2022-2023 GRAND JURY COMPLIANCE REPORT

Responses to the 2020-2021 Shasta County Grand Jury Reports

SUMMARY

This Compliance Report covers responses to the 2020-2021 Grand Jury Final Report. The final report is available at *www.shastacountygrandjury.org*. California Penal Code §§933 and 933.05 mandate the timeliness and content of responses to findings and recommendations in grand jury reports. Elected officials must respond within 60 days and governing bodies within 90 days after a report is released to the public. The 2022-2023 Grand Jury reviewed responses to the 2020-2021 reports. All responses are in compliance with California Penal Codes §933 and §933.05.

METHODOLOGY

The grand Jury reviewed the 2020-2021 Grand Jury's investigative reports:

- Carr Fire Incident Report "When Rank Has Its Privileges or Adding Fuel to The Fire"
- Anderson Union High School District Report "Teaching Current and Future Leaders"
- SHASCOM 9-1-1 Investigation Report "Who Is Helping the Helpers"
- Shasta County Coroner's Office Report "Dead Men Tell No Tales"

DISCUSSION

The 2020-2021 Shasta County Grand Jury Final Report contained four individual investigative reports with a consolidated total of 22 findings and 16 recommendations. There were six required respondents identified in the 2020-2021 Final Report

The tables below contain the responses received in their entirety, followed by the respective response letters.

2020-2021 SHASTA GRAND JURY RESPONSE SUMMARY CHARTS

Carr Fire Incident Report "When Rank Has Its Privileges or Adding Fuel to The Fire"		
THE 2020-2021 SHASTA COUNTY GRAND JURY FOUND AND/OR RECOMMENDED:	**REQUIRED RESPONDENT**	**RESPONSES**
F1. During the 2018 Carr fire evacuations the Supervisor of District 2 of Shasta County used the authority of his office to enter the evacuated area and fuel his personal home generator multiple times for personal gain.	Shasta County Board of Supervisors	The Board of Supervisors agrees with the finding.
F2. Review by the SCGJ finds that this activity is prohibited by California State Assembly Bill No. 1234.	Shasta County Board of Supervisors	The Board of Supervisors disagrees partially with this finding. AB 1234 establishes a requirement that certain public officials complete two hours of training in general ethics principles every two years, and there was no finding by the Grand Jury that the Supervisor of District 2 of Shasta County failed to complete such training. In addition, the Grand Jury expressly found that "no laws were broken." The Board of Supervisors agrees with the Grand Jury that there is a general governmental ethics principle, as noted in AB 1234, prohibiting the use of public resources for personal purposes, and that the District 2 Supervisor's conduct is a breach of that general principle.
R1. The Shasta County Board of Supervisors will place on their agenda by October 15, 2021, a motion to publicly censure the Supervisor of District 2 for actions taken during the 2018 Carr Fire.	Shasta County Board of Supervisors	The recommendation has been implemented. A resolution of censure against the Supervisor of District 2 was adopted by a majority of the Board of Supervisors on June 8, 2021.
R2. The Shasta County Board of Supervisors by October 15, 2021, will offer the Supervisor of District 2 an opportunity to publicly apologize for his actions.	Shasta County Board of Supervisors	The recommendation has been implemented. On June 8, 2021, a resolution was adopted by a majority of the Board of Supervisors offering this opportunity to the Supervisor of District 2.

Superior Court of California
County of Shasta

MONIQUE D. McKEE
Presiding Judge

ADAM B. RYAN
Asst. Presiding Judge

June 14, 2021

Joe Chimenti, Chair
Board of Supervisors
County of Shasta
1450 Court St., Suite 308B
Redding, CA 96001-1680

Re: Grand Jury Report re "When Rank has its Privileges, or Adding Fuel During the Fire"

Dear Mr. Chimenti:

This is to acknowledge receipt of your response dated June 8, 2021, to the 2020-2021 Grand Jury report regarding "When Rank has its Privileges, or Adding Fuel During the Fire".

I would like to thank you for your response to the Grand Jury Report. Pursuant to the provisions of Penal Code §933, I shall transmit your response to the Office of the County Clerk to be maintained on file there. An additional copy shall be provided to the Clerk of the Court also to be maintained on file.

Thank you again for your response.

Sincerely,

Monique D. McKee
Presiding Judge

cc: Office of the County Clerk (original response)
Melissa Fowler-Bradley, Clerk of the Court (for Admin file)
Grand Jury

Shasta County

June 8, 2021

The Honorable Monique McKee
Presiding Judge, Shasta County Superior Court
1500 Court St., Rm. 205
Redding, CA 96001

Dear Judge McKee:

Re: Response of the Board of Supervisors to the Grand Jury Report, "When Rank Has Its Privileges, or Adding Fuel During the Fire."

The Shasta County Board of Supervisors appreciates the time and dedication which the Fiscal Year (FY) 2020-21 Grand Jurors contributed to their charge. The following findings and recommendations are under serious consideration and discussions are being held regarding solutions to any unresolved problems.

FINDINGS

F1. During the 2018 Carr fire [sic] evacuations the Supervisor of District 2 of Shasta County usedthe authority of his office to enter the evacuated area and fuel his personal home generator multiple times for personal gain.

Response: The Board of Supervisors agrees with the finding.

F2. Review by the SCGJ finds that this activity is prohibited by California State Assembly Bill No. 1234.

Response: The Board of Supervisors disagrees partially with this finding. AB 1234 establishes a requirement that certain public officials complete two hours of training in general ethics principles every two years, and there was no finding by the Grand Jury that the Supervisor of District 2 of Shasta County failed to complete such training. In addition, the Grand Jury expressly found that "no laws were broken." The Board of Supervisors agrees with the Grand Jury that there is a general governmental ethics principle, as noted in AB 1234, prohibiting the use of public resources for personal purposes, and that the District 2 Supervisor's conduct is a breach of that general principle.

RECOMMENDATIONS

R1. ***The Shasta County Board of Supervisors will place on their agenda by October 15, 2021,a motion to publicly censure the Supervisor of District 2 for actions taken during the 2018 Carr Fire.***

Response: The recommendation has been implemented. A resolution of censure against the Supervisor of District 2 was adopted by a majority of the Board of Supervisors on June 8, 2021.

R2. ***The Shasta County Board of Supervisors by October 15, 2021, will offer the Supervisor of District 2 an opportunity to publicly apologize for his actions.***

Response: The recommendation has been implemented. On June 8, 2021, a resolution was adopted by a majority of the Board of Supervisors offering this opportunity to the Supervisor of District 2.

This concludes the responses of the Shasta County Board of Supervisors to the FY 2020-2021 Grand Jury Report, "When Rank Has Its Privileges, or Adding Fuel During the Fire."

Sincerely,

JOE CHIMENTI, CHAIR
Board of Supervisors
County of Shasta

Anderson Union High School District Report "Teaching Current and Future Leaders"		
THE 2020-2021 SHASTA COUNTY GRAND JURY FOUND AND/OR RECOMMENDED:	**REQUIRED RESPONDENT**	**RESPONSES**
F1. AUHSD meeting agendas are not continuously available for 72 hours prior to Board meetings as required by the Brown Act. On nights and weekends, gates to the campus and district office are closed and locked preventing public access to meeting agendas and minutes, effectively hindering public access for review.	Anderson Union High School District Board of Trustees and Superintendent	The District agrees with the finding and has corrected this finding. Board Agendas are now posted at the Anderson Technology Department building on Olinda Road, Anderson, CA 96007. This facility is well-lit in the evenings and accessible 24/7.
F2. The lack of a "prominent" clickable button on the AUHSD website home page does not meet Brown Act requirements and makes finding Board meetings and agendas cumbersome for the general public. This could potentially hinder public access to Board meeting information.	Anderson Union High School District Board of Trustees and Superintendent	Despite the disagreement listed above, the District will add an upfront direct link next to the "Board of Trustees" link that says "Current Board of Trustees Meeting Agenda" by the date requested.

F3. When AUHSD Trustees conduct business during closed session, accurate reporting of closed sessions during the public session ensures transparency, increases public confidence in trustee activity, and meets Brown Act requirements.	Anderson Union High School District Board of Trustees and Superintendent	Finding #3 does not state a particular shortcoming of the District's Brown Act compliance, but to the extent the finding implies a lack of compliance with closed session reporting rules, the District disagrees wholly with the finding. AUHSD trustees follow Brown Act protocols when reporting out of closed session: a) if the Board took action, the Board president reports in open session the disposition of the action taken b) We note that "Non-action items, such as obtaining direction from the legislative body, regardless of whether a vote is taken on that direction, need not be reported out." (Lozano Smith Brown Act Handbook, 2021, p.26) To explain: Government Code section 54957.1 is cited in the grand jury report but the report only lists the portion of the statute that says a legislative body shall report "any action taken." However, this is not the sum of what section 54957.1 requires. Crucially, not all actions taken are required to be reported, nor should they for confidentiality reasons. Only the specific categories of actions listed in section 54957.1 are reported out. For example, section 54957.1 only requires reporting of "Action taken to appoint, employ, dismiss, accept the resignation of, or otherwise affect the employment status of a public employee in closed session ..." It would be inappropriate for confidentiality reasons to detail closed session discussions or direction given on private personnel matters that do not rise to the level of action that affects employment status. Section 54957.1 goes on to list a similar narrow category of reports that are made from closed session for items such as real property negotiations, conferences with legal counsel, and so on. The report states that "years" of agendas were reviewed and expresses concern that no action is reported out in some cases. Because the report does not identify any particular action that was taken in closed session

		that should have been reported out, the District is unable to examine any particular scenario and assess compliance. We note, however, that it is common and lawful to have discussion and for boards to give direction in closed session, but to still have no reportable action. We have reviewed our practices · and are confident that required reports are made, that staff and board members are knowledgeable about the required reports, and that assistance of legal counsel is used when needed to ensure Brown Act compliance. Response: This has already been implemented, as Board members do regularly review the Brown Act, and the Board President has reviewed the closed session reporting requirements. Staff and the Board as a whole endeavor to ensure compliance with the reporting rules and we have not identified any situations where reports are lacking. The District appreciates the recommendation and agrees that Brown Act compliance is a critical component of government transparency.
F4. AUHSD has little organized training opportunities for trustees. Limited training is available for trustees who wish to participate. The lack of an organized training protocol results in inefficiency.	Anderson Union High School District Board of Trustees and Superintendent	(See response to R4)

