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2007-2008 Sonoma County Grand Jury Final Report

Under California law, the civil grand jury is an independent institution that oversees all aspects of the legislative and administrative departments that make up county, city and special district governments. The civil grand jury has the power to investigate them to ensure that they are efficient, honest, fair and dedicated to serving the public and individual citizens. The civil grand jury is an arm of the court and has subpoena powers.

Investigations are begun on the basis of citizen complaints or by the jury acting on its own initiative. The Sonoma County grand jury has a membership of 19 citizens who have been screened, interviewed individually by Superior Court Judges, and then selected at random from the 30 best-qualified applicants. A minimum of 12 of the 19 grand jurors must authorize the undertaking of an investigation. The grand jury has four standing committees that carry out authorized investigations: Law and Justice, Human Services, County, and Cities and Special Districts. Ad hoc committees may be formed for special investigations.

By law, grand jurors may not disclose the evidence obtained in their investigations or reveal the names of complainants or witnesses. Similarly, witnesses are prohibited from disclosing any proceedings of the grand jury.

The results of major investigations are contained in reports that set forth findings concerning the problems investigated and make recommendations for solutions. These documents are published either as Interim Reports during the year or in a Final Report at the expiration of the grand jury's term of office. Sonoma County civil grand jury reports are distributed to the public through the Press Democrat and copies are sent to all branches of the Sonoma County Library.

Any individual who feels unfairly treated by the county, city or special district, or who believes that any agency, officer or employee thereof, is acting improperly may file a written complaint with the Sonoma County civil grand jury. All complaints are in strict confidence.

A complaint form is at the back of this report or one may be obtained by calling the grand jury at (707) 565-6330. Completed forms should be mailed to:

Sonoma County Civil Grand Jury
P. O. Box 5109
Santa Rosa, CA 95402



THE SONOMA COUNTY CIVIL GRAND JURY

P.O. Box 5109 · Santa Rosa · California · 95402 · (707) 565-6330
http://www.sonomasuperiorcourt.com/pages/gjury_info.php

July 9, 2008

To the citizens of Sonoma County and the Honorable Judge Boyd:

In accordance with California Penal Code, Section 933, I present the final report of the 2007-2008 Sonoma County Grand Jury. The reports are the culmination of wide-ranging investigations into city and county government agencies and other public entities operating in Sonoma County.

California's civil grand juries were begun to examine the state of county jails. This jury spent a great deal of time and effort looking into recent incidents at the Sonoma County Sheriff Department's Main Adult Detention Facility involving prisoners in need of health care. In particular, prisoners withdrawing from alcohol or other drug addiction need to be monitored more closely, as indicated in our report, "Death by Incarceration."

The state of the Sonoma County health-care system is the subject of two of our reports, "The Outlook for Palm Drive Hospital" and "Assignment of Health Care Access Agreement." Despite Sutter Medical Center reversing its earlier decision to transfer its contract with the County to Santa Rosa Memorial Hospital, the results of the jury's in-depth investigation of the relationship between these two hospitals and all other health-care providers in Sonoma County point out many areas of concern.

The recent earthquakes in China are the latest reminder that we must always be prepared for disasters that strike close to home. In "Disaster Will Strike! Are Schools Ready?" the jury found some schools well trained and provisioned to care for their students and staff in the event of a disaster during school hours. Unfortunately, we also discovered many schools ill-prepared for earthquakes and other emergencies.

Other subjects of jury reports are the Sonoma County Office of Education, the County Administrator's Office, the Santa Rosa Central Library, and the relationship between local law enforcement and the Federal Immigration and Customs Enforcement operations in Sonoma County.

I would like to commend my fellow jurors, all of whom demonstrated through their time, effort, and concern a sincere commitment to public service. It was a privilege

I would like to commend my fellow jurors, all of whom demonstrated through their time, effort, and concern a sincere commitment to public service. It was a privilege to serve with them on the 2007-2008 Sonoma County Grand Jury, and I thank them on behalf of the people of the County.

Lastly, I would like to thank the residents of Sonoma County for their dedication to their communities. Nearly all jury investigations begin when a concerned citizen submits a complaint. Unfortunately, not all complaints can be investigated, but all complaints are given due consideration. I encourage my neighbors to participate in public affairs and have their voice heard.

Sincerely,

A handwritten signature in cursive script that reads "Dennis O'Reilly". The signature is written in dark ink and is positioned to the right of the typed name.

Dennis O'Reilly
Foreperson

Superior Court
State of California

ROBERT S. BOYD
JUDGE

COUNTY OF SONOMA
600 ADMINISTRATION DRIVE
SANTA ROSA, CALIFORNIA 95403



June 18, 2008

Dear Members of the Sonoma County Grand Jury:

I have reviewed your Final Report for the fiscal year 2007-2008 and find that the report complies with Penal Code section 933. I commend you for your thorough investigation of the subject matter of your report and the soundness of your findings and recommendations. Throughout the past 12 months, I have been continually impressed with your hard work and dedication to duty.

I am impressed with the broad scope of the topics the Grand Jury decided to investigate. The research focusing on issues involving our schools will be helpful in advancing school safety and the quality of the education provided to our next generation of citizen decision makers. The report on immigration will be particularly helpful and provide better understanding of the interplay of federal and local law enforcement. Efforts will be made to have this report transcribed into other languages to disseminate this valuable information to our Sonoma County immigration community.

Thank you for your willingness to have contributed to the betterment of our County by your service as members of this Grand Jury. The important role of local government to provide services to local citizens is premised on a foundation of responsibility and accountability. Your role of impartial oversight is vital to ensure that the delivery of such services continues to improve. Our entire Court thanks you for your efforts and dedication to your work as members of the 2007-2008 Grand Jury.

I appreciate very much this opportunity to have been associated with your efforts as the 2007-2008 Grand Jury. I wish to particularly express my appreciation for the dedication and efforts of Dennis O'Reilly, your foreperson.

Congratulations on a job well done. Sonoma County is, and will be, a better place because of all the work you have done.

Very truly yours,

A handwritten signature in blue ink, appearing to be "R. Boyd", written over a circular stamp or seal.

Robert S. Boyd, Judge
Sonoma County Superior Court

Sonoma County Grand Jury

Why be a Grand Juror?

It is a privilege to be selected to serve on the Sonoma County civil grand jury. Each June, nineteen concerned citizens of Sonoma County are sworn in to serve a one-year term. They enter their service with interest and curiosity for learning more about the administration and operation of the government of Sonoma County. They give generously of their time for the betterment of our government.

Would You Be Interested in Serving?

Each year, applications for the new grand jury are solicited from the public for the fiscal year beginning in July. In the spring beginning around the first week in April, applicants are screened and interviewed by Superior Court Judges and 30 prospective grand jurors are selected from the applicant pool. The prospective grand jurors are summoned to appear before the Presiding Judge of the Superior court in public session. At that time, the clerk of the court draws individual names at random. They are added to the holdover members (usually up to 4) until a total of 19 is reached. The remaining names drawn are placed in "stand-by" status should any seated jurors need to leave.

Statutory requirements for service as a grand juror:

- must be a U.S. citizen at least eighteen years of age
- must be a resident of Sonoma County for at least one year
- must have a command of the English language
- must not be serving as an elected official
- must not be serving as a trial juror
- nor have felony or malfeasance convictions

In addition to the statutory requirements, a grand juror should have a genuine interest in community affairs, be able to fulfill the major time commitment required to be effective. They must also be able to work with others, be tolerant of opposing views, and be free of personal agendas. It is extremely helpful to have some familiarity with investigative techniques, report writing, and such computer skills as e-mail and Microsoft Office.

How to Apply

Complete and mail the following application form. After mailing your application, you will receive a questionnaire. Questionnaires must be returned usually by early April. If you pass that screening you will then be asked to meet with a judge normally in May for an interview, then a background check and finally, in late June or early July names are drawn to select the new jury.

Yes, I am interested in serving on the Sonoma County Grand Jury

Please send me a questionnaire next March so that I can apply for the Grand Jury or nominate someone else.

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
TELEPHONE: Home _____ Office _____

Mail or fax this form to:

THE SONOMA COUNTY GRAND JURY
P. O. Box 5109, Santa Rosa CA 95402
Tel: 707-565-6330 Fax: 707-565-6328

DEATH BY INCARCERATION

Summary

Many people question the need to provide a level of medical care to inmates that surpasses what is affordable to the general public. People in custody, whether awaiting trial or serving out a sentence, are denied the right to manage their medical care. That is why the constitution, federal, and state law require that medical services be provided for inmates. The quality and high cost of medical care provided in the Sonoma County jail has been the subject of several Grand Jury reports in recent years. The comprehensive and expensive nature of healthcare provided to inmates has been well documented. However, the medical services fail in one important area. That is keeping alcohol dependent inmates alive. The cause of this failure is easy to identify and relatively low cost procedural changes can safeguard the lives of high- risk inmates.

Reason for Investigation

California Law empowers, and in fact mandates, a Civil Grand Jury to independently investigate detention facilities. On September 30, 2007, The Press Democrat published an article "When Inmates Die", which documented the deaths of three inmates in the previous four months. In fact, four (4) people died while in the custody of the Main Adult Detention Facility (MADF) between October 2006 and September 2007. Preliminary indications were that drug and alcohol withdrawal played key roles in three (3) of these deaths.

The Grand Jury discovered that Alcohol Toxicity and Alcohol Withdrawal Syndrome (AWS) are among the leading contributors to deaths in U.S. jails including those in Sonoma County. By reclassification and better treatment of inmates at risk from AWS, death due to the effects of AWS is easily preventable. Our focus was narrowed down to the issues concerning the adequacy of the current procedures used in classification and treatment of inmates at risk from AWS.

Background

The MADF is responsible for the housing of all persons arrested by any law enforcement agency in the county. There are detailed protocols and procedures in place which cover all aspects of the processing classification (booking) of prisoners into the facility. MADF is responsible for the medical care of incarcerated individuals. The California Forensic Medical Group (CFMG) is contracted by the Sheriff's Department to manage the medical classification and care of inmates. The County pays CFMG approximately \$5.3M annually to provide medical services. These services include the identification and treatment of individuals who arrive under the influence of alcohol to various degrees.

The **Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA-Ar)** is the widely accepted medical protocol used to determine the risk of AWS in a clinical environment. Most detention facilities use a condensed version of this procedure. While the efficacy of the CIWA-Ar is well documented; the same is not true for abbreviated versions including the one used at the Sonoma County jail. Typically an RN performs the assessment in the booking area. The assessments, based on this condensed version, can lead to a subjective determination by the registered nurse. In this environment, there are considerations other than the best medical interests of the patient/inmate.

It is acknowledged that the current CFMG protocol for the assessment and treatment of intoxicated individuals meets the minimum standards set by the California Code of Regulations. These standards are detailed in Title 15, Sections 1213 and 1056 and also in the Institute of Medical Quality (IMQ) Standard #303E. It is also noted that Title 15 does not detail the specifics of detoxification treatment but only states that there should be one developed by the Medical Doctor charged with insuring the facility meets all standards of practice.

In the jail environment, once an inmate is moved into the general population, there is significant risk of catastrophic Alcohol Withdrawal Syndrome (AWS). The continuous monitoring of inmates while in booking at MADF is adequate protection and, in fact, similar to the procedures employed in a hospital environment. This risk arises from the inherent reduction of inmate observation in general population. The potential for the onset of AWS to be unobserved exists for a class of severe chronic alcoholics. The unmitigated, severe risk under current procedure exists for a person arriving at the jail with the following characteristics:

- A history of chronic alcohol abuse
- Recent ingestion of large quantities of alcohol
- A history of previous alcohol withdrawal events, especially previous instances of seizures or *delirium tremens*.

Background (continued)

Current policy allows this inmate to be placed into general population without medical observation or treatment for intervals exceeding 10 hours. Several inmates have not survived the application of current policy.

The MADF requires that inmates are observed in their cells at 30 minute intervals, 24 hours a day, and 7 days a week. This "Rounds" procedure is performed by correctional officers (CO).

The medical staff designates prisoners with potential withdrawal issues with a special **W classification**. This classification is posted on the inmate's cell door. This is done primarily to allow correctional officers to interpret inmate behavior in a medical context. However, CO's are not trained to identify specific alcohol and/or drug withdrawal symptoms. The frequency of these observations presents an opportunity for CO's to assist the medical staff in identifying the beginning signs of distress with these high risk inmates.

Investigative Procedures

- Toured the Sonoma County detention facility with a focus on booking and classification procedure, sobering cells, and general population protocols used by correctional officers.
- Obtained copies of the most recent certifications of medical operations in the Sonoma County jail. Including the April 6, 2006 accreditation report and the August 10, 2006 IMQ report.
- Verified Sonoma County's compliance with California TITLE 15 requirements.
- Researched published documents pertaining to the assessment and treatment of Alcohol detoxification.
- Obtained medical procedure document from the Sonoma County detention facility and from their medical contractor (CFMG).
- The entire scope of medical procedures at MADF was thoroughly examined.
- Interviewed two Sonoma County correctional officers regarding their understanding of the W classification as it applies to Rounds procedures.
- Interviewed three independent medical experts specializing in alcohol detoxification including one detention facility supervisor from a neighboring county.
- Obtained medical procedure documents from detention facilities in the Bay Area, Los Angeles, and Sacramento.
- Reviewed alcohol withdrawal assessment and treatment procedures employed by Kaiser Hospital and San Francisco General Hospital.

Findings

- F1** The CFMG assessment protocol lacks the formality and specificity to detect inmates with high risk for AWS. For example; the absence of a point system, the omission of specific awareness questions and general brevity of the assessment makes one consider the degree to which the outcome depends on the skill, working conditions and attitude of the medical staff. The lack of formality leaves too much to the subjective interpretation of the RN. A more comprehensive assessment would also enhance the County's and the Contractor's position with regard to contingent liability.
- F2** Lack of withdrawal symptoms prior to assignment to general population housing is not a valid criterion for those inmates who may still have significant blood alcohol concentrations at the time of assessment. Blood Alcohol Concentration (BAC) or a breathalyzer test would reveal the need to closely monitor the inmate and reassess the AWS dangers when the BAC is low enough for the evaluation to be medically valid.
- F3** To protect high risk inmates (as defined here), the withdrawal and detoxification protocol in use should be mandatory, as opposed to, being at the discretion of the RN. Initially, the protocol must include frequent monitoring of the inmate
- F4** A twice-a-day monitoring schedule is inadequate to monitor W class inmates for withdrawal symptoms. Medical checks, at four-hour intervals, are generally accepted as adequate in a hospital environment and in other detention environments.
- F5** If a more frequent monitoring protocol were to be initiated in the first 48 hours of incarceration, it may be possible to deliver medication to prevent the onset of AWS which would diminish the probability of potentially fatal withdrawal incidents.
- F6** The primary responsibility for the medical welfare of inmates resides with the medical staff. However, correctional officers observe inmates every half hour. With the implementation of special observation criteria, they could significantly diminish the risk to the most serious AWS candidates. (Opening the cell door and requiring a verbal response from high risk inmates may be sufficient).
- F7** Two medical experts indicated that the high-risk inmates we identified would have benefited from blood alcohol testing prior to being placed in general population.

