This document is an extract of a larger publication.

civilgrandjury.org is a project of UnGovr.org, a US-based 501(c)(3) nonprofit dedicated to government transparency and public accountability.

PLUMAS COUNTY SHERIFF'S DEPARTMENT

Background

Information was developed by the Grand Jury during its regular review of the Plumas County Sheriff's Department. It was alleged that some members of the Sheriff's Department were possibly involved in inappropriate activities while on and/or off duty.

The Grand Jury conducted investigations and interviews with numerous citizens of Plumas County who volunteered information relative to those allegations. The Grand Jury concluded that the information warranted the investigation by the California State Attorney General's Office.

Recommendations

The Grand Jury recommends that:

The 2005-2006 Plumas County Grand Jury assist the California State Attorney General's Office in the investigation of the Sheriff's Department.

PLUMAS COUNTY JAIL

Function

The Plumas County Jail was completed in 1976 for the detention of both male and female adult inmates. In 1985 an addition was completed and the facility is now capable of housing sixty-seven (67) inmates. The facility houses pretrial defendants and persons who are serving a sentence of one (1) year or less. Inmates sentenced to state prison are housed at the jail awaiting transportation to a prison facility.

Background

Pursuant to California Penal Code Section 919 the Grand Jury must annually inquire into the condition and management of all public prisons located within the County. To that end, interviews were conducted with the Sheriff, the Undersheriff, the Jail Commander, all five (5) Supervisors, the Quincy Fire Chief / Fire Warden, the Supervising Deputy State Fire Marshal, and the Facility Services Director. Tours of the jail facility were conducted on September 22, 2004, October 20, 2004, and February 16, 2005. In addition, this Grand Jury reviewed reports of inspections of the jail facility by the California Board of Corrections, the Department of Consumer Affairs Environmental Health, the Office of the State Fire Marshal, the Quincy Fire Protection District, and past Grand Jury Final Reports.

Findings

1. During the interviews and early tours of the jail facility, it became apparent to this Grand Jury that communication regarding jail conditions between the Plumas County Jail, the Plumas County Sheriff's Department, the Plumas County Facility

Services Department, and the Plumas County Board of Supervisors was inadequate. There is no written system or follow-up procedure in place to ensure that maintenance problems be attended to in a timely manner.

2. The jail facility is annually inspected by the local Fire Warden and the Grand Jury, and is inspected biennially by the California Board of Corrections. This Grand Jury found that the small repairs recommended by these agencies' inspections were eventually taken care of, but the more serious repairs that were required have been brushed off with statements of "not my responsibility", "waiting for someone to get back to me", and "waiting for bids".

3. There are serious security issues at the jail facility which compromise the safety of not only the Sheriff's Department staff and jail detainees, but also the citizens of Plumas County. Issues of concern are:

    a. There is no perimeter fence around the jail thus allowing members of the public direct access to the exercise yards. Items could be left for inmates or yard fencing could be cut to facilitate an escape.

    b. The doors to access the main electrical breakers that provide power to the facility are unsecured allowing for a complete shutdown of power to the jail.

    c. The jail facility is understaffed.

4. There are some security and maintenance issues that have been present for a number of years, as has been noted in past Grand Jury reports, and have still not been corrected:

    a. The Control Room still contains a crowded maze of wires piled up on the floor which according to jail staff occasionally emit sparks and smoke.

    b. There are no slots in the maximum security cell doors for the passage of food trays and other items requiring the jail staff to come in direct contact with the maximum security inmates.

    c. There is no automated lock-in control when moving inmates from one cell to another.

5. The Plumas County Board of Supervisors is aware of the unsafe and potentially dangerous conditions that exist at the jail, but most appear apathetic. The Board appears to have ignored its responsibility where the jail is concerned and seems satisfied with passing all of the responsibility onto the Sheriff's Department. At the time of this report's completion, no member of the Board had yet implemented the 2003-4 Grand Juries' recommendation to visit the jail facility at least once yearly.

6. The Sheriff and the Undersheriff (overseer of the jail facility) appear to ignore, deny, or be unwilling to accept the responsibility for any maintenance, repairs, or remedial work and are complacent, relying and acquiescing to the Facility Services Department.