F5. The 2020-2021 SCGJ has found that the current Superintendent is doing a good job of efficiently operating and providing leadership for the AUHSD. The Superintendent's performance is admirable given the current challenges.	Anderson Union High School District Board of Trustees and Superintendent	The Board agrees with the finding and thanks the grand jury for acknowledging the positive efforts and accomplishments of our Superintendent. We appreciate the encouragement during these difficult times as we endeavor to keep our students, staff, and community safe during the ongoing coronavirus pandemic.
R1. In order for the AUHSD to address and correct the meeting agenda problem specified in Finding 1, the AUHSD should post agendas on a lighted front door or administration office door that is ADA accessible. The AUHSD may elect to build or buy a lighted kiosk to make the agenda accessible at any time. The jury believes that posting the agenda on the front door of every AUHSD school would also be a good practice.	Anderson Union High School District Board of Trustees and Superintendent	The District agrees with the finding and has corrected this finding. Board Agendas are now posted at the Anderson Technology Department building on Olinda Road, Anderson, CA 96007. This facility is well-lit in the evenings and accessible 24/7.
R2. The Superintendent should address and correct the website shortcoming described in Finding 2 by October 31, 2021, by adding an easily identifiable direct link or button on the AUHSD homepage to the "Board of Trustees Meeting Agenda."	Anderson Union High School District Board of Trustees and Superintendent	Despite the disagreement listed above, the District will add an upfront direct link next to the "Board of Trustees" link that says "Current Board of Trustees Meeting Agenda" by the date requested.

R3. The AUHSD Board President should review reporting requirements and follow those guidelines when reporting closed session items during the public portion of Board meetings. This will help improve the public trust in the Board.	Anderson Union High School District Board of Trustees and Superintendent	Finding #3 does not state a particular shortcoming of the District's Brown Act compliance, but to the extent the finding implies a lack of compliance with closed session reporting rules, the District disagrees wholly with the finding. AUHSD trustees follow Brown Act protocols when reporting out of closed session: a) if the Board took action, the Board president reports in open session the disposition of the action taken b) We note that "Non-action items, such as obtaining direction from the legislative body, regardless of whether a vote is taken on that direction, need not be reported out." (Lozano Smith Brown Act Handbook, 2021, p.26) To explain: Government Code section 54957.1 is cited in the grand jury report but the report only lists the portion of the statute that says a legislative body shall report "any action taken." However, this is not the sum of what section 54957.1 requires. Crucially, not all actions taken are required to be reported, nor should they for confidentiality reasons. Only the specific categories of actions listed in section 54957.1 are reported out. For example, section 54957.1 only requires reporting of "Action taken to appoint, employ, dismiss, accept the resignation of, or otherwise affect the employment status of a public employee in closed session ..." It would be inappropriate for confidentiality reasons to detail closed session discussions or direction given on private personnel matters that do not rise to the level of action that affects employment status. Section 54957.1 goes on to list a similar narrow category of reports that are made from closed session for items such as real property negotiations, conferences with legal counsel, and so on. The report states that "years" of agendas were reviewed and expresses concern that no action is reported out in some cases. Because the report does not identify any particular action that was taken in closed session that should have been reported out,

		the District is unable to examine any particular scenario and assess compliance. We note, however, that it is common and lawful to have discussion and for boards to give direction in closed session, but to still have no reportable action. We have reviewed our practices and are confident that required reports . are made, that staff and board members are knowledgeable about the required reports, and that assistance of legal counsel is used when needed to ensure Brown Act compliance. Response: This has already been implemented, as Board members do regularly review the Brown Act, and the Board President has reviewed the closed session reporting requirements. Staff and the Board as a whole endeavor to ensure compliance with the reporting rules and we have not identified any situations where reports are lacking. The District appreciates the recommendation and agrees that Brown Act compliance is a critical component of government transparency.
R4. By January 1, 2022, the AUHSD Superintendent should identify and implement a comprehensive training program to establish training for Trustees and administrative personnel. Topics should include but are not limited to: Brown Act requirements, district operation, collegiality, computer skills, Form 700 conflict of interest, AUHSD Board Bylaws, and effective media relations.	Anderson Union High School District Board of Trustees and Superintendent	Respectfully, this recommendation delves into substantive policy determinations about particular subjects of training selected for officers of the District, rather than reporting on the procedural or operational aspects of school district business. (An excellent discussion of the Attorney General's viewpoint on the scope of grand jury review of school district operations can be found at 78 Ops. Cal. Atty. Gen. 290 (1995).) We respectfully believe that while a recommendation for increased training is appropriate, the topics listed are sensitive policy decisions for the school board and its administration to make, especially given that the topics listed cover a wide range of subject matter areas, many unrelated to the substance of this report. The District will partially implement the recommendation by (1) recommending Brown Act training for its board members in the 2021-22 school year,

		and (2) continuing its ongoing practice of offering other training opportunities on current topics to Board members.

Superior Court of California
County of Shasta

MONIQUE D. McKEE
Presiding Judge

ADAM B. RYAN
Asst. Presiding Judge

September 28, 2021

Victor Hopper, Superintendent
Anderson Union High School District
1469 Ferry St.
Anderson, CA 96007

Re: Grand Jury Report "Teaching Current and Future Leaders"

Dear Mr. Hopper:

This is to acknowledge receipt of your response dated August 17, 2021, to the 2020-2021 Grand Jury report regarding "Teaching Current and Future Leaders".

I would like to thank you for your response to the Grand Jury Report. Pursuant to the provisions of Penal Code §933, I shall transmit your response to the Office of the County Clerk to be maintained on file there. An additional copy shall be provided to the Clerk of the Court also to be maintained on file.

Thank you again for your response.

Sincerely,

Monique McKee

Monique D. McKee
Presiding Judge

cc: Office of the County Clerk (original response)
Melissa Fowler-Bradley, Clerk of the Court (for Admin file)
Grand Jury

Anderson Union High School District

1469 Ferry St., Anderson, CA 96007 ~ (530) 378-0568 ~ FAX (530) 378-0834

Victor Hopper, Superintendent

August 17, 2021

The Honorable Monique McKee
Presiding judge, Shasta County Superior Court
1500 Court Street, Room 205
Redding, CA 96001

Dear Judge McKee:

The Anderson Union High School District ("District") would like to thank the Grand Jury for all of their hard work and dedication, as well as the courtesy and professionalism shown in completing their work. As required under Penal Code Section 933.05, the District and Superintendent Hopper would like to offer the following response to the report titled, "Teaching Current and Future Leaders" (the "Report"):

Finding F1:
AUHSD meeting agendas are not continuously available for 72 hours prior to Board meetings as required by the Brown Act. On nights and weekends, gates to the campus and district office are closed and locked preventing public access to meeting agendas and minutes, effectively hindering public access for review.

Recommendation 1:
In order for the AUHSD to address and correct the meeting agenda problem specified in Finding 1, the AUHSD should post agendas on a lighted front door or administration office door that is ADA accessible. The AUHSD may elect to build or buy a lighted kiosk to make the agenda accessible at any time. The jury believes that posting the agenda on the front door of every AUHSD school would also be a good practice.

Response:
The District agrees with the finding and has corrected this finding. Board Agendas are now posted at the Anderson Technology Department building on Olinda Road, Anderson, CA 96007. This facility is well-lit in the evenings and accessible 24/7.

Finding F2:
The lack of a "prominent" clickable button on the AUHSD website home page does not meet Brown Act requirements and makes finding Board meetings and agendas cumbersome for the general public. This could potentially hinder public access to Board meeting information.

Recommendation 2.
The Superintendent should address and correct the website shortcoming described in Finding 2 by October 31, 2021, by adding an easily identifiable direct link or button on the AUHSD homepage to the "Board of Trustees Meeting Agenda."

Response:
Despite the disagreement listed above, the District will add an upfront direct link next to the "Board of Trustees" link that says "Current Board of Trustees Meeting Agenda" by the date requested.

Finding F3:
When AUHSD Trustees conduct business during closed session, accurate reporting of closed sessions during the public session ensures transparency, increases public confidence in trustee activity, and meets Brown Act requirements.

Recommendation 3:
The AUHSD Board President should review reporting requirements and follow those guidelines when reporting closed session items during the public portion of Board meetings. This will help improve the public trust in the Board.

Response:
Finding #3 does not state a particular shortcoming of the District's Brown Act compliance, but to the extent the finding implies a lack of compliance with closed session reporting rules, the District disagrees wholly with the finding. AUHSD trustees follow Brown Act protocols when reporting out of closed session: a) if the Board took action, the Board president reports in open session the disposition of the action taken b) We note that "Non-action items, such as obtaining direction from the legislative body, regardless of whether a vote is taken on that direction, need not be reported out." (Lozano Smith Brown Act Handbook, 2021, p.26) To explain: Government Code section 54957.1 is cited in the grand jury report but the report only lists the portion of the statute that says a legislative body shall report "any action taken." However, this is not the sum of what section 54957.1 requires. Crucially, not all actions taken are required to be reported, nor should they for confidentiality reasons. Only the specific categories of actions listed in section 54957.1 are reported out. For example, section 54957.1 only requires reporting of "Action taken to appoint, employ, dismiss, accept the resignation of, or otherwise affect the employment status of a public employee in closed session ..." It would be inappropriate for confidentiality reasons to detail closed session discussions

or direction given on private personnel matters that do not rise to the level of action that affects employment status. Section 54957.1 goes on to list a similar narrow category of reports that are made from closed session for items such as real property negotiations, conferences with legal counsel, and so on.

The report states that "years" of agendas were reviewed and expresses concern that no action is reported out in some cases. Because the report does not identify any particular action that was taken in closed session that should have been reported out, the District is unable to examine any particular scenario and assess compliance. We note, however, that it is common and lawful to have discussion and for boards to give direction in closed session, but to still have no reportable action. We have reviewed our practices and are confident that required reports are made, that staff and board members are knowledgeable about the required reports, and that assistance of legal counsel is used when needed to ensure Brown Act compliance.

Response: This has already been implemented, as Board members do regularly review the Brown Act, and the Board President has reviewed the closed session reporting requirements. Staff and the Board as a whole endeavor to ensure compliance with the reporting rules and we have not identified any situations where reports are lacking. The District appreciates the recommendation and agrees that Brown Act compliance is a critical component of government transparency.