Conclusions

It is difficult to determine AWS risk. Fatal incidents can occur any time from a few hours to several days after the cessation of alcohol use. It is generally accepted that the greatest risk of life threatening events, such as seizures and delirium tremens, occurs in the first 48 hours. The CIWA-Ar protocol has a well documented track record for the assessment and treatment of AWS. Shortcuts to the CIWA-Ar save little time and can lead to catastrophically inaccurate assessments. The formal protocol takes only five (5) minutes to administer, and the result is less prone to subjective medical errors in the jail environment.

There is a class of very high-risk people who can be easily identified. They are chronic alcoholics with a recent, very large intake of alcohol. They have a history of previous detoxification incidents, such as delirium tremens, and/or they have previously been given medication to mitigate their withdrawal.

All of the research reviewed by the Grand Jury indicates that four-hour observation intervals, along with the recording of vital signs, are the minimum requirements for a safe alcohol detoxification. Numerous published Documents and the opinions of three independent medical experts support this. Two observations a day are not good enough. During our investigation at least one inmate died on that reduced observation schedule. **Every Medical expert we interviewed expressed the opinion that deaths from AWS are completely preventable.**

There are relatively inexpensive procedures that can be employed to protect these inmates. Our recommendations outline what is required. If high risk inmates were temporarily housed in the Medical module (I module) there would be little impact on the added labor required to do this closer monitoring. The County should take responsibility to treat these sick inmates in an environment that is appropriate for their condition.

Conclusions (continued)

Inmate health is at-risk because they are being treated for **AWS** in a jail environment. As noted in F7, the high risk inmates that we identified, would have benefited from blood alcohol testing (BAC) prior to their assignment to general population cells. The experts we cite each stated two reasons for this. One reason was that alcohol poisoning potential (a separate life threatening problem) can be detected in a chronic alcoholic who may not exhibit symptoms that would cause a casual drunk to lose consciousness. The second reason was to validate the risk- assessment protocol. People with a high BAC will not exhibit the symptoms used to indicate AWS risk. Several hours later however, symptoms that would put them in a hospital may be undetected while they are in their cell. The Grand Jury checked these opinions with a third medical expert who supervises detention medicine in another county. He concurred, but pointed out that BAC testing was not a common practice in detention facilities, including the one he works in.

Commendations

The Grand Jury must commend the medical experts we interviewed. They provided extensive resource material, personal experiences, medical documentation and countless hours of their time to assist us in formulating our hypothesis and validating our conclusions. Their input was invaluable.

Recommendations

- R1** The Sheriff's Department should require that the CFMG alcohol withdrawal risk assessment procedure should be modified to more closely follow the CIWA-Ar including all the parameters and the rating scale in the formal procedure.
- R2** The Sheriff's Department should require that the CFMG assessment protocol should identify chronic alcoholics, who arrive intoxicated and have a medical history of AWS, as a special class of inmates needing closer monitoring. Reassessment of AWS risk is required when BAC concentrations drop below .1%.
- R3** The Sheriff's Department should require that CFMG should monitor **W class** inmates at least once every four hours.
- R4** The Sheriff's Department should require that CFMG should consider the administration of widely-held medication practices to AWS inmates as a seizure precaution.
- R5** Specific Rounds procedures should be defined and followed by COs for **W class** inmates until CFMG reviews AWS risk and determines that special attention is no longer necessary. The new W class procedure should require a verbal response from the inmate. Also, COs must open the cell door and/or turn on the light to elicit a response.

Required Responses to Findings

Sonoma County Sheriff
– F1, F2, F3, F4, F5, F6, F7

Requested Responses to Findings

California Forensic Medical Group, Inc.
– F1, F2, F3, F4, F5, F6, F7

Required Responses to Recommendations

Sonoma County Sheriff
– R1, R2, R3, R4, R5

Requested Responses to Recommendations

California Forensic Medical Group, Inc.
– R1, R2, R3, R4, R5

Review of Moses McDowall Fatal Incident

On November 6, 2006, Moses McDowall died while in custody at the Sonoma County Main Adult Detention Facility (MADF). As required by state law, a fatal-incident investigation was initiated by the Sheriff's Department. The Grand Jury's review of the Sheriff's investigation revealed evidence that strongly suggests that Mr. McDowall (a profoundly chronic alcoholic) died within the first few hours after being transferred from the booking area to a general-population cell at approximately 3:15 a.m. on November 6, 2006. Sheriff's Department policy requires that each prisoner's cell be checked by a Correctional Officer (CO) every 30 minutes. Thus Mr. McDowall should have been checked five times from his arrival in general population to the delivery of his breakfast at 6:00 a.m. Any one of these checks may have prevented his demise. Did these checks take place? If so, which CO performed them? Documents and sworn testimony regarding these questions contain discrepancies and contradictions, leaving many important questions unresolved. The Sheriff's Department investigation and the District Attorney's review of that investigation ignore these unresolved aspects of the incident.

The Grand Jury has determined that the initial Sheriff's Department investigation of this fatal incident, and the subsequent review of the investigation by the District Attorney were inadequate. The Grand Jury further concludes that the Sonoma County Law Enforcement Chiefs' Fatal Incident Protocol fails to ensure an independent and impartial investigation of jail deaths.

Reason for Investigation

The Grand Jury is required by state law to review all officer-involved fatal incidents that occur in Sonoma County. This requirement includes the obligation to review inmate jail deaths. In the past, the Grand Jury has discharged this responsibility with a cursory review of the incident summary report provided by the District Attorney. In the period between November 2006 and October 2007 four people have died while in custody at the MADF. Mr. McDowall died within hours of being placed in his cell. These circumstances prompted the Grand Jury to examine the McDowall incident closely, and to look into the procedures used to investigate fatalities occurring at the jail.

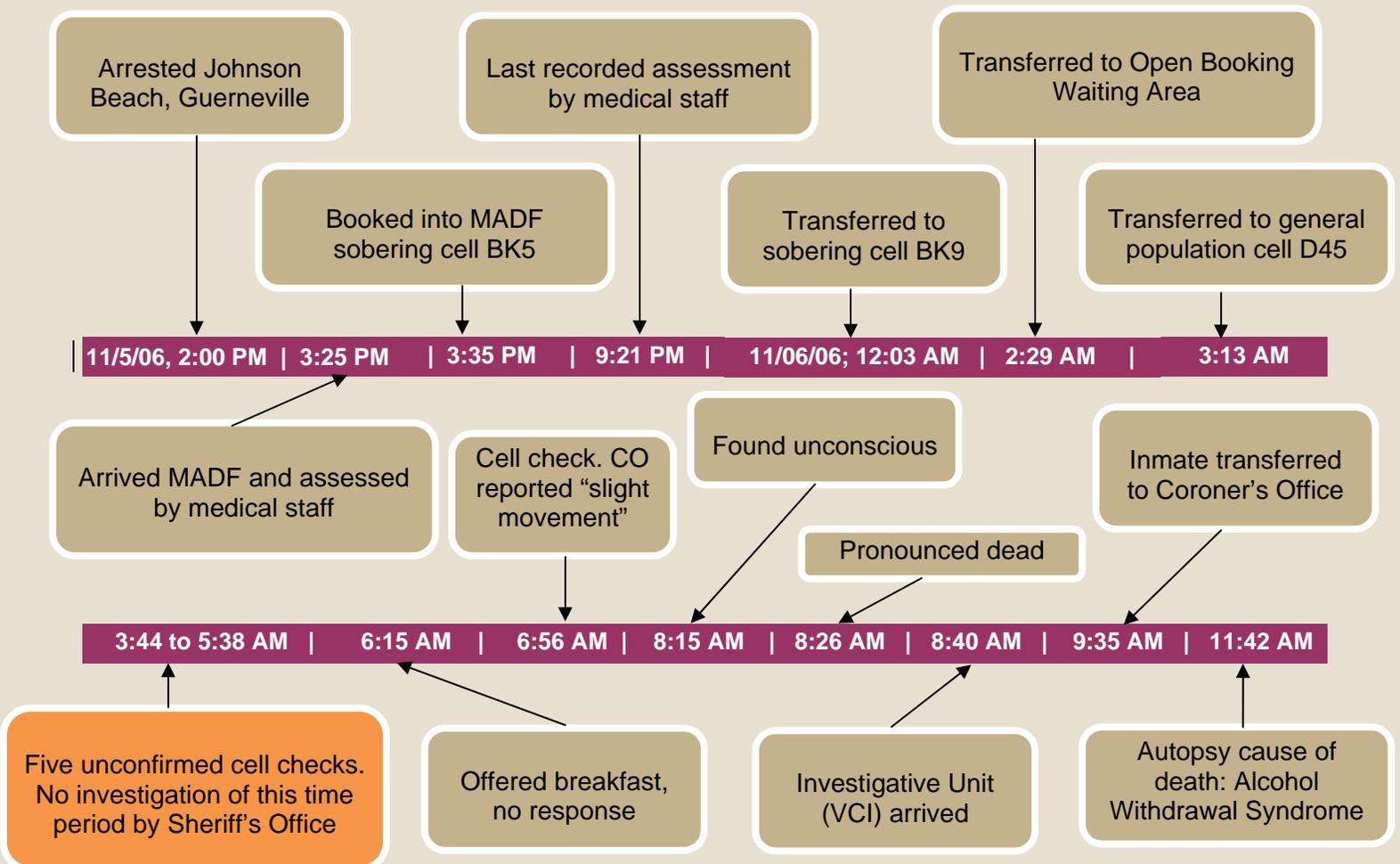
Background

Mr. McDowall was arrested when Sheriff's Department patrol deputies determined that he had two outstanding warrants from San Francisco. He was inebriated when he arrived at the MADF at 3:15 p.m. on November 5, 2006. He spent the next 12 hours in the booking area of the jail, being processed and classified. This exhaustive classification procedure revealed the following information about Mr. McDowall:

- He had consumed 1.75 liters of whisky that day.
- He was a chronic alcoholic;
- He had a history of *delirium tremens*, a potentially fatal aspect of Alcohol Withdrawal Syndrome.

The MADF relies on an independent contractor to manage the medical welfare of detainees. Inmates such as Mr. McDowall who may have medical complications related to alcohol or drug withdrawal are designated with a W classification. This classification is attached to the inmates' computerized records and can be removed only by the medical staff. It is also placed on the inmate's cell door. This is only to ensure that COs are aware of the inmates' medical condition, and that they are able to interpret the inmates' behavior in that context. Several COs interviewed by the Grand Jury confirmed that special attention is paid to inmates with a W classification. (The details of the medical procedures in the jail are the subject of a separate report by this Grand Jury.) Mr. McDowall was moved out of the booking area and placed into a general-population cell at 3:15 a.m. on November 6, 2006. He was found dead in that cell five hours later.

The uniform protocol for the investigation of an officer-involved fatal incident is defined by the Sonoma County Law Enforcement Chiefs' Association. This protocol describes the procedures and the roles of the participants, including the District Attorney. Subsequent to a 1997 Sonoma County Grand Jury recommendation, the protocol was revised to require that the investigation be led by a law-enforcement agency other than the one that is the employer of the involved officers. The purpose of this provision is to ensure the impartiality of the investigation, and to protect the investigated agency from the appearance of impropriety. **Incidents in the MADF are exempt from this requirement. As noted in section 1 subsection H 7 of the current protocol, the Violent Crimes Unit (VCU) of the Sheriff's Department Administration Division will lead the investigation of the Sheriff's Department Detention Division.**



Background (continued)

The Sheriff's Department Internal Affairs Division (IA) is required to conduct a separate investigation of every jail death. The purpose of the IA investigation is to determine:

- If the department's policies and procedures were followed;
- If there could be improvement in those policies and procedures;
- If any disciplinary action should be imposed against a particular individual or individuals.

The IA task is separate from the criminal investigation and does not require that there be criminal culpability to recommend disciplinary action. The content of the criminal investigation is available to IA, but by law the IA investigation may not be used in a criminal investigation of the incident. The IA investigation of Mr. McDowall's death appears to be adequate.

However, without any specific complaint in the McDowall case, IA relied completely on the flawed VCU investigation and did no independent interviews or fact-finding.

The District Attorney is required to participate in and review the investigation, and to submit its review to the Grand Jury. The District Attorney's review is intended solely to determine whether a criminal act, an unlawful act, or an act of omission has occurred. However, the protocol also requires the DA's office to participate in the investigation with the VCU. The protocol allows the DA to conduct an investigation independent from the lead agency. In Mr. McDowall's case, two DA investigators assisted the VCU, and no independent DA investigation was conducted.

The District Attorney is required to participate in and review the investigation, and to submit its review to the Grand Jury. The District Attorney's review is intended solely to determine whether a criminal act, an unlawful act, or an act of omission has occurred. However, the protocol also requires the DA's office to participate in the investigation with the VCU. The protocol allows the DA to conduct an investigation independent from the lead agency. In Mr. McDowall's case, two DA investigators assisted the VCU, and no independent DA investigation was conducted.

Every cell at the main detention facility is required to be visually checked by a CO approximately once every 30 minutes. The checks are automatically recorded by the Rounds Automatic Tracking System (RATS). The Grand Jury attempted to verify that Mr. McDowall's cell was checked five times on the morning he died, as was indicated by printed RATS logs included in the investigative reports. We were informed that this log could not be verified because of a subsequent computer failure. The VCU investigation revealed that no specific CO could be identified as having performed the required cell checks in the early morning hours of November 6, 2006. The Grand Jury determined that several critical issues relating to these visual checks were bypassed by the VCU investigation. These include:

- The CO in charge of the module in which Mr. McDowall was housed stated that he left the module prior to Mr. McDowall's arrival there and did not return that night;
- Another CO, presumed by IA to have performed the cell checks, stated to the VCU investigators that he did not get to the module until 6:00 a.m. that morning.
- RATS computer files were unable to verify the checks by COs of Mr. McDowall's cell.

Investigative Procedures

The Grand Jury interviewed the Assistant Sheriff in charge of the county detention facilities and toured the MADF. We examined closely the complex and exhaustive procedures used to classify inmates during booking. We observed the methods and procedures of COs working in the general-population modules of the MADF.

We obtained all Sheriff's Department documents relating to Mr. McDowall's time in the MADF. These included medical-classification documents generated during the 12 hours Mr. McDowall spent in the booking area. We verified that Mr. McDowall had been assigned a W classification due to his potential for alcohol withdrawal while in custody. Two Medical Experts were interviewed to determine the severity of the risks associated with alcohol withdrawal.

We interviewed the VCU lead investigator and obtained a copy of the department's own investigation, including recordings of interviews conducted by the investigators. The VCU investigation concluded that Mr. McDowall died after breakfast was served in Module D. Breakfast service ended at 6:30 a.m. It claimed that an inmate in Module D heard Mr. McDowall breathing loudly at about 6:15 a.m., but the Grand Jury found evidence in the recorded interviews which contradicted this claim. The remaining basis for the VCU conclusion as to time of death was that a CO observed "slight movement" (while sleeping) at 6:56 a.m. We interviewed the CO involved and investigated the circumstances of his observation. The Grand Jury determined that this CO's account of slight movement from outside a closed cell door was dubious at best.

