June 2004

To the People of San Luis Obispo County

This Final Report is presented to you by the 2003-2004 San Luis Obispo County Grand Jury. It is the compilation of the major inquiries conducted during our service.

Each July the Superior Court for the County of San Luis Obispo impanels a Grand Jury to serve through the following June. Thirty candidates, including up to ten holdovers from the previous jury, are nominated by Judges of the Superior Court. The names, minus holdovers, are then drawn in a lottery-type process. The first nineteen, including holdovers, are sworn in and constitute the Grand Jury. Eleven alternates are chosen in the order in which they are drawn. At the filing of this report, the 2003-2004 Grand Jury consists of seventeen jurors, including three who were originally chosen as alternates.

The 2003-2004 Grand Jury represents a wide range of ages, from a young Cal Poly senior political science major, to residents well into their retirement. Our education and experience includes retired teachers, farmers, executives, a social worker, an employed technician, professionals, and a retired city manager, professor, and law enforcement officer. Most of the county geographical areas were represented. The commonality among jurors was the commitment and responsibility to the citizens of the county they represented. For many of us, serving as jurors was a significant education on how local government functions. It was also an opportunity to provide recommendations, where appropriate, for improvements.

Each juror participated on two committees that met at least weekly, and more often as the year progressed. The committees were: County, City, Law & Justice, and Health & Social Services. We also held weekly general session meetings, where the committees provided status reports and the Grand Jury deliberated on voting matters. A quorum of at least 12 members was always present for official voting.

Our inquiries were initiated by citizen complaints or by a juror, committee, or the Grand Jury as a whole. The 2003-2004 Grand Jury received nearly eight hundred citizen complaints concerning fifty different issues. These complaints were first referred to the appropriate committee to review and to conduct a preliminary investigation. If the complaint met the established criteria, the committee would recommend that the Grand Jury authorize further investigation.

Many complaints did not require action beyond the initial review. In some cases these complaints were not within our county or civil jurisdiction, or we determined that the issues could best be resolved through other avenues. Other reasons we did not pursue a complaint included: the matter was currently in the legal process, it was received too late in our term, or, in the judgment of the Grand Jury, it was not in the best interest of the community to pursue.

Grand Jury work was not confined to the jury offices. As you will read in our reports, jurors conducted numerous on-site inspections, including the required reviews of the California Men's Colony and the El Paso de Robles Youth Authority. We also met with many department heads, and visited the San Luis Obispo County Jail, Juvenile Hall, and Office of Emergency Services. Toward the end of our term, we toured the PG&E Diablo Canyon Power Plant.

In the course of our investigations, we interviewed more than 70 witnesses. We thank all those who contributed their time and energy in providing important information to us. The offices of both the District Attorney and County Counsel provided significant legal guidance for our investigations. Their responsiveness and thoroughness was greatly appreciated.

The California Penal Code requires that the Grand Jury submit a Final Report to the Presiding Judge of the Superior Court prior to the end of its term. As required, the judge approved this report prior to its publication.

For a report that includes findings and recommendations, elected county officers and heads of county agencies and departments must reply to the Presiding Judge within 60 days. The governing bodies of other public agencies, concerning matters under their control, must respond within 90 days.

The required responses are specified in Penal Code § 933.05, as follows:

> (a) ... 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 therefor.
>
> (b) ...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. The 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 therefor.

Agency, Board of Supervisors, and other responses to Grand Jury findings and recommendations are required to be on file with the clerk of the public agency, the office of the county clerk, and the currently impaneled Grand Jury. We anticipate that the responses to this report will be available on the Grand Jury web site by the end of this year.

Myron Gilbert, Cambria
Foreperson

Cari Keane, San Luis Obispo

Ron Greenlee, San Luis Obispo
Pro Tem

Paul A. Knecht, San Luis Obispo

M.B. (Buff) Lawson, Los Osos
Secretary

Bette J. Kulp, San Luis Obispo

Stephen Allyn, San Luis Obispo

Ronald V. Magofffin, San Luis Obispo

John Brison, San Luis Obispo

Terry Mulhall, Atascadero

Jim Carson, Arroyo Grande

Earle Polinsky, Arroyo Grande

Carol Colclough, Pismo Beach

Joyce D. Short, Pismo Beach

David Cole, Morro Bay

Don Vickers, Arroyo Grande

Cosmo Insalaco, Arroyo Grande

VEHICULAR MANSLAUGHTER CASE TABLED ON DEPUTY DA'S TABLE

Synopsis

On the evening of September 7, 2002, the Grover Beach Police Department responded to the report of an accident involving a vehicle and two pedestrians crossing Grand Avenue at Fifth Street. This accident caused one pedestrian fatality. The police investigated and sent their report to the San Luis Obispo County District Attorney's Office. The District Attorney's Office did not file any charges against the driver or reject the case, and, after six months, sent the case to the Attorney General's Office for its review. The Attorney General also declined to file charges and returned the case to the District Attorney's Office on August 26, 2003. Later, two deputies from the Attorney General's Office came to our Grand Jury office to present their reasons for declining to file charges against the driver.

This Grand Jury report examines the handling of the case by the Grover Beach Police Department and the San Luis Obispo County District Attorney. Key issues include: 1) the time taken to process the case in the District Attorney's Office, 2) why it was transferred to the California State Attorney General's Office, 3) the time the case was held at the Attorney General's Office, and 4) why and how the District Attorney finally filed the charge after the Attorney General's rejection. California law requires the prosecuting attorney to file charges in a misdemeanor manslaughter case within one year of the victim's death; otherwise, the statute of limitation prevents filing and prosecution. The Grand Jury, knowing of the approaching statute of limitation deadline, made this investigation a top priority. It was not until September 5, 2003 that the District Attorney filed one charge of misdemeanor manslaughter.

Why the Grand Jury Investigated

In August 2003, the parents of the fatally injured girl petitioned the Grand Jury to explore why the District Attorney's Office did not act. The family had been frustrated in their attempts to receive information about the status of the case, and later, by the Attorney General's decision not to file. The concerned family and others submitted 704 complaints to the Grand Jury requesting an investigation, the first arriving on August 14, 2003. The family sought to motivate action because the impending September 11, 2003 expiration of the statute of limitation would prevent any subsequent criminal prosecution.

Authority

The Grand Jury exercises its authority to investigate the San Luis Obispo County District Attorney under Penal Code 925, which states "The grand jury shall investigate and report on the operations, accounts, and records of the officers, departments or functions of the county" and for the Grover Beach Police Department under Penal Code 925a, which authorizes the investigation of city departments. The last two parts of this report are informational only, and are included to help the reader make the bridge between the case leaving, then returning to the county.

Background

A traffic accident occurred in Grover Beach that resulted in the death of a 17-year-old girl. Typically, in a case of a traffic accident resulting in a fatality, the law enforcement agency of the local jurisdiction where the accident occurred conducts a comprehensive investigation of the accident scene, the vehicle, and any persons who were involved or witnessed the event. After assessing the information compiled, the local agency then forwards its report, along with any recommended charges, to the County District Attorney's (DA) Office for review of the file, any necessary additional investigation, and a decision whether or not to file charges against any participants. If the DA's Office feels that charges are appropriate and a reasonable chance exists to sustain the charges, the DA will file the determined charges with the appropriate court of law.

The DA is elected by the voters of the county to a four-year term to lead the county's prosecuting agency. Due to the volume of misdemeanor and felony cases forwarded to the DA's Office by local law enforcement agencies each year, the DA employs a staff of deputy DAs to assist with review and prosecution of cases. Among these are a chief deputy who serves to oversee the deputies; a filing deputy responsible for case review and filing of the less serious, or misdemeanor cases; and a filing deputy for the more serious felony cases. The filing deputies must make the decision whether or not to file charges before the statute of limitation expires. Once it expires, the opportunity to prosecute ends, regardless of the merit of the charges or the ability to successfully prosecute the case. When the filing of a case involving injury or death occurs, the Victim Witness (VW) Division of the DA's Office is notified. VW then assigns a staff advocate to provide assistance and support to the victim and/or family throughout the process of prosecution.

When a valid or perceived conflict of interest exists, the DA's Office may request a review by the Attorney General's (AG) Office. The AG's Office also employs a staff of deputies and assistants to handle the review and prosecution of cases. If, in the opinion of the AG's staff attorneys, sufficient grounds exist to file charges and a reasonable chance for prosecution exists, the AG's Office will file charges in an appropriate court. Generally, if the AG's Office determines that grounds are insufficient, the case is closed and the matter ends.

Method of Investigation

The Grand Jury requested, in some cases subpoenaed, copies of the police file, the driver's previous driving history, his court and probation records, and his insurance claim pertaining to this accident. Some of the documents gathered for the investigation include the District Attorney's *Protocol Addressing Conflict of Interest* and *Case Management* and *Complaint Filing Procedures.* In addition we obtained Victim Witness notes, various correspondence, attendance sheets, and workload records for the Misdemeanor Filing Deputy District Attorney (Filing Deputy). The Jury also examined minutes of the Pension Trust Fund meetings for the past five years, Pension Trust Fund travel and expense vouchers for that Filing Deputy and the Tax Collector who is the father of the driver involved in the accident. We then reviewed the above materials, which precipitated our need to question individuals on several matters.

The jury conducted interviews with police officers from the Grover Beach and Pismo Beach departments who responded to the accident. We interviewed many District Attorney personnel to learn what actually transpired in the District Attorney's Office after the police report was submitted. We questioned the intake secretary, the Filing Deputy, the Chief Deputy District Attorney, three other deputy district attorneys, the information technology lead programmer, and three victim witness advocates including the Victim Witness Director who had talked with the family. In all interviews conducted, the GJ placed the witnesses under oath and admonished them not to discuss the proceedings with anyone else. At least nine jurors were present at each interview, and the proceedings were tape recorded for later reference and review by the jurors who were not able to attend. Some of these interviews were transcribed by one of the jurors for clarification of the facts.

Members of the Grand Jury visited the location of the accident at night, observed the scene, the lighting, and even crossed the street using the same crosswalk. Later, two deputies from the Attorney General's Office came to our Grand Jury Office to present their reasons for declining to file charges against the driver.

We developed this report for the public after reviewing the information extracted from a myriad of sources. We have organized the data chronologically within each section as much as possible. The investigative Parts 1 and 2 detail the events by numerical order. The informational sections, Parts 3 and 4, use the narrative form. Acronyms will be used throughout the report for convenience. The following table of acronyms will help the reader.

Acronyms Used	
AG	**California Attorney General**
AGH	**Arroyo Grande Hospital**
DA	**San Luis Co. District Attorney**
GB	**Grover Beach**
GBPD	**Grover Beach Police Dept**
GJ	**San Luis Co. Grand Jury**
MAIT	**Calif. Highway Patrol's Multidisciplinary Accident Investigation Team**
PB	**Pismo Beach**
SLO	**San Luis Obispo**
VW	**Victim Witness**

Part One: Grover Beach Police Department (GBPD)'s accident investigation

Part Two: San Luis Obispo County District Attorney (DA)'s Office processing and Victim Witness (VW) handling of the case

A) Communication within DA staff and filing conflicts:
What went on in the DA's Office?

B) Case remains in the DA's Office for six months without a decision to file or reject: How could "shelving" of the file go unnoticed for six months?

C) Victim Witness involvement: How could the VW Office better assist the family?

Part Three: Transfer of the case to the California Attorney General (AG) Office

Part Four: The District Attorney reclaims the case. AG Office relinquishes the case to the SLO DA Office and DA files the charge of vehicular manslaughter without gross negligence.

PART ONE
Grover Beach Police Department Investigates

Facts:

(1) Two teenage female pedestrians were crossing Grand Avenue northbound at 5th Street in Grover Beach at 9:04 p.m. on Saturday, September 7, 2002.

(2) A 1997 Chevrolet Tahoe was traveling west on Grand Avenue at the same time.

(3) The vehicle struck the pedestrians, causing serious injuries that resulted in the subsequent death of one girl and minor injury to the other.

(4) GBPD responded to the emergency call.

Findings:

(1) The GB police officer on patrol at the time arrived within two minutes of the accident.

(2) The San Luis Obispo Ambulance Service was requested at 9:06 p.m., arriving at 9:10, to provide medical attention and to transport the seriously injured victim to Arroyo Grande Hospital (AGH). A second ambulance, summoned at 9:12 p.m., arrived at 9:17, took the other victim to AGH where she was treated and released.

(3) The GB responding officer interviewed and took statements from five witnesses at the site of the accident.

(4) The GB officer interviewed the driver and administered a preliminary alcohol breath test, then released him.

(5) When another GB police officer came on duty, that officer went to the driver's home, and at 10:11 p.m., took him to AGH to obtain a blood sample.

(6) Neither the first-responding GB police officer, nor his watch commander on duty at the time of the accident, had the training required to issue a citation at the scene of the accident unless he had witnessed the accident.

(7) A Pismo Beach police officer with advanced traffic accident training arrived at 9:57 p.m. and assisted with the investigation, as requested by GB police.

(8) The GB police officer's report did not indicate any adverse weather or lighting conditions as contributing causes of the accident.

(9) The police report showed no tire skid marks on the pavement.

(10) The GBPD impounded the vehicle and arranged for a full inspection.

(11) The GB officer and a police volunteer took photos that night, and later, during the accident reconstruction.

(12) On September 10, 2002, the GBPD requested that California Highway Patrol Multidisciplinary Accident Investigation Team (MAIT) inspect the vehicle. MAIT inspected the vehicle on September 12, 2002.

(13) MAIT's vehicle inspection ruled out malfunction as a cause of the accident.

(14) September 11, 2002, four days after the accident, the seriously injured victim died from the injuries she had sustained.

(15) On September 24, 2002, the GBPD submitted a complete report in triplicate - including accident details, photos, medical reports, and witness statements - to the SLO County DA Office.

(16) The GB police accident report recommended that the DA review the report for possible prosecution of the driver for violation of *Penal Code Section 192(C)*, vehicular manslaughter without gross negligence, and *Vehicle Code Section 21950(a),* pedestrian right of way at a crosswalk.

(17) After submitting its report to the DA's Office, GBPD considered its task complete. Per the department's standard operating procedure, police personnel did not make any further inquiries about the case or the possible prosecution of the driver.

Conclusions:

(1) The GBPD conducted a thorough investigation of the accident.

(2) Accident reconstruction efforts followed guidelines detailed in the *Collision Investigation Manual.*

(3) Weather, lighting, and vehicular malfunction were ruled out as causative factors.

(4) GBPD insured that the appropriate medical reports were included in the investigation package before delivery to the DA.

(5) The initial responding officers were unable to write a citation at the scene because they lacked the requisite training.

(6) GBPD processed the case efficiently and effectively.

(7) GBPD's delivery of the complete report to the DA's office was timely.

Recommendations:

(1) The GBPD should make every reasonable effort to train additional field personnel so that citations may be written at the scene, when appropriate.

(2) In future cases involving death or serious injury, the GBPD should routinely follow up and inquire of the DA as to the status of the case.

GBPD Response Requirement

Under Penal Code Section 933(c), the governing body of the GBPD shall comment to the presiding judge on these findings and recommendations no later than 90 days from this report's publication.

PART TWO
District Attorney's Office Processing and Victim Witness Handling of the Case

A. What went on in the District Attorney's Office?

Facts:

(1) The DA's receptionist received the file from the GBPD on September 24, 2002 and date-stamped it.

(2) The Intake Secretary personally delivered the large file to the Deputy DA responsible for misdemeanor filings after numbering and processing the file.

(3) No system was in place at that time for tracking misdemeanor cases.

(4) The file remained in the Filing Deputy's office from late September 2002 until March 26, 2003.

(5) The Filing Deputy did not contact GB or PB police officers about their accident investigation, or call upon the DA investigators to conduct additional investigation.

(6) The Filing Deputy stated to the GJ that he did not discuss with his colleagues his problem with filing.

(7) The District Attorney received a letter from the victim's mother on March 18, 2003, questioning the delay in filing charges.

(8) On March 26, 2003, the Chief Deputy DA told the filing deputy to file the case.

(9) The Filing Deputy said he could not file the case because he could not find a violation of the vehicle code.

(10) This same Filing Deputy filed serious criminal charges against this same driver in 1999 which resulted in a conviction.

(11) The Filing Deputy told the GJ that in reviewing the file in March 2003, he discovered that the driver is the son of the County Tax Collector whom he knows. The Filing Deputy serves with the County Tax Collector on the County Pension Trust Fund board, which poses a possible appearance of conflict of interest.

(12) Upon learning that the County Tax Collector is the driver's father, the Chief Deputy took the file for transfer to the AG's Office on March 26, 2003 to avoid any perception of conflict of interest.

Findings:

(1) The Filing Deputy had opportunity to examine the file in late September 2002.

(2) The file remained in the Filing Deputy's office for six months without the knowledge of senior DA personnel due, in part, to the lack of a tracking system.

(3) The Filing Deputy did not act on the case, to either file or decline to file, during the six months the case remained on his desk.

(4) He did not seek advice of the Chief Deputy DA or the DA after he read the file.

(5) He did not discuss with other DAs, before March 26, 2003, any perceived problem about filing.

(6) Each time the victim's mother requested to speak to him he declined. He chose to communicate through the victim's family's attorney.

(7) The Chief Deputy, on March 26, 2003, directed the Filing Deputy by saying, "You need to file this case." It was then that the Filing Deputy said he first noticed a document from the tax collector's office bearing the name of the driver's father.

(8) The Chief Deputy, acting on this possible conflict, contacted the AG Office in Los Angeles, asking that office to review the file.

(9) The Senior Assistant AG stated that the case did not meet the usual parameters of conflict, but would take it as a courtesy.

(10) GJ investigation of Pension Trust Fund minutes of January 26, 1998 through July 28, 2003, travel vouchers, conference expenses, and Auditor/Controller records of the past five years did not expose any connections that suggested a conflict

between the Filing Deputy and the County Tax Collector, despite their serving on that same committee.

Conclusions:

(1) The Filing Deputy did not act to perform his duty to file or reject this case.

(2) The Filing Deputy withdrew from any of the alternative actions available to him.

(3) The Filing Deputy, when questioned by the Grand Jury, had no acceptable explanation for his inaction.

(4) The lack of a tracking system for misdemeanors allowed this case to go unresolved and unnoticed for six months.

(5) The Chief Deputy DA accepted the perception of a conflict of interest and referred the case to the AG.

(6) The District Attorney's Office did not file or reject the case in March 2003, causing additional extended stress to the victim's family.

(7) Because of this case, in April 2003, the Chief Deputy DA requested two new systems of tracking. One was to track the more serious high misdemeanor (red dot) pending cases; the more recent one, for pending cases neither filed nor rejected.

(8) This case fueled the formulation of a new procedure (still in draft in the DA's Office) titled *Filing Procedures for Vehicular Manslaughter Cases (and Other Cases Involving a Fatality).*

(9) The Grand Jury found nothing to indicate to us that a conflict of interest existed with the DA handling the case, in the interviews we conducted or the records we reviewed.

(10) The Grand Jury's initial observation was that the Filing Deputy's performance in the handling of this case should be sanctioned. However, a closer examination revealed that management personnel either knew, or should have known, that a review of this fatal accident was pending. News articles, for example, were printed at the time of the accident in local newspapers in which the driver was named. News articles in December 2002 identified the driver as the son of the County Tax Collector.

Recommendations:

(1) The DA's Office should track all cases, starting from the time a file comes to the office, rather than when the deputy files it. [The new *Pending Cases (Neither Filed or Rejected)* does this tracking now.]

(2) Encourage Deputy DAs to seek input of each other and of their superiors regarding problematic and difficult cases.

(3) The Grand Jury recognizes that this is a small county and therefore many people in county government know each other. This makes it even more imperative that the DA's Office identifies conflicts early on in their handling of criminal cases.

(4) The DA's Office should substantiate claims of conflict of interest more carefully before referring cases elsewhere.

B. How could "shelving" of the file in the DA's Office go unnoticed for six months?

Facts:

(1) No computer program existed for tracking misdemeanors.

(2) At that time, no system of "red flagging" existed for misdemeanors before filing a case.