Finding F4:
AUHSD has little organized training opportunities for trustees. Limited training is available for trustees who wish to participate. The lack of an organized training protocol results in inefficiency.

Recommendation 4:
By January 1, 2022, the AUHSD Superintendent should identify and implement a comprehensive training program to establish training for Trustees and administrative personnel. Topics should include but are not limited to: Brown Act requirements, district operation, collegiality, computer skills, Form 700 conflict of interest, AUHSD Board Bylaws, and effective media relations.

Response:
Respectfully, this recommendation delves into substantive policy determinations about particular subjects of training selected for officers of the District, rather than reporting on the procedural or operational aspects of school district business. (An excellent discussion of the Attorney General's viewpoint on the scope of grand jury review of school district operations can be found at 78 Ops. Cal. Atty. Gen. 290 (1995).) We respectfully believe that while a recommendation for increased training is appropriate, the topics listed are sensitive policy decisions for the school board and its administration to make, especially given that the topics listed cover a wide range of subject matter

areas, many unrelated to the substance of this report. The District will partially implement the recommendation by (1) recommending Brown Act training for its board members in the 2021-22 school year, and (2) continuing its ongoing practice of offering other training opportunities on current topics to Board members.

Finding 5:

The 2020-2021 SCGJ has found that the current Superintendent is doing a good job of efficiently operating and providing leadership for the AUHSD. The Superintendent's performance is admirable given the current challenges.

Response:

The Board agrees with the finding and thanks the grand jury for acknowledging the positive efforts and accomplishments of our Superintendent. We appreciate the encouragement during these difficult times as we endeavor to keep our students, staff, and community safe during the ongoing coronavirus pandemic.

SHASCOM 9-1-1 Investigation Report "Who Is Helping the Helpers"		
THE 2019-2020 SHASTA COUNTY GRAND JURY FOUND AND/OR RECOMMENDED:	**REQUIRED RESPONDENT**	**RESPONSES**
F1. SHASCOM's Board of Directors is not in compliance with California's Open Meetings Law (The Ralph M. Brown Act) as amended by Assembly Bill No. 2257 in 2016, affecting applicable local government meetings held after January 1, 2019.	SHASCOM-911 Board of Directors	Disagree wholly. It was reported by the Grand Jury that on one (1) particular meeting date that an agenda was not posted for public view at SHASCOM-911. Nine months later it is not possible to verify this claim. Additionally, to state that this unverified, isolated incident deserves a broad-brush stroke that the Board of Directors is not in compliance with the Brown Act is overstated. Regardless, the Board of Directors will continue to adhere, as they always have, to the Brown Act in all manners related to the governing of SHASCOM-911.
F2. By October 2019, SHASCOM's Board of Directors was to instruct the agency's Director to provide quarterly reports on recruitment efforts and outcomes. This is being done.	SHASCOM-911 Board of Directors	Agree.
F3. By October 31, 2019, SHASCOM's Board of Directors was to instruct the agency's Director to prepare a comprehensive written recruitment plan analyzing appropriate targets and details regarding the timing and methods of recruitment. This has not been done.	SHASCOM-911 Board of Directors	Disagree wholly. The 2018-2019 Grand Jury's recommendation was to prepare a comprehensive recruitment plan which the Director and his management team successfully accomplished and implemented. Finding F3 inaccurately states the plan had to be written.
F4. Beginning at the September 2019 SHASCOM Board of Directors meeting and at each bi-monthly meeting thereafter, the Board was to require written updates on CAD system performance until all issues are resolved to the satisfaction of each participating agency. This has not been done.	SHASCOM-911 Board of Directors	Disagree partially. Member agencies were satisfied as it relates to Spillman and the CAD system. CAD falls under the purview of the Integrated Public Safety (IPS) Board which consists of agency heads from the Redding Police Department, Shasta County Sheriff's Office, and Anderson Police Department. A comprehensive update was provided by the RMS project manager to the IPS Board at their last scheduled meeting. The Board was satisfied with the progress of issue resolution.

F5. The Spillman Technologies CAD system does not yet satisfactorily meet the needs of SHASCOM, which causes dispatch and first responder complications with a potential for adverse outcomes for first responders as well as citizens requesting assistance.	SHASCOM-911 Board of Directors	Disagree partially. The RMS project management team continues to work diligently with the CAD vendor (Motorola Solutions) to address outstanding performance issues and concerns. The system is currently undergoing a comprehensive design review process with the vendor to determine if there are other suitable remedies to bring the system to an acceptable state. It is important to note that no final acceptance has been given for the CAD update.
F6. As of November 30, 2019, SHASCOM's Board of Directors was to require SHASCOM's Director to present a timeline for achieving compliance with accreditation certification of the dispatch center, either through POST or an alternate accreditation organization. This was accomplished by August 26, 2020.	SHASCOM-911 Board of Directors	Agree.
F7. By January 31, 2021, SHASCOM's Board of Directors was to instruct the Agency's Director to present a project plan for incorporating information on people with access and functional needs into the CAD database. This has not been done.	SHASCOM-911 Board of Directors	Agree. The Spillman CAD database is the responsibility of the IPS Board which supports the Redding Police Department, Shasta County Sheriff's Office, Anderson Police Department, and other public safety agencies. These agencies have the capability to develop a means to collect this data and input it into the Spillman CAD database. For example, the Redding Police Department provides a resource for the City of Redding called SNAP (Special Needs Alert Program). People with access and functional needs can upload their information and the data is flagged in the Spillman CAD database by the Redding Police Department. SHASCOM dispatchers can then relay this crucial information to first responders. The Anderson Police Department and the Shasta County Sheriff's Office are currently in the process of implementing the SNAP program for their respective agencies.

R1. By October 31, 2021, SHASCOM's Board of Directors shall implement procedures to bring the governing board into compliance with California's Brown Act.	SHASCOM-911 Board of Directors	This recommendation has been implemented. SHASCOM has been in compliance with the Brown Act since the formation of the SHASCOM Joint Powers Agreement.
R2. By October 31, 2021, SHASCOM's Board of Directors shall instruct the agency's Director to prepare and implement a comprehensive written recruitment plan analyzing appropriate targets and detailing the timing and methods of recruitment for use by current and future administration personnel. The Director shall provide a written plan to the governing board no later than January 1, 2022.	SHASCOM-911 Board of Directors	The recommendation has been implemented and was presented to the SHASCOM board at the November 8, 2021 regular meeting.
R3. By October 31, 2021, shall require at its November 2021 board meeting, and at each bimonthly meeting thereafter, written updates on performance of the CAD system until all issues are resolved to the satisfaction of SHASCOM dispatchers.	SHASCOM-911 Board of Directors	The recommendation will not be implemented. The implementation and acceptance of the Spillman CAD and other Spillman components falls under the terms and conditions of a contract agreed upon by the Governing bodies of the City of Redding, County of Shasta, and the City of Anderson. In addition, the contract was approved by the Integrated Public Safety Board (IPS). Motorola is working with IPS and the implementation team to satisfy the conditions of the contract to include CAD malfunctions. Successful resolution of all issues with the CAD system to the satisfaction of SHASCOM dispatchers is not a condition of the contract with Motorola. Issues will be resolved pursuant to the language in the contract
R4. By October 31, 2021, SHASCOM's Board of Directors shall instruct the agency's Director to present a written project plan for incorporating information on people with access and functional needs into the CAD database. The agency's Director shall provide a written plan to SHASCOM's Board of Director's no later than January 1, 2022.	SHASCOM-911 Board of Directors	This recommendation will not be implemented. Discussions will continue with the member agencies to do their own data collection for their specific jurisdictions. This information can then be uploaded into Spillman for use by SHASCOM. SHASCOM's current organization does not have the means to staff the personnel required to complete and maintain such a program.

SHASCOM 911
SHASTA AREA SAFETY COMMUNICATIONS AGENCY
3101 South Street, Redding, CA 96001-2379
(530) 245-6501 Administrative Office
(530) 245-6500 Dispatch
FAX (530) 245-6530

November 8, 2021

Honorable Gregory S. Gaul
Presiding Judge, Shasta County Superior Court
1500 Court Street, Room 205
Redding, CA 96001

Dear Judge Gaul:

Re: Response to the SHASCOM-911 Investigation Report by the 2020-2021 Shasta County Grand Jury.

The SHASCOM-911 Board of Directors appreciates the time and dedication of the 2020-2021 Grand Jury. The following are the responses to the findings and recommendations The Board of Directors will continue to work collaboratively with SHASCOM-911 management regarding solutions to any unresolved problems.

FINDINGS

F1. ***SHASCOM'S Board of Directors is not in compliance with California's Open Meetings Law (The Ralph M. Brown Act) as amended by Assembly Bill No. 2257 in 2016, affecting applicable local government meetings held after January 1, 2019.***

Response: Disagree wholly. It was reported by the Grand Jury that on one (1) particular meeting date that an agenda was not posted for public view at SHASCOM-911. Nine months later it is not possible to verify this claim. Additionally, to state that this unverified, isolated incident deserves a broad-brush stroke that the Board of Directors is not in compliance with the Brown Act is overstated. Regardless, the Board of Directors will continue to adhere, as they always have, to the Brown Act in all manners related to the governing of SHASCOM-911.

F2. ***By October 31, 2019, SHASCOM's Board of Directors was to instruct the agency's Director to provide quarterly reports on recruitment efforts and outcomes. <u>This is being done.</u>***

Response: Agree.

F3. ***By October 31, 2019, SHASCOM's Board of Directors was to instruct the agency's Director to prepare a comprehensive written recruitment plan analyzing appropriate targets and details regarding the timing and methods of recruitment. <u>This has not been done.</u>***

Response: Disagree wholly. The 2018-2019 Grand Jury's recommendation was to prepare a comprehensive recruitment plan which the Director and his management team successfully accomplished and implemented. Finding F3 inaccurately states the plan had to be written.

F4. ***Beginning at the September 2019 SHASCOM Board of Directors meeting and at each bi-monthly meeting thereafter, the Board was to require written updates on CAD system performance until all issues are resolved to the satisfaction of each participating agency. <u>This has not been done.</u>***

Response: Disagree partially. Member agencies were satisfied as it relates to Spillman and the CAD system. CAD falls under the purview of the Integrated Public Safety (IPS) Board which consists of agency heads from the Redding Police Department, Shasta County Sheriff's Office, and Anderson Police Department. A comprehensive update was provided by the RMS project manager to the IPS Board at their last scheduled meeting. The Board was satisfied with the progress of issue resolution.