7. The Automatic Fire Sprinkler System is in disrepair. There is no regard for these conditions by the Facility Services Department, the Sheriff's Department or the jail personnel. The Office of the State Fire Marshal noted the following deficiencies:

   a. The sprinkler system inspection is past due for its required five (5) year servicing.

   b. The facility does not have any records showing that the sprinkler system is tested and inspected quarterly as required.

   c. The Corporal's office does not have fire sprinkler coverage.

8. The following additional deficiencies with the Sprinkler System were noted either in the above mentioned inspection reports or by personal observations made during this Jury's three (3) tours of the facility:

   a. There is no contract for the five (5) year required servicing and certification of the sprinkler system.

   b. There is no contract for the quarterly inspection of the sprinkler system.

   c. An eighteen (18) inch minimum clearance around the sprinkler heads is not maintained in the nurse's office, the library, the laundry corridor, or the file room.

   d. The sprinkler repair kit in the cleaning closet is not accessible.

   e. No fire watches were performed or fire watch logs maintained while the fire alarms system was not functioning.

   f. No fire drill procedure is in place nor is a fire drill log maintained.

   g. There are times when there is no deputy on duty who meets the training standards for general fire safety relating to the jail facility.

   h. The exterior sprinkler system alarm is not connected.

   i. The exterior sprinkler system electrical plug is covered over with duct tape.

   j. The exterior sprinkler activation alarm bell is not connected.

   k. The exterior sprinkler system valve is not working.

   l. No locking device is installed on the sprinkler system shut-off valve.

   m. The work furlough day room does not have fire sprinkler coverage.

   n. The work furlough sleeping area does not have fire sprinkler coverage

9. Using the above mentioned inspection reports, as well as personal observations made during this Grand Jury's three (3) tours of the facility, the following list of deficiencies with the jail facility's electrical system was compiled:

a. Extension cords are being used as permanent wiring in the control room and the air handler room.

b. Wiring on the floor in the control room is not in conduit.

c. Exposed wiring in the wall of the control room is not in conduit.

d. An EXIT light in the minimum security corridor is missing.

e. An EXIT light in the main security corridor is missing.

f. There are exposed junction boxes in the air handler room.

g. There is an exposed junction box in a cell.

10. The following list of miscellaneous deficiencies with the jail facility was compiled by this Grand Jury using the above mentioned inspection reports as well as personal observations made during this Grand Jury's three (3) tours of the facility:

a. There are holes in the wall and ceiling in the air handler room.

b. There is a hole in the ceiling in the North Minimum holding cell.

c. There is a hole in the wall in the work furlough sleeping area.

d. There is an air diffuser missing in the laundry corridor.

e. Weed abatement of ten (10) feet from the building is not maintained.

f. There is no generator testing log or maintenance log.

g. There is no service contract to inspect or maintain the generator.

h. The dishwasher is not working and sanitizing properly.

i. There is a need to update the Health Services Policies and Procedures manual.

j. There is a need to update the Dental Care Procedures manual.

k. There is no psychotropic medications policy.

l. The openings in the ceiling air grills' mesh are larger than the recommended 3/16" sq or 16-mesh psi.

m. There is a need to update the Policies and Procedures manual.

n. There is a need to update the Inmate Discipline Policy and Plan.

o. There is a need to update the limitations on the Disciplinary Policy and Procedure plan.

p. There is no sobering cell or suicidal placement plan.

q. The plumbing access panel in the maximum security corridor is not locked.

Recommendations

1. The Undersheriff and the Facility Services Director should create a documented system to ensure all maintenance problems be addressed and corrected in a timely manner. This system should include the identification of the responsible party and time frames for completion.

2. The Undersheriff and the Facility Services Director should oversee the implementation of a program of ongoing inspections of the jail facility. This program should include the documentation of all inspection results and any repairs made.

3. The Board of Supervisors should be notified in open session at least once quarterly regarding the conditions at the jail facility. The Board of Supervisors should take an active part to ensure unsafe conditions and maintenance issues are addressed and remedied with expedience.

4. In open session, the Board of Supervisors should discuss and ask for the public's comments on the possible formation of a Jail Oversight Committee. This committee could consist of a Supervisor, the Undersheriff, the Facility Services Director, two members of the Grand Jury, and others.

