**COUNTY OF SACRAMENTO**
**CALIFORNIA**

For the Agenda of:
August 26, 2003
Timed: 10:00 AM

To: Board of Supervisors

From: County Executive Office

Subject: Proposed Response To 2002-2003 Grand Jury Final Report

Contact: Paul Lake, 874-8537

*Overview:*
The 2002-2003 Grand Jury Final Report identified issues involving four County departments: Coroner; Environmental Management; Finance; Sheriff. The attached report responds to the findings and recommendations of the Grand Jury.

*Recommendations:*
1. Adopt this Report as Sacramento County's response to recommendations contained in the 2002-2003 Grand Jury Final Report.

2. Instruct the Clerk of the Board to forward a copy of this Response to 2002-2003 Grand Jury Final Report, to the Presiding Judge of the Superior Court.

3. Instruct the Clerk of the Board to forward a copy of this Report, Response to 2002-2003 Grand Jury Final Report, to the Grand Jury Foreman, and to each county Agency Administrator and department head.

*Fiscal Impact:*
Department staff invested a total of 50 hours into responding to the Grand Jury Report (not counting the Sheriff's Department, whose time and cost data was not available at the time of this report). The cost of this time was $4,555.

**BACKGROUND:**

Each year the Sacramento County Grand Jury concludes its work and releases its Final Report, typically during the last week of June. The Report, which can deal with a variety of activities, functions and responsibilities of local governmental bodies, typically contains findings and recommendations. State law requires the affected governing bodies to respond to each of these recommendations. The law requires that this response be directed to the Presiding Judge of the Superior Court by September 30, 2003.

#37

**COUNTY OF SACRAMENTO**
**Inter-Department Correspondence**

August 26, 2003

**TO:** Terry Schutten
County Executive

**FROM:** Cindy H. Turner, Clerk
Board of Supervisors

**SUBJECT:** **Item #37, August 26, 2003, Agenda**
**Proposed Response To 2002-2003 Grand Jury Final Report**

The Board of Supervisors, at a regular meeting held on Tuesday, August 26, 2003, adopted the report as the County response. The Board further instructed the Clerk forward a copy of the response to the Grand Jury Foreman, the Presiding Judge of the Superior Court, County Agency Administrators and Department Heads.

Cc: Grand Jury
Presiding Judge, Superior Court
Agency Administrators
Department Heads

Gd:mem37aug26.03.doc

The form of the County's responses as required by law is as follows:

> As to each grand jury **finding**, the responding person or entity shall indicate one of the following:
> (1) The respondent agrees with the finding.
> (2) The respondent disagrees wholly or partially with the finding, in which case the response shall specify the portion of the finding that is disputed and shall include an explanation of the reasons.
>
> As to each grand jury **recommendation**, the responding person or entity shall report one of the following actions:
> (1) The recommendation has been implemented, with a summary regarding the implemented action.
> (2) The recommendation has not yet been implemented, but will be implemented in the future, with a timeframe for implementation.
> (3) The recommendation requires further analysis, with an explanation and the scope and parameters of an analysis or study, and a timeframe for the matter to be prepared for discussion by the officer or head of the agency or department being investigated or reviewed, including the governing body of the public agency when applicable. This timeframe shall not exceed six months from the date of publication of the grand jury report.
> (4) The recommendation will not be implemented because it is not warranted or is not reasonable, with an explanation.

The recommended responses follow these requirements.

## DISCUSSION:

Staff has arranged this year's response to the Grand Jury's Final Report (Fiscal Year 2002-2003) by county agency, with findings and recommendations applicable to individual departments within the agency. Page numbers indicate where each item is located within the Grand Jury's Final Report. In addition, for ease of reference, staff has numbered all recommendations consecutively.

## FISCAL ANALYSIS:

Total hours and costs for departments responding the Grand Jury Report are as follows:

| Department | Time (Hours) | | Cost |
|---|---|---|---|
| Coroner | 17.5 | $ | 1,457 |
| EMD | 12.0 | $ | 1,728 |
| Finance | 4.5 | $ | 200 |
| Sheriff | n/a | | n/a |
| County Executive | 16.0 | $ | 1,170 |
| TOTAL | 50.0 | $ | 4,555 |

As always, we are pleased with the work of the Grand Jury and although there may be some differences of opinion, we are most appreciative of their hard work, commitment, and dedication.

Respectfully submitted,

TERRY SCHUTTEN
County Executive

# Sacramento County Agenda and Record Processing Application
# Approval List



**Approval List for Agenda Item 100228**

John O'Farrell 08/19/2003 Approved

COUNTY OF SACRAMENTO
CALIFORNIA

# RESPONSE TO 2002-03 GRAND JURY FINAL REPORT

## PUBLIC PROTECTION AGENCY

### Sacramento County Coroner's Office (pp. 1-16)

**Findings and recommendations:**

**Grand Jury Finding #1.** Death investigation historically has been folded into law enforcement duties. This combination is inappropriate in the face of advanced medical knowledge in the diagnosis of unnatural and violent deaths. Death investigation is a medical science and should be performed by medically qualified people. Death certification is a healthcare issue.

**County Response:** **Disagree With Finding** - Death investigation is a team effort that is jointly conducted by the forensic pathologists and the Deputy Coroners to determine the circumstances, manner and cause of death. The forensic pathologists are qualified to determine the cause of death. The Deputy Coroners are trained in law enforcement techniques to ascertain the circumstances surrounding the death and medically educated to determine the manner of death, which can be a homicide, a suicide, an accident, a natural death, or undetermined.