(3) The Filing Deputy did not act or say anything to his colleagues about this case.

(4) Management in the DA's office was not aware of the inaction.

Findings:

(1) Only felony cases were trackable at the time.

(2) Communication within the DA's Office regarding this file was insufficient.

Conclusions:

(1) Tracking systems for misdemeanors could have prevented the lengthy "shelving" of the file.

(2) The Filing Deputy failed to make a timely decision to file or reject.

Recommendations:

(1) The Chief Deputy should periodically evaluate the computer programs designed and implemented for tracking high misdemeanor (red dot) cases and the new pending cases, now that such tracking is available.

(2) The Chief Deputy DA should exercise closer control/oversight of deputies' caseloads to monitor status of cases.

(3) Management should take a more assertive role in supervising employees of the DA's Office and take corrective action when needed.

C. How could the Victim Witness Office better assist the family?

Facts:

(1) The case was delivered to the DA's Victim Witness (VW) Division Assistant Director's desk, but no action was initiated because a filing had not occurred yet.

(2) No procedure was in place to require a contact with victims' families until after a filing occurred.

(3) The victim's mother made the first contact with VW Assistant Director on December 23, 2002, asking to see the Filing Deputy.

(4) The victim's mother requested the help of VW on seven occasions. She had questions about the lack of progress of the case.

(5) Subsequent communication between the victim's mother was with another VW advocate. The Assistant Director assigned this advocate to the case on February 6, 2003.

(6) VW made no other attempts to satisfy the request of the victim's mother when the filing deputy declined to talk with her.

(7) The VW advocate and Assistant Director did not communicate with the Director of the VW Office concerning victim's parents' inquiries.

(8) The first contact *initiated* by VW to advocate on behalf of the victim's family was on March 10, 2003. [The accident was in September 2002.]

(9) The Filing Deputy advised the VW advocate on March 10, 2003, that he was inclined not to file the case.

(10) The Director of VW stated that she did not know of the police report until March 31, 2003.

(11) The Director of VW and Chief Deputy DA met with the victim's mother on April 10, 2003, to inform her that the DA had referred the case to the AG's Office.

(12) The Director of VW spoke with the DA on July 24, 2003, after victim's mother requested the DA re-review the case.

Findings:

(1) At the time of the accident, Victim Witness lacked policy for discussing with victims' family where death is involved. [New policy addresses this.]

(2) Communication within the VW Office was insufficient in this case.

(3) The VW Assistant Director realized the father-son relationship of the County Tax Collector and the driver upon his review of the file.

(4) The victim's family did not receive support and VW advocacy until the case went to the AG's Office.

Conclusions:

(1) Lack of communication within the VW Division hindered effectiveness of service to this victim's family.

(2) VW did not reach out to the family until after filing of the case, almost seven months later.

(3) The VW advocate was not helpful in addressing this victim's parents' anxieties when they repeatedly requested status reports.

(4) Lack of initiative and responsiveness reflects negatively on staff and division.

(5) Policy and procedures failed to address this case while the Filing Deputy remained undecided.

(6) The policy in existence at the time and the lack of a tracking system prevented timely assistance to victim's family.

Recommendations:

(1) The director should schedule regular VW Division meetings for discussion of current cases among all advocates.

(2) The division should develop guidelines to offer appropriate assistance to families of victims while waiting for the DA's decision to file or reject. [New procedure has been drafted and instituted as of December 11, 2003 as a result of this case.]

(3) Assistant directors should monitor DA intake data to assess need for VW intervention. [Also part of new procedure.]

(4) VW advocates should promptly notify the Chief Deputy DA when filing deputies are not responding in a timely manner to victim's requests.

DA and VW Response Requirement

Penal Code Section 933(c) mandates that the DA shall comment within 90 days to the presiding judge on the findings and recommendations in this report directed to the DA Office and the Victim Witness Division.

PART THREE
Transfer of the Case to the California Attorney General (AG) Office

The DA's office sent the case to the Los Angeles office of the California Attorney General on March 26, 2003, with a letter advising that

> 1) "... a conflict of interest exists which would preclude the prosecution of the above-entitled matter by our office," 2) the "…case does not fit the strict traditional definition of a conflict of interest, but better judgment would indicate that an impartial review and prosecution of the case would be in the public interest due to the complex net of interactions that the father of the defendant has with members of our office," and 3) "We would appreciate it if your office would be kind enough to handle this matter to avoid any appearance of impropriety in the handling of this case by our office."

The DA 's Office sent the file, containing only material related to this incident, to the AG after the AG agreed to take the case. The AG's staff conducted their investigation, holding the case four months before determining that there were not sufficient grounds to file charges against the driver. We have incorporated in this summary the AG representatives' explanation to the GJ of some of their investigative process.

On July 21, 2003 the AG met with the victim's family in SLO to apprise them of their decision to reject the case. Later that week the girl's mother called VW to request the DA re-review the case. Meanwhile the AG sent a letter to inform the DA of the decision. On August 19, 2003 the family and others came to meet with the DA and express their anger and frustration at the long delay of the filing decision. They also communicated their dissatisfaction with their lack of access to the Filing Deputy. The GJ received these same complaints in August.

On September 3, 2003, two AG representatives came to the SLO County GJ Office. They stated this was a highly unusual action. They explained their decision to us and described what they did in reviewing the case. The AG does not consider the character, behavior, or prior infractions of a suspect unless it is relevant, or proves some fact, or is evidence that is usable to support a charge.

They stated that they had reviewed the case in light of practices typically applied to cases reviewed in the Los Angeles urban area, where the number of such cases is greater. They file only the most provable cases with aggravated circumstances. They said that they did not consider the possibility of successful prosecution in a less populous county, despite the fact that workload considerations vary greatly between the two jurisdictions. On May 4, 2003 a Deputy AG personally visited the site of the incident and interviewed the GB Police officer who responded to the 911 call.

The AG staff considered whether sufficient evidence existed for filing charges against the driver. They cited these factors in making their decision:

1) the street lighting at the intersection
2) the dark clothing worn by the victims
3) conflicting evidence that both girls were within the crosswalk at the time the vehicle struck the girls
4) that the driver's speed was assumed to be within the posted speed limit, and
5) no evidence that the driver had consumed alcohol.

They examined the cell phone records of the driver for calls made on the evening of the incident and determined that he was not talking on his cell phone at the time that his vehicle struck the two girls. They believed that the two victims might have been outside the crosswalk at the time the vehicle struck the girls.

Because of the focused involvement of the GJ, the AG investigator returned to SLO to re-examine evidence during the week of August 25-29. They nevertheless concluded that, in their opinion, the driver could not have avoided striking the victims. Listening to the AG's report, the GJ realized that the case file submitted to the AG by the DA's Office did not include the long list of the driver's prior driving citations and prior road rage convictions nor had they seen the accident photos.

At the conclusion of the AG's presentation, the GJ's position was that the AG's Office should reconsider its decision. The GJ asked the AG to review additional materials and provided them with accident photos and documents. The jury had compiled this supplemental information in its investigation of the matter. When the GJ apprised the AG representatives of these prior convictions, the AG staff responded that they could not use much of the driver's prior traffic record because that information would not be admissible as evidence. The AGs agreed to take the box of materials from the GJ back to Los Angeles with them. The additional items, however, did not change the AG's opinion, and they so informed the GJ the next day.

The AG notified the victim's mother again on September 4, 2003 that they were not prosecuting the case, but that the DA had the option of reclaiming the case. The victim's mother immediately called VW urging the DA to resume control and file charges against the driver.

PART FOUR
The District Attorney Reclaims the Case

The Senior Assistant Attorney General informed the Chief Deputy DA in a letter dated July 23, 2003 that the AG staff's review of the case was completed and that the AG's Office decided not to file any criminal charges against the driver. The letter arrived to the desk of the Chief Deputy DA while he was out of the office on leave. Apparently no one was assigned to process his mail in his absence. He returned to work August 11 and immediately showed the letter to the DA. The Chief Deputy asked the AG to return the case paperwork to the SLO DA's Office.

Meanwhile, after learning of the AG's original negative decision, the GJ wrote to the AG's Office on August 15, 2003, just after receiving the family's complaints. The GJ wanted an explanation of the factors contributing to the AG's decision. The GJ advised the AG of the extensive local news coverage generated by the case and the hundreds of complaints the GJ had received. The AG decided to present an explanation to the GJ in person, something rarely done by that office.

On September 3, 2003 two representatives of the Los Angeles division of the AG's Office met with the GJ at the GJ office in San Luis Obispo to explain their decision of July 23. As explained in Part 3 of this report, the GJ disagreed with the AG Office's decision and provided the AG representatives with additional information the GJ had compiled, including photos of the accident scene and information about prior offenses and convictions of the driver. However, that additional information apparently did not change the AG Office's decision not to file charges. The day following that visit to the SLO GJ, the AG indicated their opinion had not changed despite the input from the GJ.

On September 4, 2003 the attorney for the victim's family sent a letter to the Chief Deputy DA stating that "It is our hope that… your office will now file the misdemeanor complaint against … and pursue prosecution in this matter."

On September 5, 2003 the Senior Assistant Attorney General sent a letter to the District Attorney forwarding more than 300 pages of material, including "…material you have not previously seen or requested." She also referred information to the DA relating to a Department of Motor Vehicles administrative hearing decision to return the driver's license and some information regarding the cell phone previously installed in the vehicle. None of that information proved to be relevant to this investigation.

The AG indicated that the DA's Office was free to file if they chose to do so. That same day, September 5, 2003, the DA assigned the case to another Filing Deputy with the instruction to research and review the case and to recommend whether or not to file any charges. (Remember that on March 26 the Chief Deputy had instructed the filing deputy to "file the case.") Later that same day the DA's Office filed one count of misdemeanor vehicular manslaughter against the driver.

Case Status:

The DA's Office filed charges on September 5, 2003 in the San Luis Obispo County Superior Court and counsel for defense immediately proceeded to file a series of motions. In January 2004 a defense motion to recuse the DA's Office from the case and effectively end the prosecution failed in superior court. Defense counsel had requested an April 2, 2004 hearing regarding his motion involving the prosecution's failure to preserve the victim's blood sample. Arroyo Grande Hospital did not keep the victim's blood drawn on the evening of the accident. The defense position is that the blood sample is potentially significant in the case because a preliminary screening by hospital staff had shown the presence of methamphetamine in the victim. The defense attorney, however, had a conflict on April 2, and the motion was continued to April 16. A ruling on all motions is necessary before the trial scheduling date of May 28. The SLO DA is ready to proceed with the trial, which has been set for June 22.

ATASCADERO HIGH SCHOOL MARCHING BAND PLAYS AT POLITICAL CANDIDATE'S CAMPAIGN RALLY

On Sunday, September 28, 2003 the Atascadero High School Marching Band played at a political rally for then candidate for governor, Arnold Schwarzenegger. To some county residents, this appeared to be in violation of the California Education Code, which prohibits use of school resources for political purposes. Reports of the story in local newspapers included an opinion from the California Department of Education deputy legal counsel indicating that, if asked, he would have advised against the band playing. Within weeks of the event, the Grand Jury received two complaints from citizens citing this and other news reports, and expressing concern that the Atascadero Unified School District had violated the law in permitting the band to play at the rally.

Authority for the Inquiry

The authority for the Grand Jury to inquire into this matter is given in Section 933.5 of the California Penal Code: "The grand jury may at any time examine the books and records of any special-purpose assessing or taxing district located wholly or partly in the county or the local agency formation commission in the county, and, in addition to any other investigatory powers granted by this chapter, may investigate and report upon the method or system of performing the duties of such district or commission."

Overview

The Atascadero Unified School District (AUSD) is responsible for the operation and supervision of thirteen schools, including Atascadero High School. The schools are located in the northern part of the county, serving the communities of Atascadero, Creston and Santa Margarita. The district is governed by a Board of Trustees consisting of seven members who are publicly elected to four-year terms. The Board establishes the policies that govern the operations of the schools in the district, and hires the District Superintendent, who is responsible for policy implementation.

Many of the Board policies reference the California Education Code, which sets the legal requirements for public schools in the state. The section of the code relevant to this inquiry is 7054(a), which states:

> No school district or community college district funds, services, supplies, or equipment shall be used for the purpose of urging the support or defeat of any ballot measure or candidate, including, but not limited to, any candidate for election to the governing board of the district.

The applicable AUSD policy mirrors and references this section, and reads:

> No district funds, services, supplies or equipment shall be used to urge the support or defeat of any ballot measure or candidate, including any candidate for election to the Board. (Education Code 7054)

Section 7058 of the Education Code further clarifies 7054 as follows:

> Nothing in this article shall prohibit the use of a forum under the control of the governing board of a school district or community college district if the forum is made available to all sides on an equitable basis.

Since the band performance in question occurred at a political rally for a gubernatorial candidate, some residents questioned whether it violated the Education Code and AUSD policies. The performance was requested by Assemblyman Abel Maldonado, and the expenses for it were billed to his office. Nevertheless, some individuals question whether this is adequate to counter the perception that AUSD resources were used to support a political candidate.

Method

We obtained the information reported here through review of AUSD policies, correspondence and an interview with the AUSD Superintendent, and an interpretation provided by legal counsel for AUSD. The Grand Jury requested and received the applicable AUSD policies and procedures related to the band playing at the rally, as well as information regarding the payment of the expenses incurred. Jurors interviewed the superintendent and reviewed the related documents.

Description of Inquiry

In providing information on behalf of the district, the superintendent repeatedly emphasized that the band performance at the rally was never intended to show support for a candidate, but was considered to be simply an opportunity for the band to perform. Given the political nature of the rally, specific concerns included whether AUSD funds were used, whether students were required to participate, and whether the decisions relative to the band playing at the rally were made in accordance with district policies and public considerations. Our findings are summarized below.

(1) The AUSD Request for Transportation form details that there were two buses used for seventy-five students and ten adults to attend the rally in Santa Maria on September 28, 2003. The charges for the two bus drivers, bus mileage, and meals are itemized in accordance with the AUSD 2003/2004 Transportation Rates. The mileage rate includes an allocation for vehicle maintenance and insurance. The listed expenses totaled $718.85.

(2) An invoice for $718.85 was sent to Assemblyman Maldonado at his office in San Luis Obispo, and was paid by a check on an account of "Californians for Schwarzenegger" dated November 18, 2003.

(3) The band members were not required to participate. The band's performance at the rally was considered to be an extracurricular field trip, for which parental approval was necessary. One family did not approve and the band member did not perform.

(4) The decision to allow the band to perform at the rally was made by the principal of Atascadero High School. This is the appropriate level for approval of field trips, according to the district's organizational delegation of authority. The principal sought additional review because the performance had the potential for appearing to support a political candidate. In the absence of the superintendent, the principal consulted with the Assistant Superintendent of Educational Services, who concurred that the field trip was appropriate.

(5) The interpretation of the AUSD legal counsel, requested after the fact, supports the decision to allow the band to perform. The legal opinion was provided in writing at the request of the Grand Jury, and highlights the reimbursement for the AUSD expenses relating to the performance. The legal counsel's concluding remarks are as follows:

> In this instance, where no District funds were expended, the activity was voluntary, it was not during school hours, and the intent of the District administration was to provide students with an opportunity to perform publicly, there was no violation of Education Code section 7054 (a).
>
> The District's Board and administration has the discretion to determine that there is an educational benefit to AUSDHS band students performing publicly. Such a determination is appropriate given that public performance is a natural part of learning to play a musical instrument in any band. Had the students been provided with the same opportunity to perform for other candidates, and the students were able to perform, the intent and impartiality of the District administration might be more easily understood. But the lack of additional invitations and opportunity cannot convert the proper intent of the administration to an improper intent.

> While the District must avoid using District funds, services, supplies and equipment for the purpose of supporting or opposing particular candidates or issues, it is nevertheless our opinion that the AUSDHS Band may voluntarily participate in a public performance, even at a political event, where no District funds are expended, and the intent is not to support the candidate, but rather to provide students with the opportunity to perform publicly.

Conclusion

The issues surrounding the band performance at the political rally appear to be a matter of legal interpretation. A conclusive opinion would have to come through the courts or further legislative action. The decision to allow the band to perform in this instance, however, was made within the spirit and intent of the law as interpreted by the AUSD legal counsel and consistent with District policy. A new or changed policy that would direct a different decision regarding marching band performances is a matter for the AUSD Board of Trustees to consider.

Required Responses

This is an informational report. No formal response to this 2003-2004 Grand Jury report is required from any agency.

CALIFORNIA MEN'S COLONY

The California Men's Colony (CMC) is located on Highway 1 just north of the San Luis Obispo city limits. It is a low and medium security prison under the direction of the State of California Department of Corrections, and includes two main facilities on 356 acres. The West facility houses the lower security inmates in a barracks-type setting. The East facility, with more traditional prison cells, primarily houses inmates with medium security classifications. The total inmate population at CMC in March 2004 was 6,542.

The average CMC employment level is 1,673, of which 952 are custody staff positions that include correctional officers, counselors, and medical technical assistants. The local facility and operations are managed by a warden who is appointed by the governor. Following the former warden's retirement, Assistant Warden Leslie Blanks served as acting warden for almost two years. Current Warden John Marshall was appointed on October 30, 2003.

Authority for the Inquiry

The California Penal Code § 919 (b) establishes the authority for this inquiry as follows: "The grand jury shall inquire into the condition and management of the public prisons within the county."

Method

We obtained the information reported here through interviews, documents review, and visits to the prison. Early in our term, Acting Warden Blanks presented an informational overview to the full Grand Jury. Members of the jury toured CMC on September 30, 2003, visiting both the East and West facilities. Jurors returned on January 29, 2004, to meet with the new warden, to visit a vocational class, and to follow up on questions concerning the Inmate Trust Fund. We were encouraged to talk to inmates and correctional officers during both visits.

Description and Observations

Our initial visit to the East facility included a tour of prisoner cells, the education facilities, the operations of the Prison Industries Authority, and a "typical" inmate lunch in an inmate dining hall. We were driven in a CMC bus from the East to the West facility where we observed the barracks, the recreational yards, and the Arts in Correction program.

Housing

Inmates are assigned to the East or West facility based on their security levels, which consider many factors. The lower security inmates (levels 1 and 2) housed at the West facility typically have no history of prison disciplinary action, no prior escapes, and a majority of their sentences served. Higher security levels 3 and 4 are assigned based on the type of crime, post-conviction behavior, outstanding holds/warrants, length of commitment and balance of sentence. Inmates housed in the East facility have level 3, or medium, security level designations. In addition to security assignments, each inmate is given an activity assignment that typically requires him to participate in either an education or an employment program.

Even from our brief tours, it was clear that the housing conditions at both facilities are crowded. The inmate cells that we observed in the East facility were designed for single occupancy, although there are currently two inmates living in each 5' X 8' cell. The second added bunk is hinged on the wall and must be pulled up for the occupants to move about the cell. The design capacity for the East facility is 2,425, although its average daily inmate population in March 2004 was 3,689.

The West facility inmates are housed in military-style barracks, each holding approximately ninety bunks. We observed that there was little room to move around the barracks even when most of the inmates were outside in the yard. The March 2004 inmate population of 2,853 is almost double the West facility design capacity of 1,459.

Education

Educational activities primarily include adult basic and high school level academic classes and vocational programs. Vocational courses include: machine shop, dry cleaning, electronics, welding, auto shop, small engine/motorcycle repair, landscaping, and office services/related technology. Both the academic and vocational programs are located at the East facility.

On our second visit we observed the office services/related technology class; both the instructor and the curriculum were impressive. It is a self-paced program, with 30 students who use computers with standard business applications. The curriculum progresses from basic typing and business math, through more advanced subjects such as bookkeeping and business law. The final modules cover computer applications, including databases, word processing, spreadsheets, and desktop publishing. It should be noted that the instructor also includes life skills such as goal setting, self improvement and presentation skills in the curriculum. We were encouraged to talk to the inmates in the class and found them to be generally appreciative of the class and the instructor's efforts.