The Grand Jury examined all of the accounts of Mr. McDowall's body when it was discovered in his cell at 8:18 a.m. on November 6, 2006. These included documented opinions by several "first responders" that he had died hours earlier. We explored the transcripts describing his degree of *rigor mortis* and lividity. Our research into the forensic significance of the observations made by the "first responders" indicates that Mr. McDowall died at least several hours before his body was discovered. We obtained expert verification of our research. An independent forensic pathologist and several other Doctors were consulted. They reviewed the autopsy, photographic evidence and documented observations. The expert's interpretation of the evidence confirmed our analysis and revealed additional indications of an earlier time of death.

After careful examination of the VCU documentation and recorded testimony, we focused our investigation on the discrepancies noted in the timeline between Mr. McDowall's arrival in Module D at 3:15 a.m. on November 6, 2006, and the time his body was discovered. The Grand Jury's own interviews of several COs discovered more inconsistencies and contradictions in the accounts of Mr. McDowall's time in Module D of the MADF.

Documents produced by the VCU investigation indicate that a CO performed the required cell checks in Module D on the morning of Mr. McDowall's death. The Grand Jury requested RATS logs for several modules in an attempt to cross-check the validity of the information included in the VCU report. The Sheriff's Department was unable to produce the requested information because the logs could not be regenerated from the RATS database due to a computer failure which occurred 17 days after the incident. An MADF computer specialist was interviewed to determine the nature of the "glitch", the overall integrity of the system, and other details of RATS.

The separate Internal Affairs report was reviewed and determined to be entirely based on the information provided by the VCU investigation. We searched in vain to find any indication of interviews conducted by IA. We looked for the basis on which IA determined the identity of the CO who performed the 5 cell checks between 3:15 and 5:38 a.m. We sought any IA investigation of that time period. The Internal affairs report included none of this information.

The Deputy District Attorney in charge of the fatal-incident review was questioned to determine the extent of the DA's participation in the investigation and the criteria used by the DA's office to conclude that no criminal acts, unlawful acts, or acts of omission occurred.

Findings

- F1** The preponderance of forensic evidence and the testimony of several witnesses suggest that Mr. McDowall expired two to four hours before he was found dead at 8:18 a.m. on November 6, 2006.
- F2** An independent forensic pathologist, consulted by the Grand Jury, concluded that the preponderance of evidence indicates that Mr. McDowall died before 6:00 a.m., and probably much earlier.
- F3** The VCU/DA conclusion that Mr. McDowall was alive at breakfast (sometime after 6:00 a.m.) is unsupported by the testimony of the only inmate witness to the incident. This erroneous assumption on the part of the lead investigator (a former CO) diverted and minimized the investigation of events earlier that morning. Furthermore, this misinterpretation was an important premise of the IA investigation.
- F4** The statement of one CO (no longer with the department) that slight movement was noticed at 6:56am is questionable in light of the inmate witness's testimony, the testimony of other employees, and the forensic expert's estimated time of death. The testimony (to VCU) by this same CO indicates that he first arrived in Module D at 5:45 a.m. on November 6, 2006. No documentary evidence was provided to indicate his assignment to, or presence in, Module D before 6 a.m. that morning. If the five earlier Module D rounds were done, evidence indicating which CO conducted those rounds and the nature of those checks is missing from the VCU investigation.
- F5** The Rounds Automatic Tracking System data files were lost due to hard-drive failure 17 days after the fatal incident and are unavailable to verify the paper documents indicating that rounds were completed in Modules C and D (Mr. McDowall's module) on the morning of November 6, 2006. The only available paper logs contradict statements of several COs interviewed. There is no reliable system available to identify who performed the rounds in Modules C and D that night.
- F6** The Association of Joint Chiefs' Fatal Incident Protocol specified that this investigation be led by a division of the same law enforcement agency in which the fatal incident occurred (employer agency). The lead investigator was a former CO. The Grand Jury had to consider the obvious possibility that discrepancies in the investigation may have been intentionally overlooked. The appearance of, and possibly the actuality of, an impartial independent investigation is destroyed by this exception to the Fatal Incident Protocol.
- F7** The District Attorney's review of the VCU investigation concludes that no criminal acts, unlawful acts, or acts of omission occurred between 3:15 a.m. and 6:00 a.m., which in all probability was when Mr. McDowall died. There is no clear evidence indicating which, if any, CO performed the five required cell checks during this period. Any one of these security checks, if done, may have saved his life. The DA and the VCU investigation failed to look into what occurred during this critical time. The unlikelihood of a successful criminal prosecution was given as a justification for the lack of pursuit of these issues. Justifications aside, the Grand Jury found that the Deputy District Attorney did not identify any of the issues we raised.
- F8** Our review discovered errors in the investigation, which resulted in false assumptions. Principal among these were miscalculation of Mr. McDowall's time of death, and a failure to properly investigate events prior to the presumed time of death.

Conclusions

- The investigation of the in-custody death of Mr. McDowall represents a perfect example of “**how not to do it**” by all parties involved. Mr. McDowall’s demise was officially recorded in the autopsy as “Alcoholic Withdrawal Syndrome as a result of chronic alcoholism, a natural cause of death.” There is a viewpoint expressed by CO’s and staff in the Sheriff’s Department Detention Division that sick people die everywhere, including in jail. The Grand Jury disagrees with both the attitude and the assessment. Mr. McDowall’s severe alcoholism had put his health at risk for many years. Until he was incarcerated, he was able to cope with the affliction in his own way. In jail, he does not have that option. It is the responsibility of the Sheriff’s Department to assess Mr. McDowall’s health and take the necessary measures to keep him alive. **With appropriate attention and minimal effort, this death was preventable.** Neither the initial VCU investigation nor the subsequent Grand Jury investigation indicate that the Sheriff’s Department lived up to its responsibility to sufficiently monitor an inmate whose health was at risk. The Fatal Incident Report sheds no light on the matter.
- Mr. McDowall died sometime after he entered his cell at 3:15 am but before he was offered breakfast that morning. Our own research of the evidence and the independent assessment by a forensic pathologist concur. Usually the Coroner’s autopsy report includes no speculation as to time of death. The autopsy was normal in that respect. Several of the doctors we consulted, including the forensic pathologist, commented that the cause of death was unusually non-specific.
- The VCU did not competently and impartially investigate the Detention Division’s role in Mr. McDowall’s death. The interviews of involved parties appeared to be prompted rather than interrogatory. The VCU investigator asked leading questions of the witnesses he interviewed. Misinterpreted testimony led to the failure to explore important issues.

The Sheriff’s Department did not decide on its own to lead the investigation of its own Detention Division. That decision is mandated by the Association of Law Enforcement Chiefs’ Protocol. For that reason, the inference that the Sheriff’s Department wanted an in-house investigation for some clandestine purpose is **not supported by the Grand Jury.**
- The District Attorney’s participation and review of the Fatal Incident Report was not adequate to conclude that there was no criminal act, unlawful act, or act of omission. The Deputy District Attorney’s review of the VCU investigation should have raised the same questions posed by the Grand Jury. Several prosecutors indicate that it is very difficult to prevail in a case involving a correctional officer. We do not presume that there was a criminal act. However, there could be criminal liability. The unlikelihood of a successful prosecution does not justify failure to investigate.
- The IA investigation relied on documentary evidence from the flawed VCU investigation. No independent interviews were conducted. The presumption that a specific CO did rounds in Module D before 6:00 a.m. on November 6, 2006, is unsupported by any documentary or testimonial evidence in either investigation.
- The Law Enforcement Chiefs’ Association Fatal Incident Protocol generally provides for an impartial investigation free from the appearance of impropriety because the inquiry is led by a separate law-enforcement agency. The association’s exemption for jail fatalities leaves those investigations open to the suspicion of bias and conspiracy.
- Sonoma County correctional officers are confronted with over 12,000 bookings annually into a jail system with a constantly changing average population of 1,100 inmates. COs often view an inmate withdrawing from alcohol addiction as “just another drunk.” This indifference can result in cursory security checks and missed opportunities for intervention in health crises. An inmate’s death may be the byproduct of such apathy.

Recommendations

- R1** The Sheriff's Department should initiate another investigation of Mr. McDowall's death. This investigation should be led by an outside law-enforcement agency. The focus of this investigation may be limited to the resolution of the issues (F1, F3, F4, F5) raised in this Grand Jury report.
- R2** The Sheriff's Department should develop a procedure to identify the COs performing rounds in MADF modules.
- R3** The Sheriff's Department should review the integrity of RATS and provide redundant storage of RATS data.
- R4** The Sheriff's Department Internal Affairs Unit should investigate independently what occurred in Module D during the time that Mr. McDowall was housed there, specifically findings F1, F3, F4 and F5. This investigation should determine: which COs were involved, if procedures were followed, and if procedures need to be revised. If warranted, recommendations for disciplinary action should be made.
- R5** The District Attorney should conduct a new investigation into Mr. McDowall's death, either independently or in concert with the outside agency referred to in R1.
- R6** The Law Enforcement Chiefs' Association should amend the Law Enforcement Employee-Involved Fatal Incident Protocol to require that investigations of deaths in custody be led by an outside law-enforcement agency. The exceptions to the routine prohibition--that the employer agency not lead or directly participate in the investigation--would be consistent with the procedures mandated for other law-enforcement employee-involved fatal incidents.

Required Responses to Findings

Sheriff's Department	F1, F3, F4, F5
District Attorney	F7
Law Enforcement Chiefs' Association	F6

Requested Responses to Recommendations

District Attorney	R1
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Required Responses to Recommendations

Sheriff's Department	R1, R2, R3, R4
District Attorney	R5
Law Enforcement Chiefs' Association	R6

Disaster Will Strike! Are Schools Ready?

Residents of Sonoma County are constantly reminded that natural disasters in California are a matter of when, not if. Earthquakes threaten, fires rage, floods create havoc, and school shootings and bomb threats are frequently in the news. Parents send their children to school believing that they will be safe in the care of the teachers and on-site administrators. Is school safety a top priority for Sonoma County school administrators and staff? Do school personnel plan, practice, and provide for the very difficult situations that will arise when disasters occur? How can parents be assured that Sonoma County schools are well prepared and able to respond when a disaster strikes?

Reason for Investigation

This investigation was initiated by a citizen complaint. The complainant felt the schools of Sonoma County were not adequately prepared to respond to a disaster. A request was made for an investigation to determine if all state mandates regarding safety were in place for the protection of the children.

Many children in Sonoma County are at risk in the event of a natural disaster or attack. Implementing an emergency preparedness plan in each school is essential. Some schools are well prepared and others have not made adequate plans for coping with the difficult task of protecting students in an emergency situation. County government provides no financial support for school disaster preparedness, and support from school districts is uneven around the County. Because of budget cuts at the State level, local support is increasingly necessary to provide financing and training for disaster preparedness.

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Investigative Procedures

This investigation focused on Sonoma County Elementary Schools of diverse socio-economic backgrounds.

Interviews were conducted with the following individuals and offices:

- Principals of four elementary schools in various socio-economic areas of the County
- Superintendent of a local school district
- Sonoma County Superintendent of Schools
- Emergency Services Coordinator for Redwood Empire Schools' Insurance Group (RESIG)
- City of Santa Rosa School Safety Coordinator

The investigation included review of the following documents:

- RESIG Emergency Services Program Pamphlet and Protocol.
- RESIG RAP (Office Newsletter)

- Community Emergency Response Team (CERT) Field Operating Guide
- Sonoma County Operational Area Emergency Operations Plan
- Model Emergency Operations Plan for Schools (July 2006) provided by schoolguard.org.
- Sonoma County Office of Education (SCOE) Emergency Operations Plan
- SCOE School Crisis Response and Recovery Manual
- Safe Schools: A Planning Guide for Action Workbook (2002 edition-most current available)
- Emergency Operations Center (EOC) Management and Basic Standardized Emergency Management System /National Incident Management System (SEMS/NIMS) Flowchart
- California Education Code

Findings

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|-----------|--|------------|---|
| F1 | California Education Code 32281(a) states that "Each School District and the County Office of Education is responsible for the overall development of all comprehensive school safety plans for its schools operating kindergarten or any of grades 1-12 inclusive. Except as provided in subdivision (d) with regard to a small school district, and the schoolsite council established pursuant to section 52012 or 52852 shall write and develop a comprehensive school safety plan relevant to the needs and resources of that particular school. The schoolsite council may delegate responsibility to a school safety planning committee.... (b)(1) As used in this article, 'small schools district means a school district that has fewer than 2,501 units of average daily attendance at the beginning of each fiscal year'.(d)(2) Section 52012 does not appear in the on-line Education Code. | F4 | The Superintendent of SCOE was not aware that the State Education Code mandates the development of a comprehensive school safety plan (Ed. Code 32281) by the County Office of Education or schoolsite councils |
| F2 | According to California Education Code 52852, "A schoolsite council shall be established at each school... The council shall be composed of the principal and representatives of: teachers.... other school personnel.... parents of pupils,.. and in secondary schools, pupils....." | F5 | SCOE does not provide funding for training or supplies for disaster preparedness for Sonoma County Schools. |
| F3 | School districts, SCOE and/or schoolsite councils may be unaware that some schools do not have adequate supplies needed in case of emergency. | F6 | SCOE is not involved in developing emergency preparedness plans for County schools. They are in compliance with State mandates for the schools directly under their jurisdiction (Alternative Education Programs), but do not check for other County schools' compliance. |
| | | F7 | According to the California Education Code, the school safety plan must be reviewed annually by the schoolsite council and adopted by the school board. |
| | | F8 | Enforcement of State mandates is lax because of infrequent inspection, which is done "every five years or so," according to an interviewee, and then only for selected schools. |
| | | F9 | The Safe Schools Planning Guide for Action Workbook offers a checklist for compliance on requirements for a Comprehensive School Safety Plan. |
| | | F10 | Enrollment in RESIG's school disaster preparedness programs is voluntary, and many schools are not taking advantage of this valuable service. |

Findings, continued

- F11** If teachers leave the school site to enroll in RESIG's programs, schools must pay for substitute teachers. Most schools are in financial crisis, and funds for training are often not available.
- F12** SEMS and NIMS training may be completed on line, but it is time consuming and voluntary.
- F13** According to school principals interviewed, school personnel are considered "first responders" to emergencies. If a crisis occurs, they must assess the situation, provide first aid and comfort, and not leave campus until released by the principal. Many school employees do not receive the necessary training to fulfill this role.
- F14** The State mandates that schools conduct fire drills at the elementary level at least once a month, at the intermediate level four times a year, and at the secondary level not less than twice a year. (Ed. Code 32001) Earthquake drills must be held once every quarter at the elementary level and once each semester at the secondary level. (Ed. Code 32282)
- F15** There is a need for continued training on how to provide for children stranded on campus when a disaster occurs.
- F16** The State is placing disaster emergency preparedness responsibility on the schools yet does not provide funding.
- F17** No one is accountable to assure that all schools are prepared to protect our children when a disaster occurs.
- F18** SCOE's department of school safety suggests training in SEMS and NIMS but does not itself provide training. The office does provide opportunities for training sessions that include emphasis on such matters as bullying on campus and grief counseling.