**Grand Jury Finding #2.** In the United States there has been a trend in large population centers to convert to a medical examiner system of death investigation. Such a system now serves 48 percent of the population of the United States and 40 percent in California.

**County Response:** **Disagree With Finding** - There is no trend in California to convert to Medical Examiner Offices. California has four Medical Examiner's Offices (San Diego, San Francisco, Santa Clara, and Ventura), compared to 11 separate Coroner Offices and 43 Sheriff-Coroner Offices. In short, there is no statewide trend to making the change recommended by the Grand Jury. In the early 1990s, the Los Angeles County Board of supervisors eliminated the Medical Examiner's Office and converted to a separate Coroner's Office similar to Sacramento County's Coroner's Office.

**Grand Jury Finding #3.** Coroners with few exceptions are administrators and/or peace officers with no medical qualifications or training. Very few are physicians. Medical Examiners are licensed physicians who have completed medical school, four to six years of postgraduate training in pathology, including forensic pathology fellowship. They are board certified in anatomic, clinical, and forensic pathology.

**County Response:** **Disagree With Finding** - The Coroners and Deputy Coroners in California are medically trained, based on a combination of their education, prior work experience, and in-service training, and educated in law enforcement principles. This dual training makes them uniquely qualified to investigate deaths, report their findings to the forensic pathologists, and complete the necessary interviews and protocols required to close cases.

**Grand Jury Finding #4.** Death investigation should be performed by an independently funded, autonomous office unrelated to law enforcement or prosecutorial agencies, answering only to the governing board of the jurisdiction. There should be clear separation of scientific medical decisions from non-qualified individuals, agencies and political interests.

**County Response: Agree In Principal, With Qualification-** The Coroner is appointed by the Board of Supervisors based on recommendations from the Public Protection Agency Administrator and the County Executive. The Coroner's Office is separate from both the Sheriff's Department and the District Attorney's Office so it can be independently funded, and other law enforcement or prosecutorial departments do not influence the findings of the Coroner's Office. The forensic pathologists have the responsibility and authority to determine the cause of death for all coroner cases.

The Coroner's Office staff of forensic pathologists, Deputy Coroners, and support personnel have done an excellent job investigating very complicated cases in Sacramento County as well as those cases referred by other Counties because of the high quality reputation of this Office.

**Grand Jury Finding #5.** The performance of death investigation does not require law enforcement background. Forensic pathology fellowship includes this training, and forensic board certification requires this knowledge.

**County Response: Disagree With Finding -** Although board certified forensic pathologists are trained in death investigation, many doctors in California and throughout the country are performing autopsies, who are not specially trained or board certified. They rely on Deputy Coroners with law enforcement training to respond to death scenes, collect the relevant information, and prepare a report of findings. Responding to death scenes is an essential requirement for both Medical Examiner Offices and Coroner Offices. Since there are only 500 board certified forensic pathologists in the United States, it would be impossible for these few doctors to respond to all suspicious or unexplained death scenes. In contrast, the forensic pathologists in the Sacramento County Coroner's Office respond to homicide cases with the Deputy Coroners. This reflects the team approach of specialists established by this Office.

**Grand Jury Finding #6.** There is no legal impediment to a medical examiner discharging all functions of death investigation. In Sacramento County the authority for death investigation would be conveyed by creation of the Office of Medical Examiner.

**County Response: Disagree Partially With Finding -** While there is no legal impediment to a medical examiner discharging all functions of death investigation, there is likewise no legal impediment to a board certified forensic pathologist applying for the Coroner position when it is vacant. A Medical Examiner's Office is not required for a physician to apply for this job and would require voter approval and a charter amendment to establish a Medical Examiner's Office in Sacramento County.

**Grand Jury Finding #7.** In Sacramento County the Office of the Coroner is within the Public Protection Agency and operates under the administrator of that agency and the County Executive. It is defined as an administrative position with no formal medical qualifications required. It is frequently combined with other county positions.

**County Response:** **Disagree Partially With Finding** – The Class Specifications for the Coroner requires knowledge of forensic medicine, investigative techniques and procedures, and understanding of the laws relating to the Coroner's function. These are minimal qualifications, which are exceeded by the current Coroner. The Sacramento County Coroner's résumé was shared with members of the Grand Jury that summarizes his 20 years experience in hospital administration, State of California responsibilities for health planning, and his doctorate from the University of Southern California that has a specialization in health services administration. In short, the Coroner and Deputy Coroners in the Sacramento County Coroner's Office are highly qualified and trained.

Although the Coroner did have dual responsibility for the Coroner's Office and Correctional Health Services for a temporary period of time, this is no longer the case. The Coroner works full-time in the capacity of Coroner.

**Grand Jury Finding #8.** In Sacramento County, on an annual basis, a deputy coroner with no formal medical qualifications authorizes the signature of death certificates in approximately 4500 reportable deaths without consultation or knowledge of the department forensic pathologists. The assistant coroner, also with no formal medical training, is empowered to determine the extent of death investigation and the final manner of death and cause of death of the approximately 1400 decedents transported to the office for evaluation. This provision can include overruling the judgment of the pathologist. The compromise of medical autonomy is not just theoretical; cases confirming have been documented.

**County Response:** **Disagree With Findings** - The Assistant Coroners and Deputy Coroners have been trained to conduct death investigations, identify the circumstances surrounding death scenes, and determine the manner of death. The 4500 reportable cases referred to in this finding are hospice and hospital deaths where the attending physician agrees to sign the death certificate that lists the cause of death the doctor specifies in these natural deaths. The forensic pathologists determine the cause of death for the 1400 decedents who are transported to the Coroner's Office; and the Assistant Coroner or Deputy Coroner consults with the forensic pathologists if there are questions regarding the manner of death.