F5. ***The Spillman Technologies CAD system <u>does not yet</u> satisfactorily meet the needs of SHASCOM, which causes dispatch and first responder complications with a potential for adverse outcomes for first responders as well as citizens requesting assistance.***

Response: Disagree partially. The RMS project management team continues to work diligently with the CAD vendor (Motorola Solutions) to address outstanding performance issues and concerns. The system is currently undergoing a comprehensive design review process with the vendor to determine if there are other suitable remedies to bring the system to an acceptable state. It is important to note that no final acceptance has been given for the CAD update.

F6. ***As of November 30, 2019, SHASCOM's Board of Directors was to require SHASCOM's Director to present a timeline for achieving compliance with accreditation certification of the dispatch center, either through POST or an alternate accreditation organization. <u>This was accomplished by August 26, 2020.</u>***

Response: Agree.

F7. ***By January 31, 2021, SHASCOM's Board of Directors was to instruct the Agency's Director to present a project plan for incorporating information on people with access and functional needs into the CAD database. <u>This has not been done.</u>***

Response: ***Agree.*** The Spillman CAD database is the responsibility of the IPS Board which supports the Redding Police Department, Shasta County Sheriff's Office, Anderson Police Department, and other public safety agencies. These agencies have the capability to develop a means to collect this data and input it into the Spillman CAD database. For example, the Redding Police Department provides a resource for the City of Redding called SNAP (Special Needs Alert Program). People with access and functional needs can upload their information and the data is flagged in the Spillman CAD database by the Redding Police Department. SHASCOM dispatchers can then relay this crucial information to first responders. The Anderson Police Department and the Shasta County Sheriff's Office are currently in the process of implementing the SNAP program for their respective agencies.

<u>Recommendations</u>

R1. ***By October 31, 2021, SHASCOM's Board of Directors shall implement procedures to bring the governing board into compliance with California's Brown Act.***

Response: This recommendation has been implemented. SHASCOM has been in compliance with the Brown Act since the formation of the SHASCOM Joint Powers Agreement.

R2. ***By October 31, 2021, SHASCOM's Board of Directors shall instruct the agency's Director to prepare and implement a comprehensive written recruitment plan analyzing appropriate targets and detailing the timing and methods of recruitment for use by current and future administration personnel. The Director shall provide a written plan to the governing board no later than January 1, 2022.***

Response: The recommendation has been implemented and was presented to the SHASCOM board at the November 8, 2021 regular meeting.

R3. ***By October 31, 2021, SHASCOM's Board of Directors shall require at its November 2021 board meeting, and at each bi-monthly meeting thereafter, written updates on performance of the CAD system until all issues are resolved to the satisfaction of SHASCOM dispatchers.***

Response: The recommendation will not be implemented. The implementation and acceptance of the Spillman CAD and other Spillman components falls under the terms and conditions of a contract agreed upon by the Governing bodies of the City of Redding, County of Shasta, and the City of Anderson. In addition, the contract was approved by the Integrated Public Safety Board (IPS). Motorola is working with IPS and the implementation team to satisfy the conditions of the contract to include CAD malfunctions. Successful resolution of all issues with the CAD system to the satisfaction of SHASCOM dispatchers is not a condition of the contract with Motorola. Issues will be resolved pursuant to the language in the contract.

R4. ***By October 31, 2021, SHASCOM's Board of Directors shall instruct the agency's Director to present a written project plan for incorporating information on people with access and functional needs into the CAD database. The agency's Director shall provide a written plan to SHASCOM's Board of Director's no later than January 1, 2022.***

Response: This recommendation will not be implemented. Discussions will continue with the member agencies to do their own data collection for their specific jurisdictions. This information can then be uploaded into Spillman for use by SHASCOM. SHASCOM's current organization does not have the means to staff the personnel required to complete and maintain such a program.

This concludes the responses of the SHASCOM Board of Directors to the FY 2020-21 Grand Jury investigation report regarding SHASCOM.

Sincerely,

Matt Pontes
Chair, SHASCOM

Shasta County Coroner's Office Report "Dead Men Tell No Tales"		
THE 2020-2021 SHASTA COUNTY GRAND JURY FOUND AND/OR RECOMMENDED:	**REQUIRED RESPONDENT**	**RESPONSES**
F1. The Coroner's Office does not have a formal manual of applicable policies and procedures for day-to-day operations. Therefore, it has been found that training is not always current, complete or consistent.	Shasta County Board of Supervisors and Sheriff	Shasta County Board of Supervisors: The Board of Supervisors disagrees partially with the finding. While the finding is unclear in that it addresses whether there is a formal manual of applicable policies and procedures for the day-to-day operations and training is not always current, complete or consistent, the Board of Supervisors response is addressed to the findings as it understands them. The Board of Supervisors agrees that there is not a formal manual of applicable policies and procedures for day-to-day operation. The Shasta County Sheriff's Office is governed by several Government and Health and Safety Codes. Low staffing levels at the Coroner's office have caused a delay in the completion of the policies and procedures manual. The Board of Supervisors disagrees that training is not always current, complete or consistent. All current Deputy Coroner Investigators have attended and successfully completed the required training courses, mandated by the State, associated with their job duties. Sheriff: The Sheriff-Coroner partially disagrees with this finding. The Shasta County Sheriff's Office is governed by several Government and Health and Safety Codes. The Coroner's Office has, however, been working on a procedures manual to assist employees. Unfortunately, due to low staffing levels, the manual has not been finalized. When staffing levels are restored, this manual can

		again be focused on and completed. Training is, in fact, current within the Coroner's Office. All current Deputy Coroner Investigators have attended the required 80-hour POST certified death investigation course along with a 40-hour PC 832 Arrest and Control course. Further advanced trainings have been scheduled and will continue to be scheduled as courses become available and staffing levels allow.
F2. The autopsy viewing area has no audio, limits viewing from the autopsy suite and during this grand jury term briefing and/or debriefing of the incidents involving the deceased were rare. This resulted in zero transparency to any grand jurors viewing the autopsy.	Shasta County Board of Supervisors and Sheriff	Shasta County Board of Supervisors: The BOS disagrees partially with the finding. While the finding is unclear in that it addresses whether there is audio in the autopsy suite, whether viewing is limited, and, apparently, whether briefing and/or debriefing of the incidents involving the deceased were rare, the Board of Supervisors response is addressed to the findings as it understands them. The Board of Supervisors agrees that there is no audio in the autopsy suite. This limitation is due to safety concerns within the autopsy suite. Two-way audio may distract or disturb an autopsy, in addition, sensitive case information and case confidentiality may be jeopardized. The Board of Supervisors agrees that the autopsy viewing area has limited viewing but viewing the autopsy from the autopsy suite itself is not a viable option due to limited space. Additional people in the autopsy suite could cause safety issues, not only for the employees but also the Grand Jury members. The Board of Supervisors disagrees that briefing and/or debriefing of the incidents involving the deceased were rare. The Grand Jury is provided with briefings prior to an autopsy and staff is accessible and available to answer any questions after an autopsy.

		Based upon the foregoing responses, the Board of Supervisors disagrees that there is "zero transparency to any grand jurors viewing" autopsies. Shasta County Sheriff: The Sheriff-Coroner partially disagrees with this finding. There is no audio available for the Grand Jury in the viewing room. This limitation is due to safety concerns within the autopsy suite if there was two-way audio. Distractions from unexpected audio communication can lead to injuries to personnel from instruments they use within the autopsy suite. Personnel inside the autopsy suite regularly handle sharp instruments and also handle fragile samples and evidence. Also, sensitive case information and case confidentiality may be jeopardized. Certain confidential details of the investigation are sometimes discussed within the autopsy suite, and if that information were to be released, it could jeopardize the outcome of the investigation and future prosecution. Viewing an autopsy from the autopsy suite itself is not a viable option due to limited space within the autopsy suite and the number of employees already in the suite during autopsy. Adding more people to the autopsy suite can cause safety issues, not only for the employees but also the Grand Jury members. However, the Coroner's Office provides briefings to the Grand Jury members prior to autopsies along with providing them with the Grand Jury Critical Incident Report Form upon notification to attend the autopsies. Members of the Coroner's Office are regularly available to answer questions the Grand Jury may have. We disagree that there was zero transparency during these critical incident autopsies based on the above information.

F3. The autopsy suite does not meet all the minimum Center for Disease Control standards for an autopsy facility. The minimum standards prevent contamination of specimens but more importantly provide safety to personnel from airborne pathogens, viruses, and the like	Shasta County Board of Supervisors and Sheriff	Shasta County Board of Supervisors: The Board of Supervisors disagrees partially with the finding. The finding is vague and unclear in that it claims the autopsy suite does not meet all the minimum Center for Disease Control standards for an autopsy facility, it does not specify what standard(s) was not met. In addition, the Center for Disease Control standards provides guidelines, not mandates. In regard to the safety to personnel from airborne pathogens, viruses, and the like, in 2020--HEPA filters were installed; in 2021 the HVAC system in the autopsy suite was inspected and the entire system was determined to be functioning properly per OSHA standards and met the number of required air exchanges per hour using 100% outside air supply. The autopsy suite is cleaned routinely and is in compliance with sanitary level standards. The Board of Supervisors agrees that guidelines can help prevent contamination of specimens and assist to provide safety to personnel from airborne pathogens, viruses, and the like. However, the Board of Supervisors disagrees that the autopsy suite does not meet the guidelines recommended by the Center for Disease Control. Shasta County Sheriff: The Sheriff-Coroner partially disagrees with this finding. The CDC provides guidelines for autopsy suites during certain types of autopsy. These are guidelines only, not mandates. During 2021 the Coroner's Office had the HVAC system inspected inside the autopsy suite. The entire system was determined to be functioning properly per CalOSHA standards and met the number of required air exchanges per hour using 100% outside air supply. The air inside the autopsy suite is exhausted out of the roof of the building via powered exhaust fans. HEPA filters were also installed during