We also visited the Arts in Corrections program located at the West facility for lower security inmates. Although not formally identified as an education program, activities for inmates provide outlets for artistic expression in words, painting and music. Fifty-four inmates attend a structured program there as their official assignment. An additional 90

inmates voluntarily participate in Arts and Corrections activities during their unassigned time. We watched a video of an inmate-produced play, and listened to a live performance of a three person self-written and produced musical piece.

Employment

During our initial visit we met with the director of the CMC Prison Industry Authority (PIA) programs. The PIA provides jobs for inmates in the production of goods and services used both inside and outside of the prison system. We toured the PIA shoe factory, the T-shirt factory, and the print plant where state auto registration stickers and brochures are produced. Other PIAs include a knitting mill, jacket factory, glove factory, laundry and maintenance. In the generally repetitive and fairly low skilled PIA jobs, inmates earn from $0.30 to $0.95 per hour. With the exception of those sentenced to life with no parole and "three-strikers," inmates also earn one day off their sentence for each day of work.

We were interested in recidivism (return rate) statistics for inmates who work and learn employable skills in the PIA, as compared with those who were not involved in PIA during their incarceration. Although the state does not currently provide statistics by facility, the state-wide recidivism figures for the year 2000 provide insight into the influence of the PIA program. For PIA inmates, the recidivism rates were 19 percent for the first, and 43 percent for the second year. The rate for inmates who had not held PIA jobs was more than double in the first year (43 percent) and was 56 percent in the second year.

In addition to PIA, prisoners may be assigned to other work programs, such as in the prison's Food Services division. Other prisoners are assigned as Inmate Firefighters, who can make from $32 to $52 per month, or to the Hazardous Materials Unit where inmates receive $48 per month.

Inmate Trust Fund

We requested and received a detailed presentation on the Inmate Trust Fund during our January visit. The Associate Warden for Business Services and the fund's Business Manager provided an overview of the fund's management. Their philosophy reflects a respect for the inmates' right to understand and monitor their funds. The general approach is that of a bank, and each inmate receives a monthly trust fund balance report. Additional time is spent explaining these reports to inmates as needed. The fund is also subject to regular state level audits, which have reported no problems in recent years.

Community Services

During calendar year 2003, CMC had 76,000 hours of inmate time, and 6,071 hours of staff time involved in fire suppression and "Fire Kitchen" operations. These figures include inmates directly fighting fires as well as those involved in setting up and staffing the kitchens that feed the firefighters. In addition, 4,000 correctional officer hours were spent supervising these inmates. Inmates also set up a kitchen to serve all those assisting after the December 22, 2003 San Simeon earthquake.

CMC provides inmate service crews to local communities to perform such services as weed abatement, general clean-up, sandbagging, tree trimming, seaweed cleanup of beaches, clearing culverts, trash pickup on highways, and fence repair. CMC has entered into contracts to provide Community Service Crews to the cities of Arroyo Grande, Grover Beach, Morro Bay and Pismo Beach, to the County of San Luis Obispo General Services and Roads Department, and to Port of San Luis. These crews have also been provided at no charge to Cal-Trans and San Luis Obispo School District. CMC estimates that communities saved $189,594 by using the CMC crews during the last year.

Inmate groups make cash donations to community groups. In 2003, the Leisure Time Activity Groups (Prisoners Against Child Abuse and CMC Literacy Council) distributed $13,250 in cash donations, and an additional $4,000 for the annual Holiday Party for Inmates' Children. Some other recipients of donations include: Alpha Academy, SLO Child Development Center, County Mental Health Youth Services, North County Women's Shelter, SLO Literacy Council, SLO Prado Day Center, and the Good Samaritan Shelter.

Required Responses

This is an informational report. No formal response to this 2003-2004 Grand Jury report is required from any agency.

CALIFORNIA VALLEY
COMMUNITY SERVICES DISTRICT

Synopsis

The 2003/2004 San Luis Obispo County Grand Jury received several complaints from citizens of California Valley regarding the operations of the California Valley Community Services District (CVCSD) Board of Directors. The Grand Jury examined the complaints, interviewed several witnesses and reviewed the history of other complaints that had been previously submitted to prior grand juries. After careful consideration, the Grand Jury determined that insufficient evidence existed for an investigative report, and instead chose to prepare an informational report to draw attention to the grievances submitted by the complainants.

Origin of the Inquiry

The complaints submitted to the Grand Jury stated that the CVCSD Board of Directors did not conform to Brown Act meeting notification requirements or follow appropriate procedures in handling citizen complaints. In addition, the complainants submitted to the Grand Jury a petition signed by 73 CVCSD residents requesting that we help them obtain the following amenities:

1. A gas station,
2. A clinic with doctors once a week,
3. Transportation into town two or three times a week,
4. A mercantile or convenience store, and
5. A water purification system for the entire valley.

Other comments submitted by the residents included unpaved roads in the district area and the lack of garbage collection.

Authority for the Inquiry

California Penal Code § 933.5 authorizes the Grand Jury to investigate operations of a special legislative district such as the CVCSD.

Method

Six members of the Grand Jury traveled to California Valley on Monday, February 16, 2004 for an informal meeting with the original complainant and several other subsequent

complainants. In addition, the Grand Jury interviewed the County District Five Supervisor, the County Health Director, the County Director of Public Works, and the County Auditor/Controller. Grand Jurors also reviewed reports from previous Grand Jury investigations of the CVCSD.

Setting

The CVCSD is established as a community services district under the provisions of section 61000 et seq. of the California Government Code. The district is governed by a five-member board of directors elected at large to four-year overlapping terms. The district has an annual operating budget of approximately $400,000 and is responsible for provision of basic services, including refuse collection.

The district board hires a general manager to administer and oversee the efficient and effective provision of these services. During the 2003-2004 fiscal year a large amount of the district's general fund reserves was determined to be missing. After a brief investigation, the County District Attorney's Office filed charges of embezzlement against the general manager, who pled guilty to the charges. Although the mystery of the missing funds has been solved, the fact remains that the district's general fund reserves have been severely depleted, leaving the board with insufficient money to continue to provide several services, including refuse collection, to its residents.

The County Health Director advised the Grand Jury that the CVCSD, per their charter, has the responsibility for garbage collection in the district area. The County Public Works Director advised the Grand Jury that the unpaved roads listed in the citizen complaints are CVCSD roads and, therefore, cannot be paved or maintained by the county. The County Fifth District Supervisor affirmed that the CVCSD is responsible for basic service delivery to the area, and advised the Grand Jury that the county does not have sufficient resources to provide the other services and amenities that California Valley citizens expect.

The Grand Jury found that CVCSD residents have previously submitted complaints about the CVCSD Board of Directors to past grand juries. For example, the 1999-2000 Grand Jury found a history of inefficient and inappropriate operation of the district's organization and service delivery.

Conclusions

This Grand Jury attempted to assist the residents of the CVCSD in resolving their complaints and requests. However, the Grand Jury did not find any evidence of specific Brown Act violations by the CVCSD Board of Directors. Further, the services and needs detailed by the residents were beyond the jurisdictional reach of the Grand Jury and the county.

In their report, the 1999-2000 Grand Jury stated that, "…the CVCSD has a history of inefficient and inappropriate operation." The report then emphasized that:

> Ultimately, voter participation is the only effective oversight for the CVCSD. The effectiveness and responsiveness of the board of Directors are directly related to the attendance and awareness of the electorate. The Grand Jury urges constituents of the District to keep this in mind and to become aware of, and involved in, the activities of their District.

This Grand Jury concurs with those conclusions.

Many of the issues in California Valley must be solved by the residents and their Board of Directors. These issues would be costly to address and may well be beyond the ability of the board to implement. Prioritization is even more important due to the district's unfortunate financial situation. The district has the authority under the California Government Code to levy the necessary tax assessments to fund the district's operations, and must take the responsibility to do so.

Suggested Actions

Under Penal Code § 933.05, the CVCSD was required to respond to the aforementioned recommendations and findings of the 1999/2000 Grand Jury Final Report. This Grand Jury did not find evidence that such response was ever completed and submitted.

Accordingly, this Grand Jury recommends that the County Counsel advise the CVCSD Board of Directors that their response to the 1999/2000 Grand Jury Final Report must be submitted to the Superior Court within 90 days of issuance of this report.

The problems that were brought to this Grand Jury must be solved by the CVCSD. The Grand Jury recognizes the district's financial condition and understands that the resident's complaints and demands cannot be addressed or implemented overnight. The Grand Jury contends that the Board of Directors must make a concerted effort to conscientiously address each of these matters in a timely manner. Accordingly, the Grand Jury also recommends that the CVCSD immediately contact the California Special Districts Association for any applicable assistance, training and technical support to prepare and implement a long-term program to address the issues raised by the residents.

If such a long-term program cannot be implemented successfully on a timely basis due to financial, realistic or other considerations, the Grand Jury recommends that the residents of the CVCSD service area seriously consider disbanding the district. Under such a dissolution, service delivery responsibility would revert to the county, and the District's Board of Directors would be replaced by the County Board of Supervisors.

Required Response

This is an informational report. No formal response to the 2003-2004 Grand Jury report is required from any agency.

EL PASO DE ROBLES
YOUTH CORRECTIONAL FACILITY

The El Paso de Robles Youth Correctional Facility (El Paso) is one of eight institutions operated by the California Youth Authority (CYA) for the detention, training and education of youthful offenders. The CYA is a department of the California Youth and Adult Correctional Agency. Recently, the agency has been under the scrutiny of the Governor, the California Attorney General, the Legislature, and the new Director of the Youth Authority. As a result, there has been considerable press coverage of CYA and its facilities during the first part of 2004.

The El Paso facility is located across from the Paso Robles Airport. It houses male offenders, referred to as "wards," who have been committed to CYA by the Superior or Juvenile Court for offenses that would have been felonies if committed by adults. Under a special contract with the Monterey County Juvenile Probations Department, some of their wards were also located at the El Paso facility. The ward population at El Paso has been declining in recent years, mainly due to legislative changes. In April 2002 there were 644 CYA wards and 327 full time staff at El Paso. The ward population and staff level in April 2004 was 300 CYA wards, 48 Monterey County juveniles, and 264 full time staff.

Authority for the Inquiry

The California Penal Code §919 (b) states, "The grand jury shall inquire into the condition and management of the public prisons within the county."

Method

The superintendent and assistant superintendent met with the full Grand Jury in August 2003 to provide an overview of El Paso's mission and operations. They emphasized that the facility is open "24/7" and we were invited to visit at any time. Members of the Grand Jury visited the El Paso facility on three occasions during subsequent months. In addition to meetings and tours, the El Paso management and staff provided extensive documentation about the facility and its programs.

Informational Description and Observations

Our initial visit to the El Paso facility in October 2003 included presentations by the senior staff and department heads. They provided current program and performance data related to their area of responsibility. The format allowed questions and interaction

with all attendees. We also reviewed with the staff previous Grand Jury findings, recommendations, and CYA's responses to them.

We then toured the ward housing units, referred to as "cottages." There were nine active housing units at the time of our first visit, each named for communities in San Luis Obispo county. The number of wards housed in each unit ranged from 13 to 75, varying according to capacity and the program it houses. The Cambria cottage is the designated maximum detention unit. The environment is one of discipline and close personal and video scrutiny. We verified that there were no "cages" utilized for restraint or punishment of the type that had been reported in the press at some CYA facilities.

Wards are assigned to a cottage based on their program assignment, which includes initial reception and evaluation, drug dependency, food service and firefighters (fire-fighter wards have since been integrated into other cottages as a result of budget cuts detailed below). All wards assigned to a program and cottage wear colored T-shirts specific to that unit. This allows the correctional officers to quickly identify the wards when they are going from one area to another and to verify that they are in the proper location.

An informative part of our tour was a demonstration by the ward firefighters. This unit, comprised of the most trusted wards, provided significant county and state service. In 2003, the wards expended 111,772 man-hours in emergency fire fighting, controlled burns, and brush clearance.

Other programs also allowed wards to provide community service. They contributed over 1,000 man-hours for the December 2003 San Simeon earthquake emergency response and clean up. An additional 30,000 man hours were dedicated to community and state activities that included: park maintenance, road/ground maintenance, flood control, and general construction. A partial listing of other public service activities the wards performed included: maintenance for Paso Robles City, Hearst Castle, Atascadero City and Templeton Community Service District, Paso Robles spring clean up, Camp Roberts weed abatement and wood cutting, and the Mid-State Fair Paso Robles High School graduation set-up and teardown.

These disciplined service activities provided the wards with an opportunity to make positive contributions and gave them an incentive to return to society with job-related behaviors and skills. Nevertheless, as of the time of this report, the state budget cuts had eliminated the firefighters and the other community service programs, effective February 29, 2004. There are ongoing efforts to reinstate some of the programs. Resource groups that continue to be available to wards include: victim's awareness, substance abuse counseling, parenting, gang awareness, anger management, and employability skills.

Members of the Grand Jury attended a lunch meeting with the Citizens Advisory Committee on March 1, 2004. The approximately twenty members of the Advisory

Council represent various volunteer and non-profit organizations that provide support functions for the wards. The Paso Robles Police Chief is also an active member. The El Paso senior staff members attend the monthly Council meetings and present updates in their areas of management. In our one meeting observation, the Advisory Council appears to function less as an advising body than as an interface between the CYA and the local community.

At the March meeting, the assistant superintendent gave us copies of two reports commissioned by the California Attorney General and the Youth Authority: *The Review of Health Care Services in the California Youth Authority* released August 22, 2003, and *The General Corrections Review of the California Youth Authority* released December 23, 2003. Both reports were the result of thorough investigations over an extended review period, and both reports are highly critical of the central (state) and local management of all CYA institutions. The recommendations, if implemented, will result in major changes to the CYA.

On March 9, 2004, members of the Grand Jury returned to the facility to observe high school and general education classes. Our observations were that, although the instructors were making an honest effort to provide a disciplined and educational environment, many of the wards did not seem to be engaged in the classroom activities. The CYA should address whether the instructional content or end results are meaningful to the general ward population.

Investigation of Pharmacy Medications

In February 2004, *The Tribune* of San Luis Obispo reported that the state commission report on health services had found that the El Paso de Robles pharmacy contained expired medications. Based on that information, and without prior notice, we asked to review the pharmacy during our March 1 visit. Our intent was to verify that appropriate corrective action had been implemented. Contrary to the previously touted "24/7" availability, the superintendent and assistant superintendent initially balked at our request, citing various reasons that would prohibit our inspection of the pharmacy. At our insistence they reluctantly agreed, and three jurors were escorted to the medical building.

The pharmacy is a secured room within the clinic. We found boxes of expired medications on top of the counters and the floor covered with several boxes of new medications that were not properly stored. Upon subsequent review we found that the August report described a similar situation: "the pharmacy contained boxes and bags of medications stored on the floor. Many of the medications had expired, or were about to expire." (*Review of Health Care Services in the California Youth Authority,* p. 47)

The superintendent indicated to us that there was no effective means of disposal for expired medication. However, jurors later performed an internet search and quickly identified information regarding the availability of registered disposal companies, one of which is based in California.

Findings

(1) Expired medications are stored in the pharmacy.

(2) Significant quantities of medications are not properly stored in the pharmacy.

Recommendations

(1) The El Paso de Robles Youth Authority should take advantage of available services to properly dispose of expired medications.

(2) Pharmaceuticals should be ordered on an as-needed basis and should be expeditiously inventoried and stored.

Conclusion

Although the management expressed an openness to Grand Jury inspection on a “24/7" basis, a more closed, protective attitude surfaced when we asked for an unannounced tour of the pharmacy. This response seems consistent with that mentioned in the December *General Corrections Review of the California Youth Authority* report which noted that middle management had referred to prior investigations at El Paso as “the witch hunt.” We would suggest that a less defensive posture toward authorized inspections would better serve the institution.

Overall, El Paso de Robles Youth Authority provides a reasonably safe environment for the wards, staff, and correctional officers under conditions that are frequently hostile and dangerous. The effectiveness of local and state mandated policies and the state-wide improvements that are needed are best addressed by the state CYA, the formal state review panel, and ultimately the Legislature.

Required Response

Pursuant to Penal Code §933 (c), the following agencies are required to respond to the findings and recommendations contained in this report: The El Paso de Robles Youth Authority Youth Correctional and The California Youth Authority.

FLOOD CONTROL: CLOGGED BY BUREAUCRACY AND ATTEMPTS TO TRANSFER RESPONSIBILITY

Synopsis

In March of 2001, the Arroyo Grande Channel Levee section of the San Luis Obispo County Flood Control and Water Conservation District Zone 1/1a was breached following heavy rains. This resulted in the flooding of several hundred acres of agricultural fields, businesses, residences and mobile homes. These heavy damages led to claims against San Luis Obispo County with costs totaling $1,289,000. The San Luis Obispo County Board of Supervisors responded by reinstating a citizen advisory committee to specifically oversee the Arroyo Grande Creek Flood Control District. This was the first time any citizen oversight group had met in over 20 years for that purpose.

That committee was comprised of concerned residents of the county, many of whom were directly affected by the flood breach. The committee found the zone did not have enough funds to meet the current maintenance requirements. The committee also recommended a study to identify alternative means for clearing the creek and to guard against future flooding. To this end, the Board of Supervisors appropriated $150,000 for an Alternative Analysis Study to be included in the County Public Works budget of 2002-2003, only to later withdraw that funding.

Origin of the Inquiry

The Grand Jury received a complaint from a county resident whose property was damaged from flooding stemming from the way in which the creek has been maintained.

Authority of the Inquiry

According to the California Penal Code § 925: "The grand jury shall investigate and report on the operations, accounts, and records of the officers, departments, or functions of the county including those operations, accounts, and records of any special legislative district or other district in the county created pursuant to state law."

Method

During the course of the investigation the Grand Jury obtained its information from several sources. The information in this report is a compilation of information received from attending watershed forums, interviewing many county officials, both

elected and appointed, as well as visiting the site. Through the course of the investigation we met with, and interviewed, the Project Manager of the Arroyo Grande Watershed Forum, San Luis Obispo Assistant County Counsel, Executive Director of Environment in the Public Interest, County Public Works Director, County Deputy Director of Public Works for Engineering Services, Coastal San Luis Resource Conservation District Board President, State Division of Flood Management Chief, and a representative from the Environmental Defense Center. We also interviewed the complainant on multiple occasions.

Setting

The Arroyo Grande and Los Berros Creeks, located in the South County area of Arroyo Grande and Oceano, flow into the adjacent lowlands, much of which is, and has been, farmland for generations. A Public Works Department map of the area is included as an Appendix to this report. Serious floods occurred in 1969, 1983, and 1995.

For visitors, and even long time residents, the Arroyo Grande Creek is part of the charm of the Village historical area of Arroyo Grande, but most people know very little about the creek that flows beneath the swinging bridge on its way to the sea. The creek is one of several that flow from higher elevations east of Arroyo Grande, in this case from Lopez Lake. It winds naturally toward the Village with a downhill flow and levels out as it reaches farmland in the area west of Highway 101. This relatively flat area slows the flow of the creek. The levee, built in the 1950's, starts in the farmland near Halcyon and extends three miles, including lower portions of Los Berros Creek.

Early ranchers and farmers used the creek for their crops and animals, but there was often a price to pay when flooding occurred. Documented floods go back to the year 1862 and occurred with regularity from the early 1900's through the 1940's. A huge crop loss in 1952 made it apparent that a project was necessary to improve the creek's ability to move water. In 1957, the U.S. Department of Agriculture (USDA) coordinated construction of the Arroyo Grande Channel Improvement Project.

The high probability of future flooding exists because over the years sedimentation and riparian growth within the creek have restricted the capacity of the stream flow. To monitor and protect the surrounding area, the County Board of Supervisors approved creation of flood control districts 1 and 1/A in the late 1950s. The county attempted to clear the waterway from time to time as the creek channel filled with soil moved from upstream.

Over the years the process for repairing the channel was made more difficult with the increasing number of permits needed before work could begin, the extent of work permitted, and the time limitations for such work. Budgetary constraints further complicate any repair project. Permits are now required from the California Coastal Commission, the U.S. Army Corp of Engineers, the USDA, and other agencies. Because of the complex situation, county engineers have recently coordinated permit applications for maintaining the channel.