Although this finding states that cases have been documented where the Assistant Coroner has overruled the judgment of the pathologist, only one Sudden Infant Death Syndrom (SIDS) case was cited in the Background and Facts section of the Grand Jury Report to substantiate this statement.

This 2001 case involved a child death that was classified by the Coroner's Office as a SIDS case without an autopsy being performed. The details of this specific case were communicated to the Board of Supervisors in a December 19, 2003, letter that was signed by Penelope Clarke, Public Protection Agency Administrator. Since there were no suspicious circumstances regarding the death, the University of California Davis Medical Center (UCDMC) doctor signed the death certificate as SIDS, and the family did not want an autopsy performed due to religious objections, the Coroner's Office closed this case without an autopsy as permitted in the California Government Code (Section 27491.41).

Dr. Mark Super, the Chief Forensic Pathologist for the Coroner's Office, informed the Grand Jury members that he and the other forensic pathologists have complete medical autonomy in

determining the cause of death for coroner cases. This is the single most important function of the forensic pathologists, and they request information from community physicians, health care facilities, Deputy Coroners, law enforcement agencies, and other community resources to make a final determination as to the cause of death. These medical findings are not altered by the Coroner or Deputy Coroners and are listed on the death certificate that is finally issued by the Coroner's Office.

**Grand Jury Finding #9.** On September 11, 2001, the Board of Supervisors authorized changes in the Coroner's office from contractual pathology and morgue services to county employees, further compromising medical autonomy and discharging a pathology group that by all accounts was professionally excellent. The transition may have created problems with respect to recruitment of pathologists and homicide testimony. The decision was made despite significant opposing written advice and testimony from the local medical community. The chief forensic pathologist continues to be a contractual employee.

**County Response: Disagree With Finding** - The change approved by the Board of Supervisors in September of 2001 was recommended because it provided more flexibility to the Coroner's Office in recruiting both contract and County forensic pathologists, resulted in a cost saving to the County general fund and increased services to both the Sacramento County residents and agencies within the community.

Recruitment of excellent forensic pathologists has not been a problem since the conversion to County staff, and all three of the current pathologists have testified on homicide cases for the District Attorney's Office. In contrast, the president of Northern California Forensic Pathology was not board certified or board eligible while working on a contractual basis for the Sacramento County Coroner's Office. This is in conflict with Grand Jury Recommendation #3 of the Grand Jury Report.

The Coroner's Office has achieved in excess of $300,000 in General fund savings because of this change. In addition, customer service has significantly improved. The forensic pathologists are now providing in-service education to the Deputy Coroners, responding to homicide scenes and discussing cases with law enforcement agencies, and answering next of kin questions regarding autopsies performed by the physicians. This was not done when Northern California Forensic Pathology had the contract with the Coroner's Office for forensic pathology services.

The Sierra Sacramento Valley Medical Society, Dr. Robert Anthony's attorney, and a local physician supported Dr. Robert Anthony, the president of Northern California Forensic Pathology, urged the Board of Supervisors not to approve the change recommended by the Coroner's Office. Although there was some opposition to this change by selected members of the medical community, their concerns regarding recruitment of forensic pathologists and medical autonomy have proven to be unfounded.
The Coroner's Office has three excellent and highly qualified forensic pathologists who were recruited since the Board of Supervisors approved the transition plan to County staff in September of 2001. Dr. Mark Super has informed the Grand Jury members that medical autonomy has not been compromised as a result of this change.

**Grand Jury Finding #10.** On December 11, 2001, the Board of Supervisors created a conflict of interest in the investigation of in-custody deaths by placing the coroner in charge of

correctional health. This conflict was in place at a time of intense scrutiny regarding inmate deaths/suicides. There is pending litigation. The conflict was only partially resolved by an autopsy contract with San Joaquin County and the very recent transfer of correctional health to the Sheriff's Department. This action was also the subject of major objection in the medical community. Investigation of in-custody deaths by an independent medical examiner's office in concert with a district attorney's investigator will resolve this conflict.

**County Response: Disagree With Finding** - The Coroner is no longer responsible for Correctional Health Services. As documented by the Grand Jury, the cause of inmate deaths was determined by the San Joaquin County Sheriff-Coroner's Office while the Sacramento County Coroner was responsible for CHS. Since the Sheriff's Department now manages CHS, it is appropriate for the Coroner's Office to resume full responsibility for these death investigations, including performing the autopsies for these cases.

**Grand Jury Finding #11.** Coroner and Medical Examiner systems operate outside the usual medical oversight and control. There are no national standards or guidelines. Therefore voluntary review and certification by organizations such as National Association of Medical Examiners (NAME) and American Board of Medical Legal Death Investigators (ABMDI) are desirable. Affiliation with the UCD Department of Pathology would facilitate subspecialty consultation, development of policy and quality assurance.

**County Response: Agree With Finding** - Deputy Coroners are encouraged to apply for ABMDI membership and certification, and several Deputies have either completed or are in the process of finishing these certification requirements. Also, the Coroner's Office already has an affiliation with the University for morgue services, a forensic fellowship, UCDMC resident rotation, and clinical appointment of the forensic pathologists for in-service training and education. With the recent budget reductions, NAME certification may not be possible because of NAME staffing requirements.

Dr. Super is a fellow in the American Academy of Forensic Sciences and has a membership in the National Association of Medical Examiners. Dr. Fiore has membership in both the American Academy of Forensic Sciences and in NAME. Dr. Rollins is a member of the American Academy of Forensic Sciences.