		2020. The autopsy suite is cleaned after autopsies, after intake of decedents if needed, and after release of decedents if needed to meet sanitary level standards.
F4. Almost all current employees of the Shasta County Coroner's Office are undertrained in medical and forensic protocol. This can create a dangerous/unhealthy environment as well as incorrect or incomplete autopsy results.	Shasta County Board of Supervisors and Sheriff	Shasta County Board of Supervisors: The Shasta County Board of Supervisors disagrees partially with the finding. The Board of Supervisors disagrees that current employees at the Shasta County Coroner's Office are undertrained in medical and forensic protocol. All current employees are properly trained and receive on the job training for medical and forensic protocol with senior Deputy Coroner Investigators, Forensic Pathologists, or Pathologists. Qualified, licensed, and trained Forensic Pathologists or Pathologists complete all autopsies within the Coroner's Office. Currently, the County contracts the services of a Pathologist with outside experienced vendors. Shasta County Deputy Coroner Investigators do not determine autopsy results or findings. Autopsy results are the sole responsibility of the Pathologist conducting the autopsy. The Board of Supervisors agrees that staff undertrained in any field of work can create a dangerous/unhealthy environment but disagrees that current employees at the Shasta County Coroner's Office are undertrained in medical and forensic protocol. Again, all staff receive the required State mandated training Shasta County Sheriff: The Sheriff-Coroner wholly disagrees with this finding. Employees at the Coroner's Office have been subject to a department specific "Communicable Diseases" policy, in addition to the County of Shasta's "Airborne

		Transmissible Disease Prevention Program". Employees also receive annual training regarding Bloodborne Pathogens, Aerosol Transmissible Diseases, and Hazard Communication. Furthermore, employees receive on the job training for medical and forensic protocol with senior Deputy Coroner Investigators, Forensic Pathologists, or Pathologists. Trained and experienced Forensic Pathologists or Pathologists complete all autopsies within the Coroner's Office. Deputy Coroner Investigators do not determine autopsy results or findings. Autopsy results are the responsibility of the Pathologist conducting the autopsy.
F5. The Shasta County Sheriff's Office does not encourage or provide available training for Coroner's Office personnel. This results in undertrained staff who are limited by the knowledge they are provided and unable to move forward in their professional growth.	Shasta County Board of Supervisors and Sheriff	Shasta County Board of Supervisors: The Board of Supervisors disagrees wholly with the finding. The Board of Supervisors disagrees that Shasta County Sheriff's Office does not encourage or provide training for Coroner's Office personnel. Deputy Coroner Investigators are required to attend and successfully complete multiple training courses within one year of hire. Currently, all Deputy Investigators have met this requirement. The Board of Supervisors disagrees that Coroner's Office personnel is undertrained and are limited by the knowledge they are provided. Coroner's Office personnel are not undertrained. However, advanced training opportunities were cancelled due to Covid Restrictions compounded with low staffing levels. Advanced training courses have resumed and participation will be subject to staffing levels and availability. The Board of Supervisors disagrees that Coroner Office personnel are not able to move forward in their professional growth, advanced training opportunities are scheduled for 2022. Additionally, in October 2021, the Board of Supervisors approved

		adding a I/II/III series to the Deputy Coroner Investigator classification to promote growth opportunities. Shasta County Sheriff: The Sheriff-Coroner wholly disagrees with this finding. All Deputy Coroner Investigators are required to attend an 80-hour Peace Officer Standards and Training (POST) certified death investigation course along with a 40-hour Penal Code 832 Arrest and Control course within one year of their hire date to meet POST requirements. All Deputy Coroner Investigators are current on these requirements. Due to staffing levels and Covid restrictions, further advanced trainings were cancelled or put on hold during the 2020-2021 Covid-19 pandemic. Currently, those trainings have resumed, and Deputy Coroner Investigators will continue to attend trainings as they become available. The attendance of these trainings will depend on staffing levels at the Coroner's Office and availability of the trainings. The Shasta County Coroner's Office will continue to schedule advanced trainings and conferences for employees in order to promote career advancement and development. Advanced trainings have already been scheduled, for Deputy Coroner Investigators, during 2022.

F6. There is currently no chance for advancement within the Coroner's Office for any assigned Coroner's Office personnel. There is only one DCI level and no Captain position. This has led to a higher than average (with respect to the County) turnover of over 50 percent since July 2020.	Shasta County Board of Supervisors and Sheriff	Shasta County Board of Supervisors: The Board of Supervisors disagrees partially with the finding. The Board of Supervisors disagrees that there is no chance for advancement within the Coroner's office and disagrees that there is only one DCI level. As presented to this Board on October 19, 2021, the classification of DCI was deleted and the classification of DCI I/II/III was added providing advancement opportunity to the Coroner's office. The Board of Supervisors agrees that there is not a Captain position in the Coroner's office. It is the Board of Supervisors' understanding that the Sheriff believes there is not a need for one at this time. The Coroner's office has a total of eight allocated positions which include a Lieutenant position. The Coroner's office is currently managed by a Lieutenant/Chief Deputy Coroner. The Board of Supervisors disagrees that advancement, job classification or lack of a Captain position in the Coroner's office has led to a "higher than average turnover". There are certainly other factors that play an important role in whether employment with a particular entity is attractive or whether an employee will choose to remain with a particular entity. Furthermore, as of July 2021, the Coroner's office had two vacant positions, one DCI position and one Forensic Pathologist position. As of today, the two aforementioned positions remain vacant and the DCI lll position that was added in October 2021 is vacant pending appointment. Shasta County Sheriff: The Sheriff-Coroner partially disagrees with this finding. The Coroner's Office is currently managed by a Lieutenant/Chief Deputy Coroner. The Coroner's Office is a rela-

		tively small unit with eight total allocated positions, which includes the Lieutenant and Pathologist. Again, based on the size of the office and current overall structure of the organization, a Captain position is not needed at this time. There are now three separate classifications for Deputy Coroner Investigators: Deputy Coroner Investigator I, Deputy Coroner Investigator II, and Deputy Coroner Investigator III. The Coroner's Office was recently approved for a fifth Deputy Coroner Investigator position, with the plan to fill the fifth position with the Deputy Coroner Investigator III classification.
F7. The Coroner's Office has no biohazard plan, which leads to an unsafe working environment.	Shasta County Board of Supervisors and Sheriff	Shasta County Board of Supervisors: The finding is merely a vague statement of what the Grand Jury found with no further detail or specific information regarding what the Grand Jury means by the use of the phrase "biohazard plan" and, as result, the Board of Supervisors wholly disagrees with the finding. The Shasta County Coroner's Office follows the protocols consistent with industry standards and maintains a safe working environment. Shasta County Sheriff: With no further detail or more specific information regarding a "biohazard plan," the Sheriff-Coroner wholly disagrees with this finding. Employees at the Coroner's Office follow protocol from training and industry standards for biohazards. This protocol includes the proper use of personal protective equipment, proper handling of specimens and sharps, and proper disposal of waste. The Coroner's Office contracts with a biohazard company for pickup and disposal of biohazard materials

F8. The existing cold storage facility accommodates up to 20 gurneys. When the number of cadavers exceeds this number (and has been as high as 30), the cadavers (in body bags) are stored two to a gurney.	Shasta County Board of Supervisors and Sheriff	Shasta County Board of Supervisors: The Board of Supervisors disagrees wholly with the finding. The cold storage facility in the Coroner's Office can accommodate six gurneys which is what is available and used. In addition, the cold storage facility has eight stainless steel rolling tables which can temporarily accommodate two decedents (in body bags) should the decedents exceed the number of gurneys and tables available. Maximum capacity of decedents in the cold storage facility at the Coroner's Office is twenty-two. Should the Coroner's Office reach maximum capacity, local mortuaries allow storage of decedents, at their facilities until room becomes available at the Coroner's Office. Shasta County Sheriff: The Sheriff-Coroner wholly disagrees with this finding. The cold storage facility in the Coroner's Office can accommodate 8 stainless steel rolling tables and 6 gurneys which is what is available and used. If decedents exceed the number of tables and gurneys available, the decedents (in body bags) can be temporarily stored two to a table but only 1 on a gurney. Maximum capacity of decedents in the cold storage at the Coroner's Office is 22. If the Coroner's Office reaches maximum capacity, local mortuaries allow storage of decedents, at their facilities, until room becomes available at the Coroner's Office.

R1. This Grand Jury recommends that the Sheriff's Office develop written day-to-day procedures for the Coroner's Office to include office, morgue and field work that meet industry standards, such as those outlined in the California Death Investigations template, by June 30, 2022.	Shasta County Sheriff	Shasta County Sheriff: The recommendation will not be implemented as it is not warranted or is not reasonable. As similarly outlined in the earlier response to F1, The Shasta County Sheriff's Office is governed by several Government and Health and Safety Codes. These codes are what guide and direct employees. The Coroner's Office has, however, been working on a procedures manual to assist employees above and beyond the Government Codes and Health and Safety Codes. Unfortunately, due to staffing levels, the manual has not been finalized. When staffing levels are restored, this manual can again be focused on to complete.
R2. This Grand Jury recommends that the Sheriff's Office determine the feasibility of expanding the classifications of the Deputy Coroner Investigator into multiple levels (dependent on completed levels of forensic and related training) and present a plan for implementation to the Board of Supervisors no later than December 31, 2022.	Shasta County Board of Supervisors and Sheriff	Shasta County Board of Supervisors: The recommendation has been implemented. On October 19, 2021 the Board of Supervisor, by unanimous vote, added a I/II/III series to the Deputy Coroner Investigator classification. The County of Shasta continuously evaluates positions, classifications and feasibility of changes. Shasta County Sheriff: The recommendation has been implemented. There are now three separate classifications for Deputy Coroner Investigators: Deputy Coroner Investigator I, Deputy Coroner Investigator II, and Deputy Coroner Investigator III. The Coroner's Office was recently approved for a fifth Deputy Coroner Investigator position which will be filled with the Deputy Coroner Investigator III classification. Applications for this position have been received and are being reviewed.