Findings

(1) On March 27, 2003 the San Luis Obispo County Board of Supervisors sent a letter to the California Department of Water Resources (DWR) advising that SLO County was considering relinquishing responsibility for the Arroyo Grande Creek Flood Control Channel to the state.

(2) On March 28, 2003, a letter from Chief of the DWR Division of Flood Control Management stated that relinquishment by San Luis Obispo County would not resolve the issue. The letter advised that the decision on how to best proceed should be done carefully with public dialogue.

(3) On April 1, 2003, the San Luis Obispo County Board of Supervisors adopted Resolution No. 2003-105 seeking to transfer responsibility for the Arroyo Grande Channel to the State. That item was not listed on the agenda posted at the SLO County Board of Supervisors' website, and the item was passed as a consent agenda item without any public input.

(4) One week later on April 8, 2003, the Coastal San Luis Resource Conservation District (RCD) Board President and staff met with SLO County Public Works representatives. A Public Works representative informed the RCD Board President that the $150,000 Alternative Analysis Study was "off the table" for the fiscal year 2002-2003. The county, believing that it was no longer responsible for any damage that may occur in the coming, or following rainy seasons, then opted not to reallocate funding for the study in the next fiscal year budget, beginning July 1, 2003.

(5) On June 13 the DWR Chief of Flood Control Management sent a letter to the SLO County Department of Public Works acknowledging the receipt of SLO County Resolution No. 2003-105. The state then told the county that such jurisdictional transfer couldn't even be considered before July 2004, and possibly not until 2005 due to limited resources.

(6) Each agency says the other has the responsibility; neither is willing to do anything now. In the meantime, probability of floods causing serious damage to the property owners, the public, and farmers increases significantly. Future lawsuits and any insurance claims against the county paid out will ultimately affect the county taxpayer.

(7) Despite the position of the county on jurisdictional transfer, they were quick to respond after the earthquake of December 22, 2003. The following day the County Public Works Department contracted for repair of four earthquake-damaged locations on the Arroyo Grande channel levee. The county still maintains that it has turned over responsibility for maintenance and repair to the state.

Conclusions

Today the creek is clogged and flows slowly between the levees through the Oceano area, emptying into the ocean south of the vehicle entrance to the beach. Anyone wishing to see first hand the condition of the creek can do so by visiting the 22nd Street Bridge in Oceano. From this vantage point it is possible to look toward the mesa and see that at one time the entire area was a wetland. Nature's power is evident, both in what was once here, and in what is occurring today.

The Grand Jury found that the problem in addressing a waterway with protected wildlife is compounded by the numerous permit requirements found at the state level, and those that are even more restrictive at the federal level. Even within the same agency, whether state or federal, there often are overlapping divisions with differing processes, programs, and priorities.

The Grand Jury determined that the number and nature of the permits required for such a project is dependent upon the nature of the work to be done, which, in turn, is dependent upon the results of required scientific studies. The studies themselves are often very costly and time-consuming. A vast and complex array of mandated public hearings and response must be completed prior to issuance of the permits necessary for a project to address flooding in a creek channel such as Arroyo Grande Creek. Assuming an acceptable alternative solution is identified as a result of any required studies, the proposed project is then dependent upon the time duration of the various permits, the cost of the project, the availability of funding, and seasonal construction restrictions.

In short, the permit process is so difficult, complex, costly and confusing that even the most knowledgeable government official finds it almost impossible to decipher and implement. Even if the agency responsible for a drainage waterway is able to identify and undertake the necessary steps, the cost of such projects must compete with many other capital improvement projects for that government's limited budget funds, an important consideration in the present fiscal climate.

In the opinion of the Grand Jury, by adopting Resolution No. 2003-105, the Board of Supervisors attempted to absolve itself of the long term expense and aggravation of the permit process. Following this action, the Board of Supervisors removed the $150,000 which had been initially budgeted for the "Alternative Analysis" study. In the opinion of the Board of Supervisors they were no longer responsible for the creek, and so there was no need to perform that study. This action is especially disconcerting because the Grand Jury has been told that the county actually holds an existing permit for some work that could be done on the Arroyo Grande Creek channel. However, the county will not proceed with the work allowed by that permit process because, in the estimation of County Counsel, jurisdiction of the creek maintenance was immediately transferred to the state upon adoption of Resolution No. 2003-105, and county action on that permit would mitigate against the county's position that the state now has responsibility for maintenance of the Creek.

In the meantime, the property owners affected by creek flooding, including the original complainant, are left waiting and wondering if anyone will help them avoid further damage and expense. While the state disagrees that the county transferred jurisdiction by adoption of Resolution No. 2003-105, the one thing both entities agree on is that an appropriate court of authority as a result of litigation could determine maintenance responsibility. That, however, is very small consolation to the threatened property owners.

Many federal, state, county, Coastal Commission and related environmental permits are required for such drainage control work. Further, the cost of any logical solution to repair or maintain the creek channel would be better borne by an agency with sufficient authority and resources.

The U.S. Army Corps of Engineers historically has had responsibility for flood control management in the continental United States. In 1999 the Corps of Engineers performed a preliminary evaluation for potential solutions to the Arroyo Grande flood control problem. Therefore, the Corps may be the appropriate agency to acquire the necessary permits and complete the necessary work to protect the property and residents in this area.

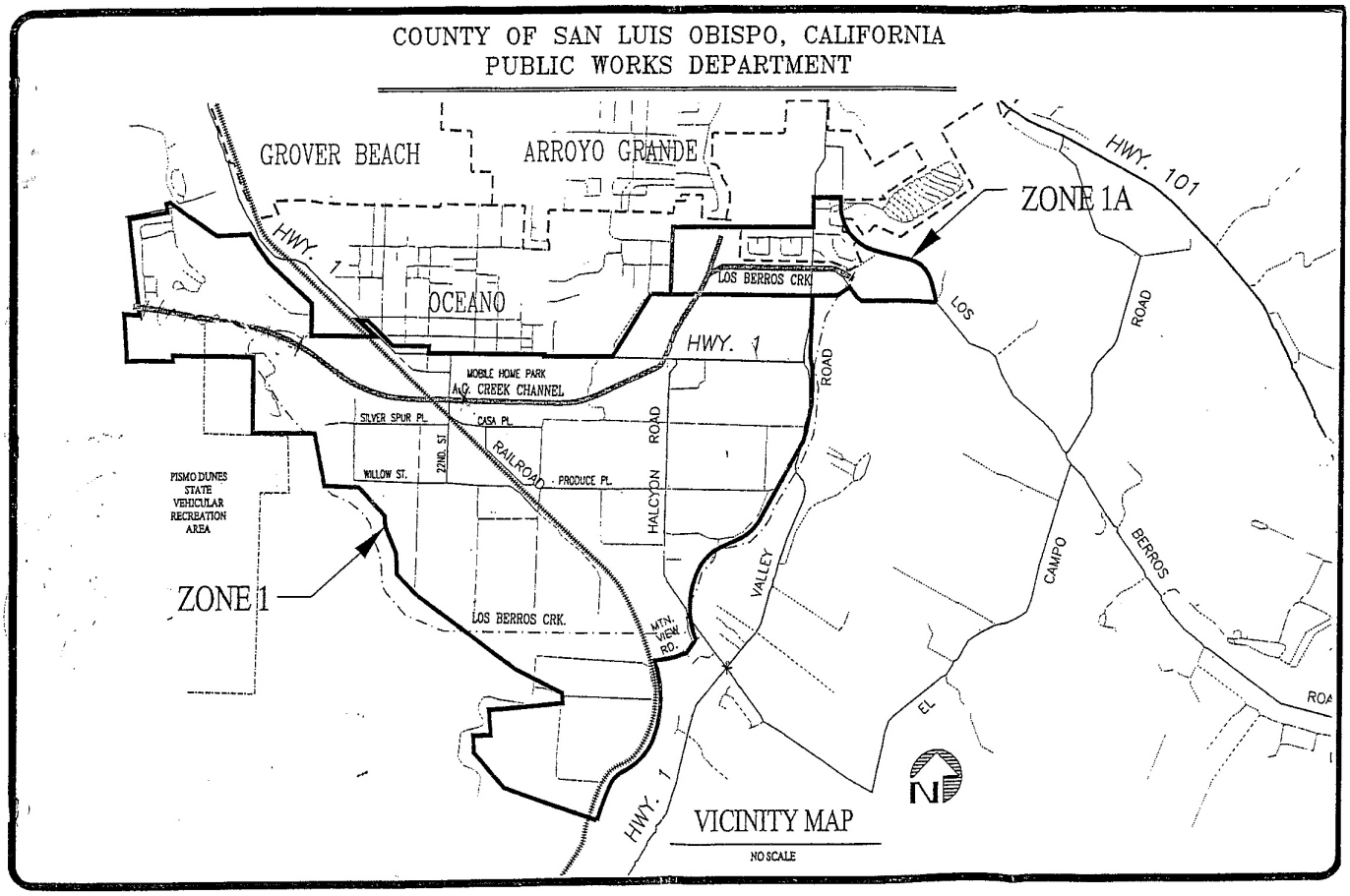
Recommendation

The Grand Jury recommends that the County Board of Supervisors establish a citizens' committee to meet with the appropriate congressional representatives to obtain their assistance in directing the Corps of Engineers to immediately undertake a flood control remediation project to resolve the Arroyo Grande Creek channel flooding problems.

Required Response

As required by California Penal Code Section 933 (c), within 90 days the County Board of Supervisors shall comment to the presiding judge on the findings and recommendations in this report.

Appendix


COUNTY OF SAN LUIS OBISPO, CALIFORNIA
PUBLIC WORKS DEPARTMENT
GROVER BEACH
ARROYO GRANDE
HWY. 1
OCEANO
HWY. 101
ZONE 1A
LOS BERROS CRK
HWY. 1
MOBILE HOME PARK
AG. CREEK CHANNEL
SILVER SPUR PL.
CASA PL.
WILLOW ST.
22ND. ST.
RAILROAD
PRODUCE PL.
HALCYON ROAD
PISMO DUNES STATE VEHICULAR RECREATION AREA
ZONE 1
LOS BERROS CRK.
MTN. VIEW RD.
VALLEY
ROAD
LOS
ROAD
CAMPO
BERROS
EL
ROA
HWY. 1
N
VICINITY MAP
NO SCALE

SAN LUIS OBISPO COUNTY JAIL

The county jail, located on Highway 1 between the cities of San Luis Obispo and Morro Bay, is operated by the San Luis Obispo County Sheriff's Department. The facility houses inmates who have been convicted of misdemeanors or felonies, inmates who have not been sentenced, and some who are awaiting transport to a state prison.

Authority for the Inquiry

Penal Code §925 states, "The grand jury shall investigate and report on the operations, accounts, and records of the officers, departments or functions of the county."

Method of Inquiry

The bases for this report include a grand jury tour of the jail and a meeting and follow-up discussions with the sheriff. Additional information reviewed for this report include statistical data provided by members of the Sheriff's Department, and a summary of the *Board of Corrections Biennial Inspection Report* dated February 26, 2004.

Description of the Inquiry

Grand Jurors toured the county jail on October 27, 2003, accompanied by the sheriff and a correctional lieutenant. Issues of concern include overcrowding in the women's section of the jail, the prevalence of inmates requiring mental health services, and inmate safety cells.

Jail - Women's section

The California Board of Corrections (BOC) conducts biennial inspections of the jail, in accordance with Penal Code §6031. The approved board rated capacity of the jail is for 412 male and 41 female inmates. However, there are currently 75 beds in the women's areas. The cells and dormitory units we observed were not only crowded, but the single cells contained two beds and some prisoners were required to sleep on mattresses on the floor. The average daily population of female prisoners in 2003 was 62. During the months of October and November 2003, there were nine days when the female population was over 80, peaking at 89 on October 23.

The February, 2004 BOC inspection of the jail found the women's jail facilities, including the female single cells, dorm and honor farm "...continue to remain out of compliance with Title 24 regulations due to the beds placed in these areas" (2/26/04 BOC letter to

Sheriff Hedges). This finding was also reported in the 2001 BOC inspection. Previous Grand Jury reports have recommended that this problem be addressed.

According to the Sheriff's Department, funds for expansion of the women's facilities have been requested through the County's Capital Improvement Project process each year since fiscal year 1990-91. The county budget office confirmed that expansion of the women's jail is included in a master plan for development of the jail site, and that $694,000 was included in the 1999-2000 budget for design work on the project. At the start of the 2003-2004 fiscal year, there was $562,000 remaining of this approved amount.

Mental health

An increasing percentage of the jail inmate population is in need of mental health services. The Sheriff's Department cites the County Mental Health staff estimates that 30 percent of the inmates are receiving medication or counseling for mental health issues. To address these issues, the Sheriff's Department is partially funding a mental heath therapist located at the jail. The department also reports that, in conjunction with the Mental Health Department, it has initiated a program that provides inmates with a ten day supply of medication upon their release from the jail. In addition, the Sheriff's Department is active in the county's Homeless Task Force which is seeking to address the problem within current systems, rather than create additional organizational overhead and expense.

Cameras in safety cells

Previous Grand Juries have recommended that cameras be placed in the jail cells where suicide-prone inmates are housed. The Sheriff's Department August 2000 response to this recommendation stated that this was not necessary since they had been successful with their existing program for monitoring suicide-prone inmates. The department later explained that an exposed video camera in the cell could become a suicide risk factor.

We inspected these cells during our tour of the jail and expressed concern that a small window in the door was the only means of visually monitoring the inmate. In subsequent discussions with the Grand Jury, the sheriff confirmed that current technology would allow enclosed cameras to be installed in the cells, and that he is exploring funding to acquire them.

Conclusion

The 2001-2002 Grand Jury reported on the overcrowding in the women's jail and recommended that the sheriff act to correct the situation. We join them in highlighting this unacceptable situation. Without funding and county action, however, the Sheriff's Department cannot expand the facility. It is the responsibility of the Board of Supervisors and the county to move quickly beyond the design stage to implement a solution to this ongoing problem.

The Sheriff's Department appears to effectively operate and maintain a secure facility with limited resources. They are to be commended for their efforts in coordinating with the Mental Health Department to provide services to the increasing number of inmates who require counseling and/or medication. We also commend the sheriff for working toward adding enclosed cameras in the safety cells. Given the increased inmate population with mental health issues, it would be reasonable to expect that the number of inmates with suicidal tendencies would also increase.

The jail staff, who are not trained mental health professionals, are likely to feel additional stress in working with the mentally ill population in the jail. We encourage the department to work with the Mental Health Department and to identify other resources in order to provide the jail staff with appropriate training in working with mentally ill inmates.

Required Response

This is an informational report. No formal response to this 2003-2004 Grand Jury report is required from any agency.

THE SAFETY AND BEST INTEREST OF CHILDREN? AN INQUIRY INTO CHILD WELFARE SERVICES

Synopsis

The 2003-2004 Grand Jury received multiple complaints against the San Luis Obispo County Department of Social Services (DSS). These complaints accused the Child Welfare Services (CWS) division of failing to provide for the safety and stability of children who are at risk of abuse and/or neglect. Investigation of the complaints led us to examine several CWS systems.

Our investigation focused on two areas where CWS has important responsibilities: the county system for reporting and investigating suspected child abuse, and the processes involved in the placement of children who have been removed from their homes. We found problems in both systems that involve lack of communication and coordination with related agencies. In reporting child abuse, CWS fails to provide law enforcement and the district attorney with required, timely information. In Juvenile Court cases concerning the placement of children, CWS acts to keep information and other professionals who work with the children outside of the process.

While confidentiality is of the utmost importance in child welfare and court cases, the same confidentiality that is supposed to protect these children is used to prevent related agencies from communicating with CWS and the court. There appears to be little or no accountability as to how CWS arrives at many important decisions. Grand Jury members received specialized training and were allowed access to confidential CWS case information. We question whether the court is receiving all of the relevant information, or even the correct information.

We also reviewed the CWS organization in our effort to understand its situation. We found an organization that is faced with enormous challenges, many of which are inherent in the work it performs. There are currently added pressures from California mandated changes and budgetary concerns. The most difficult obstacle to overcome, however, may be the distrust between social workers and upper management at CWS. Unless this problem is addressed, it is questionable whether CWS can effectively meet its other challenges.

Origin of the Investigation

This investigation began as a result of a complaint that was accepted by the 2002-2003 Grand Jury. The complaint alleged that the Department of Social Services, Child Welfare Services division, failed to protect and to act in the best interest of two children. After initial review late in its term, the 2002-2003 Grand Jury assessed that the complaint may underscore more serious problems within the department. Because of the time constraints, that Grand Jury forwarded the complaint to the 2003-2004 Grand Jury for our consideration. Upon review of the forwarded complaint, we accepted it as the first case of the 2003-2004 Grand Jury.

By March 2004 we had received similar complaints and allegations involving 17 CWS cases, 16 families and 38 children. The allegations against CWS cover a range of issues, including failure to respond to reports of child abuse and neglect, and inappropriate actions in foster care and adoption cases. As we investigated each case, several themes emerged that shaped our investigation and this report. The central question that we address in this report is, does CWS effectively implement systems that protect the safety and best interest of children?

Authority for the Investigation

Our authority to pursue the investigation is pursuant to Section 925 of the California Penal Code that states, "The grand jury shall investigate and report on the operations, accounts, and records of the officers, departments or functions of the county." The Department of Social Services is a county agency under the purview of the Board of Supervisors, and Child Welfare Services is a division within that agency.

Overview: Child Welfare Services

This investigation focuses on the Child Welfare Services (CWS) division of the San Luis Obispo County Department of Social Services (DSS). Within the county structure, the Board of Supervisors appoints the DSS Director. Leland Collins has held this position since August of 2000. DSS provides services under three main categories: Aid Programs, Adult Protective Services, and Child Welfare Services. Since the time of Mr. Collins' appointment as DSS Director, the CWS division has been under the direction of Deputy Director Debby Jeter.

The DSS budget derives its revenues from allocations of state and federal funds, special grants, and county funds. The approved 2003-2004 DSS budget includes expenditures of $74.26 million, of which about 65 percent is for DSS administration and 35 percent is for direct benefit payments. The county General Fund Support for the DSS 2003-2004 budget was originally approved at $3.53 million, although in January, 2004 this amount was increased by nearly $2 million. The increases were attributed to the complex funding and state reimbursement for CWS services. With the budget adjustments that were approved in May, the total General Fund Support for the 2003-2004 DSS budget was $6.97 million.

The major programs implemented through CWS are under the jurisdiction of the California Department of Social Services and are regulated by California's Penal Code (PC), Welfare and Institutions Code, and Health and Safety Code. The county receives federal funds for CWS programs, along with the federal regulatory requirements, from the state DSS. The *California DSS Manual of Policies and Procedures, Division 31 Child Welfare Services Program*, is the primary operating manual governing CWS programs. Local CWS policies and procedures define specific implementation and practices in San Luis Obispo County. During the last year, CWS has been compiling local procedures as "Desk Guides" for workers to access via the departmental intranet.

The county's 2003 *DSS Public Information Report* states, "The goal of Child Welfare Services is to provide for the safety and stability of children who are at risk of abuse or neglect" (March, 2004 p.16). CWS services are listed in the following categories: Early Intervention/ Emergency Response, Family Maintenance Voluntary/Family Preservation, Family Maintenance Court Ordered, Family Reunification, and Permanency Planning. The work of CWS involves receiving and responding to reports of child abuse or neglect, working with families to facilitate effective parenting and safe environments for children, and, when necessary, removing children from their homes and finding alternative placements for them.

The Juvenile Court, a division of the California Superior Court, has jurisdiction when CWS takes a child from parents or legal guardians. CWS must petition the court to detain, take custody, and/or place children in foster care or other placements. Recommendations and placement plans are developed by CWS and submitted for court review and approval. In this capacity, CWS plays an important role in providing the critical information on which the court bases its decisions.