**Grand Jury Finding #12.** With the above review and affiliation, the excellent physical plant already in place and conversion to a medical examiner system assuring medical autonomy, Sacramento County will attract excellent forensic pathologists and be in position to develop a state of the art death investigation program.

**County Response: Disagree With Finding** - The Coroner's Office already has recruited excellent forensic pathologists and has over the years developed a state of the art reputation for death investigation. This reputation is why other counties refer complex cases to the Sacramento County Coroner's Office for cause of death determination.

Dr. Mark Super, the Chief Forensic Pathologist, is fully board certified and has many years of experience working in a Medical Examiner's Office and in a private forensic group practice providing services to northern California Coroner and Sheriff-Coroner Offices.

Dr. Stephany Fiore is fully board certified, previously worked as a fellow in the Sacramento County Coroner's Office, and completed a two-year fellowship in neuropathology in the Medical Examiner's Office in New York during the 911 tragedy.

Dr. Curtis Rollins is both an odontologist and has passed his boards in forensic pathology. He completed his fellowship in forensic pathology in the Sacramento County Coroner's Office and worked as the Medical Examiner in Arizona before returning to the Sacramento County Coroner's Office. He plans to take his examination in anatomical pathology next summer.

Dr. Rollins is also responsible for performing the homicide, rule-out homicide, and possible SIDS cases for Amador County and El Dorado County. He was instrumental in helping Sacramento contract with these jurisdictions for autopsy services. He has also provided court testimony on Sacramento County homicide cases he processed prior to moving to Arizona. Since his employment as a County forensic pathologist in 2001, Dr. Rollins has testified seven times in homicide cases (Sacramento County 3 times, San Joaquin County once, Alameda County once, and twice in El Dorado County). As a point of information, the District Attorney's Office has objected to Dr. Rollins performing homicide autopsies on Sacramento County cases. The Coroner's Office does not have a "permanent restriction" on the autopsies Dr. Rollins can perform and is working with the District Attorney's Office to resolve this issue.

**Grand Jury Finding #13.** Conversion to a medical examiner system would not be difficult from an operational standpoint. The Coroner's staff would not have to be replaced and would adapt quickly to medical emphasis and supervision.

**County Response:** **Disagree With Finding** - At least three additional board certified forensic pathologists would have to be recruited, additional County general fund would be needed to finance this change, and a charter amendment is required to establish a Medical Examiner's Office in Sacramento County. This conversion to a medical examiner system would be costly, involve the displacement of some County personnel, reclassification of civil service classifications for Deputy Coroners, and recruitment of three board certified forensic pathologists.

**Grand Jury Finding #14.** A financial analysis of the transition has been reviewed by the jury and thought to be neutral, with no additional funding necessary for the operation of a medical examiner system.

**County Response:** **Disagree With Finding** - Creation of a Medical Examiner's Office is not budget neutral. In addition to the cost of recruiting, there is the added expense of at least $449,000 for forensic pathology personnel and related expenditures.

The Grand Jury did not share its comparative financial analysis to support this conclusion. However, discussions with the Chief Forensic Pathologist, who has worked in the Medical Examiner's Office in San Diego, and other coroner personnel familiar with Medical Examiner operations unanimously agree there would be a significant cost increase to transition to a Medical Examiner organization. These cost increases are summarized below. Based on the most recent budget reductions, no savings would be achieved in Deputy Coroner positions, morgue attendants, or support staff if a decision was made to convert to a Medical Examiner's Office.

There would be a net increase of $449,500 to replace the coroner with a medical examiner. These increased expenditures would have to be funded from an additional County general fund allocation and transferred to the new Medical Examiner's Office if Sacramento County residents voted to make this change. Other costs would increase in order to be able to recruit a medical examiner. It is standard throughout the country that a medical examiner have an executive secretary (which the department does not currently have), additional medical equipment in his/her office, and a higher-level, more expensive continuing education budget. These cost differentials are detailed below.

| Cost Item | Cost Increase/ (Decrease)* |
|---|---|
| Medical Examiner | $ 225,000 |
| (2) Assistant Medical Examiners | $ 414,000 |
| Executive Secretary for ME and Assistant MEs | $ 65,000 |
| Equipment and Supplies | $ 30,000 |
| Medical Education Costs for ME and Asst. MEs | $ 13,500 |
| Elimination of Existing Coroner Position | $ (184,000) |
| Elimination of Existing Assistant Coroner Position | $ (114,000) |
| TOTAL COST INCREASE | $ 449,500 |

*Includes salaries and benefits

**Grand Jury Finding #15.** Change to a medical examiner system requires a charter amendment and electorate participation.

**County Response: Agree With Finding, With Qualification** - Although a voter approved Charter amendment is required to establish a Medical Examiner's Office in Sacramento County, no findings of mismanagement or inappropriate handling of cases were cited by the Grand Jury to justify eliminating the Coroner's Office organization structure and replacing it with a Medical Examiner's Office, resulting in a significant increase in County general fund costs.

**Grand Jury Finding #16.** There have been complaints of inappropriate pressure by deputy coroners placed upon attending physicians to certify deaths when the physicians had inadequate knowledge as to the cause of death. This problem appears resolved.

**County Response: Disagree With Finding** - The Coroner's Office does not concur that Deputy Coroners have applied inappropriate pressure to private physicians attending Sacramento County residents prior to their death. These issues arise when private doctors have access to the decedent's medical record and history but are reluctant to sign the death certificate. This is an educational process, which has involved the County's Public Health Officer, so doctors better understand how to correctly complete death certificates that list the cause and manner of death for patients under their care.

