Sheriff's Office.

Comment

The Grand Jury recognizes the difficult job that peace officers have in the performance of their duties and that their lives are frequently in danger. However, these officers elected to follow their profession and we in the community they serve expect them to keep themselves polished by constantly upgrading their skills and to respect the sanctity of human life. We expect their chiefs and captains to create an environment which encourages officers to excel in all aspects of their jobs and to take advantage of all training available to them.

It is disheartening to the Grand Jury to learn that the Chief of Police indicated additional training probably would not have changed this incident's outcome. The Grand Jury urges the UPD to use this incident in training, focusing on how to prevent any such incident in the future.

Response Required

Ukiah City Council
Mendocino County Board of Supervisors
Mendocino County Sheriff

Response Requested

Ukiah Police Department
Mendocino County Department of Mental Health

Investigation of a Complaint Filed Against the Fort Bragg Police Department and the Mendocino County District Attorney's Office

The Fort Bragg Police Department (Police) responded to a criminal complaint filed by a citizen (Complainant) seeking return of property stolen from him and then sold. A Deputy District Attorney (DDA) investigated the case. Most of the property was either returned or paid for, with the exception of a painting which had sentimental value. Complainant knows who has the painting (Possessor) and where it is, but has been unable to regain possession.

Reason for Investigation

The owner of the stolen property filed a complaint with the Grand Jury against Police and the District Attorney's Office for not adequately investigating the complaint and securing the return of his property.

Method of Investigation

The Grand Jury interviewed police officers who were involved in the investigation, the DDA, a party to the sale of the property (Party) and other persons with knowledge of the events. The Grand Jury also reviewed police and the DDA reports of the crime.

Events Leading to the Grand Jury Complaint

In September, 1997, Complainant filed a crime report with Police, alleging that persons renting a house from him had sold a number of items belonging to him which had been in the house. Police spoke to the tenants and confirmed that they had sold the items. The tenants cooperated in retrieving much of the stolen property; they pled guilty to felony charges and are now incarcerated.

An item that was sold separately was a 4'x8' painting, which by accounts was sold by the tenant's nephew (Party) to a buyer (Possessor). Possessor, allegedly after learning the painting was stolen, then affixed the painting to his expensive cedar wall with screws and a strong adhesive. At different times, the Police and the DDA visited the home of Possessor and observed the painting on the wall. A police report along with a written statement from the complainant states that Possessor had purchased the painting from Party. Party's name was mentioned a total of **eight times** in reports and statements, but he was **never questioned** regarding this incident by anyone except the Grand Jury.

In January, 1998, the DDA charged Possessor with a felony and ordered him to appear in court. Possessor's attorney contacted DDA and requested a conference; in the meantime, Possessor twice failed to appear in court and a bench warrant was issued for him. The DDA had the warrant recalled and set a March arraignment date. The attorney contacted the DDA, saying Possessor wanted to avoid an arraignment and suggesting that the DDA go and view the painting. The DDA, accompanied by Complainant, did so. The DDA had the arraignment put off until April 27, 1998. A week before the scheduled arraignment, the attorney wrote the DDA asking him to drop the charges and allow the incident to be handled as a civil matter. An April 24, 1998 letter from the attorney confirmed a conversation with the DDA in which the DDA agreed to dismiss the charges on April 27, 1998. On April 27, 1998, the charges were dismissed on the DDA's motion. Complainant thereupon filed a civil

suit and was granted a writ for recovery of painting. Possessor has said he will return the painting if Complainant will pay for damage to his wall resulting from the removal process.

Findings

1 . Police investigation of this incident was incomplete as they failed to contact Party, though they had reason to know that he was involved.

2. Prior to this incident, Party and Possessor were friendly with police officers who investigated this case and have gone fishing together on Possessor's party boat.

3. DDA's handling of the matter was inadequate as he did not have Police contact Party. No investigation was done regarding Party and no charges were brought against Possessor. The DDA's rationale for dropping the criminal charges was that there was no proof of any criminal activity. The Grand Jury finds that this decision was based on an inadequate investigation.

4. Complainant has not recovered his property. He has a court order for return of the property, but Possessor, who knowingly has possession of stolen property, insists that Complainant pay substantial damages for its retrieval.

Recommendations

1. The Fort Bragg Police Department should ensure that officers are trained in investigative techniques and investigate complaints fully.

2. The Fort Bragg Police Department should ensure that officers avoid the appearance of impropriety in allowing personal relationships to affect their investigations.