The *DSS Public Information Report* also describes 15 "innovative practices and initiatives" that CWS has implemented in its efforts to keep children safe. Many of these initiatives have been in response to, or in anticipation of, social work benchmarks and state priorities. Since 1998, standards of excellence in social services have been referred to as *Best Practices* and CWS has sought special funding in support of local implementation. Recently, many such standards have been incorporated as state mandates and performance goals in the *California Child Welfare Services Redesign* (generally referred to as "Redesign").[1]

This statewide Redesign, which is being implemented from 2004 through 2007, also requires major systems changes in local CWS operations. The state has selected San Luis Obispo as one of the counties that will receive special funding as "early implementers" of the Redesign. CWS will receive a total of $2.85 million beyond its normal allocated state funding over the next four years. The first $300,000 was accepted in January 2004, and the remaining payments are to be distributed annually through fiscal year 2007-2008.

A central component of the Redesign is the legislatively mandated statewide accountability and monitoring system (Assembly Bill 636), which involves tracking performance measures. The online California CWS Case Management System (CWS/CMS), which the county CWS has been phasing in over the past five years, enables the state to track county performance. The system can also be used to track individual social worker performance.

State mandates and local initiatives in recent years have required county CWS employees to learn, implement, and adapt to a myriad of changes. They also must provide vital services with fewer staff. DSS has had a hiring freeze in place since May 2002, resulting in more than 70 unfilled positions in 2004. In addition, in January 2004, the Board of Supervisors approved the elimination of temporary CWS employees and of 18.5 permanent positions, including two of the five senior management jobs.

Methods of Investigation

Our efforts to identify actions and behaviors that led to the complaints against CWS involved conducting interviews, reviewing CWS case files, and examining various documents. We conducted 37 individual interviews at the Grand Jury office, each lasting from one to three hours. Interviewees included complainants, social service professionals, mandated reporters, lawyers, court commissioners, and current and former CWS managers, supervisors, and social workers. A minimum of five Grand Jury members participated in each interview, although there were typically eight to ten jurors present. The majority of the interviews were tape recorded for the review of other jurors and for later reference. In addition to these Grand Jury office interviews, we visited several law enforcement agencies to talk with officers over the course of our investigation. At least two jurors participated in each of these visits.

Because of the sensitive nature of CWS cases, confidentiality, by law, is at a high level. All jurors received special training in confidentiality from Office of County Counsel attorneys prior to having access to confidential information or to CWS files. Discussions of cases and our review of CWS files was completed in accordance with a Standing Order of the Superior Court, as revised during the period of our investigation. At least two jurors reviewed each file. Other documents reviewed for this investigation included the California Penal Code and Welfare and Institutions Code, state and local agency publications, presentation handouts and budget summaries, and correspondence and documentation provided by complainants and related parties. When information in this report is derived from public information, the source is indicated.

The range of issues that surfaced in the course of this investigation resulted in three areas of focus that are developed in the remainder of this report. We have identified findings and recommendations under each section, and include our concluding remarks at the end of the report. This report includes the following sections:

I. Suspected Child Abuse Reports
II. CWS Placement Cases and Issues
III. Organizational Issues
IV. Concluding Remarks and Response Requirements

I. Suspected Child Abuse Reports

The focus of this section is the system used for reporting child abuse in California and its implementation in San Luis Obispo County. We first review the legal requirements and then discuss local processes.

The Child Abuse and Neglect Reporting Act, California Penal Code §11164 et. seq., is intended to protect children from abuse. Many sections of the Penal Code and the Welfare and Institution Code support this act and in many instances the section numbers of the two codes are the same. Both law enforcement and Child Welfare Services (CWS) play important roles in ensuring compliance with the law.

SCAR is the acronym for Suspected Child Abuse Report, a Department of Justice form that is used to report suspected physical, mental, emotional, or sexual abuse, and severe or general neglect. Any person can make a report, but mandated reporters are required by law to complete a SCAR form. Mandated reporters generally include any person who has direct or indirect contact with children. Penal Code §11165.7, included here as Appendix A, identifies legally designated mandated reporters, and a copy of the SCAR form is provided in Appendix B. All employers of mandated reporters are required by law to inform their employees about the requirements for reporting child abuse.

Mandated reporters are required to submit a SCAR whenever the reporters, in their professional capacity or within the scope of employment, have knowledge of, observe, or reasonably suspect a child has been the victim of abuse or neglect. These suspicions are to be reported immediately or as soon as possible by telephone to any police or sheriff's department or to the county child welfare services. The SCAR form containing information concerning the incident must be sent to the agency that was telephoned within 36 hours. As specified in the instructions printed on the reverse side of the form, color specific copies are to be distributed to child welfare services, the local law enforcement agency, and the district attorney's office. The fourth copy is for reporting parties to keep for their record.

The report flow shown in Figure 1 is designed to ensure that all interested agencies are notified in order to initiate their investigations. The Penal Code specifies penalties for failure to follow the designated procedures. A mandated reporter who fails to report any suspected child abuse or neglect "...is guilty of a misdemeanor punishable by up to six months in a county jail or by a fine of one thousand dollars ($1,000) or by both fine and punishment" (PC §11166). The section further states "...any supervisor or administrator who violates or hinders the distribution of the SCAR is guilty of an infraction punishable by a fine not to exceed five thousand dollars ($5,000)" (PC §11166.01).

The purpose of requiring the distribution of the four part handwritten form is to ensure that all appropriate investigative agencies are provided with original information. Any agency receiving a SCAR must accept it. When an agency receives a report for which it lacks jurisdiction, the agency must immediately evaluate it and refer the applicable cases by telephone, fax, or electronic transmission to the agency with proper jurisdiction.

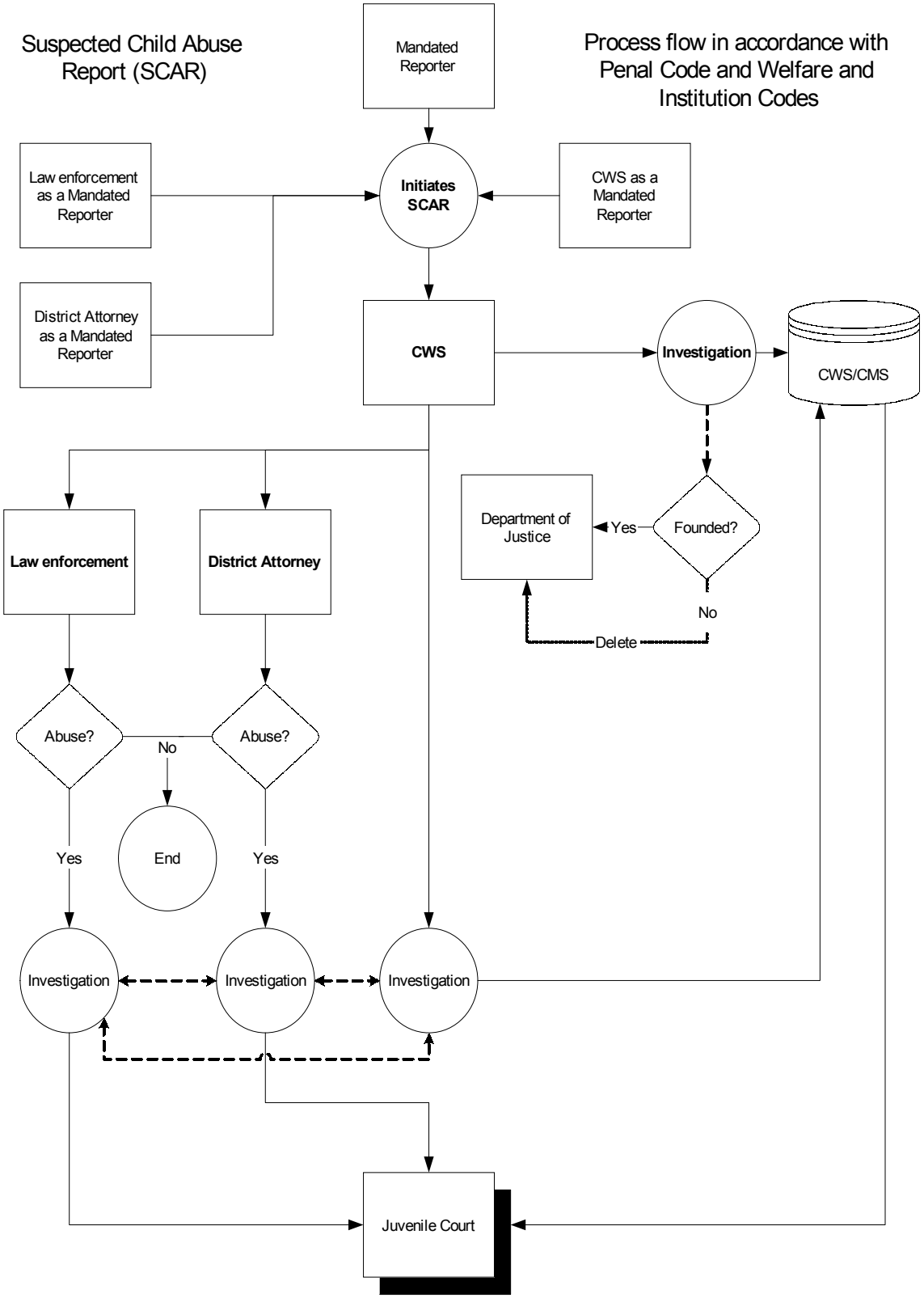

Suspected Child Abuse Report (SCAR)
Mandated Reporter
Process flow in accordance with Penal Code and Welfare and Institution Codes
Law enforcement as a Mandated Reporter
Initiates SCAR
CWS as a Mandated Reporter
District Attorney as a Mandated Reporter
CWS
Investigation
CWS/CMS
Law enforcement
District Attorney
Department of Justice
Yes
Founded?
No
Delete
Abuse?
No
Abuse?
Yes
End
Yes
Investigation
Investigation
Investigation
Juvenile Court

Figure 1

The intent of the law is to ensure a multi-agency involvement process. The goal is for all information to be cross checked so that no child falls through the cracks of the process, and that independent investigative reports are available to the courts.

SCARs in San Luis Obispo County

The issue of SCARs was brought to the Grand Jury's attention when two mandated reporters filed a complaint asking us to follow up on why investigations were not initiated after they had properly filled out and sent a SCAR to the county Child Welfare Services. This prompted the part of this investigation that involved reviewing the distribution of SCAR forms in our county.

In following up on the initial and subsequent complaints, we reviewed 17 CWS files involving 38 children. We found 44 SCAR forms that had been completed in the last three years, mostly by mandated reporters. Thirty-five of the forms still included the copies intended for distribution to law enforcement and the district attorney. In only one of the files was there indication that the mandated reporter was sent an acknowledgment as required by the process.

Upon investigation, we learned that since August 2000, CWS has been initiating a computerized CWS/CMS version of the SCAR when they receive a report of suspected child abuse that meets their criteria for action. Copies of that version of the SCAR are distributed to law enforcement and the district attorney when required. A result of this practice is that in most cases, the other agencies do not see the originally submitted SCAR that may contain information that is not included on the CWS form. In instances when the original form is also submitted, either by a mandated reporter or CWS, the result is that other agencies are receiving duplicate reports. An effective approach, which we found used in a few instances, was CWS attaching the agency copy of the original SCAR to the CWS form they distribute.

Local CWS procedures are currently being developed as "Desk Guides" for electronic distribution to employees through the county DSS internal network. The working "Draft CWS Desk Guide Subject: Intake Referral" (Draft Revised 7/17/03) calls for systematic distribution of the reports as depicted in Figure 2.

We noted that the Desk Guide does not specify that a copy of the SCAR must be distributed to the district attorney when it alleges physical or sexual abuse or severe neglect. While we confirmed that the district attorney's office does receive some copies of CWS generated SCARs, it is difficult to know whether they are consistently distributed as required by law. There is also a delay in receiving the reports from CWS. Even with the Desk Guide in place, we identified additional areas of concern related to CWS communication with mandated reporters and the coordination with law enforcement.

Mandated Reporters

Many of the SCARs that we reviewed had been determined to be unsubstantiated or unfounded by CWS. An unsubstantiated designation means that not enough evidence was

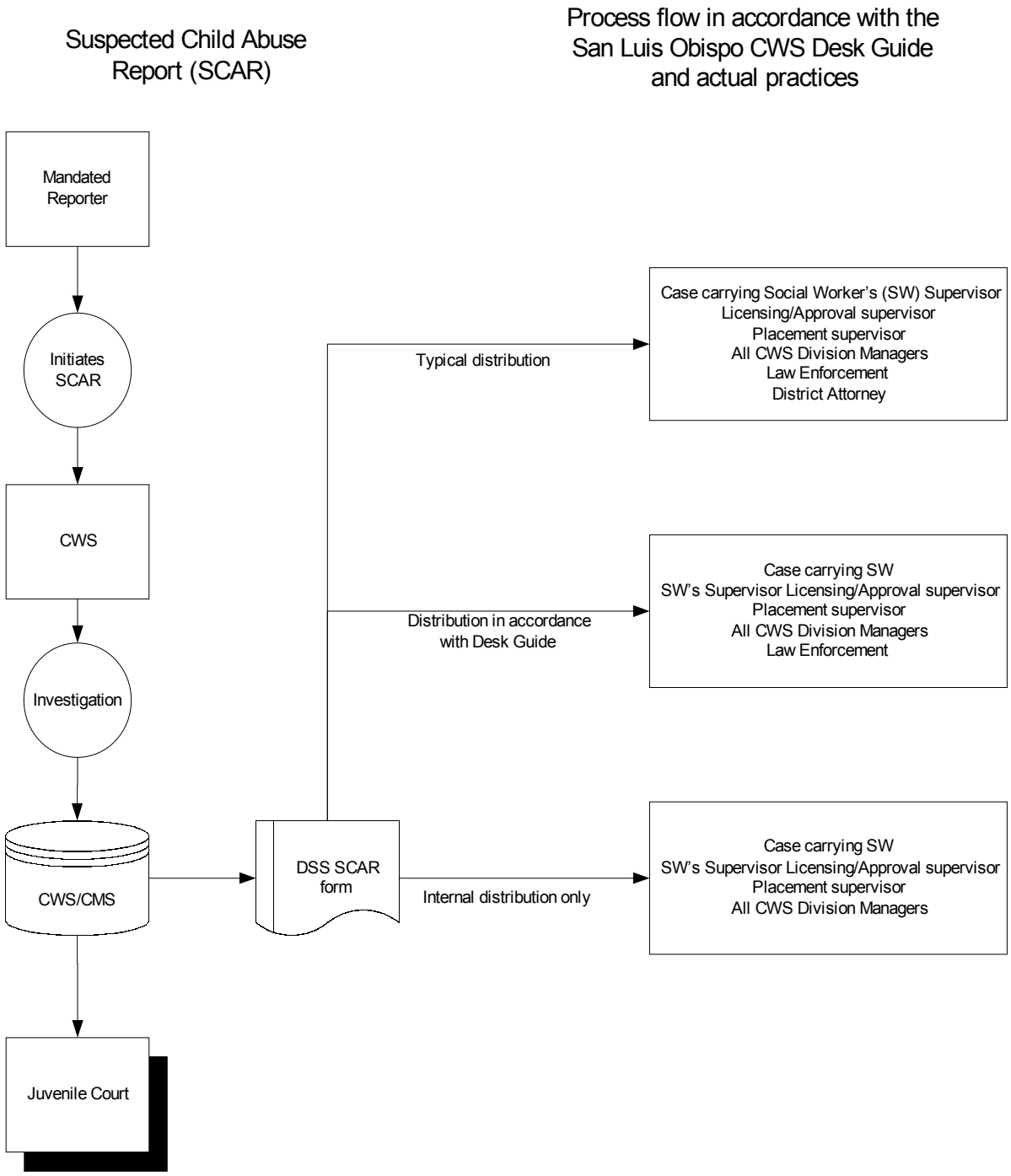

Suspected Child Abuse Report (SCAR)
Process flow in accordance with the San Luis Obispo CWS Desk Guide and actual practices
Mandated Reporter
Initiates SCAR
CWS
Investigation
CWS/CMS
Juvenile Court
DSS SCAR form
Typical distribution
Case carrying Social Worker's (SW) Supervisor
Licensing/Approval supervisor
Placement supervisor
All CWS Division Managers
Law Enforcement
District Attorney
Distribution in accordance with Desk Guide
Case carrying SW
SW's Supervisor Licensing/Approval supervisor
Placement supervisor
All CWS Division Managers
Law Enforcement
Internal distribution only
Case carrying SW
SW's Supervisor Licensing/Approval supervisor
Placement supervisor
All CWS Division Managers

Figure 2

found to support the allegation. In an unfounded determination, CWS has found no evidence or basis for the accusation.

Several mandated reporters questioned how these determinations had been made. In many cases, it appeared to this Grand Jury and to law enforcement agencies that there was enough documentation to warrant further investigation or another conclusion. One example is a SCAR submitted by mandated reporters that included statements and evidence from a doctor, teachers, psychologists, and even a child's drawing to substantiate their accusations. Even with this supporting documentation, the SCAR was deemed to be unsubstantiated by CWS. When asked how this conclusion had been determined, CWS told the mandated reporters that the information could not be shared due to confidentiality.

Law Enforcement

In our interviews with law enforcement, we learned that in some agencies the dispatchers routinely receive calls from CWS when suspected child abuse is reported. Other agencies reported that they do not receive calls as often as they should. This call is important because it allows the law enforcement agency to respond quickly. Failure to receive immediate notice delays law enforcement investigations. Important evidence such as bruising and markings may be lost, the information provided by the victim and suspect may change, and one or the other of them may leave town.

The reporting process is designed for the telephone reports to be followed by a copy of the CWS/CMS version of the SCAR form in cases of physical or sexual abuse. Each law enforcement agency has developed its own system for matching the reports they receive by telephone with the corresponding paper work. In cases where there was no call received, the SCAR may be the first time law enforcement was made aware of the suspected abuse.

Problems also occur in the paper flow from CWS. SCAR forms are often distributed by CWS to the wrong law enforcement agency. This puts an extra burden on the receiving agency to re-route the SCAR, particularly since some receive up to 70 per month.

A related issue is the delivery time. The Penal Code is clear that a written SCAR must be sent within 36 real (consecutive) hours to the agency that receives a telephone report. In many cases, we found the CWS initiated SCAR was not filled out until several days after the initial call. After it has been processed by CWS, it was another three to five working days, often more than a week, before the law enforcement agencies and the district attorney's office received their copies. The county agencies that we interviewed received the written SCARs from CWS through the county's inter-office mail system.

Findings

(1) CWS is not sending a written SCAR within 36 hours of receiving reports of abuse or severe neglect to the agency to which it made a telephone report in accordance with Penal Code §11165.7(h). Law enforcement and the district attorney's office are receiving the SCARs longer than three days and frequently more than a week later.

(2) Some law enforcement agencies do not receive immediate telephone calls on incidents for which they later receive a SCAR.

(3) The CWS Desk Guide instructions do not specify that a SCAR is to be distributed to the district attorney as required in PC §11165.12 (c).

(4) When CWS determines that reports of sexual and physical abuse and severe neglect are unfounded or unsubstantiated, they do not distribute the written SCAR to the appropriate agencies. This appears to be in violation of PC §11166.

(5) Some law enforcement agencies are receiving SCARs that are not within their jurisdiction and must forward them to the appropriate agency. This is a time consuming activity and hinders the timely investigation by the appropriate agency.

(6) Some law enforcement agencies are receiving duplicate copies of SCARs, one initiated by the mandated reporter and one initiated by the CMS/CWS. Receiving duplicate SCARs for the same incident can be confusing and time consuming for the law enforcement agency.

(7) When a SCAR decision is made regarding a referral from a mandated reporter, CWS does not consistently send an acknowledgment of the outcome to the reporting party.

(8) Training for mandated reporters of child abuse and members of the child welfare delivery system is not regularly provided, as required in PC §16206.

(9) CWS reporting and coordination is not consistent among law enforcement agencies.

Recommendations

(1) CWS should ensure that the appropriate law enforcement agency is immediately telephoned when CWS receives a report of child abuse or severe neglect.

(2) CWS should ensure that SCARs are distributed to the appropriate law enforcement agency and the district attorney. The CWS Desk Guides and internal procedures should be corrected to reflect this.