**Grand Jury Recommendation #1.** The citizens of Sacramento County should be served by a medical examiner system headed by a board certified forensic pathologist appointed by the governing board. The Office of the Medical Examiner is autonomous, independently funded, and responds only to the Board of Supervisors.

**County Response: Implementation of Recommendation Not Warranted** - The Grand Jury does not present a factual basis for its recommendation to establish a Medical Examiner's Office. There are no references to mismanagement in the Coroner's Office or situations where cases were inappropriately handled. Rather, a theoretical construct and/or preference for a Medical Examiner's Office is presented that is based on research. The Coroner's Office is autonomous, independently funded as a separate department, and reports to the Board of Supervisors through the Public Protection Agency Administrator and County Executive. Creation of a Medical Examiner's Office would increase County costs without significantly improving services to Sacramento County.

**Grand Jury Recommendation #2.** To establish this office the Board of Supervisors should propose and place on the ballot a charter amendment to abolish the Office of Coroner and replace it with the Office of Medical Examiner. Failing that, the board should propose and place on the ballot a charter amendment to require the coroner to be a forensic pathologist. Failing that, the board should appoint a forensic pathologist to be coroner at the earliest opportunity.

**County Response: Implementation of Recommendation Not Warranted** - No factual basis is presented by the Grand Jury to support this recommendation. Appointment of a board certified forensic pathologist to manage the Coroner's Office and/or a Medical Examiner's Office would increase County general fund costs without improving the County's mandate to determine the circumstances, manner, and cause of coroner cases in Sacramento County.

**Grand Jury Recommendation #3.** The Chief Medical Examiner should be selected by a search committee of medical experts utilizing non-political and strictly professional criteria, including prior administrative experience. All staff pathologists should be board certified in forensic pathology. They can be contractual or county employees.

**County Response: Implementation of Recommendation Not Warranted (In Part)** - The Coroner's Office does not concur that a Chief Medical Examiner is needed to manage a Medical Examiner's Office. However, this Office does agree that the Coroner should be selected though a competitive Civil Service process to ensure the most qualified doctor or non-physician be identified and submitted to the Board of Supervisors for appointment. Also, the Coroner's Office agrees that the forensic pathologists should be board certified or eligible to sit for the examinations, not only in forensic pathology but also in anatomic pathology.

Dr. Mark Super, the Chief Forensic Pathologist, is fully board certified and has many years of experience working in a Medical Examiner's Office and in a private forensic group practice providing services to northern California Coroner and Sheriff-Coroner Offices.

Dr. Stephany Fiore is fully board certified, previously worked as a fellow in the Sacramento County Coroner's Office, and completed a two-year fellowship in neuropathology in the Medical Examiner's Office in New York during the 911 tragedy.

Dr. Curtis Rollins is both an odontologist and has passed his boards in forensic pathology. He completed his fellowship in forensic pathology in the Sacramento County Coroner's Office and worked as the Medical Examiner in Arizona before returning to the Sacramento County Coroner's Office. He plans to take his examination in anatomical pathology next summer.

In short, all three of the current doctors have previously worked in a Medical Examiner's Office and subsequently decided to work in the Sacramento County Coroner's Office.

**Grand Jury Recommendation #4.** The Medical Examiner System of Sacramento County should establish a strong relationship with the UCD Medical Center for development of lines of consultation, quality assurance and continuing education programs. The system should utilize professional organizations for review, certification and guidelines of operation. There should be medical emphasis in the recruitment and continuing education of staff. A forensic pathologist should supervise each reported decedent investigation and sign the death certificate of all those studied in the medical examiners office. A pathologist should supervise all morgue functions.

**County Response: Implementation Under Way, With Qualification** - A Medical Examiner's Office is not needed to achieve this recommendation. The Coroner's Office agrees with the intent of this recommendation and has developed a strong relationship UCDMC since moving into the present building in July of 1996. Since 1996, UCDMC and the Coroner's Office have had a contractual agreement where UCDMC utilizes the Coroner's Office for morgue facilities and morgue attendant personnel. Pathology residents from the University rotate through the Coroner's Office for autopsy experience and in-service education provided by the County's forensic pathologists. In addition, UCDMC and the Coroner's Office have a joint affiliation to co-sponsor a forensic fellowship program. The County's forensic pathologists have clinical appointments with UCDMC so they can provide in-service training to both residents and clinical staff as needed or requested by the University.

In order for forensic pathologists to supervise each decedent investigation, sign the required death certificates, and supervise all morgue operations, at least three more physicians are needed in addition to the existing team of 13 Deputy Coroners. This increased expense is not warranted given the excellent job that is currently done by the existing forensic pathologists, Deputy Coroners, and support staff.

**Grand Jury Recommendation #5.** The investigation of in-custody deaths should be separate from correctional health and the Sheriff's Department. It should be performed by an independent medical examiner and district attorney investigator.

**County Response: Implementation of Recommendation Not Warranted (In Part)** The investigation of inmate deaths is performed by an independent Sacramento County Coroner's Office. A Medical Examiner's Office is not needed to conduct this function. All in-custody deaths include a two-part investigation that includes the Sheriff's Department and the Coroner's Office. In addition, these deaths are reported to the State Attorney General's Office for review. Cynthia Besemer, Chief Deputy District Attorney, does not concur the District Attorney's Office should be involved in the investigation of inmate deaths.

The Correctional Health Services (CHS) conflict of interest concern raised by the Grand Jury neither has been nor is an issue. The Coroner's Office has investigated inmate deaths for decades without any problems or conflict of interest allegations. When CHS was temporarily

transferred to the Coroner's Office in 2001, autopsies were performed by the San Joaquin County Sheriff-Coroner Office to ensure that cause of death was independently determined. Now that CHS has been relocated to the Sheriff's Department, the Coroner's Office has resumed this function and responsibility and reports its findings to the Sheriff's Department. The forensic pathologist's autopsy report and Investigator's Final Report are a matter of public record and available to both the media and next of kin if there are any questions regarding the cause of death or investigation conducted by the Coroner's Office.