5. The Sheriff's Department should follow the established county bid process when attempting to procure outside companies or businesses to complete work within the jail facility. The county's bid process details specific conditions to follow as well as specific deadlines for the process to be completed, The Departments of the Sheriff and Facility Services should know the stage of a particular project all times.

6. Based on the observations and findings made by this Grand Jury, as well as previous Grand Jury, an urgent recommendation is made to the Board of Supervisors to seriously begin planning to replace the jail facility. The longer the Board of Supervisors procrastinates in facing it's obligation to the citizens of Plumas County, the more the construction costs increase. As we have seen and are currently seeing, building costs in California are increasing exponentially.

   It is essential that the Board of Supervisors plan now for a new jail for Plumas County. The Plumas County Jail, from the very onset, was poorly designed and was never conducive to a safe working environment for jail employees or the incarcerated inmates.

   The working area of the facility is too small in proportion to the confinement areas thus creating a working environment that is overcrowded with employees, equipment, and supplies. Security issues are at a level that put not only people within the jail at risk, it also puts the citizens of Plumas County at risk. A new jail would not only greatly enhance the security of all concerned but would provide a facility that would accommodate Plumas County well into the 21st century.

7. The Board of Supervisors should take a more proactive part by insisting the following remaining, uncorrected deficiencies be corrected as soon as possible:

    a. A sprinkler should be installed in the Corporal's office.

    b. A company should be contracted to provide five year services and certification of the sprinkler system.

    c. A company should be contracted to provide a quarterly inspection of the sprinkler system.

    d. An eighteen (18) inch clearance around the sprinkler heads should be maintained,

    e. A fire drill procedure should be created and a fire drill log should be maintained.

    f. The exterior sprinkler system alarm and alarm bell should be connected.

    g. The exterior sprinkler system valve should be repaired.

    h. The sprinkler system shut-off valve should have a lock.

    i. Sprinklers should be installed in the work furlough day room and sleeping area.

    j. Wiring on the floor and the exposed wiring in the wall of the control room should be put in conduit.

    k. The hole in the wall of the work furlough sleeping area should be repaired.

    l. Generator testing and maintenance logs should be kept and a company should be contracted to inspect and maintain the generator.

    m. The dishwasher should be repaired or replaced.

    n. The ceiling air grilles should be replaced to meet code.

    o. All Policies and Procedures manual should be updated and kept current

    p. The plumbing access panel in the maximum security corridor should have a lock.

Commendations

Sid Roberts and Mark Rother, who accompanied this Grand Jury and the state and fire authorities on the October 20, 2004 inspection, were instrumental in correcting deficiencies. This Grand Jury would like to commend the personnel of Facility Services for their effort. These efforts have done much to improve the safety and welfare of the jail staff, detainees, and the citizens of Plumas County. During the February 16, 2005 tour of the jail, this Grand Jury was made aware of numerous corrections to the deficiencies noted. We believe that these corrections were a direct result of this Grand Jury's insistence that the jail be inspected by the state fire authorities and re-inspected by the local fire authority,

In addition to the maintenance corrections, three (3) of the serious security issues are also being resolved. They are:

1. The main electrical breakers are now secured with fencing and locks. However, not only does the chain link structure need to be enlarged to adhere to PG & E's equipment clearance guidelines, but also the roof of the chain link structure has collapsed under the weight of snow requiring the need to redesign the structure as a whole.

2. Negotiations with the Public Works Department are underway for installation of food slots in the maximum security cell doors.

3. A full-time employee of the Facility Services Department is now assigned, specifically, to maintain the Jail.

PLUMAS COUNTY ALCOHOL AND DRUG DEPARTMENT

Function

The mission of the Plumas County Alcohol and Drug Department (A&D) is to improve the quality of life in the County through lowering the impact and incidence of alcohol and other drugs of abuse. The State requires five (5) primary divisions of the A&D Department.

- The Prevention Program includes educational youth programs such as Friday Night Live.
- The Drug Courts include an adult division that entails such services as drug testing and counseling.
- The Treatment Services include outpatient and residential services.
- The Driving Under the Influence (DUI) Program is a drunk driving school.
- The Perinatal Program helps pregnant women, women with children and their families with recovery from substance abuse.

The A&D Department is funded by State and Federal dollars as well as funds from legal fines and client payments for certain services. Therefore, it is imperative for the A&D Department to collaborate with many other County departments including the Mental Health Department and the District Attorney's Office. The State and Federal funds are closely monitored by State and Federal agencies. Client fees are set by the Plumas County Board of Supervisors.