(3) CWS should complete and forward a written SCAR to the appropriate agencies within 36 consecutive hours.

(4) The law enforcement copy of a SCAR should be forwarded to the correct law enforcement agency.

(5) CWS should attach the appropriate copy of the original SCAR form to CWS/CMS SCAR forms they distribute to law enforcement and the district attorney.

(6) CWS should notify mandated reporters of the outcome of the SCARs that they submitted.

(7) CWS should take a leadership role in promoting training for mandated reporters.

(8) CWS should review agreements on SCAR reporting with all law enforcement agencies within the county to ensure consistent practices and coordination on a regular basis.

(9) County inter-office mail should not be used for delivery of time-sensitive information.

II. CWS Placement Cases and Issues

Perhaps the most difficult decision CWS social workers must make is to remove a child from his or her home. This is the least preferred outcome within the context of U.S. social values. Nevertheless, in some instances the protection of a child requires removal. This section focuses on the complaints the Grand Jury received involving the placement of these children.

When children must be taken from their homes, CWS places them in protective custody. A Juvenile Court hearing is required within two court days requesting permission to detain the child, and a detention hearing is held the next court day. When the court determines that out-of-home care is necessary, the child is typically placed in foster care and placement planning is initiated. Of the 17 cases that the Grand Jury reviewed, all but two involved placement issues.

Child Welfare Services submits reports and recommended placement plans to the Juvenile Court for review. A county attorney (County Counsel) represents CWS in court, and the court assures that all other parties to the case, including the children, have legal representation. A Juvenile Court ruling determines the placement of children. However, CWS is the conduit and often the screener of the information that the court receives. Several of the complaints that we received were from other agency professionals who had been frustrated in their efforts to have their positions represented in the reports and recommendations that CWS submitted to the court.

State and local policies are clear that the order of preference for permanent placement of children is: family reunification, adoption, guardianship, and long term foster care. This prioritization is reflected in the social work *Best Practices,* which have defined policy for many CWS decisions in recent years. Currently, the state Redesign and AB 636 in effect mandate this prioritization of placements.[2]

Fifteen of the cases that we reviewed involved children who had been removed from their homes and placed in out-of-home care for some period. In most of these cases CWS efforts were proceeding toward the goal of family reunification. The common concern among the complainants was that CWS continued to recommend reunification as a goal, even when it appeared this was detrimental to the safety and the best interest of the children.

The cases that we reviewed provide a glimpse of the complex and difficult work of CWS and the Juvenile Court. These cases represent a small percentage of the total CWS caseload. They came to our attention, however, because people who were involved with the children were so concerned for the children's welfare and safety, and so frustrated with the placement process or outcome, that they felt they had no other recourse.

Case Reviews

We present an overview of the facts and issues that led to our findings and recommendations by summarizing some of the cases we reviewed. This is sensitive information that is protected by laws regarding confidentiality. Therefore, specific details and identifying information, such as names, dates, and location, have been omitted. We have provided this information to the Superior Court and, with the permission of the Presiding Judge, to CWS. It is not our intent to second guess decisions by social workers who were directly involved in these cases.

Several of the cases, including our initial investigation, focused on children with developmental disabilities. We begin with discussion of the initial case and related issues. We then summarize additional cases with placement goals of reunification and adoption. The final case we present involves the death of a minor while in the protective custody of CWS. While each case is presented under a specific category for emphasis, many involve issues from multiple categories.

Developmentally Disabled Children

The first case, discussed below, and five subsequent cases that came to our attention involved developmentally disabled children. The complainants are professionals who worked closely with these children. Each case is unique, but in all cases the concerns were that CWS failed to understand the special needs of the children, and did not involve those with expertise either in working with the children or in developing plans and recommendations to the court.

The Tri-Counties Regional Center (TCRC) is the local agency serving developmentally disabled children and adults, under a contract with the state. In cases where developmentally disabled children have been found to be neglected or abused, they are served jointly by TCRC and CWS. According to TCRC, "Children and adults are eligible [for services] who are substantially handicapped due to conditions falling within the legal definitions of 'developmental disability.' These conditions are mental retardation, cerebral palsy, epilepsy, and autism. Or the person may have a condition closely related to mental retardation which requires similar treatment." [3] TCRC case workers are experienced in working with the developmentally disabled and their families, and TCRC can pay for resources to serve them.

Developmentally disabled children often require special medical and therapeutic services to address physical and emotional problems. Some are delayed in developing motor skills and abilities, such as dressing, toileting, feeding, etc. Depending on the nature of their disability, many of these children have difficulty communicating and expressing themselves. Special education teachers and support staff within the public school systems have expertise in

working with developmentally disabled children. They are also most likely to notice changes in the health and behavior of children with whom they work closely, often over several years.

Case The first complaint to this Grand Jury alleged that CWS was emphasizing a goal of family reunification long after there was evidence that it was not in the best interest of two developmentally disabled children. These children began their Juvenile Court dependency history in 1993, and their case had been in and out of the system since that time. Both children were in special education classes in the county, and both were served by TCRC.

The Grand Jury complaint was submitted by mandated reporters who were frustrated with CWS' placement and plan for the children. They had submitted a SCAR six months earlier reporting that the children were the subjects of neglect and physical, mental, and sexual abuse while in the care of the family members who CWS was recommending for legal guardianship. Seventeen pages of documentation, prepared by a team of professionals who worked closely with the children, was submitted with the SCAR. Child Welfare Services later sent one of the complainants a form indicating the allegations could not be substantiated.

Inspection of the files and several interviews revealed that at least ten other referrals had been reported to CWS by mandated reporters in the preceding two years. The reporters had provided documentation from experts regarding health issues, as well as correspondence from other professionals about the negative behaviors associated with the children's placement with the relatives. The CWS recommendations to the court, however, continued to be "reunification" in that home. When the concerned teachers and TCRC staff inquired about the status of the case, CWS refused to give any information. Under the cloak of confidentiality, CWS would not even provide the court dates or the name of the children's lawyer.

The outcome of this case appeared to have been predefined by CWS' goal of family reunification. Data or input from other agencies that did not support this goal was ignored or minimized in CWS reports. Although professionals working closely with the children and family argued with assertions by CWS staff that the family was complying with court ordered programs, the CWS reports to the court did not reflect these opposing views.

The children were finally removed from the family when a sewage problem made the home uninhabitable and law enforcement was called. They were placed in a TCRC foster home that was certified to work with developmentally disabled children. Although the CWS goal continued to be family reunification, the children's improved physical health and behavior while in foster care was brought to the court's attention. After eight months of documented improvement, the court approved placement goal for these children was changed to long term foster care.

Our interviews with school and other agency professionals who work with developmentally disabled children, and with CWS staff, confirmed a lack of expertise in this area within CWS. This is understandable, because only a small percentage of the CWS cases require such specialization. However, when an agency such as TCRC is actively working with children who are the subject of Juvenile Court dependency issues, the agency should have the opportunity to provide information to the court. At least in recent years, this has not been the practice. Child Welfare Services excluded participation of other agencies in the cases we reviewed.

It is also troubling that CWS does not take advantage of the expertise that is available in the community. For example, when CWS workers investigate reports of abuse of developmentally disabled children, the children they must interview often have difficulty communicating. Inclusion of a teacher or other professional who has worked with the child in the interview could help the child to understand the questions and help the CWS worker understand the child's responses. According to our discussions with several mandated reporters, this does not routinely happen. In one case, we found CWS case notes indicating that a report of abuse against a developmentally disabled child was determined to be unfounded because the CWS worker was unable to communicate with the child.

It should be noted that there are often financial aspects to placement cases, and they can be especially significant when the child is developmentally disabled. Many of these children are entitled to monthly Supplemental Security Income benefit payments,[4] and the family income may be sharply reduced when the children are removed from the home. Additionally, families who adopt or provide foster care for children with special needs can receive substantial payments through CWS. Another case we reviewed involved a family with many children with developmental disabilities. In the parents' custody dispute, the family income of nearly $10,000 per month, derived from the benefits and financial assistance for the children, was at stake.

Reunification Cases

In most of the cases we reviewed the CWS stated goal for permanency planning involved reuniting children with their parents or relatives. Of the following cases we briefly discuss here, the first three involved returning young children to homes where sexual abuse against at least one of the children had been documented.

Case In this instance, two children had repeatedly been returned to their mother following foster home placements, despite evidence that the mother could not protect the young girl from sexual and physical abuse by the father and older brother. The CWS reports to the court did not include findings from the Suspected Abuse Response Team (SART) that detailed the abuse of the young girl. The CWS court report also failed to include documents or references about another agency's opposition to returning the children to the mother's home.

Case This case concerns a family about whom repeated referrals to CWS had been made over a six year period, many from mandated reporters. At least 18 emergency referrals on each of the two children were sent to CWS over a

two and a half year period. Thirteen SCAR forms reporting neglect and risk during that time were found in the CWS file with the copies intended for law enforcement and the district attorney still attached. A drug-related law enforcement action against the father was required to finally open this CWS case and bring the children to the attention of the Juvenile Court. Neglect and long term sexual abuse of the young girl was established, and the children were placed in foster care. The father was convicted of sexual abuse.

Child Welfare Services efforts were directed toward returning the children to their paternal grandmother's home. That was the home where the father had lived, where the children lived during the time CWS received multiple reports of neglect, and where the abuse had occurred. The attorney representing the children argued that the grandmother had failed to protect the children, and filed challenges to the CWS plan. Following extended legal exchanges, the court approved a plan that would allow a continued relationship with the grandmother, but with a goal of adoption outside of the family.

Case In a similar case, the CWS goal of placement of two children with their paternal grandmother persisted despite information known to CWS of the grandmother's involvement in the drug-related charges that had sent the father to jail. The CWS file documented an abusive home environment during the time the two children lived with both parents. The mother had finally won custody of the children shortly before her death, which was surrounded by violent circumstances. The children were then placed in temporary foster care.

The CWS recommendation to the court was to place the children with their father's mother, and pursue reunification with the father. Maternal relatives objected and proposed placement with their family. CWS did not pursue this option. The CWS recommended plan to the court continued to be placement in the paternal grandmother's home and reunification with the father, even though his abuse of the children had been documented. The court referred the father to participate in a reunification program while he was in jail.

The final case we discuss in this section is an example of what seem to be competing *Best Practices*. In this case, one *Best Practice* justified the extended reunification efforts for the mother. However, during this process, CWS moved the child to three different homes within a year, violating the standard that children should not be moved frequently.

Case This case involved an infant placed in foster care while the mother was enrolled in a drug rehabilitation program, and followed the pattern of reunification at any cost. The infant was abruptly removed from the foster home and returned to the mother before she was able to provide a home for the baby. The CWS report to the court stated that the child was removed at the insistence of the foster mother, but did not explain that this was because the CWS workers had violated the confidentiality of the foster family. It also did not mention the foster family's continuing interest in the child. The mother's

CWS case was designated a "Special Project," and CWS provided extensive support services and financial assistance to her. Still, reunification was not successful, and within ten months the baby was placed in yet another foster home. The permanent placement goal for the baby was changed to adoption.

Adoption Cases

When reunification with the family is judged not possible, the second preference for permanent placement of children is adoption. One state DSS outcome goal for adoption is measured in terms of time to complete the adoption process. The ideal is to expedite the process so the children can settle into a safe and stable home.

Case This case involves another infant who was placed in foster care at about two months of age. Within a few months the infant was moved to a "fost/adopt" home, where the foster parent was interested in adopting the baby after the court terminated the parental rights. Adoption in this approved home would have met the standards of minimizing the times a child was moved and completing the adoption within less than 18 months of detention. Rather than support this adoption, CWS expended extensive time and money searching for distant relatives who might be interested in caring for the child. The identified relatives have been strangers to the child. This process has extended for more than two years and involved considerable frustration for the adoptive parent, who had to hire a private attorney to oppose CWS in court.

Case We received two complaints about a case where the issue was one of failing to provide reunification services for a mother and her four children. The complainants alleged that CWS did not provide the mother with adequate services before terminating her parental rights. Once the mother's rights were terminated, CWS proceeded quickly to finalize adoption of the children. However, information that could have influenced the decision seems to have been ignored by CWS. There is documentation that this information was directly delivered to CWS, although it was not in any of the CWS reports to the court that we reviewed. Less than two years after the adoption was finalized, the adoptive father was arrested on charges of child molestation and was found guilty on several counts.

A Child Dies While in Foster Care

Many of the CWS social workers we interviewed expressed the concern that a child would die while in foster care if their heavy caseloads and the stress at CWS continued. The following case is an illustration of this concern.

Case The complaint in this case alleges a cover-up by CWS, the sheriff/coroner, and a police department regarding the death of a child while in foster care. In our investigation of this case, we reviewed CWS files, police reports, medical records, autopsies, and coroner's reports. We interviewed police officers, social workers, deputy district attorneys, and a deputy sheriff.

Child Welfare Services placed two siblings into a foster home that was licensed to care for high-risk children. A minor with a long history of assaultive behavior was already a foster child in this home. That minor had been in many foster homes in the system during the last several years, had been assessed as a high-risk child, and was on medications for a variety of emotional illnesses.

Three and one half weeks after placement of the two siblings for their protection, the older sibling was found in a ditch in the backyard of the foster home and was dead on arrival at the local hospital. Although the cause of death was undetermined, and there were emergency shelter beds available, the younger child was ordered by CWS upper management to remain in the home that had already failed to protect her sibling. The other foster child immediately ran away, but was later picked up by law enforcement.

Our investigation did not find evidence of a cover-up. We are concerned, however, about two aspects of this case. One is the placement of these vulnerable children in a foster home with a high-risk child who had a long history of violent behavior. We are also concerned about the CWS management decision that required the younger sibling to remain in the house amidst chaos and possible danger, since at the time there had been no determination as to whether the tragedy was an accident or a crime. As of the filing of this report, the case remains open and law enforcement investigation is continuing.

Other Representatives in Juvenile Court Placement Cases

We have discussed many of the agencies and professionals who are involved with the children whose placements are being decided by the Juvenile Court. TCRC has the expertise in cases involving developmentally disabled children, as do the therapists, doctors, and other agencies that provide services. In all cases when the children are in school, the teachers, nurses, psychologists, and support staff can be valuable sources of information and insight. While CWS has several programs in place that are designed to involve other agencies working with families they serve, our interviews with several professionals indicate that CWS has not included them in placement planning and decisions. Moreover, CWS has acted to exclude them from the court process.

Two specific groups that are involved in Juvenile Court cases are Court Appointed Special Advocates (CASA) and the lawyers representing the various parties in the case. A CASA is a trained community volunteer appointed by the judge to provide advocacy and voice for the children. The relationship between CWS and the local CASA agency has been strained in recent years, and conflicts in specific cases often reflect the different missions of the organizations. The common goal, however, is the best interest of the child. Our investigation highlighted the need for CWS to be more cooperative in sharing information about children they are both serving, including such basic courtesies as notifying the CASA when a child has been moved to a new foster home. CASA reports are sent directly to the judge, with copies to all parties to the case. Currently, a CASA is appointed by the court when the Juvenile Court judge sees the need, although there are not enough volunteers to meet the demand.

The lawyer appointed to represent a child can be a deputy district attorney (in cases where there is typically a felony criminal charge against a parent) or can be selected from a panel of lawyers under contract with the county. The lawyers from the panel may be appointed to be a parent's or guardian's lawyer in some cases and a child's in others. In several of the cases that we reviewed the children's attorney was a strong advocate who was knowledgeable in the relevant law and who actively sought information regarding the children's situations. Unfortunately, this was not always the situation. Private lawyers with varying levels of expertise in Juvenile Court dependency matters are appointed to represent the children when a deputy district attorney is not appointed. These private lawyers often lack the resources to carry out an independent investigation on behalf of the children, and they have reported difficulty gaining access to information in CWS files regarding the children. While there is a legal procedure for requesting this information, it is cumbersome and often yields only selected parts of the CWS case file.

Child Welfare Services' legal representation is assigned from the Office of the County Counsel. One attorney is assigned to CWS full time, with support from additional staff as needed. In presenting and defending their recommendations to the court, CWS has a designated lawyer who is experienced and well versed in juvenile law and children's issues. Attorneys for CWS have full access to the case files and have established relationships with the social workers involved. The CWS attorney has also served as the primary court manager in recent years. The result of this is that CWS often has a significant advantage in making and supporting their cases to the court.

Findings

(1) Documentation from other agencies concerning children's situations is not consistently represented by CWS in the reports and recommendations it submits to the court.

(2) CWS does not always include in its court reports opposing professional positions that could assist the court in making its rulings.

(3) CWS has failed to effectively involve other agencies working with children in making placement plans and recommendations to the court.

(4) CWS has made it difficult for other professionals who are working with the children to obtain information about the status of a case in the name of confidentiality.

(5) CWS has refused to provide names of the children's legal representatives to mandated reporters in the name of confidentiality.

(6) CWS has failed to effectively use the available expertise of professionals who specialize in working with developmentally disabled children and their families.

(7) CWS social workers do not have adequate training and assessment skills to work with developmentally disabled children and their families.

(8) CWS has failed to protect the confidentiality of foster families.

(9) CWS has removed children from foster homes and misrepresented the reasons to the court.

(10) CWS has pursued the goal of placement with relatives in cases when the relatives were strangers to the child.

(11) CWS has pursued the goal of reunification in cases where there is documentation that it was not in the best interest of the children.

(12) CWS has inconsistently applied *Best Practices* to justify conflicting actions.

(13) CWS allowed a vulnerable child to remain in a foster home where a tragedy occurred even though there were available beds in emergency care shelters in the area. CWS does not effectively use emergency care shelters in the county.

(14) The CWS legal representative in Juvenile Court is a designated lawyer from the Office of County Counsel who is experienced in juvenile law and court proceedings. Private attorneys appointed to represent children often do not have comparable experience in juvenile law or case investigation.

(15) CWS legal representatives have full and unrestricted access to the children's files that is not as readily available to all attorneys for the children. The CWS attorney also manages the court calendar.

Recommendations

(1) CWS should ensure that the positions and documentation from other agencies and professionals who are working with the children are represented in the reports and recommendations that are submitted to the court regarding those children.

(2) CWS should proactively cooperate with other agencies and professionals working with a child in developing placement plans for the child.

(3) The issues and concerns highlighted in multi-agency meetings and discussions regarding children should be represented in documents submitted to the court.

(4) CWS social workers should receive basic training in working with developmentally disabled children, including assessment and communication skills.

(5) CWS social workers who are interviewing a developmentally disabled child should involve those who are familiar and have rapport with the child in the interview.

(6) A CWS policy should state that the placement of remaining children in a foster home should be re-evaluated when physical harm to a child has occurred in that home.

(7) CWS should evaluate its use of emergency care shelters in the county to assure that they are being effectively utilized for their intended purpose.

(8) CWS should provide the names and office information of attorneys appointed to represent children in Juvenile Court to mandated reporters who are actively working with the children.

(9) Professionals who are directly involved with children who are the subjects of CWS and/or Juvenile Court cases should be included under the umbrella of confidentiality in order to receive information that would help them in serving the children.

The following recommendation is directed to the office of the Superior Court that is responsible for the contracting and funding of legal representation services for Juvenile Court in San Luis Obispo County:

(10) An independent panel of attorneys should be designated to represent only the children in Juvenile Court dependency cases. These attorneys should have training and investigative resources comparable to those available to CWS in preparing their cases.

III. Organizational Issues

Information we have presented to this point has highlighted many of the complex systems and issues involved in Child Welfare Services work. In this section we direct attention to the CWS organization, including financial issues, the CWS/CMS system, the management style, and the CWS work environment. Change has been a constant in the work lives of CWS employees during the past five years. Given the legislative mandates and the state Redesign, continued significant change for the organization and its employees is inevitable.

The changes at CWS have come in both tangible and intangible forms. The CWS/CMS has involved fundamental changes for employees in how their work is performed. As we discuss in this section, emphasis on multiple initiatives has added complexity and often constraints to social work decisions. Several initiatives have involved a redefinition of many social work goals and priorities. Additional committee work and meetings for social workers have been required to accommodate new programs and practices. Budget pressures have also impacted the workload of CWS, resulting in more work with fewer resources. Changes in the organizational structure, including office relocations for some, have required continuing employee adaptations.