## COMMUNITY DEVELOPMENT AND NEIGHBORHOOD ASSISTANCE AGENCY

### Environmental Management Department (pp. 29-34)

**Findings and recommendations:**

**Grand Jury Finding #1.** In the past the Environmental Health Division has been very lax in its responsibility to provide mandated food inspections in a timely manner. In comparison, San Diego and Los Angeles both have established risk-based programs, which led to more inspections where extensive food preparation occurs and could be potentially hazardous. Sacramento inspectors have to waste time trying to track down mobile food carts who list only their main distribution address but not their site location, causing a backlog of these inspections.

**County Response:** **Disagree in Part** – Due to a number of vacancies and difficulty in recruitment, inspections were not performed in a timely manner. In 2001 there was a consolidation of class specifications and, therefore, salaries of Environmental Health and Hazardous Materials staff. This resulted in a net increase in salary for Environmental Health staff (including Food Protection staff). Since the consolidation, recruitment for Food Protection staff has improved and all positions are filled. It should be noted that State and Local law does not mandate a specific number of inspections. In addition, inspectors document their time activities and there is no evidence that there is time spent "tracking down" mobile food carts. Mobile food carts generally provide their site location on the application for permit as there is a State mandated requirement that a restroom be located within 200 feet of the cart operation. Records of inspection activities indicate no "backlog" of mobile food cart inspections.

**Grand Jury Recommendation #1a.** Give priority to inspections based on risk assessment, putting resources to work where the risk is highest. Increase inspections to 2 or 3 per year for full food service establishments with complex menus where large amounts of food are prepared.

**County Response:** **Implementation Under Way** – On March 11, 2003 the Environmental Management Department (EMD) recommended to the County Board of Supervisors an increase in the number of inspections at facilities identified as handling and preparing unpackaged food items (risk based inspections). The Board unanimously approved this recommendation with implementation on July 1, 2003. As a result, those facilities that handle and prepare unpackaged food will be inspected twice per year as opposed to the previous once per year. The Board also approved a fee increase to pay for additional staffing to accomplish these inspections. EMD has begun the hiring process of this new staff.

**Grand Jury Recommendation #1b.** Require owners of mobile food carts to come to the County office for their inspections during a single month of the year, e.g., January. Schedule them all during that month.

**County Response:** **Implementation Under Way** – Currently, mobile food facilities, including carts, are inspected at the EMD office location unless the facility operates out of an approved commissary. When a mobile food facility operates out of a commissary, it has been EMD's practice to schedule inspections at the commissary site to inspect many mobile facilities at one

time. As the permits on these facilities are based on a calendar year (color-coded decal placed indicating approval for a given year), these facilities can be required to obtain their permit during the month of January. This policy can be put into place beginning calendar year 2004 with notice to affected facilities during 2003.

**Grand Jury Finding #2.** The Environmental Health Division needs more staff devoted to food preparation inspections and needs to allocate tasks to maximize the staff they have.

**County Response: Disagree in Part** – There is agreement that the Environmental Health Division needs more staff to conduct inspections at specified facilities, and that staff recruitment is in progress (see County Response #2 below). However, through tracking of activities it is apparent that tasks have been "allocated" such that there is a maximizing of staff to accomplish the required tasks.

**Grand Jury Recommendation #2.** Staff should be increased from 11 to at least 22 full time inspectors. Each inspector should be provided personal digital assistant (PDA) devices (palm pilots) to enter timely results of their inspections. All inspectors should have access to the automated database. Increased inspection fees from risk-based inspections and mandatory re-inspection fees should cover the cost of increased staffing.

**County Response: Implementation of Recommendation Under Way, With Qualification** – As mentioned in Response 1a, EMD has obtained approval from the County Board of Supervisors to increase the number of inspectors to accomplish the expanded inspection frequency. It was determined through analysis of the workload that six additional full-time Environmental Specialists were required to accomplish the new inspection frequency, not the 11 new positions recommended by the Grand Jury. This would increase the current staffing from eleven full-time equivalent positions to seventeen.

In coordination with three adjacent Environmental Health agencies (Santa Clara, Alameda and Marin Counties) and through grant funding from the United States Food and Drug Administration, EMD participated in a pilot program utilizing a PDA to conduct inspections. As a result of this pilot and surveillance of other inspection programs, EMD is in the process of beginning a pilot utilizing a handheld inspection device capable of handling the required amount of information needed to conduct an inspection. The FDA-funded pilot revealed that current PDAs are not capable of maintaining and accepting that amount of information.

All inspection staff has access to the automated database as this is required to enter information on work performed.

As mentioned in Response 1a, the increased inspection frequency is paid through fees to those facilities receiving increased inspections. Re-inspection fees are currently paid by those facilities receiving the re-inspection and some of these fees are used to fund staff.

**Grand Jury Finding #3.** The Environmental Health Division is not disseminating its inspection results effectively to the public.

**County Response: Disagree in Part** – In 2001, State law required posting of a sign indicating that the last Inspection Report was available upon request. This law was enacted to provide the

public with information regarding inspection activities and was enforced throughout the State. The issue of the most effective method of disseminating inspection results to the public is an issue that EMD will be dealing with as outlined below in County Response #3a.