R3. This Grand Jury recommends the Board of Supervisors place on its agenda by March 31, 2022, to discuss utilizing the CARES ACT monies granted to the county in 2022 to upgrade and modernize the Coroner's Office Autopsy Suite to meet industry standards specified in this report	Shasta County Board of Supervisors and Sheriff	Shasta County Board of Supervisors: The recommendation will not be implemented because it is not warranted and is not reasonable. CARES ACT monies were received by the County in 2020 and had to be expended no later than December 30, 2021. Currently, there is no CARES ACT funding available for the recommended action. In addition, the County is unaware of additional CARES ACT funding available or anticipated for 2022. Finally, even if CARES ACT funding became available, it is likely that, upgrading and modernizing the Coroner's Office Autopsy Suite would not be a qualifying expense if the same rules regarding use of CARES ACT funding if such funding were once again available Shasta County Sheriff: The recommendation will not be implemented because it is not warranted or is not reasonable. The Sheriff-Coroner does not dictate the Board of Supervisors agenda
R4. This Grand Jury recommends the Sheriff's Office immediately restore the audio and the camera control to the remote autopsy viewing area in the Coroner's Office.	Shasta County Sheriff	Shasta County Sheriff: The recommendation will not be 'implemented because it is not warranted or is not reasonable. As referenced in F2, due to safety concerns within the autopsy suite, sensitive case information, and case confidentiality, full two-way audio communication, during the duration of the autopsy will not be implemented. Camera control will not be implemented either, as the investigators have control of the camera for investigation purposes.

R5. This Grand Jury recommends the Sheriff's Office develop a written procedure by June 30, 2022, that includes the Grand Jury requirements to increase transparency, such as: • A written report or a verbal briefing to the grand jury of the events leading up to the death, from a DCI, prior to the autopsy. • Access by the grand jury to the controls that operate the camera in the autopsy suite. • Access by the grand jury to an audio feed from the autopsy suite. • Access by the grand jury to the pathologist for follow-up questions after the autopsy.	Shasta County Sheriff	Shasta County Sheriff: The recommendation will not be implemented because it is not warranted or is not reasonable. Bullet point two is addressed in R4 and bullet point three is addressed in F2. As for bullet point four, the pathologist will not give findings to the Grand Jury due to case sensitivity and confidentiality. The findings will be provided in the pathologist's final written report. Any follow up questions by the Grand Jury can be directed to the Deputy Coroner Investigator and may be answered on a case-by-case basis to ensure confidentiality of the investigation. However, bullet point one, is already implemented and conducted prior to autopsy.
R6. This Grand Jury recommends the Sheriff's Office develop a written plan by June 30, 2022, that provides all DCIs with opportunities for additional forensic and job-related training, necessary for continuing professional education, at no personal cost.	Shasta County Sheriff	Shasta County Sheriff: The recommendation will not be implemented because it is not warranted or is not reasonable. A written plan is not needed. All Deputy Coroner Investigators are required to attend an 80-hour POST certified death investigation course along with a 40-hour PC 832 Arrest and Control course within one year of their hire date. Due to staffing levels and Covid restrictions, further advanced trainings were cancelled or put on hold during the Covid-19 pandemic. Some trainings have resumed, and Deputy Coroner Investigators will continue to attend trainings as they become available. The attendance of these trainings will depend on appropriate staffing levels at the Coroner's Office. The Shasta County Coroner's Office will continue to schedule trainings/seminars for employees to promote career advancement and development.

Additional Remarks from Shasta County Sheriff		The Shasta County Sheriff's Office appreciates and respects the Grand Jury process. Critical review, constructive criticism, and suggestions for improvement, via Grand Jury and/or other means, will always be received without bias and evaluated for implementation with the goal of improving service, efficiency, and professionalism within the organization. I was appointed to the Office of the Sheriff-Coroner in August 2021. I immediately conducted assessments throughout all divisions of the Sheriff's Office to include the Coroner's Office. This assessment revealed the priority to find methods to address staffing shortages within the office. Most significantly, among those concerns, was not only the staffing shortages but the excessive workload of the personnel currently occupying the positions because of these shortages. Staffing shortages and the dynamics created by the COVID 19 pandemic, combined with an increasingly growing case load, are at the core of the problem. Staff is overworked and overwhelmed. The three active Deputy Coroner Investigators rotate on call duties, responding to cases at all hours of the night, and rarely get their scheduled time off. Investigators are down a significant amount of case reports. The Sheriff's Office has routinely conducted recruiting efforts, to fill vacant positions, but locating qualified candidates has been challenging. We are currently at the mercy of two contracted pathologists that respond from out of the area on an "as-needed" basis, which often delays the processes. Additional, ongoing recruiting efforts to fill the permanent pathologist position has too been unsuccessful. The Coroner's Office Administrative Secretary is overwhelmed with phone calls, generated paperwork, and clerical duties impacted from staffing shortages. It is frustrating to read the "findings" and "recommendations" from the Grand Jury.

		The information contained within the Grand Jury report inspires skepticism about their investigative abilities. While I appreciate some of the objective findings and recommendations, others seem biased and the product of disgruntled past employee interviews without further exploration into the matter. Missing is the fair assessment of comparative Coroner's Offices within the State. Also absent is the factual information in reference to mandated compliance issues, opposed to the opinion-based findings listed in the report. In my short time with the Sheriff's Office, I have learned one single most significant factor that is also missing from this report: the men and women of the Shasta County Sheriff's Office, in all divisions and aspects of this organization, serve this community with absolute dedication, commitment, and integrity. As noted above, we are open to constructive criticism and will continue to implement change for the betterment of the citizens we serve.

Reports issued by the Grand Jury do not identify individuals interviewed. Penal Code Section 929 requires that reports of the Grand Jury not contain the name of any person or facts leading to the identity of any person who provides information to the Grand Jury.

Shasta County

BOARD OF SUPERVISORS

1450 Court Street, Suite 308B
Redding, California 96001-1680
(530) 225-5557
(800) 479-8009
(530) 225-5189-FAX

February 15, 2022

The Honorable Monique McKee
Presiding Judge, Shasta County Superior Court
1500 Court St., Rm. 205
Redding, CA 96001

Dear Judge McKee:

Re: Response of Board of Supervisors to Fiscal Year 2020-2021 Grand Jury Report: "Dead Men Tell No Tales" Shasta County Coroner's Office Report

The Shasta County Board of Supervisors appreciates the time and dedication which the Fiscal Year 2020-2021 Grand Jurors contributed to their charge. The findings and recommendations contained in the report are under serious consideration and discussions are being held regarding solutions to any unresolved problems.

FINDINGS

The Grand Jury findings:

F1. ***The Coroner's Office does not have a formal manual of applicable policies and procedures for day-to-day operations. Therefore, it has been found that training is not always current, complete or consistent.***

Response: The Board of Supervisors disagrees partially with the finding.

While the finding is unclear in that it addresses whether there is a formal manual of applicable policies and procedures for the day-to-day operations and training is not always current, complete or consistent, the Board of Supervisors response is addressed to the findings as it understands them.

The Board of Supervisors agrees that there is not a formal manual of applicable policies and procedures for day-to-day operation. The Shasta County Sheriff's Office is governed by several Government and Health and Safety Codes. Low staffing levels at the Coroner's office have caused a delay in the completion of the policies and procedures manual.

The Board of Supervisors disagrees that training is not always current, complete or consistent. All current Deputy Coroner Investigators have attended and successfully completed the required training courses, mandated by the State, associated with their job duties.

F2. ***The autopsy viewing area has no audio, limits viewing from the autopsy suite during this grand jury term briefing and/or debriefing of the incidents involving the deceased were rare. This resulted in zero transparency to any grand jurors viewing the autopsy.***

Response: The Board of Supervisors disagrees partially with the finding.

While the finding is unclear in that it addresses whether there is audio in the autopsy suite, whether viewing is limited, and, apparently, whether briefing and/or debriefing of the incidents involving the deceased were rare, the Board of Supervisors response is addressed to the findings as it understands them.

The Board of Supervisors agrees that there is no audio in the autopsy suite. This limitation is due to safety concerns within the autopsy suite. Two-way audio may distract or disturb an autopsy, in addition, sensitive case information and case confidentiality may be jeopardized.

The Board of Supervisors agrees that the autopsy viewing area has limited viewing but viewing the autopsy from the autopsy suite itself is not a viable option due to limited space. Additional people in the autopsy suite could cause safety issues, not only for the employees but also the Grand Jury members.

The Board of Supervisors disagrees that briefing and/or debriefing of the incidents involving the deceased were rare. The Grand Jury is provided with briefings prior to an autopsy and staff is accessible and available to answer any questions after an autopsy.

Based upon the foregoing responses, the Board of Supervisors disagrees that there is "zero transparency to any grand jurors viewing" autopsies.

F3. ***The autopsy suite does not meet all the minimum Center for Disease Control standards for an autopsy facility. The minimum standards prevent contamination of specimens but more importantly provide safety to personnel from airborne pathogens, viruses, and the like.***

Response: The Board of Supervisors disagrees partially with the finding.

The finding is vague and unclear in that it claims the autopsy suite does not meet all the minimum Center for Disease Control standards for an autopsy facility, it does not specify what standard(s) was not met. In addition, the Center for Disease Control standards provides guidelines, not mandates.

In regard to the safety to personnel from airborne pathogens, viruses, and the like, in 2020 HEPA filters were installed; in 2021 the HVAC system in the autopsy suite was inspected and the entire system was determined to be functioning properly per OSHA standards and met the number of required air exchanges per hour using 100% outside air supply. The autopsy suite is cleaned routinely and is in compliance with sanitary level standards. The Board of Supervisors agrees that guidelines can help prevent contamination of specimens and assist to provide safety to personnel from airborne pathogens, viruses, and the like. However, the Board of Supervisors disagrees that the autopsy suite does not meet the guidelines recommended by the Center for Disease Control.

F4. ***Almost all current employees of the Shasta County Coroner's Office are undertrained in medical and forensic protocol. This can create a dangerous/unhealthy environment as well as incorrect or incomplete autopsy results.***

Response: The Shasta County Board of Supervisors disagrees partially with the finding.

The Board of Supervisors disagrees that current employees at the Shasta County Coroner's Office are undertrained in medical and forensic protocol. All current employees are properly trained and receive on the job training for medical and forensic protocol with senior Deputy Coroner Investigators, Forensic Pathologists, or Pathologists.

Qualified, licensed, and trained Forensic Pathologists or Pathologists complete all autopsies within the Coroner's Office. Currently, the County contracts the services of a Pathologist with outside experienced vendors.

Shasta County Deputy Coroner Investigators do not determine autopsy results or findings. Autopsy results are the sole responsibility of the Pathologist conducting the autopsy.

The Board of Supervisors agrees that staff undertrained in any field of work can create a dangerous/unhealthy environment but disagrees that current employees at the Shasta County Coroner's Office are undertrained in medical and forensic protocol. Again, all staff receive the required State mandated training.