Conclusions

Some schools in the County are well prepared, rehearsed, and trained in disaster emergency response. These schools take advantage of the program sponsored by RESIG. However, many other schools lack the funding and outside resources to provide sufficient on-site supplies, comfort, and shelter in the event of a disaster. No one is actually responsible to ensure that adequate protection is in effect in such a situation. SCOE does not accept responsibility for the safety of our children in the event of a disaster, and some school districts have neglected to provide for their students.

Commendations

RESIG provides excellent training programs for disaster preparedness. Some Sonoma County School Districts are well prepared to provide for the safety of their students in a disaster. Many schools have an emergency kit available in each classroom. Some provide portable toilets, mini blankets and food and water for up to three days. These schools are commended for making the safety of the children a priority.

Recommendations

- R1** Parents should ask to review the emergency plan for their school and ascertain whether or not schools are preparing the students with adequate emergency drills.
- R2** Parents, PTAs, and community members should become more involved with schools to help provide necessary supplies to those schools which are financially unable to do so.
- R3** SCOE should consider assigning personnel to be responsible for making sure our schools are in compliance with State regulations on school disaster preparedness.
- R4** SCOE should act as facilitator for disaster preparedness for schools within the Sonoma County Region. This role should include financial help in providing funding for substitute teachers so that classroom teachers can participate in training programs.
- R5** Superintendents must require that each school develop a disaster emergency plan designed for their school, and assure that the principal has approved the plan.

Recommendations, continued

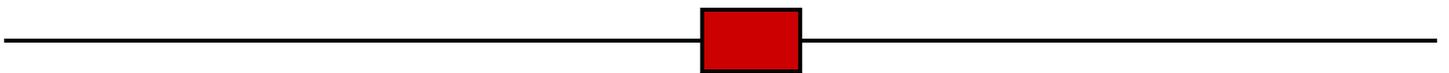
- R6** SCOE, Superintendents and Principals must consider disaster preparedness a top priority.
- R7** All schools must train their personnel in disaster preparedness.
- R8** Annually, all schools must check emergency supplies to assure that they are adequate. Consumable supplies must be checked for freshness and safety.

Required Responses to Recommendations

SCOE R3, R4, R6

Requested Responses to Recommendations

County School District Superintendents R5, R6, R7, R8



Santa Rosa Central Library at Risk

The Santa Rosa Central Library has experienced a growing problem with the homeless population using the library as a daytime shelter. No daytime shelter exists in Santa Rosa.

In September 2007 the Sonoma County Library Commission updated its 1997 Code of Conduct and issued the Library Standards of Behavior. Our investigation indicates that the new Standards of Behavior do not provide clear, definitive, and enforceable tools to minimize disruptive behavior and ensure a safe, secure environment for patrons and library staff.

In spite of the current level of coordination with shelter and mental health professionals, without the availability of daytime drop-in shelters, the situation will remain problematic.

The degree of public dissatisfaction with this disruptive atmosphere could influence future support of this vital institution.

Reason for Investigation

Libraries represent one of the few remaining public venues offering a safe, secure educational forum for the general public. The increasing presence of the homeless population in all public spaces is the subject of considerable discourse and political concern.

The Grand Jury decided to initiate a self-generated investigation following multiple visits to the Central Library in Santa Rosa. At the center of a growing homeless population within the County, the Santa Rosa Central Library has been receiving a disproportionate share of a burden that would traditionally be the purview of shelter and transitional housing programs and mental health facilities.

Background

The Library Commission's decision to undertake the updating of the Library Code of Conduct in 2006-2007 was widely covered by the Press Democrat.

The Grand Jury conducted preliminary site surveys using a detailed checklist of several Sonoma County libraries to gain an on-site appreciation of general operating conditions and compliance with the new September 2007 Standards of Behavior.

These surveys revealed an environment at the Santa Rosa Central Library where the inappropriate behavior of a small minority has created unacceptable conditions for patrons and staff.

It has been a tradition in library practice to maintain open inclusive access to all. However, the corrective action taken falls short of sending a clear message to repeat violators that their interference with the rights of all users will not be tolerated.

Investigative Procedures

Multiple surveys of library environment at various times

Discussions with homeless library patrons

Interviews performed:

- Sonoma County Library Director of Operations
- Children Services Coordinator
- Head of Division of Public Services
- Central Library Manager
- Security guard
- Circulation and Training Supervisor at the Central Library
- Sr. Client Specialist for Sonoma County Mental Health Community
- Program Director for Catholic Charities
- Executive Director of COTS
- Librarian at Petaluma Library
- Petaluma Library Manager

Investigative Procedures, continued

Documents reviewed:

- Sonoma County Library Code of Conduct (1997 to September 2007)
- Sonoma County Library Standards of Behavior (September 2007 to present)
- Patrons' comments for years 2006 through April 2008
- Central Library Incident reports years 2006 through April 2008

Internet research:

- California Law (Penal Code relating to loitering)
- Press Democrat Archives
- Sonoma County Library
- Library Law

Findings

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| <p>F1 The homeless are the principal cause of disruption of normal library operations and thereby impact the appropriate and productive use of the library by the general public.</p> <p>F2 The homeless are utilizing the library as a shelter during daytime hours, since there is no daytime drop-in shelter available in the Santa Rosa shelter system.</p> <p>F3 The homeless often bring in bundles, bedrolls, bags of recyclables and possessions, all items that are difficult for library staff to control.</p> <p>F4 Smoking and large gatherings at the library entrance are intimidating for many patrons and can discourage access.</p> <p>F5 The Library Standards of Behavior, adopted in September 2007 are less specific and direct than the earlier Code of Conduct established in 1997, relative to the consequences and action for non-compliance.</p> <p>F6 Those in violation of the Standards of Behavior, even after repetitive incidents, are rarely denied long-term use of the library.</p> <p>F7 There has been a general relaxation towards the enforcement of the Standards of Behavior: Restrictions on food and beverages, smoking, computer and cell phone use, and loitering.</p> | <p>F8 There has been a noticeable increase in complaints from the public and recorded incidents requiring police intervention.</p> <p>F9 Current locations of computer stations allow easy observation of objectionable material by patrons passing through the library main aisle.</p> <p>F10 The addition of a security guard (September 2007) has had a positive impact on relations with the homeless community.</p> <p>F11 Outreach and coordination with key shelter management and county mental health personnel has been effective in mitigating many potential problems.</p> <p>F12 There has been minimal training of library staff in identifying and handling individuals with mental health problems or potential for violent behavior.</p> <p>F13 Library volume and usage have remained relatively unchanged in the past two years despite the population increase.</p> <p>F14 The daytime shelter and outreach programs organized by the Committee for The Shelterless (COTS) in Petaluma have been successful in minimizing inappropriate use of the library in that city.</p> <p>F15 All shelter management professionals strongly recommended to consistently enforce rigid standards of behavior as well as consequences for noncompliance.</p> |
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Conclusions

There is a growing dissatisfaction among the general public regarding the changing environment at the Central Library facilities in Santa Rosa. The increasing presence and inappropriate behavior of homeless and transitional people are jeopardizing the traditionally safe, secure, and welcoming surroundings that are typical of this highly-valued institution. Library staff is called upon to spend an inordinate amount of time away from their normal duties to address behavioral problems. These issues often involve dealing with individuals who are substance abusers or mentally handicapped for which staff often have only limited training and experience. Although assistance is available from County Mental Health Division and shelter management personnel and library security, these incidents can escalate rapidly and necessitate police intervention.

Issue of a revised Library Code of Conduct in September 2007 has not given the library staff and security the necessary tools to cope with a rising level of code violations. A “three strikes” approach needs to be taken to send a clear message that strict measures will be applied to preserve acceptable conditions for all patrons. Additionally, library staff must be ensured of a working environment free of intimidation and threat of verbal abuse and physical violence.

In spite of the addition of library security and coordination with the mental health and shelter community, it is anticipated that the library environment will continue to be negatively impacted if an adequate daytime shelter is not provided within the general support area of Santa Rosa.

Public support will be crucial in order to maintain a healthy library system that is capable of expanding to meet population and advanced technology. To achieve this, it is paramount that the library system continue to offer an experience worthy of the library staff commitment and dedication.

Commendations

The dedication and commitment of the library staff has been exemplary in spite of sometimes difficult situations demanding their attention and intervention.

The security guard at the Central Library has dealt with disruptive individuals in a calm, respectful, and efficient way. His presence brought some reassurance for the patrons and staff.

The shelter management and mental health crisis intervention personnel have made major commitments in spite of their limited staff and demanding schedules.

The library environment will continue to be negatively impacted if an adequate daytime shelter is not provided within the general support area of Santa Rosa.

Recommendations

- R1** Modify the Standards of Behavior to include strict, unequivocal consequences for disruptive behavior.
- R2** Incorporate no-loitering provisions into the Standards of Behavior and provide library staff and security with the necessary support and training to enforce these rules.
- R3** Enforce a smoke-free zone on all properties surrounding the library facilities.
- R4** Modify and strictly enforce current standards to prohibit any patron from bringing into the Library bed rolls, bundles, and containers other than reasonably sized backpacks.
- R5** Prohibit cell phone use within the confines of the library.

Recommendations, continued

- R6 Rearrange and monitor computer access to limit unintended viewing and exposure to inappropriate material.
- R7 Make the Standards of Behavior more visible and proactively introduce it to all new arrivals in the library.
- R8 Sonoma County Mental Health Division and shelter management personnel should expand their commitment to training and on-site intervention.
- R9 Coordinate with the Santa Rosa Police Department to schedule random but regular visits inside the library.
- R10 **The Library Commission, City of Santa Rosa, and the Community Development Commission should coordinate a task force to investigate the feasibility of alternative daytime venues for the homeless community.**
- R11 The Library Commission should take the “pulse of the public” by producing an annual report summarizing citizen complaints and action taken by the library.

Required Responses to Recommendations

Library Commission	RI, R2, R3, R4, R5, R10, R11
Sonoma County Library Director	R6, R7, R8, R9,
City of Santa Rosa	R3, R9, R10
Sonoma County Mental Health Services Director	R8
Sonoma County Housing Authority, Community Development Commission	R8, R10
Sonoma County Board of Supervisors	R10



Sonoma County Office of Education

Misuse of State Vocational Education Funds

The people of Sonoma County trust and expect that the Sonoma County Office of Education (SCOE) spends tax dollars in the best interests of our students. A Grand Jury investigation has determined that State funds allocated to SCOE have been misspent. According to a report by the State Office of Education, some or all of this money will have to be repaid to the State by Sonoma County taxpayers.

SCOE provides several Alternative Education Programs for Sonoma County students in grades 9 through 12. These programs are designated specifically for students at risk of failing to graduate and failing to receive adequate training to enter the work force, thus becoming a burden to society. Alternative education is sometimes partially funded by grants targeting specific aspects of these programs. Are these designated funds being appropriately applied? Are the faculty and staff of these programs being used most effectively and in the best interest of students?

Reason for Investigation

The Grand Jury received a complaint alleging far-ranging budget and personnel irregularities at SCOE. The complaint alleged that Federal funds granted through an alternative education/vocational education program were used for purposes not specific to the goals stated in the grant application. The grant in question is intended solely for vocational/technical career training. Additionally, an award-winning vocational education teacher who brought this discrepancy to SCOE's attention was reassigned to a different position against the teacher's wishes.

Background

The Sonoma County Office of Education offers several programs for students who, for a number of reasons, cannot attend the regular comprehensive high schools in Sonoma County. These programs are called Alternative Education Programs. Students in the programs are at serious risk of school and social failure. Their enrollment in these programs may be due to disciplinary issues, criminal charges, being a single parent in grades 9 through 12, being truant, and/or other causes. Alternative Education Programs are designed to help these students complete their high school education.

The students may, after a stay in one of the programs, return to a comprehensive high school and be eligible for a Regional Occupational Program (ROP) class, pass the General Education Development (GED) test, or pass the California High School Proficiency Exam. In each case, the student should be better positioned to find a job and function as a productive member of society.

Alternative Education Programs receive the majority of their funding through the State, based on average daily attendance. However, there are other special funding streams from grants. The Carl Perkins Fund is a Federal grant, administered by the State, that specifically targets "occupational-specific skills necessary for economic independence as a productive and contributing member of society." (www.ed.gov/offices/OVEA/CTE/perkins)

In the 2006-2007 school year, SCOE applied for and received a Carl Perkins Grant in the amount of \$23,736 for a consortium of school districts in the Sonoma, Marin, and Shoreline Districts. Sonoma County's share of this grant was \$14,130.

Investigative Procedures

Interviews conducted:

- Complainant
- Two staff members in the SCOE Alternative Education Programs
- SCOE Director of Youth Development Support and Leadership Services
- State Department of Education Assistant Superintendent of Secondary, Post Secondary, and Adult Leadership, in charge of High School, Alternate Education, Career Technology, Vocational Education and Adult Education Post Secondary
- State Department of Education Educational Program Consultant—Administrator of Carl Perkins Vocational Education Funds
- SCOE Communications Specialist, Grant Oversight, Curriculum Oversight
- SCOE Superintendent of Schools

Investigative Procedures, continued

Documents Reviewed

- SCOE 2006-2007 Carl Perkins Grant Application
- Confidential Review of 2006-2007 Carl Perkins expenditures commissioned by the SCOE Superintendent of Schools
- Carl Perkins Fund Budget and Expenditure Schedule, 2006-2007 (included in 2006-2007 Carl Perkins Fund Grant Application)
- Revised Carl Perkins Budget and Expenditure Schedule (not found in original Grant Application)
- E-mails, a list of expenditures, correspondence with State agencies, and other documents supplied by SCOE Alternative Education Programs staff members
- The report on the State's investigation of SCOE's use of Carl Perkins Funds

Findings

- F1** Programs that qualified for funding through Carl Perkins vocational-education grants were denied funding by SCOE, and programs and materials not allowed by the Carl Perkins Act were purchased with the grant money.
- F2** SCOE's original 2006-2007 Carl Perkins Grant Application requested funds for: classified salaries (\$7,941 for guidance and counseling) employee benefits (\$1,661 for guidance and counseling) books and supplies (\$3,605) services and other expenditures (\$250).
- F3** After the initial grant application, monies were removed from "classified salaries" and "employee benefits" to "services and other expenditures," increasing the original budget in that category from \$250 to \$4,500.
- F4** The revised expenditures reflecting the final distribution of 2006-2007 Carl Perkins Funds indicates an expenditure of \$4,000 for the SASix software-attendance program that is used by the SCOE Technology Services Unit. SASix is a general education support program not specific to vocational training.
- F5** The State Administrator of Carl Perkins Funds testified that the purchase of SASix software was an **inappropriate** use of Carl Perkins Funds.
- F6** The SKILLSUSA program affords students in vocational/technical education programs the opportunity to compete for awards recognizing excellence in job skills learned.
- F7** An award-winning teacher at the Youth Camp Alternative Education Program asked SCOE for Carl Perkins Funds to allow his/her students to participate in a SKILLSUSA competition. SCOE refused to allocate funds from the program for this purpose, stating that it was **not** an appropriate use of the funds.
- F8** The State Administrator of Carl Perkins Funds testified that these funds **can** be used for SKILLSUSA competition.
- F9** A staff person requesting Carl Perkins Funds for SKILLSUSA questioned SCOE's use of the funds for SASix, and disagreed with SCOE's refusal to allow funds to be used for SKILLSUSA. This staff person, who is not the complainant, was subsequently reassigned against his/her will. The timing of this reassignment suggests poor personnel management at SCOE. Mismanagement of this kind may affect the morale of staff and undermine the support needed to ensure the success of Alternative Education Programs.
- F10** As a result of a State Department of Education investigation, SCOE will be required to repay all or part of the 2006-2007 Carl Perkins Funds it was awarded.