**Grand Jury Recommendation #3a.** Give the public what it wants and issue letter grades to restaurants inspections, which must be prominently displayed. Certificates or awards of excellence could also be given to restaurants consistently receiving a letter grade of A over 3 consecutive inspections.

**County Response: Implementation of Recommendation Not Warranted** – The recommendation to issue letter grades to restaurants which must be prominently displayed was reviewed at length during the public review period on the Food Protection Program enhancements. Of the four recommendations given to the County Board of Supervisors for consideration on March 11, 2003, this item was the only issue not related to public health improvement or discussed in State or local regulations. The recommendation in the Grand Jury Report states that EMD should "give the public what it wants..." EMD does not believe there has been adequate public information and inquiry to arrive at consensus as to the public will.

EMD staff and management engaged in significant research as to the options, issues and efficacy of various disclosure options, including letter grading, prior to developing a recommendation. While letter grading has an obvious simplistic appeal, EMD identified a number of problems that were discussed at length in our workshops, Sacramento Environmental Commission (SEC) hearing and before the Board of Supervisors. EMD recognizes the potential for letter grading to have value at a future date, specifically if and when there are State-wide standards and practices developed, and the issue should be periodically revisited.

EMD recommended posting the actual Inspection Report on site and also has begun posting inspection results (summary) and Inspection Reports on its web site. This recommendation was made after careful deliberation on what exactly public disclosure of inspection results should include. Public posting of the actual Inspection Report gives the public information on what exactly the inspector observed as violations during the inspection.

EMD recommends further analysis of this topic through use of the existing Sacramento Environmental Commission. The SEC, which consists of representatives from the County and incorporated cities, serves to provide information, analysis and advice to EMD on matters affecting environmental programs. Representatives on the SEC include individuals with backgrounds in community advocacy, environmental law, and environmental regulation among other diverse backgrounds. Use of the SEC on this topic will include opportunity for public input as their meetings are announced and open to the public. The SEC will have opportunity to accept public input, review other models for public notification and recommend to EMD an appropriate plan of action. As is required by Statute, the time line of response from the SEC and recommendation to the Grand Jury shall not exceed six months and should take no longer than three months in total.

Regarding the Certificates or Awards of Excellence for consistent high compliance levels, this recommendation was presented to the Board of Supervisors on March 11, 2003 and will be implemented in Fiscal Year 2003-2004.

**Grand Jury Recommendation #3b.** The county Environmental Health Division should establish its own Web site to post all food inspections results including grades, enforcement or closure actions, follow-up inspections, and complaint remedies.

**County Response: Implementation of Recommendation Complete** – EMD discussed the issue of posting information on its own web site during the presentation to the Board of Supervisors on March 11, 2003. EMD had been working on a web site and was planning on a July 1, 2003, implementation date to coincide with the other enhancements to the Food Protection Program. As of July 1, 2003, the EMD web site is operational and available for use at www.foodinspect.saccounty.net. The site includes all food inspections (actual reports), summary of reports, and closures.

**Grand Jury Finding #4.** The county Environmental Health Specialists (inspectors) displayed a high degree of professionalism during inspections. The inspectors took time to explain violations and to train restaurant employees.

**County Response: Agree**

**Grand Jury Recommendation #4a.** The county Environmental Health Division should encourage inspection staff development by allowing staff to attend training programs sponsored by government agencies and leaders in the food safety industry.

**County Response: Implementation of Recommendation Completed Prior to Grand Jury Report** – EMD provides training to staff through both in-house training sessions and through attendance at training programs sponsored by governmental agencies and leaders in the food safety industry. In Fiscal Year 2003-2004, each and every employee in EMD is provided an updated training plan which outlines training appropriate to the employee's job duties. In Fiscal Year 2002-2003, employees in the Food Protection Program attended training in food safety provided by the State of California Department of Health Services and the United States Food and Drug Administration, among others. Additionally, employees in this program attended training offered by the National Environmental Health Association, California Environmental Health Association, Association of Food and Drug Officials and the Conference for Food Protection.

EMD will continue to allow and encourage staff to attend training programs.

**Grand Jury Recommendation #4b.** The County Environmental Health Division should consider establishing an apprenticeship program to encourage recent college graduates to enter the field. Such a program would allow these individuals to move up to staff positions after they become Registered Environmental Health Specialists.

**County Response: Implementation of Recommendation Completed Prior to Grand Jury Report** – EMD and the Food Protection Program, in particular, has several existing Student Intern positions. During the past two years, EMD has initiated a practice to fill these positions with students who have either a particular interest in Environmental Health or have a science background necessary to work in the field of Environmental Health. Of the current staff in Food Protection, two Environmental Specialists and one Supervising Environmental Specialist are products of this outreach to students. Currently, of the four Student Interns on staff, three are

fulfilling the educational requirements to become Environmental Specialists. In addition, EMD has conducted outreach to California State University, Sacramento and to the University of the Pacific to encourage science majors to consider the field of Environmental Health as a career option.

**Grand Jury Finding #5.** The Environmental Health Division does not provide sufficient penalties for food service establishments to improve.

**County Response: Disagree in Part** – There are many tools available to the inspector in gaining compliance, and imposition of penalties is one option that is utilized when warranted. Prior to the Grand Jury Report, EMD had already implemented by Policy the option of enforcement through penalty of State and Local laws (see County Response #5a below).

**Grand Jury Recommendation #5a.** Enforcement actions with severe implications should require immediate closure of the facility and mandatory re-inspections, paid for by the violator. Increase education for minor violations.