3. The District Attorney should ensure complete investigations before deciding to drop charges.

4. The Fort Bragg Police Department should take possession of the painting and return it to the Complainant.

Response Required

Fort Bragg City Council
Mendocino County District Attorney

Response Requested

Fort Bragg Police Department

Special Education Local Plan Area (SELPA)

The state provides money for students with special needs by funding SELPA which is the structure charged with administering funds and with designing programs.

The Mendocino County SELPA which provides special education and related services within the County geographic area is a consortium made up of the twelve school districts plus the Mendocino County Office of Education (MCOE). The superintendents of those districts plus the County Superintendent of Schools make up the SELPA Policy Council which governs the Local Plan Area. The California Education Code requires that there be a Community Advisory Committee (CAC) to advise the SELPA.

Reason for Review

As part of the educational program in Mendocino County, SELPA falls within the oversight mandate of the Grand Jury.

Method of Investigation

The Grand Jury interviewed MCOE administrators, assistant superintendents, the SELPA Administrator, a school district superintendent, the CAC Chairperson, and persons from the community who are interested in SELPA. The Grand Jury attended meetings of the SELPA Policy Council and reviewed policy manuals, budgets, and other publications relating to SELPA.

Operation and Funding of Special Education Programs

Findings

1. The SELPA Policy Council is the governing board of the SELPA and provides direction and guidance to the Administrator of SELPA.

2. MCOE is the Responsible Local Agency (RLA). As such, MCOE hires SELPA employees and administers funds as recommended by the Policy Council.

3. SELPA allocates state and federal funds to augment the costs of special education programs to local districts based on the Local Plan for special education and allocation agreements as determined by the SELPA Policy Council.

4. This is the first year of the implementation of AB602, a new method for funding special education in California. With each successive year this new formula is used, it is anticipated that it will become easier to track and forecast income. A funding allocation plan is currently under development that should make clear how funds flow from the state to local districts.

5. California Education Code 56195.7(c)(6) and 56780, mandates an evaluation of the effectiveness of the program. The SELPA Policy Council is scheduled to adopt fiscal and programs audit plans. These plans will describe a comprehensive review and

evaluation of all districts and the MCOE regarding their use of special education funds and the adequacy of programs provided to students qualifying for special education.

Recommendation

Administrative documents must clearly show how the money is being spent for the students, especially in regard to the flow of funds from the state to the districts and special schools.

Evaluation of SELPA Program

Findings

1. Education Code Section 56600 requires "ongoing comprehensive evaluation of special education programs." The SELPA Local Plan includes that mandate. The Grand Jury found no evidence that the program presently receives adequate oversight or evaluation of the services for students for whom the programs are intended.

2. Program effectiveness, for the most part, is the responsibility of local school districts. The State is currently developing standards for the evaluation of the effectiveness of special education programs.

3. The Mendocino County SELPA was evaluated in 1998 through the State's Coordinated Compliance Review process. SELPA responded to the report and agreed to correct deficiencies.

4. The new SELPA Administrator has indicated that he plans to initiate an aggressive policy of evaluation of finances and program effectiveness.

Recommendation

A program of evaluation is essential in order to increase the efficiency of the program and to be within the rules mandated by state and federal guidelines. MCOE, the school districts and the SELPA Administrator must provide oversight of the SELPA programs, adequately document that oversight, and disseminate the findings to the public.

Community Advisory Committee (CAC)

Findings

l. The CAC, made up of parents of children served by the program and other interested persons, can be an important part of the policy determination and evaluation of the SELPA program.

The CAC holds monthly public meetings throughout the County, provides workshops on special education, reviews the SELPA Local Plan, participates on SELPA committees, and has a non-voting representative on the Policy Council.

2. The Local Plan mandates that the governing board of each district and the County Superintendent of Schools each appoint a representative from the district to serve two-year terms. In addition, the Policy Council may appoint five additional at-large representatives.

3. The nature of the program creates tension between CAC and the SELPA.

4. At the present time there are vacancies on the CAC. Districts without representatives are Anderson Valley, Fort Bragg, Leggett, Mendocino, Round Valley, Ukiah, Willits, and MCOE. Two at-large positions are vacant. As a result, CAC lacks some effectiveness in receiving input from all districts and presenting to the Policy Council concerns unique to the children served by the program.

Recommendations

1. The Grand Jury recommends that every effort be made to bring the CAC to full membership. Local district school boards and the County Superintendent of Schools shall appoint representatives to the CAC as mandated by the Local Plan.