Conclusions

SCOE has misused the 2006-2007 Carl Perkins Funds supplied by the State for use by the Alternative Education vocational/technical training program. This action and related inappropriate personnel decisions threaten to undermine the morale of the Alternative Education staff. In order to have a vibrant and effective program, staff must have confidence in the administration, and be able to work effectively with them. The working relationship of Alternative Education staff and SCOE managers could be eroded by such actions.

Recommendations

- R1** The SCOE Superintendent of Schools must ensure that all funds spent by the office are disbursed as intended.
- R2** SCOE must adhere to requirements for the disbursement of grant monies received for specific programs.
- R3** SCOE must acknowledge that targeted funds are to be used for designated programs, not as general funds.
- R4** SCOE programs receiving targeted funding must be audited to ensure that the funds are spent appropriately.
- R5** SCOE must include teachers and other staff members in decisions concerning the application for and disbursement of funds that may be used in program funding.
- R6** SCOE must ensure that reassignment of personnel is not punitive.
- R7** The movement of personnel, when undertaken, must benefit the students affected rather than strictly be in the best interest of SCOE, as stated in present SCOE policy (SP 4135.00).

Commendations

The Grand Jury commends the staff of SCOE's Alternative Education Programs for the many excellent opportunities they offer to students who, for a variety of reasons, are not able to attend and function well in the County's comprehensive high schools. The programs are tailored to meet the needs of a variety of student difficulties. To succeed, these programs require staff with exceptional skills. The programs are a valuable service to at-risk students, and to society in general.

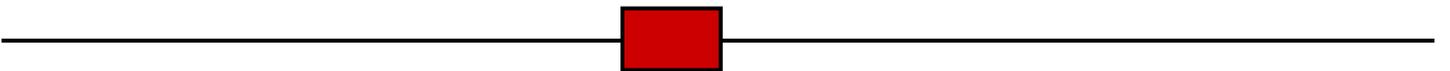
As a result of a State Department of Education investigation, SCOE will be required to repay all or part of the 2006-2007 Carl Perkins Funds it was awarded.

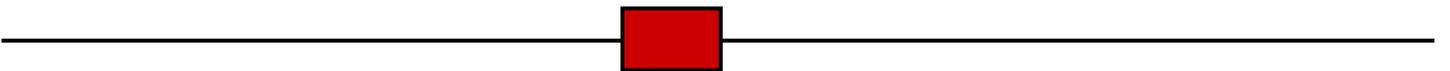
Required Responses to Findings

SCOE F1, F3, F4, F5, F7, F8, F9, F10

Required Responses to Recommendations

SCOE R1, R2, R3, R4, R5, R6, R7





Local Involvement in Immigration and Customs Enforcement

Illegal immigration is a contentious political issue in the U.S., especially in communities like Sonoma County where the population includes substantial numbers of undocumented residents. As we wrestle with these social and economic issues, it is important to understand exactly how immigration law is enforced in Sonoma County.

It is particularly important to our large Latino community to understand the extent of the separation between Federal and local law enforcement. It is the job of our local police departments to enforce local law and to provide protection to everyone, without regard to immigration status. Conversely, it is the job of the Federal Immigration and Customs Enforcement Agency (I.C.E.) to apprehend and deport individuals who are here illegally. These are separate functions which are carried out by separate agencies.

The purpose of this report is to verify that the separation exists and to explain what this means to the citizens of Sonoma County.

Format

The form of this report is different from other reports in the 2007-2008 Grand Jury Report. You will not see a list of findings, required responses, or commendations. You will find a list of important **facts** and the Grand Jury's **Conclusion**. There is also an appendix which includes documents in support of the conclusions. Our purpose here is to provide to the citizens of Sonoma County an independent, comprehensive, and authoritative understanding of the issues.

Reason for Investigation

There is a perception by many in the Latino community that a cop is a cop. They see no difference between a Federal (I.C.E.) officer and a local police officer. Also, it is believed that a local police can and will arrest a person for being undocumented.

The unfortunate consequence of this misconception is that undocumented individuals, their friends, and their families are hesitant to report a crime or ask police for help out of fear of deportation. This fosters criminal activity that hurts all of us.

There is a real and important separation between the Federal (I.C.E.) authorities and county law enforcement. Local police do not enforce immigration law and their cooperation with the I.C.E. is, with the exception of gang activities, substantially limited.

The Sonoma County Grand Jury has investigated and verified the reality and extent of this limitation.

Investigative Procedures

- Review of related Press Democrat articles dated August 26 and November 19, 2007
- Review of The Sonoma County Law Enforcement Chiefs Protocol on Immigration
- Interview with the Sonoma County Sheriff
- Interviews with the Chiefs of Police in five cities in Sonoma County
- Interview with the Sonoma County District Attorney and three senior staff
- Interview with the ACTION Trainer/Community Organizer for St. Joseph's Health System and Nuestra Voz
- Interview with the director of La Luz
- Discussions with several Officers in the Sheriff's Department.

The Facts

- The California Penal Code (834 B) defines the cooperation required of local law enforcement with the INS. (See appendix, item 1.) It should be noted that this law deals with what is required **after** a person is arrested and as such does not require that local law enforcement contact, question, or detain anyone on suspicion of being in the U.S. illegally.
- It is the stated policy of all Sonoma County police agencies and the Sheriff's Department that they will not contact, question or detain anyone solely on the basis of illegal entry. The policy is documented in the Sonoma County Law Enforcement Chiefs Protocol 99-1. (See appendix, item 2.)
- The Sheriff's Department audits jail records to ensure this policy is followed. If a person is found to be incarcerated solely on suspicion of being an undocumented alien, he or she is immediately released.
- Sheriff Cogbill has stated that the Sheriff's Department has no authority to arrest individuals for violation of federal immigration law by being in the U.S. illegally. However, if a person has previously been deported and has reentered the U.S., that reentry is a felony. A Federal warrant, or immigration detainer for the arrest of such an individual, will be honored. (See appendix, item 3.)
- The Sonoma County Sheriff's Department does not check immigration status and does **not** have access to INS computer files or records.
- Conversely, as required by PC 834 B, I.C.E. **does** have access to Sonoma County jail records and can and periodically does check the immigration status of people in county jail. If I.C.E. determines that the detainee may be in the U.S. illegally, it can place a federal hold on the individual. If that is done, the Sheriff's Department must notify I.C.E. before the person is released. Upon notification, I.C.E. must take custody within 48 hours (not including weekends and holidays). If the agency fails to or chooses not to do so, the person is released.
- It has been reported that I.C.E. does not request holds on illegal immigrants who have been arrested for minor offenses. This is apparently a matter of current I.C.E. policy, which can be changed at any time.
- Local police do not conduct or participate with I.C.E. in sweeps. The only exception to this policy is when I.C.E. requests help in "securing a perimeter" or "traffic control" for one of their operations. The Sonoma County Law Enforcement Chiefs Protocol 99-1 (See appendix, item 2) requires specific procedures to be followed before local law enforcement becomes involved in an I.C.E. operation.
- The use of a false document for identification is a felony in California. (See appendix, item 4.) An undocumented person who is suspected of a crime may be asked by an officer to identify himself. If the person offers a fake ID, he or she can be arrested on that basis alone.
- The Office of the District Attorney for Sonoma County does not report the immigration status of any victim or witness to I.C.E. Furthermore, victims, witnesses and complainants are not asked questions about their immigration status. District Attorney Passalacqua and the other members of his office interviewed by the Grand Jury are not aware of any case where a victim or witness was deported as a result of his or her cooperation or testimony in a Sonoma County criminal proceeding.
- It is illegal to intimidate a witness or victim from reporting a crime or cooperating in the prosecution of a crime.

Conclusions

The effective deterrence of crime in our community requires the cooperation of all of its residents, including undocumented immigrants. In order to achieve that common goal, the Sonoma County law enforcement agencies and the District Attorney have adopted policies to isolate themselves from immigration law enforcement. The local policies described in this report are designed to encourage those residents with immigration concerns to participate with law enforcement without fear of being deported. This is especially important in the Latino community, where residents may be hesitant to report domestic violence and neighborhood crime. The Grand Jury has seen tangible evidence that the spirit of that isolation is real. Your local cop is truly not interested in the deportation of people who are not breaking local laws.

A major exception to this policy applies to individuals involved in, or suspected of being involved in, criminal activity. If such a person is an illegal immigrant, the Sheriff's Department will actively engage I.C.E. to take federal custody of that person. The Sonoma County Joint Gang Task Force coordinates with I.C.E. on a routine basis in an effort to suppress illegal gang activity in the county.

The separation between county law enforcement and the I.C.E. is not and probably can never be complete. The clearly limited relationship is beneficial to all of us, including the Latino community.

The Bottom Line:

- **If an illegal immigrant obeys local and state laws, he or she can report crimes and obtain police assistance without fear of I.C.E. involvement. The insulation from I.C.E. for innocent bystanders, complainants, and victims of crimes is not perfect but it is substantial.**
- **Criminal activity by an undocumented individual will dramatically increase the likelihood of deportation. Minor infractions and lesser misdemeanors will produce a small but significant risk. Major crimes and gang involvement will probably result in I.C.E. intervention and possible deportation.**

Appendix

1. California penal code 834b

834b. (a) Every law enforcement agency in California shall fully cooperate with the United States Immigration and Naturalization Service regarding any person who is arrested if he or she is suspected of being present in the United States in violation of federal immigration laws.

(b) With respect to any such person who is arrested, and suspected of being present in the United States in violation of federal immigration laws, every law enforcement agency shall do the following:

(1) Attempt to verify the legal status of such person as a citizen of the United States, an alien lawfully admitted as a permanent resident, an alien lawfully admitted for a temporary period of time or as an alien who is present in the United States in violation of immigration laws. The verification process may include, but shall not be limited to, questioning the person regarding his or her date and place of birth, and entry into the United States, and demanding documentation to indicate his or her legal status.

(2) Notify the person of his or her apparent status as an alien who is present in the United States in violation of federal immigration laws and inform him or her that, apart from any criminal justice proceedings, he or she must either obtain legal status or leave the United States.

(3) Notify the Attorney General of California and the United States Immigration and Naturalization Service of the apparent illegal status and provide any additional information that may be requested by any other public entity.

(c) Any legislative, administrative, or other action by a city, county, or other legally authorized local governmental entity with jurisdictional boundaries, or by a law enforcement agency, to prevent or limit the cooperation required by subdivision (a) is expressly prohibited.

2. Protocol 99-1 Immigration

SONOMA COUNTY LAW ENFORCEMENT CHIEFS' ASSOCIATION

PROTOCOL: 99-1

ADOPTED: 08/06/99

REVISED : 09/02/05

SUBJECT: IMMIGRATION

PURPOSE: To establish a protocol regarding Sonoma County Law Enforcement response to illegal immigrants

I. POLICY

- A. Sonoma County Law Enforcement personnel shall not arrest or detain any person based solely on violation of Title 8, United States Code, Section 1325 (illegal entry).
- B. Sonoma County law enforcement personnel shall not undertake any interrogation of any person for the sole purpose of ascertaining his/her immigrant status.
- C. Sonoma County law enforcement personnel shall not undertake a law enforcement action designed solely to detect the presence of illegal immigrants.
- D. Sonoma County law enforcement personnel may assist the ICE in the investigation of criminal activity involving illegal immigrants, when requested to do so, only after approval of the on-duty Watch Commander/on duty supervisor.
- E. Watch Commanders/on-duty supervisor shall ascertain a mission statement and operational guidelines for all ICE investigations from the ICE agent in charge to determine if it meets policy guidelines prior to approval of assistance from Sonoma County law enforcement.

Appendix, continued

- F. Watch Commanders/on-duty supervisors shall request the name of the ICE agent in charge, and require verbal notification of the results of the individual investigations requiring the assistance of Sonoma County law enforcement

II. PROCEDURES

A. Detention of Illegal Immigrants

1. No person shall be detained solely to ascertain immigrant status.
2. Detention shall be based solely on reasonable suspicion to believe said person has committed a violation of State law or local ordinance or where circumstances require detention for officer safety reasons.

B. Arrest of Illegal Immigrants

In all cases, a written arrest report shall be completed when a person has been arrested for violation of State or local law, regardless of the determination later by ICE that the arrestee is an illegal immigrant.

C. Custody

1. A person determined to be an illegal immigrant by the ICE shall be advised of his/her right to be admitted to bail on the terms and conditions offered to persons arrested for State and local violations.
2. Any illegal immigrant shall be admitted to bail until an ICE hold is placed on the individual by ICE officials. ICE officials may notify detention personnel by telephone of the ICE hold, but must immediately send written confirmation by teletype or fax.
3. Per the Code of Federal Regulations, Section 242.2(a)(4), after an ICE hold has been placed on an individual, the individual shall remain in custody for a period not to exceed 48 hours to permit transfer of custody to ICE. This 48-hour time frame excludes weekend days and federal holidays.

D. Victims and Complainants

1. No questioning shall be directed to a victim or a complainant regarding his/her immigration status.

3. California penal code section 114

- 114** Any person who uses false documents to conceal his or her true citizenship or resident alien status is guilty of a felony, and shall be punished by imprisonment in the state prison for five years or by a fine of twenty-five thousand dollars (\$25,000)

4. Sheriff Cogbill's official statement regarding illegal immigration



Sonoma County Sheriff's Department

*BILL COGBILL
Sheriff-Coroner*

*RICH SWEETING
Assistant Sheriff
Law Enforcement Division*

*LINDA SUVOY
Assistant Sheriff
Detention Division*

September 4, 2007

The following represents the practice of the Sonoma County Sheriff's Department as it relates to illegal immigration.

The Sheriff's Department does not have the resources, expertise or authority to arrest individuals for violation of federal immigration law by being in this country illegally. The fact that an individual is suspected of being an undocumented alien alone shall not be the basis for contact, detention, or arrest. Pursuant to our policy we will not independently conduct sweeps or other concentrated efforts to detain suspected undocumented aliens. We cannot and will not prevent federal authorities from doing so.

In the interest of public safety the Sheriff's Department will however assist I.C.E. and other federal authorities with the following; the investigation, identification, and detention of illegal immigrants who have been identified as, or suspected of, committing a crime, involved in furthering illegal gang activity or having a criminal warrant or immigration detainer issued for their arrest.