**County Response: Implementation of Recommendation Under Way, With Qualification** – In April of 2003, EMD developed and implemented an Inspection and Enforcement Policy. The purpose of this document was to standardize staff in the Program on inspection procedures, use of education in gaining compliance and use of progressive enforcement when education does not work. The options available to an Environmental Specialist to utilize to gain compliance include use of Administrative Hearing Process, citation, referral to District Attorney and, when necessary, immediate closure of facilities that present an imminent danger to public health. This Enforcement document was reviewed and approved by County Counsel and the SEC. Though many of these enforcement tools were used prior to April 2003, the Policy now documents and formalizes a standard and uniform approach to progressive enforcement.

EMD, through County Ordinance, has instituted re-inspection fees for over 10 years. The regulated community and the public support this practice.

**Grand Jury Recommendation #5b.** Increased enforcement should lead to administrative hearings for repeat violators with ultimate license revocation.

**County Response: Implementation of Recommendation Completed Prior to Grand Jury Report** – As mentioned in our Response to Recommendation 5a above, use of an Administrative Hearing process with the ultimate outcome of permit revocation is a procedure available for use by Environmental Specialists. The procedure is outlined in the Inspection and Enforcement Policy and is also formalized through procedures specified in both State and County Code.

## CHIEF FINANCIAL OFFICER

### Department of Finance (pp. 37-48)

**Findings and recommendations:**

Note: The Grand Jury findings and recommendation referenced in this section relate to complaints and media coverage of alleged problems with fiscal management in certain water districts. The Grand Jury directed most of its findings and recommendations on this issue to the districts. The Grand Jury directed one recommendation to the County.

**Grand Jury Finding #1.** District directors on the whole do not have financial or accounting backgrounds. They rely on their audit reports to ensure that their district's operation is fiscally sound.

**County Response: County has no basis upon which to comment on this finding.**

**Grand Jury Recommendation #1b.** The Sacramento County Director of Finance should schedule regular, selective reviews of district audit reports for completeness and financial impact on ratepayers, and report any anomalies to the respective water district board of directors.

**County Response: Implementation of Recommendation Not Warranted -** It is outside of the County's responsibility to report "anomalies" to special districts' elected governing boards nor to review or comment on financial impacts on ratepayers. In accordance with Government Code section 26909, the Sacramento County Department of Finance (DOF) is only responsible to ensure that special districts located within Sacramento County have an audit performed in accordance with this section, that the audit is in accordance with proper auditing standards, and that all statements, schedules, and footnotes are included in the report. If DOF does not receive the reports by the required submission date, DOF contacts the special district to determine the status of the audit.

The audit report contains information on the financial condition of the district. The independent certified public accountant who performs the audit should be available for any specific questions that the governing board may have regarding the financial condition of the district and any related impact on rate payers.

Reviewing audit reports for financial impact on ratepayers and reporting audit anomalies to governing boards is the responsibility of the executive staff of the districts and the independent auditors. DOF could only go beyond its current responsibility with legislative change. Additionally, DOF would need time to assess the costs of such an extension of responsibility.

**SHERIFF'S DEPARTMENT**
**(pp. 49-53)**

**Findings and recommendations:**

**Grand Jury Finding #1.** The School Resource Officer is essential to the safety of students at schools.

**County Response: Agree with Finding**

**Grand Jury Recommendation #1.** That all comprehensive high schools which serve Sacramento County students have on campus a school resource officer.

**County Response: Recommendation Will Not Be Fully Implemented By Sacramento County Sheriff's Department** - The Sheriff's Department concurs with the recommendation that all high schools have an officer assigned or access to an officer. Unfortunately the Sheriff's Department sustained a $6,484,832 reduction in its 2003-04 budget. This has required the Department to prioritize its resources with 911 response and Jail Operations being the highest priorities. As a result several beneficial programs such as Problem Oriented Policing and School Resources Officers sustained reductions.

The number of S.R.O.'s in the 2002/03 budget was twenty-five (25). The number in the 2003/04 budget is thirteen (13). All of the positions in the 2003/04 are being funded by school districts. No county funds are being expended on the program for the 2003/04 Fiscal Year.

**Grand Jury Recommendation #2.** That intermediate schools have a school resource officer.

**County Response: Recommendation Will Not Be Fully Implemented By Sacramento County Sheriff's Department** - The Sheriff's Department concurs with the recommendation that all high schools have an officer assigned. Unfortunately the Sheriff's Department sustained a $6,484,832 reduction in its 2003-04 budget. This has required the Department to prioritize its resources with 911 response and Jail Operations being the highest priorities. As a result several beneficial programs such as Problem Oriented Policing and School Resources Officers sustained reductions.

The number of S.R.O.'s in the 02/03 budget was twenty-five (25). The number in the 2003/04 budget is thirteen (13). All of the positions in the 2003/04 are being funded by school districts. No county funds are being expended on the program for the 2003/04 Fiscal Year.

**Grand Jury Recommendation #3.** That continuation high schools have a school resource officer.

**County Response: Recommendation Will Not Be Fully Implemented By Sacramento County Sheriff's Department** - The Sheriff's Department concurs with the recommendation that all high schools have access to an officer. Unfortunately the Sheriff's Department sustained a $6,484,832 reduction in its 2003-04 budget. This has required the Department to prioritize its

resources with 911 response and Jail Operations being the highest priorities. As a result several beneficial programs such as Problem Oriented Policing and School Resources Officers sustained reductions.

The number of S.R.O.'s in the 02/03 budget was twenty-five (25). The number in the 03/04 budget is thirteen (13). All of the positions in the 03/04 are being funded by school districts. No county funds are being expended on the program for the 2003/04 Fiscal Year.

**Grand Jury Recommendations #5 and #6.** These are not within the control of the Sheriff's Department.