Employee stress associated with such constant change and reduced resources would be expected under any circumstances. In addition, the work of CWS is inherently stressful. In San Luis Obispo, this situation is accompanied by what can best be described as a “disconnect” between the CWS upper management and many CWS professional employees. The CWS upper management includes the DSS Director and the CWS Deputy Director. Most of the professional employees at CWS are social workers and social worker supervisors. We found that a lack of trust between social workers and upper management has been escalat-

ing for some time, and we are concerned that the leadership necessary to effectively implement the required changes is absent.

Redesign, Grants, and Financial Pressures

The changes demanded by the AB 636 accountability requirements and the strategies outlined in the Redesign are extensive. They require not only modifying decision models and practices, but also demonstrating compliance by meeting specific goals. *The California Child Welfare Outcomes and Accountability System* (April 2003) articulates eight outcomes, which we have listed in Exhibit 1. These desired outcomes or goals form the basis for compliance with federal requirements and AB 636, and for state DSS reviews of local child welfare agencies.

Exhibit 1

California Child and Family Service Review Outcomes

1. Children are, first and foremost, protected from abuse and neglect.
2. Children are maintained safely in their homes whenever possible and appropriate.
3. Children have permanency and stability in their living situations, without increasing reentry to foster care.
4. The family relationships and connections of the children served by CWS will be preserved as appropriate.
5. Children receive services adequate to their physical, emotional, and mental health needs.
6. Children receive services appropriate to their educational needs.
7. Families have enhanced capacity to provide for their children's needs.
8. Youth emancipating from foster care are prepared to transition to adulthood.

Source: *The California Child Welfare Outcomes and Accountability System* April 2003 (p. 12)

The first and overriding outcome is, “Children are, first and foremost, protected from abuse and neglect.” Our concern is that this primary goal may be compromised in the pursuit of achieving numbers used to measure progress toward other outcomes. The indicators the state is currently developing to assess whether outcomes are being met are typically measured in terms of time and percentages, resulting in pressure to demonstrate specific outcomes within a pre-defined time frame. The push to achieve the statistical goals for the second, third, and fourth outcomes underlies the repeated recommendations for reunification and placement with relatives noted in the cases reviewed in the Placement section of this report. The statistical accountability inherent in the Redesign is new to most social services. The requirement that future state and federal financial support will be tied to achieving performance goals is an even more significant change for local welfare agencies.

As an organizational entity, San Luis Obispo CWS has developed a positive relationship with the state. In 1998 it was chosen as a “pilot county” for testing the effectiveness of *Best Practices*. According to DSS Director Leland Collins, he was the only county director included in the state’s development of a response to the federal government’s review of the child welfare system. The most recent positive recognition from the state was the selection of the local CWS as an early implementer of the Redesign. This brings $2.85 million of additional funding through 2007, and also brings pressure to implement new programs and to meet the statistical goals in the many categories defined in the AB 636 framework. The CWS Deputy Director is often required to be in Sacramento working with state CWS staff.

Besides accommodating the demands of federal and state changes, DSS/CWS upper management must explain and defend budget shortfalls to the county. Additional pressure on CWS derives from commitments associated with special funding that they have received.

Grants. Several of the CWS initiatives have been implemented with grants that bring additional funding to the county. Current grant projects include *Linkages* and *Family to Family*. The *Linkages* grant provides a total of $45,000 over a 13-month period, ending in November 2004, to facilitate a partnership approach between CWS and other services available to its clients. The goal includes a new organizational structure to support a “one door model” of social services in Atascadero. *Family to Family* is a three-year grant designed to integrate principles associated with reforming the foster care system. The grant provides $100,000 for the third year, which ends in October 2004.

CWS management publicly presents grant funding as adding resources for helping children and families at no additional cost. There are, however, “hidden costs” to such grants that may exceed the value added, as several of our interviewees highlighted. These costs include accounting and reporting requirements that require staff time. An analysis provided to the Grand Jury estimated the CWS financial cost of grants to be 20 percent of the grant value.

The greater cost may be the refocus and reorientation of social workers’ most valuable resource, time. For example, compliance with the *Linkages* grant required reorganization and office relocations, adding expense and stress at a time when social work resources were already stretched. The *Family to Family* grant requires increased efforts to recruit foster families and to document an average of 40 “Team Decision Meetings” per month. Pressures for grant compliance define such activities and meetings as social worker priorities. The es-

timate provided to us was that 20 to 25 percent of CWS social worker time has been redirected to grant compliance activities in recent years.

County budget. A state DSS funding source that California counties have come to depend on is a time-lagged reimbursement for money spent over and above their state allocations. Referred to as "overmatch," this reimbursement has not been available during the state's recent budget shortfalls. As a result, San Luis Obispo County had to increase its funding for CWS programs during the 2003-2004 fiscal year, and will likely have to adjust the county share upward in coming years.

The local DSS anticipated these budget cuts and instituted a voluntary hiring freeze in May 2002. The Board of Supervisors made the hiring freeze mandatory in November 2003. When the DSS director explained the CWS budget shortfall to the Board in January 2004, he also requested authorization to further reduce CWS by 18.5 positions and eliminate all temporary positions. This request was approved. Apparently, there are no plans to use any of the $2.85 million the county will receive under the early implementer Redesign grant to add social workers or staff.

As we noted previously, placement decisions have financial consequences that are reflected in the CWS budget. In the DSS budget, the single largest item is for Foster Care and Adoptions Assistance. CWS can keep the county share of the DSS budget down by using lower cost foster care and adoption placements. The state mandated CWS placement priorities tend to be inversely related to the costs associated with them. For example, the preferred goal of reunification with family is typically the least expensive, while placement in a group home is the least preferred and one of the most expensive options. Foster care for special needs children, e.g., those with developmental disabilities, can become very expensive for the state and the county, especially when the children are placed in homes that are approved to provide special services.

Money has also become a source of distrust within CWS, especially in this time of scarce resources and financial pressures. Many employees whom we interviewed and who are being asked to do more with less, question upper management decisions that are perceived as costly. While special grants add to social worker workloads, they do not fund additional human resources.

The complexity of DSS, and particularly CWS funding, renders it difficult to understand. Neither DSS nor the CWS division, however, has had an independent financial audit in at least ten years. The DSS financial manager, a member of the executive team, disagreed with upper management on several financial analyses. His position was eliminated by the Board of Supervisors in January 2004, upon the recommendation of the DSS Director.

Within this context of change and financial pressure, tensions between upper management and CWS employees are increasing. In the next section, we discuss some of the issues surrounding the CWS/CMS data collection tool, because these issues capture many of the dynamics of this strained relationship. We will then focus on the management style and the work environment at CWS.

CWS/CMS

The Child Welfare Services Case Management System (CWS/CMS) is an online reporting system that the state now requires all CWS agencies to use. Locally, CWS has been working toward integrating the system for several years, during which time employees have been required to learn not only computer skills but also new ways of completing work.

The system is now being used to gather data at the state level and to monitor CWS social worker performance at the local level. As part of the Redesign and AB 636, the state will use the information to track the county's success in meeting the established benchmarks. Success at achieving statistically defined goals will determine state funding allocations in the future.

As a tool for gathering data, the system will likely increase both the speed and accuracy of reporting information to the state and federal levels. When fully operational, the system will eliminate the need for the local office to devote time and resources to accumulating and preparing separate reports to state and federal agencies. This is an effective use of technology for the social services. The CWS/CMS capability also has significant implications for how work is performed and evaluated at the local CWS office.

With the CWS/CMS in place, the focus of social workers' evaluations has become whether they have entered case notes and reports into the computer system on time. When asked how social worker performance is measured, CWS managers responded by explaining how the CWS/CMS allows them to monitor social worker reports and case note entries. Our concern is that the value of social workers is shifting from how effective they have been in working with a family or protecting a child toward how proficient they have become in entering data into a computer. The management argument is that they should be able to do both – that documenting what they do has always been a part of social workers' jobs.

For new social workers trained during the years since computers have been integrated into most professions, using the new technologies should be reasonably straightforward. For some seasoned social workers, however, computerized notes and reporting require significant change. The danger is that valuable experience and expertise in working with children and families will be lost if the primary evaluation criteria for social workers becomes that which can be tracked on a computer. The concerns expressed to us indicate that CWS/CMS is being used as a weapon to intimidate and eliminate social workers whose performance, which is now being measured by timely computer input, is not up to standards.

In our interviews, we were told about two ways in which CWS/CMS can be, and has been, used at CWS to undermine social workers. The first relates to management's ability to monitor individual cases and social worker input on the system. Managers explained that supervisors can use this information to identify areas where social workers need assistance. However, some social workers expressed concern that it is also being used for managers to seek detailed information about the work of individuals who they see as being uncooperative. Management then pressures supervisors to initiate progressive discipline against those social workers.

A second potential for abuse of the CWS/CMS is that it allows supervisors and managers to change information a social worker inputs to a case note or report for the court. This is particularly problematic in the context of state pressures for specific outcomes where local CWS funding may depend on this information. Changing the information in CWS/CMS is a concern that may be solved by technology. However, this is symptomatic of a larger problem – that the distrust at CWS is so intense that social workers suspect their managers of such behavior.

Management Style

A repeated theme in our interviews with CWS employees was that upper management either is unwilling or unable to communicate with employees on a professional level. This does not fit the image of a professional organization in which information and practice is freely exchanged and discussed. Social workers are professionals by definition and required qualifications, and their job descriptions include significant responsibilities and judgments. [5] Communication is central to their work, and they expect to be able to work in a professional setting.

The barriers to communication at CWS are both upward and downward. Our interviewees reported that efforts to express concerns regarding local implementation of state mandates are routinely told that, if they don't like it, they can work somewhere else. They described an atmosphere where questioning is seen as opposition rather than an opportunity for dialogue, and an environment that precludes discussing changes or suggesting alternative approaches. The message they receive is that employee input is neither sought nor welcomed.

Downward communication was described as dictatorial. We were told that decisions are made at upper levels and decreed as final, on simple procedures as well as fundamental social work practice and resources. An example of the disconnect between management and employees became clear in our discussions of the new procedural Desk Guides. The managers we interviewed told us that Desk Guides were being developed with the input from all social workers who would be affected by them. The social workers we interviewed, however, told us the Desk Guides were coming to them fully written, with no opportunity for input or discussion. This heavy-handed management style has also been applied to decisions about social work resources, such as group homes, and even discussion of a professionally accepted diagnosis.

Resource decision. Group homes, a resource considered by many social workers to be a critical placement option for children in the CWS system, were in effect eliminated in San Luis Obispo County. This appeared to some to be a unilateral decision to appeal to state standards.

Group homes are identified as the most restrictive (i.e., the least desirable) in placement priorities because they are believed to lack the individual nurturing environment of families. They are also among the most expensive placements. Multiple children can be placed in group homes that are operated by paid staff, many of whom are professionals in the human services. While a general perception of group homes is one of a mini-institution, social workers indicated to us that these placements may be the most appropriate for some children

who are better able to function within the clearly defined structure of a group home. This is most often true for older and/or emotionally disturbed children. Such children can be extremely disruptive, and at times dangerous, in family settings.

Nevertheless, in recent years *Best Practices,* and now federal and state standards, have discouraged group home placements. In response, local group homes were for a time removed as a resource. The result left CWS social workers without appropriate local placement options for some children. Instead, they were left with either placing children in foster homes against their better judgment, or sending them out of county, and even out of state. This latter option is expensive, separates the child from most family support systems, and requires extensive social worker travel time and money to comply with the monthly visit requirements.

Diagnosis discussion. A psychiatric diagnosis that is applied to some children in the CWS system is Reactive Attachment Disorder of Infancy or Early Childhood (RAD). It is a recognized diagnosis by the American Psychiatric Association and defined in its *Diagnostic and Statistical Manual of Mental Disorders*. RAD is associated with failure of a child to bond with a caregiver early in life, and is characterized by "markedly disturbed and developmentally inappropriate social relatedness in most contexts, beginning before age 5 years."[6] Among the methods used to treat children diagnosed with RAD, one was the subject of a recent public controversy.

Coincidental with the national publicity about this treatment, local CWS management took the extraordinary measure of attempting to ban discussion or mention of the legitimate diagnosis of RAD. Social workers told us that even written material mentioning RAD was removed from CWS reference sources. In the spring of 2003, the main presenter at a professional conference in Morro Bay was a therapist whose expertise included RAD. The DSS Director urged the sponsoring agency to cancel the conference and, failing that, refused to authorize any DSS staff to attend.

CWS Workers and the Work Environment

We heard from several sources that the work environment at CWS is not supportive of the social workers who most directly deliver services to children and families. Our sources included current and former CWS employees as well as professional employees of other agencies who work with CWS. While our interviewees emphasized the competence and dedication of many of the front line social workers, they noted that even the best employees were being stressed by a tense atmosphere often punctuated with intimidation by CWS management.

The CWS employees we interviewed dated the start of their dissatisfaction at about the time the current DSS Director was hired (August 2000), which was the same time the Deputy Director for CWS was appointed. This timing was also identified by other agency professionals. The image that emerged from our interviews and documentation is of a divided agency, with CWS management aligned against a significant number of social workers.

As with the individuals who appealed to the Grand Jury out of their frustration in dealing with CWS on placement cases, current and former CWS employees contacted us after their efforts to address the issues directly with management were ineffective. Attempts to resolve

the problems had included individual efforts to discuss concerns with management, and an appeal to the Deputy Director in a letter signed by CWS social workers in 2002. The reported response to the letter was a verbal lashing by the Deputy Director at a meeting, and no improvement in communication.

In April 2003, the San Luis Obispo County Employees' Association (SLOCEA) began a concerted effort to work on the problems at DSS. Approximately 76 percent of the then-employed permanent CWS social workers signed a SLOCEA supported petition that resulted in a June 2003 meeting with the DSS Director and 130 DSS employees. The employee concerns presented at this meeting were categorized as: accountability of managers to employees, lack of leadership on the part of managers, fear and intimidation in the workplace, and unmanageable workloads. The director's response was to communicate by e-mail, addressing each area of concern. As of the filing of this report, employees had received e-mails from the director on three of the four topics, but had not received one discussing the issue of workloads. According to a SLOCEA survey conducted in the fall 2003, the problems at DSS continued with little change.

The workload of social workers at CWS is of particular concern, because the safety and welfare of children is at stake. There are several issues involved, making it difficult to reduce simply to a question of caseload size. In fact, the DSS/CWS management response to concerns about caseloads is that they are within range of state averages.

Social worker responsibilities at CWS, in addition to working with families and children, include participation in committees and meetings associated with various grant initiatives and Redesign implementation. The hiring freeze and staff reductions have further strained the resources. Social workers and supervisors on various types of leave are no longer replaced, and existing workers are expected to cover their cases during their absence. Employees reported several instances in which social workers have been required to assume responsibilities beyond their qualifications, job classification, and salary. At least one social worker cited a heavy workload as the primary contributor to inappropriate decisions affecting children's welfare. Many others expressed concern that such decisions were inevitable in the current environment.

To support administrative requirements, some social workers have been assigned to non-case-carrying positions. Recent reorganizations have resulted in supervisors not familiar with the work or the employees they are responsible for managing. Office and records relocations have added to the adjustments needed to accomplish basic tasks. Increased scrutiny of reports and case notes through the CWS/CMS has added pressures for timely documentation. Management has increased the use of formal documentation necessary to initiate the progressive discipline process, leaving employees in fear of losing their jobs.

Our interviewees also expressed concerns about the lack of relevant and professional training provided to CWS employees. Training sessions are offered for procedural matters such as orientation to new Desk Guides, but are not available for discussing the implications of new policies or thinking through their implementation. There is training for new social workers offered through the state's Core Academy, and an orientation to county policies, but there are no training periods or programs for social workers and supervisors who are transferred to new units or given additional responsibilities. There is little continuing education in

social work practices available through the department. When the professional conference referenced earlier was held in Morro Bay, CWS employees were not permitted to attend.

Many of the experienced social workers we interviewed acknowledged that scarce resources and work overload are part of a normal cycle in social services. They had been through a number of such cycles over the course of their careers and understand that periods of belt-tightening are to be expected. What distinguishes the current situation to them is that the sense of support and unity to help them through the difficult phase is missing. Instead, it has been replaced by a managerial harshness and indifference to employees' concerns.

The current work environment at CWS is not conducive to meeting the considerable challenges facing the organization. The state has warned local CWS agencies about the fundamental changes inherent in implementing the Redesign. California DSS-published documents outline not only the positive potential but also acknowledge the difficulty of the transition processes. The *Child Welfare Redesign Final Report* (September 2003) highlights the need for effective leadership in implementing the fundamental changes, and the change in the organizational culture that will be required in many local agencies. It is this Grand Jury's assessment that the San Luis Obispo CWS does not have the demonstrated leadership required to bring about these drastic changes.

Findings

Management style/communication

(1) The CWS upper management's autocratic leadership and communication style increase the inherent job stress of social workers.

(2) Key decisions affecting social work resources and practice are made unilaterally from the top, with little discussion or input from those who must implement these decisions.

(3) Communication at CWS is top down only, is not open to employee input, and is not appropriate for professional employees such as social workers. Upper management is neither accessible nor visible to many social workers.

(4) CWS upper management efforts have been directed more toward the state, county and grant funding sources than toward creating an open, supportive, and cooperative work environment.

(5) Upper management has demonstrated that they are unwilling to engage in professional dialogue with employees.

(6) Distrust exists between social workers and upper management at CWS.

(7) The climate at CWS has led to social workers' anxiety that they may be fired without prior notice or placed on administrative leave without explanation.

(8) The decision to remove local group homes as a placement option for children in the CWS system has resulted in additional travel, time, and expense.

(9) CWS upper management blocked access to information and discussion of a recognized psychiatric diagnosis. Additionally, CWS workers were not authorized to attend a professional conference because it may have included discussion of this diagnosis.

(10) CWS employee efforts to formally communicate problems were not accepted by the CWS Deputy Director. CWS employee attempts to communicate concerns with the DSS Director have not resulted in meaningful change.

Workload

(11) The unrecognized costs to grants received by CWS increase administrative and social worker responsibilities.

(12) Special initiatives and grants redirect social worker efforts toward compliance activities and have the effect of adding work without adding resources to social workers. CWS grant money is not used to add social worker positions.

(13) The Redesign implementation adds meetings and other tasks to the workload of social workers.

(14) The cumulative effect of the DSS hiring freeze, the elimination of permanent and temporary positions, and not filling in for social workers on leave, has resulted in increased workloads of social workers and supervisors.

(15) With the current workload requirements, it is unrealistic for social workers to be expected to complete their work within the hours of a normal work week.

(16) Some CWS social workers are working above their job classification.

(17) No social worker job analysis has been conducted to reflect the current technology and the work requirements under the Redesign.

Training

(18) Newly-hired CWS social workers are not given adequate time for caseload and procedures orientation.

(19) Neither relevant training nor transition time is provided for CWS employees when they are reassigned to new work units or positions.

(20) Relevant training and continuing professional education for CWS social workers is limited.

(21) There is no provision for training social workers or managers for: a) the culture change required by the Redesign, and b) team dynamics to support the demands of CWS requirements for teamwork.

CWS/CMS

(22) The CWS/CMS can be an efficient and effective application of technology for purposes of case reporting and documenting, and for identifying areas where there is need for improvement in caseload management.

(23) Social worker notes and reports can be, and are, monitored by supervisors and management using the CWS/CMS.

(24) The potential for abuse of CWS/CMS includes supervisors and managers changing social worker notes and reports, and upper management's scrutiny of social worker inputs to find cause for disciplinary actions.

(25) The CWS/CMS tracking capacity is being used to measure social worker performance in terms of reports, case notes and documentation entered into the system rather than evaluating social worker effectiveness in working with children and families.

Financial issues

(26) Financial decisions have become a source of distrust within CWS.

(27) DSS/CWS has not had an independent financial audit in at least ten years.