We believe the entire community, including the Latino community, benefits from this type of enforcement as it makes Sonoma County a safer place to live.

Like other small community hospitals, Palm Drive Hospital in Sebastopol operates with declining reimbursements and utilization, an increase in non-paying patients, and tight competition.

Hospitals with fewer than 100 beds are hardest hit.

The Outlook for

Palm Drive Hospital

In order to remain in operation, the Palm Drive Health Care District (PDHCD) approved a parcel tax in April 2001. PDHCD sought and received a second parcel tax in 2004 (Measure W). Despite the property tax revenue, negative cash flow caused the District to file for Chapter 9 Bankruptcy in April 2007. The future success of Palm Drive Hospital necessitates that management and the Board of Directors of the PDHCD work together to prepare and plan strategies for dealing with the major issues they are facing.

Reason for Investigation

The Grand Jury received a citizen complaint stating that:

- The electorate had insufficient financial information to make their decision on the 2004 parcel tax.
- There had been mismanagement of this public entity.

It was determined early on that Audited Financials were available to the public for review before the 2004 parcel tax election. The primary focus of this report is the charge of mismanagement of this entity.

Background

The Palm Drive Health Care District is a Health Care District providing access for the West County to local emergency, acute care, and other medical and physician services for its residents and visitors. Due to the size and diversity of the West Sonoma County region, local access to quality health care is essential. The aging population, commuting trends, and increased traffic congestion necessitate keeping Palm Drive Hospital (PDH) open for the health and well-being of West Sonoma County residents.

The Board of Directors has the responsibility, as the governing body of the District, to make appropriate delegations of its powers to officers and employees, and to make necessary policies.

Through the 1990s PDH lost money. In 2000, the people of West County created a foundation. In 2001, the first Parcel tax was passed. The PDHCD was formed and the 2nd Parcel tax was approved in April 2004. The purpose of the 2004 parcel tax was to raise revenue for the District to use in order to ensure the survival of Palm Drive Hospital. The tax provides for ongoing expenses, repair and improvements to equipment and technology. The primary purpose of the Measure was to ensure that PDH, with its Emergency Room serving approximately 8,500 patients yearly could remain open.

Investigative Procedures

Interviews Held:

- Former Chief Financial Officers (2)
- Former Board member
- Former Board Chair
- Interim Chief Financial Officer
- Finance Committee member
- Interim Chief Executive Officer
- Director, County Health Services

Meetings Attended:

- PDHCD Board of Directors meetings
- Finance Committee meetings

Documents Reviewed:

- Financial Health of California Hospitals 2007
- “California’s Closed Hospitals”
- Sonoma Valley Hospital Business Plan
- Chief Financial Officer’s Reports to Finance Committee
- Audited Financial Reports 2003-2007
- Local Media Archives
- Bylaws of Palm Drive Health Care District (PDHCD)
- Finance Committee Agendas and Reports

Findings

F1 Hospital executives and Board Members did an inadequate job of evaluating and communicating the serious financial trends and looking for ways to resolve the situation.

F2 Financial Data:

Fiscal Year Ending June 30

	2003	2004	2005	2006	2007
Net Revenues from Operations	\$17,052,090	\$14,958,886	\$15,930,615	\$16,772,800	\$15,104,279
Operating Income or (Loss)	(\$3,451,399)	(\$4,304,254)	(\$4,499,097)	(\$4,936,734)	(\$6,925,239)
Tax Revenues	\$1,838,051	\$1,859,911	\$4,402,300	\$3,687,385	\$4,030,946

Source: Audited Financial Statements

F3 Audited financial statements indicate:

- Declining net revenue from Operations
- Growing losses in operating income caused in part by low insurance and reimbursement rates.
- Poor Accounts Receivable procedures and collections.
- Bad decisions, i.e., closing and reopening the Intensive Care Unit. Opening long-term nursing facility and then closing it due to necessary repairs.

F4 2007 Auditor's comments:

"These conditions raise substantial doubt about the District's ability to continue Hospital Operations in the future."

F5 Despite a County Healthcare budget in excess of \$200 million, there were no county funds earmarked to assist the small hospitals in the county like Palm Drive.

F6 The performance review process for the executive staff was ineffective.

F7 A Joint Powers Agreement (JPA) was formed to allow hospitals to save money by coordinating purchasing, etc.

F8 Most board members have limited experience in hospital operations and financial analysis; there has been considerable turnover of Board and key hospital operations personnel in the 2003-2007 periods.

Conclusions

As noted, there are several areas of improvement:

Key Statistics Average

	7-1- 2007 YTD	12-31- 2007 YTD	Variance
Hospital IP Census	8.4	10.9	30%
ER Visits	20.9	21.4	2%
Lab & X-ray	37.1	36.1	-3%
IP & OP Surgeries	4.3	4.7	9%
Other OP	2.6	3.7	42%
Hospital Admits	524	708	35%
Hospital Patient Days (Acute & Swing)	1,796	2,339	30%
ICU Admits	N/A	187	
ICU Days	N/A	472	
ER Visits	4,484	4,593	2%
Lab & X-ray	7,975	7,762	-3%
IP & OP Surgeries	934	1,004	7%
Other OP	555	795	43%

- Higher reimbursement rates from insurance
- Improved billing and collection procedures

PROJECTIONS

- Five- year projections show a continued need for parcel taxes and long-term debt.
- An essential element of the Plan of Adjustment is for the District to issue Certificates of Participation (COP). COPs are similar to bonds in that they are used to finance debt. They are paid for by Measure “W” proceeds, and DO NOT require voter approval. A portion of the proceeds will be :
 - Used to create the “Plan Fund” to pay creditors who have allowed Claims filed with the Bankruptcy Court,
 - Used to repay the Operating Loan,
 - Applied by the district to finance future long-term capital and operating needs for the District,
 - Used to retire the approximately \$9.2 million remaining in the 2001 bond issue. The amount of the COP is approximately \$23 million.

Commendations

The District has been fortunate to have the leadership and financial acumen of Dan Smith, a concerned citizen whose financial generosity single-handedly kept the hospital doors open during dire times.

Recommendations

- R1** All Board members should receive basic financial training. California Special District Association offers training for new board members. Financial institutions and auditors also offer financial training.
- R2** A five-year strategic plan, with benchmarks, should be developed and reviewed annually.
- R3** PDHCD should create a management-support group for the doctor population.
- R4** The district should increase efforts to improve the image of Palm Drive Hospital in order to attract quality physicians and avoid losing patients to competing hospitals.
- R5** As a member of the JPA, Palm Drive should investigate specialization in specific medical areas.
- R6** The Board and Hospital Management should create job descriptions for all executive employees, emphasizing the importance of communications.
- R7** PDHCD should continue to keep taxpayers informed on financial matters.
- R8** PDHCD should institute and manage an effective A/R collection program to enhance management-support practices.
- R9** PDHCD should institute an effective performance-review program for management.
- R10** Sonoma County should show financial interest and use of influence to aid smaller hospitals. The County, as stated in its mission statement, is committed to providing superior and courteous services to support, preserve, and enhance the health of Sonoma County citizens. Therefore, Palm Drive Hospital should be preserved.

Required Responses to Recommendations

- Palm Drive Health Care District R1, R2, R3, R4, R5, R6, R7, R8, R9
- Sonoma County Board of Supervisors R10



OFFICER-INVOLVED FATAL-INCIDENT REPORTS

The 2007-2008 Sonoma County Civil Grand Jury reviewed three Fatal-Incident Reports regarding officer-involved shootings. Two of the incidents involved mentally ill subjects and one, a known felon and murder suspect, was said to be armed and dangerous. Each report reflected a thorough and detailed investigation of the covered incident. The District Attorney concluded in each report that there was no criminal wrongdoing by the law-enforcement officers involved in each incident.

Reason for Investigation

The Grand Jury has historically reviewed Fatal Incident Reports received from the District Attorney during its term to determine that county law-enforcement agencies:

- Complied with county fatal-incident protocol
- Acted appropriately during the fatal incident
- Wrote reports without bias
- Wrote reports that contained factual witness statements, determined by comparison of each written report
- Established a timeline of events leading up to and including the fatal incident

Background

The California Penal Code requires that a formal investigation of an officer-involved critical incident be conducted to determine if a criminal violation has occurred. The "Sonoma County Law Enforcement Chiefs Association Employee-Involved Fatal Incident Protocol" (Protocol), establishes the County-wide policy and procedures for prompt and efficient investigation if:

- A specific officer-involved critical incident occurred in Sonoma County
- A law enforcement employee was involved and a fatal, or potentially fatal, injury occurred

The protocol dictates that a task force of three separate agencies be formed to investigate, review, and write reports. This task force is comprised of:

- An outside law-enforcement agency not involved in the incident
- The primary law-enforcement agency involved in the incident
- The District Attorney's Office

The District Attorney's Office, based on the evidence gathered, establishes the presence or absence of criminal liability and develops a Fatal Incident Report. This report details the evidence and cites the District Attorney's conclusions. It is submitted to the Sonoma County Civil Grand Jury for an independent review.

Investigative Procedures

The Grand Jury reviewed the completed reports by the primary and outside agency, as well as the District Attorney's reports on the following incidents:

- 2/23/07 Fleeing murder suspect, known to be armed and dangerous, officer-involved shooting
- 3/12/07 Mentally ill juvenile armed and holding brother hostage, non-lethal intervention failed, officer-involved shooting
- 4/09/07 Mentally ill male firing bullets into ceiling, non-lethal intervention failed, officer-involved shooting

Findings

- F1** The Law Enforcement Employee-Involved Fatal Incident Protocol requires that investigations be conducted "free of conflicts of interest." For that reason, the investigations were conducted by a law-enforcement agency whose employees were not involved in the incidents. The District Attorney's Office also participated in the investigations and had the authority to investigate separately.
- F2** Upon completion of each incident investigation, the District Attorney's Office reviewed the physical evidence, the transcribed witness interviews, photographs, and all other evidentiary material.
- F3** Based on the evidence, the District Attorney's Office reached its conclusions and issued fatal-incident reports for the cases. In each, the District Attorney's Office concluded there was insufficient evidence of criminal liability.
- F4** The agencies that employ the involved officers conducted their own Administrative investigation of each incident. Administrative investigations seek to determine whether the agency's policies and procedures were followed in the incident and whether there could be improvement in those policies and procedures. They also make a determination as to whether any disciplinary action should be imposed against a particular individual or individuals.
- F5** Two of the incidents in this report involved the fatal shooting of mentally ill people. The Sonoma County Sheriff's Department is committed to its Crisis Intervention Training Academy (CIT) and has obtained \$360,000 in funding over the next five years from the Sonoma County Board of Supervisors to support the program. The initial 32-hour class was started on March 8, 2008. The Sheriff's commitment to CIT will result in the training of 35 Sonoma County law-enforcement officers twice a year. The overall program goal is to train 350 Sonoma County law-enforcement officers over the next five years. This class deals directly with the problems that officers encounter when confronting a mentally ill person.

Conclusions

Two of these cases were truly tragic deaths because they involved mentally ill subjects. It needs to be said that in Sonoma County there is no viable crisis-intervention option for the families of these mentally ill subjects. As a result, some of the responsibility for these deaths may be placed on the Sonoma County mental health care system.

A domestic violence call involving a mentally ill person is by far the most dangerous situation that a police officer will encounter. An officer is called to resolve this crisis when no one else can. The mentally ill subject is often irrational, experiencing delusions, and acting unpredictably. When there are weapons involved (as was the case here), the risk to the officer and everyone in the vicinity escalates dramatically.

If your loved one is wielding a weapon or firing a gun, the consequences are predictable. Police officers are human beings with families who take a sworn oath to protect lives and preserve peace. When they are confronted with violence they are not trained to retreat. They will react and use the force necessary to diffuse a situation safely. In some cases, lethal force is a result of the escalation of events. Saving their own lives, as well as those they are charged with protecting, is their duty.

In both of these cases non-lethal force was used, but had no affect on the mentally ill subjects. It was only after the failure of non-lethal force that lethal force was used to protect the lives of others. The Sonoma County District Attorney has concluded that all officer-involved protocols were followed and that no wrongdoing was found. After reviewing these fatal incidents, the Sonoma County Civil Grand Jury concurs with the District Attorney's findings.

The public is understandably shocked and dismayed when it hears about a mentally ill person being killed by a police officer. The thought that immediately comes to mind is that there must be a better way. Sonoma County law enforcement shares this concern. The new CIT program described in our findings is a giant step towards the achievement of a better outcome in these extreme situations. The course outline we reviewed should help our police officers understand and apply techniques to minimize the use of lethal force in these crisis situations.

Recommendations

- R1. The Sonoma County Grand Jury recommends that the District Attorney continue to notify them as soon as a fatal- incident protocol is initiated.
- R2. The District Attorney should continue to supply the Grand Jury with a copy of the fatal-incident report status log in a timely fashion and on a monthly basis.

Required Responses to Recommendations

District Attorney	R1, R2
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Ensuring Fairness in Child-Support Services

The Grand Jury investigated how child-support payments are monitored and tracked by the Sonoma County Department of Child Support Services (DCSS). These payments were formerly administered by the District Attorney (DA).

Our investigation indicates that management of child-support payments has improved since DCSS assumed responsibility of the program in 2002. Internal DCSS analysis led to changes in the management of child-support payments that made the process more sensitive to the concerns of parents and all other parties involved. Further steps must be taken by DCSS to ensure that everyone affected by the child-support system is well served.

Reason for Investigation

The Grand Jury received complaints alleging mismanagement of child-support payment procedures for custodial and non-custodial parents. The complainants claimed that from the 1990s through the first half of this decade, the DA's office and DCSS were unresponsive to complaints regarding inaccurate and inappropriate child-support responsibilities. This lack of responsiveness resulted in detrimental credit records of program participants, among other negative consequences.

Investigative Procedures

The Grand Jury interviewed and investigated the following sources:

- Two complainants
- Director of Sonoma County Department of Child Support Services
- Chief Attorney for Sonoma County Department of Child Support Services
- Policies, services, and procedures within DCSS
- Documentation from complainants

Findings

- F1** DCSS did not previously have a system for clear documentation of child-support payments.
- F2** DCSS did not accurately monitor responsibility of health insurance for the supported children.
- F3** DCSS was not monitoring to see that custody arrangements were not violated.
- F4** DCSS did not previously accept and review all pertinent documentation for support-payment cases.
- F5** DCSS clients are intimidated by the court system.
- F6** Some DCSS policies and procedures were not clear to participants, nor were they communicated effectively.
- F7** Terminology that was offensive to some parents was dictated at the State level; such terminology has since been modified or changed.

Conclusions

Previously, child-support services were under the jurisdiction of the DA. Once the responsibility transferred to DCSS, shortcomings of the child-support payment system received the attention they required. While DCSS continues to improve management of this system, mechanisms are required to manage the system more effectively, and to address the concerns of parents.

Commendations

The Grand Jury commends DCSS for establishing a more clean-cut tracking system for documenting child-support cases. In the past, the department offered employees classes in sensitivity training, and parenting classes for clients. It also developed a non-custodial-parent training program to assist in understanding that the custodial and non-custodial parents are in a business-partner relationship. Additionally, DCSS has improved its bilingual and cultural services. It is also commended for converting the child-support management system to a computerized database.