2. The SELPA and the CAC must learn to work closely together.

Response Required

Anderson Valley Unified School District Board of Trustees
Arena Elementary School District Board of Trustees
Fort Bragg Unified School District Board of Trustees
Laytonville Unified School District Board of Trustees
Leggett Valley Unified School District Board of Trustees
Manchester Elementary School District Board of Trustees
Mendocino Unified School District Board of Trustees
Round Valley Unified School District Board of Trustees
Point Arena High School District Board of Trustees
Potter Valley Unified School District Board of Trustees
Ukiah Unified School District Board of Trustees
Willits Unified School District Board of Trustees
Mendocino County Superintendent of Schools

Response Requested

Mendocino County SELPA Administrator

Investigation of a Suicide at the Mendocino County Adult Detention Facility

A 19-year-old male resident of Ukiah who had a record of mental illness committed suicide while incarcerated at the Mendocino County Adult Detention Facility (Jail).

Reason for Investigation

The Grand Jury received a complaint.

Method of Investigation

The Grand Jury interviewed the complainant, the mother of the decedent, private Medical Contractor personnel including the psychiatric technician, as well as correctional officers who were on duty at the time of the suicide. The Grand Jury reviewed documents relating to Jail regulations and procedures for suicide prevention.

History of the Decedent

Findings

1. According to a September 1, 1996, psychiatric evaluation, supplemented by information from the mother of the decedent, he was, in general, in good physical health, but had a history of mental instability beginning at an early age, involving various diagnoses: major depression, dysthymia, oppositional defiant disorder, narcissistic personality traits, and post traumatic stress disorder. He had been hospitalized several times based on incidents of assaultive behavior, suicidal gestures, fighting with peers or adults and "creating mayhem and breaking into cottages and vandalizing campus property" (September 1, 1996 evaluation).

2. The evaluation also indicated that the decedent had a long history of drug use; at the age of nine he was using marijuana. He also admitted to use of LSD and psychedelic mushrooms, but, at one time, denied using cocaine, methamphetamine, inhalants or narcotics, although in a December 30, 1996, comment, he admitted to "long use" of "speed," or methamphetamine. His major drug problem was with alcohol, involving frequent use, sometimes resulting in blackouts. Though his symptoms indicated alcoholism, he had taken part in no treatment programs for that condition.

3. Prior to turning 18, the decedent spent time in Juvenile Hall on a number of occasions for such activities as petty theft, shoplifting, vandalism, fighting and marijuana possession. He spent his eighteenth birthday, October 17, 1996, in that facility and transferred the following day to the Jail. His jail medical record includes entries from his stay in Juvenile Hall.

4. At the time he entered the Jail, he was taking psychiatric medication (Depakote) and on October 22, 1996, he saw the contract psychiatrist who said he should continue with it.

Released on October 28, 1996, he was back the following month and saw the psychiatrist on November 13, 1996; the doctor repeated the Depakote recommendation. Released on November 16, 1996, he was back again in December. On booking for that period of incarceration, December 22, 1996, he had answered "yes" to the question "mental/emotional upset," and "yes" to the question, "Do you want to talk to a mental health [sic] or a psychiatrist?" with a notation, "Bi-Polar." On December 30, 1996, eight days after submitting a request, he saw the psychiatric technician, who recommended restarting the Depakote, which he had apparently discontinued. He saw the psychiatrist the next day and declined to begin again with the Depakote. However, he did agree to "anti-depressants," as witnessed by the psychiatrist. The record indicates that on January 19, 1997, he had refused his last six doses of Prozac. He was released on February 26, 1997.

5. In May, 1997, he was in the Sonoma County Jail, transferring to the Mendocino County Jail on June 9, 1997. Upon booking at that time, he denied any mental health involvement or any desire to see a mental health worker. On June 13, 1997, he submitted a sick call slip, noting, "I would like to speak with mental health. ASAP." That slip was picked up the following day. The psychiatric technician saw him five days later, on June 18, 1997. At that time, he said he wanted to get back on the medication, which he had stopped taking because "I didn't think I needed them." On June 20, 1997, he again asked, "I would like to see mental health." His request was picked up on June 22, 1997 and the psychiatric technician saw him four days later, on June 26, 1997. He was released on July 28, 1997.

6. As illustrated above, there were many points at which the decedent's history and behavior indicated his unstable mental condition. Jail personnel should have been aware of the decedent's need for help.

Recommendations

1. The Sheriff's Department must establish a booking system which includes a means for identifying inmates whose past incarceration record shows them as having mental health issues, so that upon rebooking into the Jail, the receiving officer can notify the Medical Contractor mental health staff, who can then make it a point to evaluate the state of mind of the inmate.