Background

The Alcohol and Drug Department (A&D) was chosen for investigation because it had not had a comprehensive review by the Grand Jury since the 1995-1996 term of the Grand Jury. However, a citizen's complaint did prompt a cursory review of the Department in the 2000-2001 term.

Interviews were conducted with the Program Director, the Program Chief, County Counsel, the Chairman of the Alcohol and Drug Advisory Board and seven (7) additional Department staff members and citizens.

Findings

1. There is a split between the staff within the Department generally based upon length of service; ostensibly the "old camp" of employees who have been with the Department longer than the employees of the "new camp". This split has effected morale to such an extent that an alarmingly high number of employees have taken Worker's Compensation leave for stress.

2. There has been nearly continuous litigation against the County brought by a number of members of one of the "camps" over the last five years. While it is for the Courts, and not the Grand Jury, to decide the merits of each of the lawsuits, we have found that the strong convictions that prompted the litigations are not shared by both "camps" and have in fact facilitated this split. The antagonism between the two "camps" of employees precludes the Department's programs or therapists from being as effective as they might.

3. The past involvement of County Counsel and the Employee's Union in this Department's personnel matters has hampered the current Administration in its ability to manage and evaluate the staff. While input from County Counsel is appropriate particularly for its new Deputy County Counsel, when there is pending litigation, the concern lies with the fact that there is always pending litigation because of a nearly continuous stream of lawsuits.

4. There has been a lack of continuity of management in the A&D Department for many years resulting in a disruption of operation and an inconsistency of employee reviews.

5. There are people within the County that are reluctant (or have refused) to refer clients to the A&D Department because of the perception of this department's dysfunction.

6. There appears to be only minimal cooperation between the A&D and the Mental Health Department in the field of Co-Occurring Illnesses; that is a mental health patient who also has a substance abuse problem. This results in situations where these clients with Co-Occurring Illness are "falling through the cracks". There appears to be little acceptance of responsibility for these clients because of the lack of adequate interaction between these Departments.

7. There is little evidence that the Alcohol and Drug Advisory Board has any influence or oversight in the operation of the A&D Department. In addition, the Advisory Board's participation in the selection of the new A&D Director was discouraged by the Board of Supervisors.

8. There is little evidence that the Board of Supervisors has performed oversight activities in the A&D Department.

9. The A&D facility is inadequate and isolated from other services. The walls of the therapist meeting rooms are thin enough to allow passers-by to hear the conversations within and are therefore not adequate to ensure confidentiality.

10. The number of DUI arrests reported to the State, for the purpose of receiving various funding, was under-reported for the years 2002 and 2003. While the statistics reported were inaccurate, the perception within various State and County agencies that this Department inflates these statistics to increase their grant monies appears to be incorrect.

11. The expenditure for out-of-county residential treatment programs has increased steadily over the last several years, and has nearly doubled since last year. There are many factors for determining whether a client is better served by the programs available within the County, or by residential treatment programs not available within the County. However, the Grand Jury has found that the lack of trust between the two "camps" of employees has led to an undetermined number of clients either being underserved within the County or being sent out of the County for treatment at additional expense.

Recommendations

The Grand Jury recommends that:

1. The administration of the A & D strives to follow all labor regulations and Human Resources policies with regards to personnel, especially in the area of performance evaluations. Accurate and timely documentation of all personnel problems as well as achievements should do much to decrease employee's perception they are being retaliated against and thereby improve morale.

2. The Administration of the A&D continues the implementation of their progressive plan to mend strained relationships between the two "camps" of employees.

3. The Administration of the A&D work with Human Resources on revising the job descriptions for the Department to more accurately reflect the actual duties and training required of the positions.

4. The Administration of the A&D assign employees to be liaisons between the A&D and other Departments in which there is a shared clientele, such as Probation, the Sheriffs Department and Mental Health. These liaisons could do much to address the concerns and the perceptions of inadequacies in the A&D.