F5. ***The Shasta County Sheriff's Office does not encourage or provide available training for Coroner's Office personnel. This results in undertrained staff who are limited by the knowledge they are provided and unable to move forward in their professional growth.***

Response: The Board of Supervisors disagrees wholly with the finding.

The Board of Supervisors disagrees that Shasta County Sheriff's Office does not encourage or provide training for Coroner's Office personnel. Deputy Coroner Investigators are required to attend and successfully complete multiple training courses within one year of hire. Currently, all Deputy Investigators have met this requirement.

The Board of Supervisors disagrees that Coroner's Office personnel is undertrained and are limited by the knowledge they are provided. Coroner's Office personnel are not undertrained. However, advanced training opportunities were cancelled due to Covid Restrictions compounded with low staffing levels. Advanced training courses have resumed and participation will be subject to staffing levels and availability.

The Board of Supervisors disagrees that Coroner Office personnel are not able to move forward in their professional growth, advanced training opportunities are scheduled for 2022. Additionally, in October 2021, the Board of Supervisors approved adding a I/II/III series to the Deputy Coroner Investigator classification to promote growth opportunities.

F6. ***There is currently no chance for advancement within the Coroner's Office for any assigned Coroner's Office personnel. There is only one DCI level and no Captain position. This has led to a higher than average (with respect to the County) turnover of over 50 percent since July 2020.***

Response: The Board of Supervisors disagrees partially with the finding.

The Board of Supervisors disagrees that there is no chance for advancement within the Coroner's office and disagrees that there is only one DCI level. As presented to this Board on October 19, 2021, the classification of DCI was deleted and the classification of DCI I/II/III was added providing advancement opportunity to the Coroner's office.

The Board of Supervisors agrees that there is not a Captain position in the Coroner's office. It is the Board of Supervisors' understanding that the Sheriff believes there

is not a need for one at this time. The Coroner's office has a total of eight allocated positions which include a Lieutenant position. The Coroner's office is currently managed by a Lieutenant/Chief Deputy Coroner.

The Board of Supervisors disagrees that advancement, job classification or lack of a Captain position in the Coroner's office has led to a "higher than average turnover". There are certainly other factors that play an important role in whether employment with a particular entity is attractive or whether an employee will choose to remain with a particular entity. Furthermore, as of July 2021, the Coroner's office had two vacant positions, one DCI position and one Forensic Pathologist position. As of today, the two aforementioned positions remain vacant and the DCI III position that was added in October 2021 is vacant pending appointment.

F7. ***The Coroner's Office has no biohazard plan, which leads to an unsafe working environment.***

Response: The finding is merely a vague statement of what the Grand Jury found with no further detail or specific information regarding what the Grand Jury means by the use of the phrase "biohazard plan" and, as result, the Board of Supervisors wholly disagrees with the finding. The Shasta County Coroner's Office follows the protocols consistent with industry standards and maintains a safe working environment.

F8. ***The existing cold storage facility accommodates up to 20 gurneys. When the number of cadavers exceeds this number (and has been as high as 30), the cadavers (in body bags) are stored two to a gurney.***

Response: The Board of Supervisors disagrees wholly with the finding.

The cold storage facility in the Coroner's Office can accommodate six gurneys which is what is available and used. In addition, the cold storage facility has eight stainless steel rolling tables which can temporarily accommodate two decedents (in body bags) should the decedents exceed the number of gurneys and tables available. Maximum capacity of decedents in the cold storage facility at the Coroner's Office is twenty-two. Should the Coroner's Office reach maximum capacity, local mortuaries allow storage of decedents, at their facilities until room becomes available at the Coroner's Office.

RECOMMENDATIONS

The Grand Jury recommends:

R2. ***The Grand Jury recommends that the Sheriff's Office determine the feasibility of expanding the classification of the Deputy Coroner Investigator into multiple levels (dependent on completed levels of forensic and related training) and present a plan for implementation to the Board of Supervisors no later than December 31, 2022.***

Response: The recommendation has been implemented.

On October 19, 2021 the Board of Supervisor, by unanimous vote, added a I/II/III series to the Deputy Coroner Investigator classification. The County of Shasta continuously evaluates positions, classifications and feasibility of changes.

R3. ***This Grand Jury recommends the Board of Supervisors place on its agenda by March 31, 2022 to discuss utilizing the CARES ACT monies granted to the county in 2022 to up-grade and modernize the Coroner's Office Autopsy Suite to meet industry standards specified in this report.***

Response: The recommendation will not be implemented because it is not warranted and is not reasonable.

CARES ACT monies were received by the County in 2020 and had to be expended no later than December 30, 2021. Currently, there is no CARES ACT funding available for the recommended action. In addition, the County is unaware of additional CARES ACT funding available or anticipated for 2022. Finally, even if CARES ACT funding became available, it is likely that, upgrading and modernizing the Coroner's Office Autopsy Suite would not be a qualifying expense if the same rules regarding use of CARES ACT funding if such funding were once again available.

This concludes the responses of the Shasta County Board of Supervisors to the Fiscal Year 2020-2021 Grand Jury Report entitled "Dead Men Tell No Tales" Shasta County Coroner's Office Report.

Sincerely,

Mary Bickert
for Leonard Moty, Chairman
Board of Supervisors
County of Shasta

THIS INSTRUMENT IS
A CORRECT COPY OF THE ORIGINAL
ON FILE IN THIS OFFICE

ATTEST FEB 15 2022

CLERK OF THE BOARD
Supervisors of the County of Shasta, State of California
By:

Superior Court of California
County of Shasta

MONIQUE D. McKEE
Presiding Judge

ADAM B. RYAN
Asst. Presiding Judge

January 31, 2022

Michael L. Johnson, Sheriff-Coroner
Shasta County Sheriff
300 Park Marina Circle
Redding, CA 96001-1679

Re: Grand Jury Report re "Dead Men Tell No Tales"

Dear Sheriff-Coroner Johnson:

This is to acknowledge receipt of your response received on January 31, 2022, to the 2020-2021 Grand Jury report regarding "Dead Men Tell No Tales".

I would like to thank you for your response to the Grand Jury Report. Pursuant to the provisions of Penal Code §933, I shall transmit your response to the Office of the County Clerk to be maintained on file there. An additional copy shall be provided to the Clerk of the Court also to be maintained on file.

Thank you again for your response.

Sincerely,

Monique D. McKee
Presiding Judge

cc: Office of the County Clerk (original response)
Melissa Fowler-Bradley, Clerk of the Court (for Admin file)
Grand Jury

SHASTA COUNTY
SHERIFF

Michael L. Johnson
SHERIFF - CORONER

The Honorable Monique McKee
Presiding Judge, Shasta County Superior Court
1500 Court St.,
Redding, CA 96001

Dear Judge McKee,

Re: Response of Shasta County Sheriff to FY 2020-2021 Grand Jury Report.

The efforts and considerations of the 2020-2021 Grand Jury are appreciated. The men and women of the Shasta County Coroner's Office and the Sheriff-Coroner are grateful for the Grand Jury's work on their report. I would also like to extend my thanks and appreciation to the fiscal year 2020-2021 Grand Jury members for their commitment to serving Shasta County and its citizens.

Findings, Recommendations, and Responses

Shasta County Coroner's Office Grand Jury Report 2020-2021

"Dead Men Tell No Tales"

Findings:

F1. *The Coroner's Office does not have a formal manual of applicable policies and procedures for day-to-day operations. Therefore, it has been found that training is not always current, complete, or consistent.*

Response to F1: The Sheriff-Coroner partially disagrees with this finding. The Shasta County Sheriff's Office is governed by several Government and Health and Safety Codes. The Coroner's Office has, however, been working on a procedures manual to assist employees. Unfortunately, due to low staffing levels, the manual has not been finalized. When staffing levels are restored, this manual can again be focused on and completed. Training is, in fact, current within the Coroner's Office. All current Deputy Coroner Investigators have attended the required 80-hour POST certified death investigation course along with a 40-hour PC 832 Arrest and Control course. Further advanced trainings have been scheduled and will continue to be scheduled as courses become available and staffing levels allow.

F2. *The autopsy viewing area has no audio, limits viewing from the autopsy suite, and during this grand jury term briefing and/or debriefing of the incidents involving deceased were rare. This resulted in zero transparency to any grand jurors viewing the autopsy.*

Response to F2: The Sheriff-Coroner partially disagrees with this finding. There is no audio available for the Grand Jury in the viewing room. This limitation is due to safety concerns within the autopsy suite if there was two-way audio. Distractions from unexpected audio communication can lead to injuries to personnel from instruments they use within the autopsy suite. Personnel inside the autopsy suite regularly handle sharp instruments and also handle fragile samples and evidence. Also, sensitive case information and case confidentiality may be jeopardized. Certain confidential details of the investigation are sometimes discussed within the autopsy suite, and if that information were to be released, it could jeopardize the outcome of the investigation and future prosecution. Viewing an autopsy from the autopsy suite itself is not a viable option due to limited space within the autopsy suite and the number of employees already in the suite during autopsy. Adding more people to the autopsy suite can cause safety issues, not only for the employees but also the Grand Jury members. However, the Coroner's Office provides briefings to the Grand Jury members prior to autopsies along with providing them with the Grand Jury Critical Incident Report Form upon notification to attend the autopsies. Members of the Coroner's Office are regularly available to answer questions the Grand Jury may have. We disagree that there was zero transparency during these critical incident autopsies based on the above information.

F3. *The autopsy suite does not meet all the minimum Center for Disease Control standards for an autopsy facility. The minimum standards prevent contamination of specimens but more importantly provide safety to personnel from airborne pathogens, viruses, and the like.*

Response to F3: The Sheriff-Coroner partially disagrees with this finding. The CDC provides guidelines for autopsy suites during certain types of autopsy. These are guidelines only, not mandates. During 2021 the Coroner's Office had the HVAC system inspected inside the autopsy suite. The entire system was determined to be functioning properly per CalOSHA standards and met the number of required air exchanges per hour using 100% outside air supply. The air inside the autopsy suite is exhausted out of the roof of the building via powered exhaust fans. HEPA filters were also installed during 2020. The autopsy suite is cleaned after autopsies, after intake of decedents if needed, and after release of decedents if needed to meet sanitary level standards.