2. In view of the risks to individual inmates and to the County in terms of liability, the Board of Supervisors should require that the contract with the Medical Contractor include written policies requiring that inmates indicating mental health issues, either upon booking or by means of sick call slips, should see a psychiatric worker for evaluation within 24 hours, without fail. Jail administration should establish and adhere to procedures to facilitate such policies.

Events Leading up to the Suicide

Findings

1. Arrested for violation of probation, the decedent was booked into the Jail again on January 7, 1998. Upon booking, he denied any mental health problems and did not ask to see a

mental health worker.

2. On January 19, 1998, he became involved in an altercation with another prisoner. As a result, he committed to an "isolation" cell off of the dayroom of the general Jail population. The cell he was in is not entirely isolated, as he could interact with other inmates in the dayroom through a window which is covered with a heavy wire grating. Correctional officers visually check those cells on an hourly basis and log in their observations.

3. The decedent gave a sick call slip to the on-duty correctional officer at 1 a.m. on January 21, 1998, noting, "I would like to speak with mental health for personal reason." At the end of his round, the correctional officer placed the slip on the Board for the medical Contractor's personnel follow-up that morning.

4. The correctional officer, who had not been informed of the decedents mental health history, on duty the night and morning of January 22-23, 1998, when making his rounds at 4:03 a.m., had a conversation with the decedent in which the inmate spoke in ways which should have indicated a hallucinatory frame of mind. The officer assumed that the decedent was kidding. Had he known that the decedent had mental health problems, and with the proper training he could have detected that the decedent was in or close to a crisis frame of mind.

5. The decedent committed suicide by tying one end of a sheet to the wire grating over the window of the cell in which he was locked down, tying the other end around his neck and hanging himself.

6. A correctional officer discovered the decedent during regular rounds at about 5 a.m. He immediately notified his supervisor, who called for backup. Backup correctional officers arrived, untied, and lowered the decedent to the cell floor and began resuscitation. The supervisor called for the on-duty nurse, who arrived and continued resuscitation efforts unsuccessfully until emergency personnel arrived. They too were unsuccessful at resuscitation and the decedent was transported to a local hospital, where he was pronounced dead.

7. The Medical Contractor psychiatric technician went to work early on the morning of January 23, 1998, to see the decedent and was informed that he had committed suicide

Recommendations

1. The Sheriff's Department must establish a method of informing all correctional personnel for prisoners who have a record mental health problems.

2. The Sheriff's Department, in conjunction with the Mendocino County Mental Health Department, must provide training for correctional officers in identification and proper handling of inmates with mental health problems, especially those who might be suicidal.

Role of Medical Contractor Personnel

A private Medical Contractor provides all medical and mental health services at the Jail.

Findings

1. The Medical Contractor on-duty nurse came to the cell immediately upon being informed of the situation. The nurse took over resuscitation attempts from the correctional officers and continued those efforts until emergency personnel arrived.

2. The Medical Contractor psychiatric technician did not see the decedent for two days after receiving his sick call slip asking to see mental health even through it was on her schedule each day.

   Asked why, the psychiatric technician told the Grand Jury that the inmate count was higher than usual for those few days and, as Jail procedures do not allow for more than one activity - e.g., moving inmates to courthouse, sending inmates to sick call, etc. The psychiatric technician further testified that correctional officers were busy getting more prisoners than usual to their court dates, and was prevented from seeing the inmate, or any other inmate. The psychiatric technician left, intending to see him the next day. That was, according to the testimony, the situation on both January 21, 1998 and January 22, 1998.

   Jail records indicate that the head count during the shifts on January 21, 1998 and January 22, 1998, ranged from 255 to 265, figures which, according to testimony by Jail personnel , are not unusually high.

   Jail personnel also testified that, the activities taking place in the Jail on the mornings of January 21, 1998 and January 22, 1998 were not such as to preclude the medical personnel from seeing persons with health problems. The Grand Jury was told that those activities go on simultaneously just about every day.

Recommendations

1. Medical Contractor psychiatric staff must see persons who have indicated mental health problems within 24 hours and Jail procedures must allow for that to happen.

Comment

The Grand Jury believes that the failure of the Board of Supervisors to bring the Jail to full staffing contributed significantly to this incident. (See "Overview of Mendocino County Detention Facilities.")

Response Required

Mendocino County Sheriff
Mendocino County Board of Supervisors

Response Requested

Mendocino County Administrative Officer
Mendocino County Mental Health Department
Contractor

Transient Occupancy Tax

Mendocino County started collecting a tax in 1965 on all room rentals under 30 days within the unincorporated areas of the County. Responsibility for tax collection rests with the Tax Collector-Treasurer.