5. The A&D and the Mental Health Department develop a Memorandum of Understanding that outlines mutual areas of coordination and responsibilities, especially with regards to Co-Occurring Illness. The two departments could utilize the training and technical assistance available from the Substance Abuse and Mental Health Services Administration (SAMHSA) Co-Occurring Center for

Excellence publication states: “Screening, assessment, and treatment planning; Co-Occurring Disorder J are not stand-alone agencies. They are three components of a process that may be conducted by different agencies. Effective information sharing and following of clients most frequently occurs in systems where relevant agencies have formal network, cross-training for staff, and formal procedures for information sharing and referral.

6. The Alcohol and Drug Advisory Board work towards diversifying the membership of their Board as recommended by their auditing agency. New members could do much to rejuvenate the Board and may act as an impetus to increase their level of involvement in the A&D Department.

7. A Board of Supervisors member and the A&D Department staff members attend every meeting of the Alcohol and Drug Advisory Board.

8. The Board of Supervisors take a more active interest in the performance of the A&D and request in-depth information from them regularly until such time as the Board feels that the personnel issues have been resolved. We recommend a Department Progress Report that could include such information as activities of staff, success of programs, year to-date budget expenditures, and reports from the A&D liaisons.

9. A new facility, that provides appropriate accommodations and adequate security for clients, be found as quickly as possible.

10. The A&D improve communications with the California Highway Patrol and the Sheriff’s Department to help eliminate the errors found in the DUI statistical data reporting.

11. The Board of Supervisors considers the feasibility of operating needed residential care facilities within the County. The savings to the County by eliminating the need to send clients out of the county would go a long way to decrease this budget expenditure and provide a better quality of care to its residents.

Conclusion

In the course of our investigation, this Grand Jury became informed of numerous allegations of impropriety by staff members. The Grand Jury has worked diligently to not only verify each allegation, but also attempted to categorize them in an effort to keep our focus on the Department as a whole, not on an individual mistake. Put succinctly, we feel many of this department’s problems are heightened by (if not a result of) interpersonal relationship conflicts. There were several seemingly improper actions by staff members that the Grand Jury felt were a result of the antagonism that is so pervasive throughout the Department. The Grand Jury’s findings were focused on the core issues and not the small details. The Grand Jury did its best to focus on areas that may help to make this department more productive. It is the Grand Jury’s hope that with consistent management and increased oversight, this department will again be one upon which our citizens may rely.

PLUMAS COUNTY MENTAL HEALTH DEPARTMENT

Function

The Plumas County Mental Health Department (MHD) is an outpatient service providing a full range of outpatient, case management and socialization services. More intensive services such as acute hospitalization, long-term intensive residential and state hospital services are provided by contracting with the appropriate agencies in question. The services includes: emergency assessments, outpatient services, inpatient services, case management, day treatment programs, medication support and therapeutic behavioral services. The MHD is the managed care provider for all MediCal mental health services in the county.

Background

The Grand Jury received information alleging inadequate crisis intervention by the MHD. In addition, past Grand Jury records indicated that the MHD had not been reviewed since the 1999-2000 Grand Jury year. Therefore, it was appropriate and timely to review the MHD as a county entity.

The MHD operates under its director, who oversees a variety of community programs including the Sierra Drop-In Center, the Wrap-Around Program for Children, Cal-WORKS, and the Children's System of Care. In addition, the director is in charge of the fiscal portion of MHD and has provided this Grand Jury with financial statements indicating a balanced budget and a program working within its means. The current director had been the acting director of MHD since May 2000 and has been the director since October 2001.

All practicing clinicians are appropriately licensed, as is the director. At this time there are five licensed clinicians who see clients and one clinician in training. In addition to other emergency call procedures, each clinician is required to take after-hour emergency calls for a period of seven days every fifth week. Clinicians in training are excluded.

Findings

1. The MHD stands alone as a county department. The MHD has been split from the Department of Alcohol and Drugs. The MHD is not linked to the Plumas County Health Department.
2. There is inadequate interaction between the MHD and the Department of Alcohol and Drugs. The relations between the two county agencies have been acrimonious for a number of years. Relations have improved slightly in the last few months.
3. There is no Memorandum of Understanding (MOU) between the MHD and the Department of Alcohol and Drugs outlining a protocol for the needed interaction between the two departments.