(28) The county share of the 2003-2004 DSS budget was amended upward to make up for the failure of the state to reimburse for "overmatch" expenditures. DSS/CWS is under pressure to reduce its costs so as not to increase further the county share of its budget.

(29) Placing children in lower cost placements is one way to keep down the county share of the DSS budget.

Recommendations

(1) Upper management at CWS should accept responsibility for the dysfunctional work environment at CWS and commit to creating a more worker-friendly professional organization.

(2) All CWS supervisors and managers should receive training in practices designed to encourage open and trusting communication.

(3) CWS management should develop and implement practices that will create positive performance feedback and incentives, and reverse the environment of fear and reprisal.

(4) All CWS supervisors and managers should receive training in practices designed to bring about a change in organizational culture that will be conducive to implementing requirements of the Redesign.

(5) CWS social workers should be provided training in coping with stressful workplaces and the stress related to organizational change.

(6) CWS management and employees should participate together in training, facilitated by an independent professional trainer, designed to constructively confront the distrust in the workplace and begin a process of team building.

(7) Information that is part of a professional knowledge base, such as recognized psychiatric diagnoses, should be available and discussions encouraged at CWS. Management should not remove or disallow this information or curtail discussions.

(8) CWS should reallocate its training resources to include the following areas for social workers:

a) relevant field training for new social workers
b) continuing professional training for all social workers on an annual basis
c) training in team participation and team management for social workers
d) community resources identification, coordination, and utilization

(9) Social workers should be involved in discussions of procedures, grant applications, and programs that will impact their work and/or resources available to them.

(10) Social workers assigned to a case should be involved in management decisions that alter any notes, reports, or recommendations on that case.

(11) DSS should develop a protocol that defines appropriate managerial and supervisor use of the CWS/CMS system and information. It should specify that violations of the protocol are grounds for disciplinary action. The protocol should be developed with input from line social workers and should be disseminated throughout CWS when it is complete.

(12) CWS management should engage social workers in discussions of the appropriate use of group home placements and the assessment of the need for group homes for children in the CWS system. These discussions should include consideration of reinstating some group homes in the county.

IV. Concluding Remarks

The central question our investigation addressed was: Does CWS effectively implement systems that protect the safety and best interest of children? In response, we would have to answer with a qualified no. In each of the three main systems we studied, there are significant problems that prevent effective actions to ensure the protection and best interest of children. The qualification to our answer is based on two factors. The first is the appreciation we gained during the course of our investigation for the overwhelming responsibilities of CWS. The second is a respect for the work and dedication of many in the CWS organization who continue to serve children and families within difficult systems.

After concluding our investigation we discovered that many of the problems we identified had been raised in previous Grand Jury reports. San Luis Obispo CWS has been the focus of six previous Grand Jury investigations since 1993. In most of these earlier reports, the Grand Jury noted frustration at their inability to gain access to the CWS information required to complete their investigations. The CWS justification for refusing to provide information to these Grand Juries was the required confidentiality of their records. Like previous Grand Juries, we are bound by the laws of confidentiality and also received special training before we were permitted access to CWS cases. Under the terms of an amended court order, we were able to review case files that we requested more fully than had our predecessors. We appreciate the cooperation of DSS staff in facilitating our requests.

Some of the professionals outside of CWS who we interviewed for this report also expressed frustration at being asked to meet with yet another Grand Jury. Their feeling was they were going over the “same old issues” that they had been reporting annually to Grand Juries with regard to CWS, with little or no effect. We would like to express our appreciation to all those who contributed their time and energies in assisting us in our investigation. We join them in hoping that their concerns will finally be addressed by actions taken on the recommendations included in this report.

Child Welfare Services has a daunting responsibility to ensure that children are protected by coordinating the system for reporting suspected child abuse in San Luis Obispo County. This involves not only maintaining a 24 hour referral response unit of its own, but also ensuring that information is communicated and distributed to the appropriate law enforcement agency and the district attorney. While we did not focus on the CWS direct response capability, we found that their ability to involve the related agencies in a timely manner was inconsistent and often delayed. Further, CWS legal compliance is questionable in some instances. As our recommendations suggest, concerted effort will be required to correct the inadequate system for communicating and cooperating with the other critical players involved in the protection of children. This includes the mandated reporters, who are critical “eyes” of the community for reporting abuse, as well as the district attorney and law enforcement agencies who need timely information to fulfill their responsibilities.

The critical role CWS plays in the placement of children is equally important. CWS social workers are faced with immediate decisions on whether to remove children from their homes. They must also ensure that the Juvenile Court has the best possible information on

which to base placement decisions. This is where the CWS system is failing, from the perspective of many human service professionals working in other agencies. Rather than encouraging input and participation in the placement planning and court process, CWS has assumed a role of gatekeeper in keeping professionals and information out. The privilege of access to the court enjoyed by CWS is being abused. Under the cloak of confidentiality, CWS has kept other professionals who are working with children outside the court system, when they should be working together toward a common goal.

The placement cases that we reviewed portray CWS as an impenetrable wall of confidentiality. CWS was able to keep opposing information out of their court reports, and the professionals representing those positions outside of the court process. In many of these cases, CWS recommended reunification where it appeared to other professionals that this would be to the detriment of the children.

Our efforts to understand why this might be the case led us to the financial implications of placement decisions and the related importance of meeting statistical goals for preferred placement outcomes. In the complex system of externally defined placement goals and funding, the motives seemed to derive from an upper management determination to meet defined goals. We do not assume that there was personal financial gain to be realized by anyone in the local DSS or county offices. Rather, the reinforcement seemed to come from the approval of state and grant funding sources for "making the numbers." Our concern is that this statistical success is being achieved at the expense of the protection and best interest of children.

Within the organization, CWS' external success appears often to be on the backs of the employees. We recognize that CWS management is under extraordinary stress. The state mandated changes and budget pressures present major challenges. Some of the pressures, however, are self-imposed as upper management seeks to be on the leading edge of new programs and initiatives. Looking good from a county budget perspective means bringing in grant money and keeping county expenditures low. Looking good to Sacramento as a successful early implementer of the Redesign (which brings $2.85 million to the county) requires meeting or exceeding benchmarks. Meeting such goals in local operations means putting pressure on social workers to meet the numbers. The negative work environment at CWS, however, hinders rather than helps to achieve these goals.

The tendency to manage and value that which can be measured is a classic dilemma for managers. It is particularly appealing in service occupations, where performance incentives are reasonably new. However, the translation from the corporate bottom line to externally imposed performance measures in human services is dangerous. Net profit and loss do not have equivalent values in terms of decisions affecting children's lives.

This is one of the dangers of the CWS/CMS and related technology. It makes it too easy to focus on the quantitative measures and ignore the qualitative aspects that define effective social work. We are concerned that CWS management is following this path. Given the trends we have heard about, experienced social workers may become a casualty of CWS/CMS, leaving in place social workers who are more proficient at the key board than in working with children. There is also evidence of upper management's micro-managing aspects of social work that can be accessed by CWS/CMS. We hope the reports we heard of

supervisors and managers changing social workers' recommendations are isolated events. While the technology itself is neither good nor bad, the potential for abuse exists.

Overall, the common theme in all three systems we examined is an attitude on the part of CWS upper management that the organization and its systems and its people are theirs to manipulate. With this attitude, management has lost the confidence of the agencies they work with in protecting and serving children and families, and has lost the trust of its employees. This is an insidious problem that may not be able to be addressed as long as the current management style at CWS continues.

Recommendation

(1) We strongly recommend that the San Luis Obispo County Board of Supervisors undertake a thorough evaluation of the leadership of CWS, specifically including the DSS Director and the CWS Deputy Director. The evaluation should be completed by a private, independent, and credible expert in the management of social service organizations. The evaluation should focus on upper management's effectiveness in communicating with the employees and in creating a positive working environment, and should include input from all CWS employees. The results of this evaluation should be reported directly to the Board of Supervisors and should include specific recommendations as applicable. Unless and until the Board becomes directly involved, the likelihood of further deterioration of the situation at CWS is high.

Response Requirements

Penal Code § 933 requires that comment on the findings and recommendations in this report be submitted to the presiding judge of the Superior Court by the:

(1) Department of Social Services - all findings and recommendations in Part 1, all findings and recommendations 1 through 9 in Part 2, and all findings and recommendations in Part 3 of this report, within 60 days of its publication.

(2) Board of Supervisors - all findings and recommendations in Parts 1, 2, 3 and 4 report, within 90 days of its publication.

Endnotes

[1] The complete text of the Child Welfare Redesign Final Report is available at: http://www.cwsredesign.ca.gov

[2] See above for Redesign information. Legislative information about AB 636 can be accessed through: http://www.leginfo.ca.gov

[3] Tri Counties Regional Center website: http://www.tri-counties.org

[4] *Benefits for Children with Disabilities* - "SSI Benefits For Children: These are benefits payable to disabled children under age 18 who have limited income and resources, or who come from homes with limited income and resources." Electronic Booklet – http://www.ssa.gov/pubs/10026.html

[5] for a description of qualifications and job duties for CWS Social Workers I through IV, see: http://www.co.slo.ca.us

[6] American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington DC: American Psychiatric Association: 127-130.

Appendix A

Definition of Mandated Reporters
California Penal Code § 11165.7

(a) As used in this article, "mandated reporter" is defined in as any of the following:

(1) A teacher.

(2) An instructional aide.

(3) A teacher's aide or teacher's assistant employed by any public or private school.

(4) A classified employee of any public school.

(5) An administrative officer or supervisor of child welfare and attendance, or a certificated pupil personnel employee of any public or private school.

(6) An administrator of a public or private day camp.

(7) An administrator or employee of a public or private youth center, youth recreation program, or youth organization.

(8) An administrator or employee of a public or private organization whose duties require direct contact and supervision of children.

(9) Any employee of a county office of education or the California Department of Education, whose duties bring the employee into contact with children on a regular basis.

(10) A licensee, an administrator, or an employee of a licensed community care or child day care facility.

(11) A headstart teacher.

(12) A licensing worker or licensing evaluator employed by a licensing agency.

(13) A public assistance worker.

(14) An employee of a child care institution, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities.

(15) A social worker, probation officer, or parole officer.

(16) An employee of a school district police or security department.

(17) Any person who is an administrator or presenter of, or a counselor in, a child abuse prevention program in any public or private school.

(18) A district attorney investigator, inspector, or local child, support agency

caseworker unless the investigator, inspector, or caseworker is working with an attorney appointed pursuant to Section 317 of the Welfare and Institutions Code to represent a minor.

(19) A peace officer, as defined in Chapter 4.5 (commencing with Section 830) of Title 3 of Part 2, who is not otherwise described in this section.

(20) A firefighter, except for volunteer firefighters.

(21) A physician, surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, marriage, family and child counselor, clinical social worker, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

(22) Any emergency medical technician I or II, paramedic, or other person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code.

(23) A psychological assistant registered pursuant to Section 2913 of the Business and Professions Code.

(24) A marriage, family and child therapist trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code.

(25) An unlicensed marriage, family, and child therapist intern registered under Section 4980.44 of the Business and Professions Code.

(26) A state or county public health employee who treats a minor for venereal disease or any other condition.

(27) A coroner.

(28) A medical examiner, or any other person who performs autopsies.

(29) A commercial film and photographic print processor, as specified in subdivision (e) of Section 11166. As used in this article, "commercial film and photographic print processor" means any person who develops exposed photographic film into negatives, slides, or prints, or who makes prints from negatives or slides, for compensation. The term includes any employee of such a person; it does not include a person who develops film or makes prints for a public agency.

(30) A child visitation monitor. As used in this article, "child visitation monitor" means any person who, for financial compensation, acts as monitor of a visit between a child and any other person when the monitoring of that visit has been ordered by a court of law.

(31) An animal control officer or humane society officer. For the purposes of this article, the following terms have the following meanings.

(A) "Animal control officer" means any person employed by a city, county, or city and county for the purpose of enforcing animal control laws or regulations.

(B) "Humane society officer" means any person appointed or employed by a public or private entity as a humane officer who is qualified pursuant to Section 14502 or 14503 of the Corporations Code.

(32) A clergy member, as specified in subdivision (c) of Section 11166. As used in this article, "clergy member" means a priest, minister, rabbi, religious practitioner, or similar functionary of a church, temple, or recognized denomination or organization.

(33) Any custodian of records of a clergy member, as specified in this section and subdivision (c) of Section 11166.

(34) Any employee of any police department, county sheriff's department, county probation department, or county welfare department.

(35) An employee or volunteer of a Court Appointed Special Advocate program, as defined in Rule 1424 of the Rules of Court.

(b) Volunteers of public or private organizations whose duties require direct contact and supervision of children are encouraged to obtain training in the identification and reporting of child abuse.

(c) Training in the duties imposed by this article shall include training in child abuse identification and training in child abuse reporting. As part of that training, school districts shall provide to all employees being trained a written copy of the reporting requirements and a written disclosure of the employees' confidentiality rights.

(d) School districts that do not train their employees specified in subdivision (a) in the duties of mandated reporters under the child abuse reporting laws shall report to the State Department of Education the reasons why this training is not provided.

(e) The absence of training shall not excuse a mandated reporter from the duties imposed by this article.

SUSPECTED CHILD ABUSE REPORT

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

PLEASE PRINT OR TYPE

CASE NAME: _____

CASE NUMBER: _____

A. REPORTING PARTY

NAME OF MANDATED REPORTER	TITLE	MANDATED REPORTER CATEGORY
REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS Street City Zip		DID MANDATED REPORTER WITNESS THE INCIDENT? ❒ YES ❒ NO
REPORTER'S TELEPHONE (DAYTIME) ( )	SIGNATURE	TODAY'S DATE

B. REPORT NOTIFICATION

❒ LAW ENFORCEMENT ❒ COUNTY PROBATION ❒ COUNTY WELFARE / CPS (Child Protective Services)	AGENCY	
ADDRESS Street City Zip		DATE/TIME OF PHONE CALL
OFFICIAL CONTACTED - TITLE		TELEPHONE ( )

C. VICTIM (One report per victim)

NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip			TELEPHONE ( )		
PRESENT LOCATION OF VICTIM	SCHOOL		CLASS		GRADE
PHYSICALLY DISABLED? ❒ YES ❒ NO	DEVELOPMENTALLY DISABLED? ❒ YES ❒ NO	OTHER DISABILITY (SPECIFY)	PRIMARY LANGUAGE SPOKEN IN HOME		
IN FOSTER CARE? ❒ YES ❒ NO	IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: ❒ DAY CARE ❒ CHILD CARE CENTER ❒ FOSTER FAMILY HOME ❒ FAMILY FRIEND ❒ GROUP HOME OR INSTITUTION ❒ RELATIVE'S HOME		TYPE OF ABUSE *(CHECK ONE OR MORE)* ❒ PHYSICAL ❒ MENTAL ❒ SEXUAL ❒ NEGLECT ❒ OTHER (SPECIFY)		
RELATIONSHIP TO SUSPECT	PHOTOS TAKEN? ❒ YES ❒ NO		DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ❒ YES ❒ NO ❒ UNK		

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

NAME	BIRTHDATE	SEX	ETHNICITY	NAME	BIRTHDATE	SEX	ETHNICITY
1.				3.			
2.				4.			

VICTIM'S PARENTS/GUARDIANS

NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE ( )		BUSINESS PHONE ( )		
NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE ( )		BUSINESS PHONE ( )		

SUSPECT

SUSPECT'S NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip			TELEPHONE ( )		
OTHER RELEVANT INFORMATION					

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ❒ *IF MULTIPLE VICTIMS, INDICATE NUMBER:* _____

DATE / TIME OF INCIDENT	PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)

SS 8572 (Rev. 12/02)

DEFINITIONS AND INSTRUCTIONS ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY- District Attorney's Office; YELLOW COPY-Reporting Party

Appendix B

DEFINITIONS AND GENERAL INSTRUCTIONS FOR COMPLETION OF FORM SS 8572

All Penal Code (PC) references are located in Article 2.5 of the PC. This article is known as the Child Abuse and Neglect Reporting Act (CANRA). The provisions of CANRA may be viewed at: http://www.leginfo.ca.gov/calaw.html (specify "Penal Code" and search for Sections 11164-11174.3). A mandated reporter must complete and submit the form SS 8572 even if some of the requested information is not known. (PC Section 11167(a).)

I. MANDATED CHILD ABUSE REPORTERS

- Mandated child abuse reporters include all those individuals and entities listed in PC Section 11165.7.

II. TO WHOM REPORTS ARE TO BE MADE ("DESIGNATED AGENCIES")

- Reports of suspected child abuse or neglect shall be made by mandated reporters to any police department or sheriff's department (not including a school district police or security department), the county probation department (if designated by the county to receive mandated reports), or the county welfare department. (PC Section 11165.9.)

III. REPORTING RESPONSIBILITIES

- Any mandated reporter who has knowledge of or observes a child, in his or her professional capacity or within the scope of his or her employment, whom he or she knows or reasonably suspects has been the victim of child abuse or neglect shall report such suspected incident of abuse or neglect to a designated agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof ***within 36 hours*** of receiving the information concerning the incident. (PC Section 11166(a).)
- No mandated reporter who reports a suspected incident of child abuse or neglect shall be held civilly or criminally liable for any report required or authorized by CANRA. Any other person reporting a known or suspected incident of child abuse or neglect shall not incur civil or criminal liability as a result of any report authorized by CANRA unless it can be proven the report was false and the person knew it was false or made the report with reckless disregard of its truth or falsity. (PC Section 11172(a).)

IV. INSTRUCTIONS

- **SECTION A - REPORTING PARTY:** Enter the mandated reporter's name, title, category (from PC Section 11165.7), business/agency name and address, daytime telephone number, and today's date. Check yes-no whether the mandated reporter witnessed the incident. The signature area is for either the mandated reporter or, if the report is telephoned in by the mandated reporter, the person taking the telephoned report.

IV. INSTRUCTIONS (Continued)

- **SECTION B - REPORT NOTIFICATION:** Complete the name and address of the designated agency notified, the date/time of the phone call, and the name, title, and telephone number of the official contacted.
- **SECTION C - VICTIM (One Report per Victim):** Enter the victim's name, address, telephone number, birth date or approximate age, sex, ethnicity, present location, and, where applicable, enter the school, class (indicate the teacher's name or room number), and grade. List the primary language spoken in the victim's home. Check the appropriate yes-no box to indicate whether the victim may have a developmental disability or physical disability and specify any other apparent disability. Check the appropriate yes-no box to indicate whether the victim is in foster care, and check the appropriate box to indicate the type of care if the victim was in out-of-home care. Check the appropriate box to indicate the type of abuse. List the victim's relationship to the suspect. Check the appropriate yes-no box to indicate whether photos of the injuries were taken. Check the appropriate box to indicate whether the incident resulted in the victim's death.
- **SECTION D - INVOLVED PARTIES:** Enter the requested information for: Victim's Siblings, Victim's Parents/Guardians, and Suspect. Attach extra sheet(s) if needed (provide the requested information for each individual on the attached sheet(s)).
- **SECTION E - INCIDENT INFORMATION:** If multiple victims, indicate the number and submit a form for each victim. Enter date/time and place of the incident. Provide a narrative of the incident. Attach extra sheet(s) if needed.

V. DISTRIBUTION

- **Reporting Party:** After completing Form SS 8572, retain the yellow copy for your records and submit the top three copies to the designated agency.
- **Designated Agency:** ***Within 36 hours*** of receipt of Form SS 8572, send **white copy** to police or sheriff's department, **blue copy** to county welfare or probation department, and **green copy** to district attorney's office.

ETHNICITY CODES

1 Alaskan Native	6 Caribbean	11 Guamanian	16 Korean	22 Polynesian	27 White-Armenian
2 American Indian	7 Central American	12 Hawaiian	17 Laotian	23 Samoan	28 White-Central American
3 Asian Indian	8 Chinese	13 Hispanic	18 Mexican	24 South American	29 White-European
4 Black	9 Ethiopian	14 Hmong	19 Other Asian	25 Vietnamese	30 White-Middle Eastern
5 Cambodian	10 Filipino	15 Japanese	21 Other Pacific Islander	26 White	31 White-Romanian

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