Reason for Review

The Grand Jury examined the collection of the Transient Occupancy Tax (TOT) as part of its oversight responsibility.

Methodology

The Grand Jury interviewed the Auditor-Controller (Auditor), Tax Collector-Treasurer (Tax Collector), County Counsel, District Attorney, members of their staffs, and members of the Board of Supervisors (BOS). The Grand Jury reviewed audits, case files, legal opinions, BOS proceedings, and other documents.

Findings

1. The TOT raises over $3 million annually, with over 75% coming from the Fifth Supervisorial District. This money goes into the unrestricted County General Fund; it is the main source of discretionary funds.
2. Collection of the TOT from established hotels and inns has not been a major problem. Audits and warning letters resulted in full payment of tax to the county.
3. The Tax Collector has a large and widespread problem identifying smaller and less visible facilities such as Bed and Breakfast facilities, vacation rentals, and retreat facilities. There is no regular, systematic program determining how many units exist and how many are paying the TOT. A perception exists that a large percentage of properties do not report and this leads to questions of fairness and uneven enforcement. The Grand Jury confirmed that many properties do not report. Lost revenues exceed several hundred thousand dollars.

Recommendation

The BOS in conjunction with the Auditor, Assessor, and Tax Collector should establish and maintain an accurate database of all TOT units in the County and develop a program that ensures compliance.

4. In one notorious incident, a single property rental agent ended up owing the County over $170,000 in TOT and over $100,000 in penalties. (He is currently subject to both criminal and civil prosecutions.) County Counsel first became aware of a problem as early as 1988, but the office was taken off the case several times as partial compliance was achieved. The amount rose from $40,149 in January 1994 to $90,000 in June 1995, to $146,000 in May 1996, to $270,000 in July 1997. The BOS decided in March 1998 not to take legal recourse against the individual property owners in this case after earlier threatening to do so. Part of the reason was that the County had knowledge of only 20 of the 35 properties involved until mid-1997. At least one property owner who had paid the TOT after the first BOS letter was refunded his money.

Recommendation

The Grand Jury, under the authority of Penal Code Section 932, orders the District Attorney to pursue vigorous collection in this case including filing a claim against the state Real Estate Recovery Fund (assuming the County obtains a court judgment).

5. The Grand Jury finds that the County did not and does not have an aggressive enough program to collect the TOT.

Recommendation

The Tax Collector should establish procedures which include an active plan for collecting the TOT in a timely manner.

6. Another property agent refuses to give the County specifics on how much tax results from each given property. There has been no enforcement action.

7. The BOS adopted a revised ordinance in December 1998, with new reporting requirements, new sanctions in case of delinquency, and new authority for the Tax Collector in case of default. There are problems with some of the language and so a new ordinance is being prepared (April 1999).

Recommendation

The Grand Jury urges County Counsel and the Tax Collector to test the implementation of the revised TOT ordinance by bringing action against currently non-complying property owners and agents known within the Tax Collector's office.

Response Required

Board of Supervisors
Auditor-Controller
Tax Collector-Treasurer

Comment

The Grand Jury identifies several factors leading to its findings and recommendations. The fact that these departments are headed by elected officials prevents the BOS from providing meaningful oversight. As elected officials, they may desire a low, "friendly" profile that makes them vulnerable to glib or stubborn violators. Since County Counsel can only act on cases brought to it, and there is no County process for identifying potential need for action, Department Heads are the main players determining whether or not timely action is taken; there is a wide disparity in the manner and effectiveness of County Counsel utilization. All departments bemoan their limited staffing, saying this is why they cannot follow through better; if someone else collected the data they would use it, but they are too busy to gather it themselves. Also, most TOT units are on the Coast, far away from Ukiah offices, making it harder for staff based in Ukiah to address the problem. Finally, the BOS recognized in September, 1997, the need for "maximum coordination" between departments: this is a case in point.

Mendocino County: Injured Employees

In Mendocino County, there are 100 open workers compensation claims for workers injured on the job who have lost at least three days of work. The workers compensation system was developed to assist injured workers with medical expense and to provide income while recovering. The County Department of Risk Management is responsible for employee safety and for assisting workers through the workers compensation system. Numerous studies give indication that, with proper training and a proper work environment, work-related musculoskeletal disorders, now a leading cause of lost workdays and workers compensation costs, can be prevented. Returning an injured employee to work quickly with either a modified job or light-duty under the auspices of a return-to-work program not only benefits that employee, but reduces workers compensation costs to the employer.

Reason for review

The Grand Jury conducted an investigation in response to citizen complaints.