Recommendations

- R1** DCSS should educate clients on court procedures and the workings of the child-support system.
- R2** DCSS should provide clear and thorough documentation of child-support payments to all parties involved.
- R3** DCSS should clarify and verify responsibility of health insurance for children involved in each case.
- R4** To minimize disputes, DCSS should evaluate and monitor client understanding of and satisfaction with its services. Client evaluations should occur after three months, nine months, and annually thereafter.
- R5** DCSS should appoint a neutral third-party ombudsman to ensure a fair process. This volunteer would ideally have a background in child-support issues.

Recommendations, continued

- R6** DCSS investigations should include written documentation or other corroborating evidence regarding disputed issues.
- R7** If budget constraints allow, DCSS should reinstate parenting classes. If this training cannot be funded, volunteer resources should be explored.

Requested Responses to Recommendations

Sonoma County Board of Supervisors: R1, R2, R3, R4, R5, R6, R7

Required Responses to Recommendations

Sonoma County Department of Child Support Services: R1, R2, R3, R4, R5, R6, R7







ASSIGNMENT OF HEALTH CARE ACCESS AGREEMENT

Sutter Medical Center of Santa Rosa and Santa Rosa Memorial Hospital

In August 2007, the Grand Jury began an investigation on the proposed transaction between Sutter Medical Center and Santa Rosa Memorial Hospital. There was a large amount of publicity on this potential transfer, and concerns arose regarding the delivery of health care. In March 2008, after the jury completed multiple, extensive interviews, Sutter Medical Center announced the termination of its discussions with Santa Rosa Memorial and a desire to fulfill its contract with the County.

However, the Grand Jury feels that the information gained from this investigation is still pertinent and valuable for all citizens in the community. The information contained in this report would still be applicable if a similar situation arises in Sonoma County, and the only option for inpatient care should be a Catholic hospital. Therefore, we have decided to make this report available to the public.

Background

On March 26, 1996, Sonoma County leased its Community Hospital facility on Chanate Road to Sutter Medical Center and contracted for Sutter Medical Center to provide hospital services to the residents of Sonoma County through 2016.

In November 2006, faced with the necessity of seismic retrofitting of the Chanate campus, Sutter Medical Center developed plans for a new facility in the Mark West Springs Road area with a budget of \$300 million. This business plan was submitted and approved by the Board of Supervisors, which extended Sutter Medical Center's contract with the County until 2021.

Investigative Procedures

Interviews with key personnel at the following institutions:

Kaiser Permanente Medical Center Santa Rosa

Northern California Health District Board

Petaluma Valley Hospital Redwood Community Health Clinics

Santa Rosa Memorial Hospital

Sonoma County Department of Health Services

Sutter Medical Center of Santa Rosa

Sutter Medical Center Hospital Family Medicine Residency Program

The Grand Jury also interviewed several Sonoma County physicians and reviewed documents: (see reference list at end of report).

Sutter Medical Center posted significant losses in recent years and estimated a loss of \$10 million in fiscal year 2006. Faced with these realities, discussions were held between Sutter Medical Center and Santa Rosa Memorial to find solutions to this economic situation. These discussions resulted in a letter of intent submitted to Sonoma County Board of Supervisors by Sutter Medical Center and the Sisters of St. Joseph of Orange, who own Santa Rosa Memorial and eight other hospitals in California.

In January 2007, Sutter Medical Center and Santa Rosa Memorial Hospital (SRMH) came to an agreement whereby SRMH would assume Sutter Medical Center's obligations to the County. The services to be assumed by SRMH include:

- General medical and surgical care
- Women's reproductive care
- Charity care (costs exceed insurance or incurred bad debts)
- Care of the indigent
- Medicare
- Medi-Cal
- CMSP (County Medical Supplement Program)
- CCS (Crippled Children Services)
- CHDP (Child Health and Disability Program)
- Sexual assault victims
- Quarantine services
- HIV care
- Mental health services
- Drug and alcohol rehabilitation services
- Care of inmates confined at County facilities

Additionally, the agreement required Sutter Medical Center to operate the Family Medicine Residency Program, a three-year curriculum to train physicians for board certification.

Reason for Investigation

Sutter Medical Center's proposed transfer of its Health Care Agreement with the County to Santa Rosa Memorial raised questions about the delivery of healthcare in the County.

Published articles pointed to a variety of local health care issues, with the high cost of living and low reimbursement for physicians contributing to the challenges facing the delivery of health care in Sonoma County.

The Grand Jury examined the specifics of the Transfer Agreement in light of ensuring continued delivery of quality healthcare services in the area.

Findings

- F1** Sutter Medical Center has been operating with a significant financial loss since 2004. It has and will continue to require substantial subsidies from its parent company. In 2005, Sutter Medical Center had a net loss of \$6,837,400 (see Table 10, page 54, “A Preliminary study for Sonoma County Health Services”).
- F2** Santa Rosa Memorial Hospital has been operating with a stronger financial footing than Sutter Medical Center has, although its income is declining. In 2005, the SRMH had a net income of \$16,212,500 (Table 10, page 54, "A Preliminary study for Sonoma County Health Services").
- F3** The financial resources of the community would be stressed to meet the \$700 million, plus inflationary costs, in capital improvements required for seismic retrofit and updates to County medical facilities.
- F4** Research indicates that consolidation of services into one hospital has the potential for improved quality of care due to increased volume and additional resources.
- F5** The Family Medicine Residency Program, a three-year curriculum to train physicians for board certification, is not in jeopardy. The plan to transfer the program to a consortium existed prior to the letter of intent. The participants, UCSF, Sonoma County, Kaiser Permanente, SRMH, Sutter Medical Center (as an outpatient presence), and the Southwest Community Clinics had endorsed this plan.
- F6** Santa Rosa Memorial Hospital is constrained by the “*Ethical Directives for Catholic Healthcare*” which affect the delivery of women’s reproductive health care and end-of-life care. These directives do not apply to secular hospital settings (June 2001; see reference list).
- F7** The demand for cultural competency (knowledge of the language and cultural traditions of different ethnic groups) will increase with the transfer of patients from Sutter Medical Center to Santa Rosa Memorial. With an ethnically diverse patient population, lack of cultural understanding can be a barrier to in-patient-provider communication and health-care service.
- F8** Santa Rosa Memorial does not have adequate beds for obstetrics, intensive care, and neonatal intensive care to guarantee a seamless transfer of services. The earliest estimate that these beds are likely to be available is Fall of 2009.
- F9** The transfer would not significantly affect emergency services. Santa Rosa Memorial, the designated regional trauma center, is completing an expansion of its Emergency Department. Sutter Medical Center’s emergency services serve fewer patients, and those patients have less-acute conditions than those admitted to the trauma center at Santa Rosa Memorial. However, Sutter Medical Center’s services would be absorbed by development of other urgent-care facilities.

Findings, continued

- F10** Care of prisoners in the custody of the Sonoma County Sheriff's Department would not be negatively affected.
- F11** The *Ethical Directives for Catholic Healthcare* will not affect treatment of sexual assault victims mandated by California State Law.
- F12** Most therapeutic abortions are safely performed under local anesthesia in the outpatient setting. However, access to pregnancy termination services under sedation or anesthesia must be addressed, as this could be a life-threatening implication for women who require hospitalization.
- F13** The *Ethical Directives for Catholic Healthcare* prohibits birth control measures, i.e. tubal ligations for women and vasectomies for men.
- F14** This transfer would not negatively affect care for government-financed health insurance patients, i.e. Medi-Cal, Medicare, Child Health and Disability Program (CHDP), Crippled Children Services (CCS), and the County Medical Supplement Program (CMSP).
- F15** There are no measures to evaluate and monitor quality of care and compliance with contractual guidelines. The audit in the present agreement is for financial purposes only.
- F16** There has been no evidence of declining quality of care at Sutter Medical Center during the process of negotiation.
- F17** Santa Rosa Memorial Hospital's physical location and expansion plans, with helicopter transfers and neighborhood encroachment, are disturbing, inconvenient, and congested.
- F18** Concern exists over maintaining an adequate complement of physicians in the community due to financial burdens, e.g. cost of housing and office space, and low reimbursement by Medi-Cal and Medicare, as the Federal Government classifies Sonoma County as a rural area.
- F19** Santa Rosa Memorial, as the only major hospital and trauma center in the County, would have a greater advantage negotiating with insurers. With no competition in the bargaining process, this could increase rates for employers and the insured. (Rates determine premiums paid by employers and individuals for insurance coverage.)
- F20** Research shows that Catholic hospitals have not been favorable to the unionization of their employees, and the rate of pay is lower (see reference, February 2005).

Findings, continued

- F21** Lack of psychiatric beds for adults and adolescents has brought significant hardship to the citizens of Sonoma County and placed additional burdens on law enforcement. Twenty percent of adults at Sonoma County detention facilities are in need of mental health treatment.
- F22** A comprehensive evaluation of Warrack Hospital beds should be completed before they are decommissioned. Commissioning hospital beds for use is an expensive, arduous task involving State and Federal permits and inspections. Warrack has the capability for mental health or psychiatric services, and environmental and seismic issues should not be a deterrent.

Conclusions

- It is critical that the Board of Supervisors carefully review all elements of any proposed assumption of an access agreement, with guarantees that the same high standards of care be maintained if not improved.
- Neither Sutter Medical Center nor Santa Rosa Memorial is on solid financial footing. The capital investment of \$700 million required for expansion and seismic retrofitting, the growth of Kaiser Hospital, and the current national trends in medical economics make the presence of three hospitals financially unsound. The elimination of duplicate services could result in occupancy that is more efficient, increased delivery of services, and an overall higher standard of care that research shows is associated with larger facilities.
- A number of problems exist with the proposed transfer agreement, primarily centering on issues related to the contrast of the secular community hospital of Sutter Medical Center and Santa Rosa Memorial Hospital, which is constrained in its provision of services by the *Ethical Directives of Catholic Healthcare*. Women's reproductive services and end-of-life care are two important examples.
- Creative solutions to preserve a secular and universal approach to women's reproductive services are crucial to the success of this transfer of services. Currently, pregnancy terminations at Santa Rosa Memorial can be done only if the life of the mother is in imminent danger. However, sterilizations are performed when the physician is willing to claim extenuating circumstances. This policy is potentially reversible at any time by the local bishop and unacceptable when it is the only alternative for the general population.
- The nationally recognized Family Medicine Residency Program is a most valuable asset for our community and is crucial to attracting and maintaining both primary care and specialty clinicians. Sonoma County's unique combination of a high cost of living and a low rate of medical reimbursement make it difficult to replace physicians lost to retirement or relocation. The Residency Program represents our best stratagem against this dilemma. Plans are already under way to convert supervision of the program to a consortium of hospitals and clinics, which should serve to strengthen it.

Conclusions, continued

- While Kaiser Hospital serves 70% of the commercial health insurance in Sonoma County, government-insured programs such as Medi-Cal and Medicare cover 97% of Sutter Medical Center's patients. This population would constitute the majority of new patients that Santa Rosa Memorial would gain by the transfer. Santa Rosa Memorial has a fine record in dealing with charity care, as is mandated in the access agreement, but it would be challenged to serve the patient volume that would result from this transfer.
- Santa Rosa Memorial does not have the capacity at present to absorb Sutter Medical Center's obstetrical patients, intensive care patients, or neonatal intensive care patients. The additional 80 new medical-surgical beds just completed at the hospital are not situated in the correct location to allow them to be adapted to the above needs. The most optimistic estimate of when adequate numbers of these beds will be available is late 2009.
- Approximately 40% of the physicians that admit patients to Sutter Medical Center do not have privileges at Santa Rosa Memorial. Family practitioners who perform caesarean sections at Sutter Medical Center would not currently be able to obtain privileges for the same level of practice at Santa Rosa Memorial.
- There would be a greater need for cultural competency at Santa Rosa Memorial due to the increase in a younger, less affluent, ethnically diverse, and medically less-informed patient population.
- The service to the County for inpatient medical care of prisoners, treatment or quarantine of those with infectious diseases, HIV/AIDS, and residential alcohol programs that require acute services would not be affected.
- An unconscionable lack of adult and adolescent psychiatric inpatient care has affected citizens, the local medical community, law enforcement, and County detentions facilities.
- The percentage of inmates in Sonoma County jails and patients in health care facilities will increase with the recent departure of North Coast Psychiatric Center by Santa Rosa Memorial.

Commendations

The Grand Jury commends the Sonoma County Department of Health Services for its efforts to keep the public informed of the implications involved in this proposed transaction. The Grand Jury commends the Kaiser Permanente Foundation for its grant of \$2.9 million to support the development of the Family Medicine Residency Consortium.

The Grand Jury commends Sutter Medical Center for its excellent comprehensive women's health care program and cardiovascular services program. The Grand Jury commends Santa Rosa Memorial for its excellent trauma care program.

Requested Responses to Recommendations

Sonoma County Board of Supervisors

R1, R2, R4, R5, R6

Sutter Medical Center of Santa Rosa Board

R3

Recommendations

- R1** The Sonoma County Board of Supervisors should obtain guarantees from Sutter Medical Center and Santa Rosa Memorial to maintain the current high standard of care or an improved standard of care before the transfer of this or any comparable agreement.
- R2** The Sonoma County Board of Supervisors should explore every option to provide women’s reproductive health care in a secular and universally acceptable setting. The Board must not restrict the broader standard of care in the community, which the *Ethical Directives for Catholic Healthcare* limits.
- R3** Sutter Medical Center should consider other options for the use of Warrack Hospital before the beds are decommissioned, as a possible source for delivery of broad based secular care and services.
- R4** The Board of Supervisors should adopt a quality-of-care monitoring system to ensure existing standards are maintained and continuously improved. The monitoring of Health Employer Data Information Set (HEDIS) for outpatient care, and Core Measures required by the Joint Commission for Accreditation of Hospitals (JCAHO) is a baseline standard of performance. These performance measures, which are public information, are collected annually and should be reviewed by the Department of Health Services for compliance.
- R5** The Board of Supervisors should explore options, negotiate a contract, and have a formalized arrangement with an inpatient adult and adolescent psychiatric provider.
- R6** The Board of Supervisors should make a concerted effort to guarantee a fair process for physicians who currently have hospital privileges only at Sutter Medical Center to apply and receive comparable privileges at Santa Rosa Memorial before any agreement is transferred.

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Each year the Sonoma County Civil Grand Jury has the authority to examine the operation of any agency within the County. It is essential that taxpayers know that their tax dollars are being used wisely. This year the Grand Jury examined the Sonoma County Office of Education (SCOE) to learn its mandate, mission and vision for Sonoma County schools.

Sonoma County Office of Education: An Overview

Background

Among other sources, the California State Office of Education funds schools in the 58 counties of California. Funds are distributed to the county offices of education, including SCOE in Sonoma County, which then funds the schools. SCOE performs quarterly audits for compliance to monetary and performance standards. SCOE is responsible for oversight of the 40 districts. It also has primary responsibility for educating those students in three special programs:

- Regional Occupational Program (ROP)
- Court and Community Schools
 - For students in custody at juvenile facilities, or who are expelled for disciplinary reasons and removed from their district school.
- Special Education
 - For students with medical, mental, or physical disabilities and who require individual attention of aides.