4. The communication between the MHD and the Sheriff's Department is minimal. One aspect of the problem that contributes to the lack of communication is complicated by patients' confidentiality rights. The MHD clinicians cannot divulge information about a client and therefore are unwilling to release information about treatment and follow-up of that client. The perception sometimes is that "nothing is being done". This appears to be one cause for misunderstandings between the MHD and the Sheriff's Department.
5. There is no civil (non-criminal) protective locked facility for members of the community who may be a danger to themselves or to others. Currently, the MHD does not see such individuals that are considered "under the influence". As a consequence, these people remain untreated and unprotected or are taken to jail. A locked civil protective custody facility is mandated by law (Welfare and Institution Code 5170), but one does not exist in Plumas County.
6. There have been issues raised that on occasion the MHD is slow to respond to crisis intervention situations and the law enforcement officer who should be in the field is taken out of service to care for an individual during a possible mental health situation until the clinician arrives.
7. There is an MOU between the MHD and the Sheriff's Department that outlines mutual areas of coordination and responsibilities for emergency evaluations and hospitalizations.
8. As mandated by the State of California, Plumas County has a Mental Health Commission separate from the MHD. The Commission acts in an "Advise and Recommend" capacity to the Board of Supervisors on MHD issues and on the policies of the MHD. The Commission also acts in an advisory capacity directly to the MHD, as well as participates in the budgeting and planning agenda of the MHD. The Chair of the Mental Health Commission meets with the director of MHD on a regular basis and has an excellent working relationship. However, the Mental Health Commission meets with the Board of Supervisors only once a year. A Board of Supervisors member attends the Mental Health Commission's meetings irregularly.
9. There are issues of coordination within the MHD staff about clients and their treatment that may put clients at risk.
10. The MHD staff meets on a weekly basis. It was reported to the Grand Jury that communication within the staff is excellent and supportive.
11. The MHD provided a budget that indicates that the Department is efficiently run and is fiscally responsible.
12. The MHD operates a number of quality programs within its area of practice. The MHD is to be commended for the hard work of its employees and for the implementation of innovative and supportive programs. Notable, are Sierra House, the Respite Program, and the Wilderness Program.
13. The recently passed California Proposition 63 should increase revenue for the MHD.
14. The MHD staff meets face-to-face once a week for four hours. Otherwise, the small staff is spread out in the various communities it serves and rarely comes together

except for the weekly staff meetings. Most communication among staff is done by phone, a highly inefficient method for a task that requires communication and relay of client information. As a result, there have been errors.

15. MHD knowledge of Grand Jury investigations caused the stoppage of all quality control with Plumas District Hospital.

16. An administrator of MHD violated the admonition of the Grand Jury to keep discussion with the Grand Jury confidential.

Recommendations

The Grand Jury Recommends that:

1. The MHD and the Department of Alcohol and Drugs develop an MOU that outlines mutual areas of coordination and responsibilities. It is crucial that there be communication and support between the two agencies, in particular to prevent those individuals with co-occurring disorders of both mental illness and substance abuse from "falling through the cracks" between the agencies.

   In most counties in California, mental health departments and alcohol and drugs departments are closely linked. The division in Plumas County between these two departments has been going on for years. The Board of Supervisors, as the governing body of these two departments, must take a proactive stance in facilitating cooperation.

2. The MHD develops a position in which an employee acts as a liaison between the MHD and the Sheriff's Department. This employee would be approved by both departments and would be in daily contact with both departments and would address problems with communications, protocol, and allegations of misconduct.

3. As mandated by the State of California, Board of Supervisors must act to provide a civil protective custody facility for Plumas County in which to house those individuals who need protection but should not be arrested. This facility will allow law enforcement personnel to safely place individuals into protective custody and then return to law enforcement duties in the community with expediency. This will alleviate the problem of the MHD's position of not seeing an individual for assessment until the individual is free from alcohol and/or substances.

4. It is time to computerize the MHD. The staff is dispersed and timely communication is essential. The MHD and community safety would benefit greatly with a wireless computer that would allow clinicians to submit and read records and information quickly and confidentially. New data would be available instantly assuring that every staff member would be apprised of the history of client contact or client crisis in a timely manner.

5. A Board of Supervisor's member regularly attends the Mental Health Commission's meetings and report back to the Board of Supervisors

6. The Mental Health Commission publish a periodic newsletter of statistical information in order to keep the public informed of its activities.

7. Training on Grand Jury interaction and scope of Grand Jury authority be performed.