Method of Investigation

The Grand Jury interviewed County employees, County department directors, union representatives, attorneys, and complainants. The Grand Jury reviewed pertinent documents and conducted a Department of Social Services (DSS) and Sheriff's Office employee survey.

Workers Compensation System

Findings

1. There are three places for injured workers to obtain assistance regarding the Workers Compensation System: their employer, a claims adjuster or a State counselor.

2. There are 52 State counselors to handle over 1 million new claims per year. There are two counselors for the North Coast who handle Sonoma, Napa, Mendocino, Lake and Marin county.

3. In Mendocino County, department heads are provided a notebook on the Workers Compensation System and can call Risk Management for advice, but are not provided any in-depth training.

4. The County employs a private company for managing workers compensation claims. This company believes the two most important elements for a county to provide improved performance of an employer's program are:

    a. educate their front-line supervisors to more effectively communicate with employees about what they may reasonably expect from the Workers Compensation system, and

    b. provide modified duty for injured workers.

Risk Management

Findings

1. The Department of Risk Management reports to the County Administrator and is staffed with a Risk Manager (3/5 time), Safety Officer (3/4 time), an office position, and an Analyst (both full-time).

2. The Risk Manager's primary responsibilities are fiscal in nature: administering the County's health insurance, workers compensation claims, general liability claims and mitigating risk to the County. He is also responsible for general safety on County property for employees and the general public.

3. The County Safety Officer works under the supervision of the Risk Manager and is responsible for safety throughout the County and training County employees in specific issues of safety. The Safety Officer is trained to make ergonomic assessments.

4. There is a conflict of interest between the Risk Manager's fiscal management for the County and the health and welfare of individual employees. The Risk Manager may provide information to mitigate costs of Workers Compensation Claims. His only mandated obligation to employees is to provide Workers Compensation Claim forms.

5. There are no County policies or procedures for department heads to follow regarding dealing with injured workers.

6. There are no County policies or procedures regarding accommodation, modified or light-duty, for injured workers.

7. There is nothing in writing from the County government that indicated that the County values its workers or that encourages department heads to value them.

Department of Social Services

Findings

1. DSS has 334 employees and currently 22 open claims for injured workers.

2. DSS has its own Training Officer who is to provide appropriate safety training to its employees. He is also trained to perform ergonomic assessments of work stations. He does not consider himself a Safety Officer.

3. The DSS Training Officer is unaware of the numbers or types of injuries in DSS, safety problem areas, or outcomes from the training he offers.

4. The ergonomic study done in 1998 was generated by a petition of over 100 DSS employees to the BOS complaining about their workplace conditions.

5. The County Safety Officer has been discouraged from providing training in DSS, being told that the "staff did not have time."

6. A Grand Jury survey of DSS employees demonstrated that many who were injured workers felt that they worked in an uncaring environment, were not supported by their supervisors when injured, and experienced harassment and job discrimination after reporting injuries.

7. Some employees of DSS also reported that supervisors failed to support them regarding on-the-job injuries and discriminated against them for promotions.

8. DSS Director will not institute accommodation, modified work, or light-duty policies until guidance is provided by the County. This has resulted in further injuries.

Case History of an Injured Worker

The following is an actual case history of a DSS employee, injured in the course of work, illustrating problems in the workers compensation process. In 1993, the DSS placed workers on furlough due to budget cut-backs. Remaining workers were then required to work overtime to cover increasingly heavy caseloads due to reduced staff. In March, 1994, DSS began conversion to a state-wide computer system which dramatically increased the amount of time some workers spent at a computer terminal. The normal work-week was four ten-hour days with, in many cases, about nine hours per day spent at a computer terminal.

12/17/93	First injury, Carpal Tunnel Syndrome, right wrist; chronic tendonitis right arm. Workers compensation claim filed; leave from work.
4/11/94	Returned to work. Physician limited time at computer and prescribes armrests for computer chair. No armrests provided.
3/95	Grievance filed; armrests provided.
3/95	On several occasions, the employee communicated the increasing problem of work-related injuries to the County Administrator's Office.
3/95-7/95	Right shoulder pain began. Refused an ergonomic assessment by DSS.
11/95	Physician ordered reduced caseload to alleviate right shoulder pain. No accommodation.
12/95	DSS employees complained to the DSS Director regarding the work environment: inadequate desks, chairs, ergonomic set-ups, and overtime.
1/96	Wrist supports provided at computer set-ups.