SCOE employs approximately 600 Individuals. Half are certificated and work with Court and Community Schools, Special Education and Alternative Education or ROP, and half are classified and work as support staff.

Reason for Investigation

The State of California has determined that a 10-percent budget cut for schools is a probability with the new fiscal year. The Grand Jury sought to find out the effect this will have on Sonoma County schools and the plans in place to deal with this budget crisis. In addition, the Grand Jury wanted to understand the organization of SCOE, its responsibilities, and the functions of the Sonoma County Board of Education (BOE).

Investigative Procedures

Interviews with key personnel:

- SCOE, Superintendent of Schools
- SCOE, Assistant Superintendent of Business Services
- SCOE, Human Resources Director, Certificated
- SCOE, Human Resources Executive Director, Classified
- Sonoma County Board of Education, President

Documents reviewed: see bibliography

Findings

- F1** The Sonoma County Office of Education (SCOE), under the leadership of the Superintendent of Schools, distributes funds from the State of California Office of Education to the individual school districts depending on the schools' average daily attendance.
- F2** The Sonoma County Superintendent of Schools, elected to a four-year term, has the primary responsibility of providing leadership, support, and fiscal and performance oversight to all the school districts in Sonoma County. In addition, he acts as the Chief Executive Officer (CEO) to SCOE.
- F3** Sonoma County has 40 individual school districts serving approximately 71,000 students K-12. Each of these school districts has its own superintendent, board of education, teachers, and office and support staff.

Findings, continued

- F4** As an elected official, the Superintendent is accountable only to the electorate. The County Board of Education approves his salary, but his job performance is not subject to Board review.
- F5** The County Board of Education is composed of seven members who are elected from designated areas within Sonoma County, each area includes more than one school district. Their responsibilities are to approve the budget set by the Superintendent, to provide policy direction and oversight for Alternative Education and the Regional Occupational Program, to review and rule on appeals for student transfers between districts, and to serve as an appeal board for district-level student expulsion decisions.
- F6** The County Board of Education has influence over Alternative Education and ROP, but these programs represent a small part of the budget. BOE certifies learning materials used in the classroom, oversees quarterly reports of Williams Law compliance, manages lease-space requirements, approves the selling of capital equipment, and is responsible for the approval of charter schools designed to serve students throughout the county. (The Williams Law requires frequent monitoring of credentialed teachers assignments to ensure that schools with low performance scores on standardized tests have competent teachers and adequate materials).
- F7** SCOE, under the direction of the Superintendent, is responsible for fiscal and educational performance and oversight of school districts. It is required to report this information quarterly to the State Office of Education.
- F8** The State can assume control over local school districts, or SCOE can fund and assign a fiscal advisor with “stay and rescind” authority to assist the district to achieve fiscal stability.
- F9** The districts of Sonoma Valley and Healdsburg are subject to corrective administrative status after continued difficulties with the Federal Government’s guidelines for the “No Child Left Behind Act.” SCOE has assisted the Healdsburg School District with student performance and fiscal issues, and the State is reviewing the Sonoma Valley’s curriculum, testing, and teacher quality issues.
- F10** The Superintendent negotiates with several unions as their contracts come up for renewal. These unions represent teachers and ancillary staff. They are the California Federation of Teachers (CFT), Service Employees International Union (SEIU), Association of Sonoma County Office of Education (ASCOE), and Regional Occupation Program Teachers Association (ROPTA).
- F11** The Superintendent has a management team of Assistant Superintendents, Directors, and others in leadership roles. They assist and advise the Superintendent in developing and achieving the goals of SCOE, providing oversight and reporting quarterly, as mandated by the State of California.

Findings, continued

- F12** Projected State budget cuts of 10 percent will decrease or cut art and music programs and reduce the number of teacher's aides. Special Education teacher aides are mostly supported by federal funds and not likely to be affected by state budget cuts.
- F13** SCOE, under the direction of the Superintendent, is increasing its support to the districts with some of the following services:
- Performs Live Scan fingerprinting through the Department of Justice (DOJ) as a clearinghouse for prospective teachers, support staff, and volunteers to protect the security of students.
 - Assists Human Resources at the district level with up-to-date information on new laws and union procedures.
 - Conducts job searches, if requested by the districts, for superintendents and administrators at less cost than outside recruiters.
 - Offers a Beginning Teachers Support and Assessment (BTSA), a two-year program for new teachers.
 - Offers an Aspiring Administrator's Academy, in conjunction with Sonoma State University and Dominican College in San Rafael, for teachers interested in careers in administration.
 - Provides a website and phone-based automated calling system for requesting and assigning substitute teachers and assistants who have registered and been accepted by SCOE.
 - Offers a mentor program for new principals to orient and assist them with their new responsibilities.
 - Assists some of the smaller districts with purchasing supplies in bulk to minimize costs.
 - Assists districts with efforts to close the "learning gap" between native English speakers and English language learners through the Aiming High program.
 - Provides a district assistance intervention team, when requested, to help in "No Child Left Behind" program improvement to address issues and thereby avoid corrective action.
 - Promotes the K-16 Career Development Strategic Plan to assist students to prepare for and obtain meaningful careers with an efficient approach.

Findings, continued

- F14** School and College Legal Services (SCLS) is a Joint Powers Authority that contracts with schools and colleges throughout California. SCLS provides legal services to SCOE on a monthly retainer. It counsels on employer-employee issues, grievances, collective bargaining, and other aspects of school law. SCOE has a contract with SCLS through which SCOE provides payroll services for SCLS.
- F15** SCOE may support, under appropriate circumstances, teacher's use of Education Code Section 44922. At age 55 until age 70, certificated, full-time personnel may switch to part-time, receive a pro-rated salary, and are allowed health benefits the same as in their full-time position. To qualify, they must have at least 10 years of certificated employment, with the last five being full-time, without a break in service. This is informally referred to as the "Willie Brown" provision, named for its author, former Speaker of the House in the California Legislature.
- F16** SCOE does not support the practice referred to as "spiking", a process where teachers can enhance their retirement benefits by working extra hours in the year before retirement, i.e. summer teaching.
- F17** The issue of elected vs. appointed superintendents has been studied, at the request of SCOE, under the direction of the Superintendent, by a professor at Sonoma State, and previously, by the League of Women Voters in Alameda County. Neither study reached definite conclusions as to what would be the best for the counties involved.
- F18** Unification of Sonoma County's 40 school districts would address the duplication of effort and salaries of forty superintendents, district administrators and support staff.

Conclusions

- SCOE is doing an efficient job overseeing its responsibilities. The Superintendent has a background in education that has been beneficial to the organization and operations within SCOE.
- The Superintendent includes the next level of management in decision-making. Referred to as the Superintendent's Cabinet, this group meets regularly to discuss issues of oversight and reporting as mandated by the State of California.
- The Superintendent delegates to his staff and has an open door policy to encourage communication. He is always visible and strives to attract and retain the best employees.

Conclusions, continued

- SCOE has a cohesive team based on cross training. Due to deadlines, different departments are busy at different times, and they support one another when downtime occurs.
- Staff morale has been an issue in the past, but with the exception of the recent projected budget cutback, under the current management structure, a more positive environment has been incorporated into the workplace.
- It is the Grand Jury's opinion that appointing a Superintendent would increase the authority of the Board. The Board at present has no authority to evaluate the performance of the Superintendent but sets his salary and performs pro-forma duties.
- An elected superintendent must take valuable time from his office to run for re-election and if opposed, there is no guarantee that the best-qualified person for the job wins. With a job search, the County Board of Education—or a committee chosen for that purpose—researches, interviews, and approves the candidates, and it is not a political process. Additionally, running for election is costly.
- Historically, the unification of school districts in Sonoma County is a controversial issue. This matter has been studied and commented on since 1916, when there were 147 school districts in Sonoma County. Deep-seated issues of local control make this an emotionally-charged topic. Declining enrollment, changes in demographics, and monetary concerns will eventually reduce the number of districts.

Commendations

- The Grand Jury commends the Superintendent of Schools for his goal-oriented philosophy of leadership, fiscal oversight, and hiring of quality employees.
- The Grand Jury commends SCOE for its mission to educate all children in Sonoma County with quality occupational programs, special education, performance monitoring, and the desire to expand services in assisting the school districts
- The Grand Jury commends the Director of Human Resources for initiating, under the direction of the Superintendent, the recommendations of the 2006-2007 Grand Jury regarding fingerprinting and background checks for volunteers and others who are in contact with students.
- The Grand Jury commends the Assistant Superintendent of Business Services for her grasp of the issues and enthusiasm for her work.
- The Grand Jury commends the President of the County Board of Education for his knowledge of and desire to improve education in Sonoma County.

Recommendations

- R1 SCOE must ensure that school districts do not sacrifice important programs or decrease the number of teachers' aides as a way to balance the budget.
- R2 SCOE should explore the possibility of establishing an internship program for education majors at Sonoma State, Dominican College, and Santa Rosa Junior College to give student teachers classroom experience and allow them to assist teachers.
- R3 The Sonoma County Board of Education should explore options to increase its effectiveness. The Board represents a wealth of knowledge and needs to seek ways to change the paradigm of its work and increase its influence.

Required Responses to Recommendations

SCOE Superintendent of Schools	R1, R2
Sonoma County Board of Education	R3

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Sonoma County Administrator's Office

Managing a County in Transition

Sometime in the last decade, Sonoma County transitioned from being mostly rural to being mostly urban.

That's the impression of Sonoma County Administrator Bob Deis, the person with the most responsibility for running County government. With the support of the Sonoma County Board of Supervisors, his office is in the midst of transforming the way all County agencies operate. In recent years, the Board of Supervisors has made the County Administrator's Office (CAO) responsible for more of the day-to-day operation of county services. This allows Supervisors to spend more time working to achieve the county's long-term strategic goals.

Centralizing power in the CAO can improve the efficiency of County operations, which is key to meeting the County's goals during times of shrinking agency budgets. Making a single office responsible for so much of the people's business increases the risk of voices inside and outside County government not being heard by the ultimate decision-makers, the Board of Supervisors.

The CAO is doing a good job overall of handling the added responsibilities and managing the changes underway inside County government and generally throughout the community. However, more must be done by the CAO to ensure that all voices in the County—whether agency managers and employees or the citizens they serve—have the ear of the Board of Supervisors and the County Administrator.

Reason for Investigation

The Grand Jury is required to review agencies operating within the County on a regular basis to ensure that the people are being served by those entrusted to look out for their best interests. The 2004-2005 Grand Jury Reports required responses from the CAO, but dating back to 1992, there is no record of the Sonoma County Grand Jury conducting an investigation specific to the CAO.

Background

The CAO manages all aspects of County government. The County Administrator is hired by the Board of Supervisors to oversee the budgets of all County departments and special districts. The current County Administrator has served since 2003 and recently had his contract renewed by the Board of Supervisors for another five-year term. He has been employed by the CAO in various capacities since 1996 and has nearly 30 years of experience in government service.

Under the County Administrator are an Assistant County Administrator, three Deputy County Administrators, six Administrative Analysts, one Local Agency Formation Commission (LAFCO) Division Executive Officer, an Executive Secretary, and two Secretaries. Two Public Information Officer positions in the CAO have been approved by the Board of Supervisors but haven't been filled.

CAO analysts work with managers of all County agencies to determine the annual budgets of departments, requisition new positions, and plan other expenses. The CAO is also charged with developing and implementing the County's strategic plan. The County Administrator and the Clerk of the Board of Supervisors oversee the agenda of the weekly Board of Supervisors meetings.

Investigative Procedures

Interviews conducted:

- Two members of the Board of Supervisors
- One County Administrative Aide
- One County elected official
- Three former Sonoma County employees
- Two County Administrative Analysts
- Three County Budget Analysts
- One County department head
- County Administrator

Documents reviewed:

- Sonoma County Budget, 2007-2008
- CAO organization chart
- Sonoma County website

Findings

- F1** The Board of Supervisors is pleased with the County Administrator's performance.
- F2** The Board of Supervisors conducts an informal performance review of the County Administrator annually.
- F3** County employees at all levels are generally satisfied with the performance of the CAO.
- F4** The Board of Supervisors, County Administrator, and other department heads and managers in County government believe they are accessible to all County employees.
- F5** Some County employees believe they are unable to share their concerns about the operation of their specific departments and County government in general with the County Administrator or the Board of Supervisors.
- F6** Some County workers believe morale has suffered in recent years because County management doesn't address the problems that staff members bring to their attention.
- F7** The County Administrator is perceived by many County employees and managers as being less accessible than his predecessors in the position, and less likely to consider their suggestions.
- F8** The County Administrator exercises near-unilateral control over the agenda of the weekly Board of Supervisors meeting.
- F9** In recent years, most open positions have been filled by external candidates rather than through internal transfers or promotions. This requires more spending for recruitment and often results in higher salaries being offered to attract the most qualified candidates. Since this often means an entire salary range has to be increased, existing staff members in those positions may also receive raises above what they would have merited otherwise.
- F10** The County's five-year strategic plan is expected to be finalized this summer. According to the County Administrator, it focuses on matters not currently being addressed adequately by County departments. The County Administrator indicates that the plan will focus on five areas:
1. Improving roads
 2. Maintaining the criminal justice system
 3. Enhancing the visibility of County agencies to the communities they serve
 4. Adapting to demographic changes occurring in the County
 5. Upgrading County facilities

Commendations

The Grand Jury commends the CAO for devising and beginning the implementation of a strategic plan for the County. The office has also begun internal audits of County agencies in an attempt to make them more efficient.

Conclusions

The transitions now underway in the County have affected staff at every level. Some County employees believe there is no one to whom they can express their concerns about the problems they perceive in County operations. There is also concern about how well County employees are being prepared to assume greater responsibility through internal promotions. Relying on outside hires to fill department-head and other management positions as they open up increases salary ranges throughout the affected agencies at a time when salaries already account for a growing percentage of overall agency budgets.

The County's future is in the hands of the CAO. The office has made great strides in recent years toward developing and implementing a long-overdue strategic plan. The CAO has begun to remake the way County government operates. These changes can be difficult for County employees, as well as for the citizens they serve. It is imperative that during the transition the CAO make an extra effort to keep the lines of communication open with Sonoma County residents and all county workers.

Recommendations

- R1** The Board of Supervisors and the County Administrator should ensure that Sonoma County residents and County employees have a way to get their concerns heard by the people who are deciding the County's future.
- R2** The CAO should plan and implement programs to encourage career development for County employees. Grooming internal candidates for top management positions saves the County money in recruitment and helps control salaries and other personnel costs.
- R3** The CAO should continue to audit County agencies to help them operate more efficiently and identify ways to offer County residents more and higher-quality services during times of shrinking County budgets.

Required Responses to Findings

Board of Supervisors	F5, F6, F8
County Administrator	F5, F6, F7, F8, F9

Required Responses to Recommendations

Board of Supervisors	R1
County Administrator	R1, R2, R3