F4. *Almost all current employees of the Shasta County Coroner's Office are undertrained in medical and forensic protocol. This can create a dangerous/unhealthy environment as well as incorrect or incomplete autopsy results.*

Response to F4: The Sheriff-Coroner wholly disagrees with this finding. Employees at the Coroner's Office have been subject to a department specific "Communicable Diseases" policy, in addition to the County of Shasta's "Airborne Transmissible Disease Prevention Program". Employees also receive annual training regarding Bloodborne Pathogens, Aerosol Transmissible Diseases, and Hazard Communication. Furthermore, employees receive on the job training for medical and forensic protocol with senior Deputy Coroner Investigators, Forensic Pathologists, or Pathologists. Trained and experienced Forensic Pathologists or Pathologists complete all autopsies within the Coroner's Office. Deputy Coroner Investigators do not determine autopsy results or findings. Autopsy results are the responsibility of the Pathologist conducting the autopsy.

F5. *The Shasta County Sheriff's Office does not encourage or provide available training for Coroner's Office personnel. This results in undertrained staff who are limited by the knowledge they are provided and unable to move forward in their professional growth.*

Response to F5: The Sheriff-Coroner wholly disagrees with this finding. All Deputy Coroner Investigators are required to attend an 80-hour Peace Officer Standards and Training (POST) certified death investigation course along with a 40-hour Penal Code 832 Arrest and Control course within one year of their hire date to meet POST requirements. All Deputy Coroner Investigators are current on these requirements. Due to staffing levels and Covid restrictions, further advanced trainings were cancelled or put on hold during the 2020-2021 Covid-19 pandemic. Currently, those trainings have resumed, and Deputy Coroner Investigators will continue to attend trainings as they become available. The attendance of these trainings will depend on staffing levels at the Coroner's Office and availability of the trainings. The Shasta County Coroner's Office will continue to schedule advanced trainings and conferences for employees in order to promote career advancement and development. Advanced trainings have already been scheduled, for Deputy Coroner Investigators, during 2022.

F6. *There is currently no chance for advancement within the Coroner's Office for any assigned Coroner's Office personnel. There is only one DCI level and no Captain position. This has led to a higher than average (with respect to the County) turnover of over 50 percent since July 2020.*

Response to F6: The Sheriff-Coroner partially disagrees with this finding. The Coroner's Office is currently managed by a Lieutenant/Chief Deputy Coroner. The Coroner's Office is a relatively small unit with eight total allocated positions, which includes the Lieutenant and Pathologist. Again, based on the size of the office and current overall structure of the organization, a Captain position is not needed at this time. There are now three separate classifications for Deputy Coroner Investigators: Deputy Coroner Investigator I, Deputy Coroner Investigator II, and Deputy Coroner Investigator III. The Coroner's Office was recently approved for a fifth Deputy Coroner Investigator position, with the plan to fill the fifth position with the Deputy Coroner Investigator III classification.

F7. *The Coroner's Office has no biohazard plan, which leads to an unsafe working environment.*

Response to F7: With no further detail or more specific information regarding a "biohazard plan," the Sheriff-Coroner wholly disagrees with this finding. Employees at the Coroner's Office follow protocol from training and industry standards for biohazards. This protocol includes the proper use of personal protective equipment, proper handling of specimens and sharps, and proper disposal of waste. The Coroner's Office contracts with a biohazard company for pickup and disposal of biohazard materials.

F8. *The existing cold storage facility accommodates up to 20 gurneys. When the number of cadavers exceeds this number (and has been as high as 30), the cadavers (in body bags) are stored two to a gurney.*

Response to F8: The Sheriff-Coroner wholly disagrees with this finding. The cold storage facility in the Coroner's Office can accommodate 8 stainless steel rolling tables and 6 gurneys which is what is available and used. If decedents exceed the number of tables and gurneys available, the decedents (in body bags) can be temporarily stored two to a table but only 1 on a gurney. Maximum capacity of decedents in the cold storage at the Coroner's Office is 22. If the Coroner's Office reaches maximum capacity, local mortuaries allow storage of decedents, at their facilities, until room becomes available at the Coroner's Office.

Recommendations:

R1. *This Grand Jury recommends that the Sheriff's Office develop written day-to-day procedures for the Coroner's Office to include office, morgue and field work that meet industry standards, such as those outlined in the California Death Investigations template, by June 20, 2022.*

Response to R1: The recommendation will not be implemented as it is not warranted or is not reasonable. As similarly outlined in the earlier response to F1, The Shasta County Sheriff's Office is governed by several Government and Health and Safety Codes. These codes are what guide and direct employees. The Coroner's Office has, however, been working on a procedures manual to assist employees above and beyond the Government Codes and Health and Safety Codes. Unfortunately, due to staffing levels, the manual has not been finalized. When staffing levels are restored, this manual can again be focused on to complete.

R2. *This Grand Jury recommends that the Sheriff's Office determine the feasibility of expanding the classifications of the Deputy Coroner Investigator into multiple levels (dependent on completed training levels of forensic and related training) and present a plan for implementation to the Board of Supervisors no later than December 31, 2022.*

Response to R2: The recommendation has been implemented. There are now three separate classifications for Deputy Coroner Investigators: Deputy Coroner Investigator I, Deputy Coroner Investigator II, and Deputy Coroner Investigator III. The Coroner's Office was recently approved for a fifth Deputy Coroner Investigator position which will be filled with the Deputy Coroner Investigator III classification. Applications for this position have been received and are being reviewed.

R3. *This Grand Jury recommends the Board of Supervisors place on its agenda by March 31, 2022, to discuss utilizing the CARES ACT monies granted to the county in 2022 to upgrade and modernize the Coroner's Office Autopsy Suite to meet industry standards specified in this report.*

Response to R3: The recommendation will not be implemented because it is not warranted or is not reasonable. The Sheriff-Coroner does not dictate the Board of Supervisors agenda.

R4. *This Grand Jury recommends the Sheriff's Office immediately restore the audio and the camera control to the remote autopsy viewing area in the Coroner's Office.*

Response to R4: The recommendation will not be implemented because it is not warranted or is not reasonable. As referenced in F2, due to safety concerns within the autopsy suite, sensitive case information, and case confidentiality, full two-way audio communication, during the duration of the autopsy will not be implemented. Camera control will not be implemented either, as the investigators have control of the camera for investigation purposes.

R5. *This Grand Jury recommends the Sheriff's Office develop a written procedure by June 30, 2022, that includes the Grand Jury requirements to increase transparency, such as:*

- *A written report or a verbal briefing to the grand jury of the events leading up to the death, from a DCI, prior to autopsy.*
- *Access by the grand jury to the controls that operate the camera in the autopsy suite.*
- *Access by the grand jury to an audio feed from the autopsy suite.*
- *Access by the grand jury to the pathologist for follow-up questions after the autopsy.*

Response to R5: The recommendation will not be implemented because it is not warranted or is not reasonable. Bullet point two is addressed in R4 and bullet point three is addressed in F2. As for bullet point four, the pathologist will not give findings to the Grand Jury due to case sensitivity and confidentiality. The findings will be provided in the pathologist's final written report. Any follow up questions by the Grand Jury can be directed to the Deputy Coroner Investigator and may be answered on a case-by-case basis to ensure confidentiality of the investigation. However, bullet point one, is already implemented and conducted prior to autopsy.

R6. *This Grand Jury recommends the Sheriff's Office develop a written plan by June 30, 2022, that provides all DCIs with opportunities for additional forensic and job-related training, necessary for continuing professional education, at no personal cost.*

Response to R6: The recommendation will not be implemented because it is not warranted or is not reasonable. A written plan is not needed. All Deputy Coroner Investigators are required to attend an 80-hour POST certified death investigation course along with a 40-hour PC 832 Arrest and Control course within one year of their hire date. Due to staffing levels and Covid restrictions, further advanced trainings were cancelled or put on hold during the Covid-19 pandemic. Some trainings have resumed, and Deputy Coroner Investigators will continue to attend trainings as they become available. The attendance of these trainings will depend on appropriate staffing levels at the Coroner's Office. The Shasta County Coroner's Office will continue to schedule trainings/seminars for employees to promote career advancement and development.

Additional Remarks:

The Shasta County Sheriff's Office appreciates and respects the Grand Jury process. Critical review, constructive criticism, and suggestions for improvement, via Grand Jury and/or other means, will always be received without bias and evaluated for implementation with the goal of improving service, efficiency, and professionalism within the organization.

I was appointed to the Office of the Sheriff-Coroner in August 2021. I immediately conducted assessments throughout all divisions of the Sheriff's Office to include the Coroner's Office. This assessment revealed the priority to find methods to address staffing shortages within the office. Most significantly, among those concerns, was not only the staffing shortages but the excessive workload of the personnel currently occupying the positions because of these shortages. Staffing shortages and the dynamics created by the COVID 19 pandemic, combined with an increasingly growing case load, are at the core of the problem. Staff is overworked and overwhelmed. The three active Deputy Coroner Investigators rotate on call duties, responding to cases at all hours of the night, and rarely get their scheduled time off. Investigators are down a significant amount of case reports. The Sheriff's Office has routinely conducted recruiting efforts, to fill vacant positions, but locating qualified candidates has been challenging. We are currently at the mercy of

two contracted pathologists that respond from out of the area on an "as-needed" basis, which often delays the processes. Additional, ongoing recruiting efforts to fill the permanent pathologist position has too been unsuccessful. The Coroner's Office Administrative Secretary is overwhelmed with phone calls, generated paperwork, and clerical duties impacted from staffing shortages.

It is frustrating to read the "findings" and "recommendations" from the Grand Jury. The information contained within the Grand Jury report inspires skepticism about their investigative abilities. While I appreciate some of the objective findings and recommendations, others seem biased and the product of disgruntled past employee interviews without further exploration into the matter. Missing is the fair assessment of comparative Coroner's Offices within the State. Also absent is the factual information in reference to mandated compliance issues, opposed to the opinion-based findings listed in the report.

In my short time with the Sheriff's Office, I have learned one single most significant factor that is also missing from this report: the men and women of the Shasta County Sheriff's Office, in all divisions and aspects of this organization, serve this community with absolute dedication, commitment, and integrity. As noted above, we are open to constructive criticism and will continue to implement change for the betterment of the citizens we serve.

Michael L. Johnson
Sheriff - Coroner