3/3/96	Physician ordered leave due to right shoulder injury
5/96	Surgery to right shoulder
9/96	Additional surgery to right shoulder
2/97	Returned to work; placed in re-training. No ergonomic set-up.
3/31/97	Injury to left shoulder.
7/97	Denied workers compensation benefits for left shoulder injury.
8/97	Given over 100% caseload despite injury.
9/97	County offered $25,000 to settle injury claim and retirement with no medical benefits.
10/97	Private physician requested ergonomic set-up for computer station, limiting computer time and lowering caseload. No accommodation.
11/7/97	Physician noted sign of Carpal Tunnel Syndrome in left wrist. Requested decreased caseload, ergonomic set-up and limiting computer time. No accommodation..
1/98	Employee filed grievance.
2/98	County paid for an ergonomic assessment of DSS from a private agency.
3/98	Hearing for the 1/98 grievance. DSS still would not provide modified or light-duty accommodation.
4/13/98	Left shoulder ruptured, neck pain. Took leave from work.
4/98	Employee prevailed in grievance hearing.
5/98	Employee prevailed in preceding workers compensation appeal.
9/98	Surgery on left shoulder and for Carpal Tunnel Syndrome.
3/99	Employee filed Equal Employment Opportunity Commission claim.
5/99	Employee granted County disability retirement by the Retirement Board.

Summary of this claim

The local employee union states: "A worker had an injury that interfered with her ability to perform her job at the level that management expected. The worker requested accommodation from the county, providing medical documentation of her need for accommodation. The worker made repeated requests

and supplied medical evidence each time, but the County requested more and more documentation and claimed that it did not have information adequate to make a determination as to whether to not to accommodate the worker. The County never denied the employees claim; however the county never took appropriate action to alleviate the problem. In addition, the County placed the employee on corrective action for job performance problems related to her injury."

Ergonomic Programs

Findings

1. A substantial body of scientific evidence supports two basic conclusions:
   a.. There is a positive relationship between musculoskeletal disorders and work-place risk factors and
   b. Ergonomic programs and specific ergonomic interventions can reduce these injuries.

2. In February, 1998, the County paid $13,000 for an ergonomic assessment of 20 DSS office jobs. This study identified a particular job in DSS (FARS III) as being at high risk for shoulder injury and at moderate risk for wrist and hand injury.

3. An injury cost analysis indicates that this job currently has the potential of incurring $370,850 in direct and indirect costs.

4. Carpal Tunnel Syndrome, one form of hand injury, leads on average to more days away from work that any other workplace injury.

5. Ergonomic assessments by the County's Safety Officer are not routinely provided to other County departments through Risk Management, but are available upon request.

6. Work-related musculoskeletal disorders are preventable by ergonomic programs.

Return-to-Work Programs

1. Studies show that by restoring an injured worker more quickly to active employment, return-to-work programs have reduced indemnity costs by 20 to 40 percent and reduced medical and rehabilitation costs even more.

2. Currently, the County has no return-to-work program.

3. Risk Management is currently surveying other counties for return-to-work pro-grams to see if they could be effective in Mendocino County.

Comments

DSS contributes a large number of claims made for workers compensation. Most of these injuries are preventable with appropriate ergonomics assessments and accommodation of injured workers. If the DSS Director is reluctant to institute modified or light-duty for injured workers, then it is the responsibility of the BOS, through Risk Management, to give clear direction to DSS and all department heads that injured workers are valued and will be provided work.

Recommendations

1. The Board of Supervisors should establish policies and procedures for dealing promptly with employee injuries. The County should begin in-depth training of front-line supervisors on the workers compensation system in order to provide effective communication to employees on what to reasonably expect from the system.

2. The Board of Supervisors should establish policies and procedures for return-ing employees to work as soon as possible. The County should institute both modified work and return-to-work programs, no matter how limited by our small employee population.

3. The Risk Manager and County Safety Officer should be responsible for all County-wide ergonomic assessments, training, and follow-up. Staff should be increased to effect this.

Response Required

Mendocino County Board of Supervisors

Response Requested

Mendocino County Department of Social Services Director
Mendocino County Administrative Officer

1997-98 Grand Jury Final Report Response Review

The 1998-99 Grand Jury reviewed the responses to the 1997-98 Grand Jury report and determined the status of recommendations in those reports. Requirements for responses are mandated in Penal Code Sections 933 and 933.05. Copies of those codes are included elsewhere in this final report.

Responses are directed to the Presiding Judge of the Mendocino County Coordinated Courts and are available at the Mendocino County Clerk-Recorder's office where they are permanently filed.

Findings

Mendocino County Board of Supervisors

The Board of Supervisors responded adequately to most reports for which they had responsibility. (No response was ever submitted to the report "Investigation of a Suicide at the Mendocino County Adult Detention Facility," on the advice of County Counsel, since litigation may be pending. No response has been received from County Counsel to a Grand Jury inquiry concern-ing the time limit for response once litigation has concluded.)

Department directors submitted responses to the County Administrator's Office, which in several instances, rewrote the responses to reflect the Administrator's Office point of view. (The Grand Jury requested and received original responses from department directors.) The Board of Supervisors thus never knew the departmental responses to the reports.

Recommendation

Department directors' responses should go directly to the Board of Supervisors. If necessary, the Administrator's Office may coordinate the effort, but should indicate clearly comments by that office apart from the departmental responses.

The Grand Jury commends the Board of Supervisors for directing the County Administrator's Office to prepare a list of the Grand Jury recommendations and the Board's responses in order to track the implementation of recommendations. The Administrator's Office staff prepared a spreadsheet and requested that departments provide information regarding implementation. The update was presented to the Board of Supervisors in March, 1999. There are many areas where implementation dates were estimated, but at this time there is no indication that these promises of implementation have been fulfilled. Included in this report is a copy of that spreadsheet. (The Department of Social Services responded in text format rather than using the spreadsheet and stated that they were in the process of implementing all of the recommendations.)

Recommendation

The Board of Supervisors should adopt a procedure for tracking Grand Jury recommenda-tions and their implementation.

The Grand Jury commends County departments for implementing many of the recommendations noted in the reports.

The Grand Jury objects to the Board of Supervisors' response to "Medical Services at the Mendocino County Adult Detention Facility" Recommendation 5, "The Board of Supervisors should require the annual 'reviewed financial reports' as required by contract." The Board of Supervisors has failed to act, stating that they would delete this language from the contract, rather than enforce the contract. The information in the report is necessary to ensure that public money is being properly used and accounted for.

Response Required
Mendocino County Board of Supervisors

Mendocino County Sheriff
The former Mendocino County Sheriff responded to the recommendations, but not the findings, in the reports regarding the Adult Detention Facilities, and also did not respond to "Investigation of a Suicide."

The Grand Jury finds that the Sheriff's response to recommendation regarding medical care and staffing at the Jail was misleading. The Grand Jury reviewed a June 30, 1997 letter to the Sheriff which stated, "your facility met 100% of the applicable "Essential" standards with the exception of 306-Clinic Services....This standard requires on site clinic services to be performed by either a physician or mid-level practitioner five days per week." The letter also states, "This award begins June 1997 and extends for a period of two years, providing there is evidence that the clinician coverage has been increased to five days per week." Regarding staffing, the State did recapture funds that had been allotted to the County based on increasing the Jail staffing.

Response Required
Mendocino County Sheriff

Mendocino County District Attorney
The former Mendocino County District Attorney responded in January, 1999, following conclusion of litigation.

School District Board of Trustees
All school district boards of trustees responded to reports, with the exception of the Willits Unified School District Board of Trustees, which did not respond to the report, "Temporary Athletic Team Coaches." A follow-up report is included in this year's report and Willits did provide adequate information regarding their certifications.

Mendocino County Office of Education
The Mendocino County Office of Education (MCOE) Board of Trustees and the County Superintendent of Schools issued a joint response through the Superintendent. The October 2, 1998, document included responses to recommendations, but failed to respond to individual findings or to indicate a timeline for implementation of recommendations. The response states that there were many inaccuracies, but does not identify those inaccuracies. The response also stated that the Grand Jury

omitted reporting that the Court Community School Programs "work," yet the response gives no documentation of those program's success other than the administration's statement of success. The 1997-98 Grand Jury did ask for specific information regarding tracking of students and program outcomes and none was available.

Recommendation

The 1999-2000 Grand Jury should continue the inquiry into the Court Community School system to see if recommendations have been implemented, especially those concerning the use of Lottery Funds and examining the role of a MCOE teacher at a private, non-public school.

Fort Bragg Unified School District

The Fort Bragg Unified School District (FBUSD) did not respond to findings or recommendations, but instead wrote a response critical of the Grand Jury. The Grand Jury, as well as the FBUSD Board, represents the interests of the public. The 1997-98 Report acknowledged that FBUSD had corrected many of its previous problems, yet it was necessary to report previous behavior to ensure that it does not occur again.

Regarding Recommendation 1 which stated "Money paid in lieu of insurance premiums legally belongs to the FBSD and should be paid back in full," FBSD indicated that they do not agree with this recommendation.

Recommendation

The Mendocino County District Attorney should review the evidence to determine if violations of the Education Code have occurred and to consider bringing charges accordingly.

Response Required

Mendocino County District Attorney