RECOMMENDED ACTION AND JUSTIFICATION: (Policy Item: Yes__ No__)

Authorize Chair to sign an Order of the Board to reject Claim No. C02-9 for an undisclosed amount. Claimant alleges that he sustained personal injury as a result of an employee of Mariposa County falling a tree on him without proper warning. Counsel is requesting denial of this claim based on information received from the California Youth Authority (CYA) that all medical costs associated with an injury to a ward of the CYA while the ward is out on a work crew with the California Department of Forestry is covered by the CYA, as was done in this matter.

BACKGROUND AND HISTORY OF BOARD ACTIONS:

The Board usually follows Counsel’s recommendation in matters of this nature.

LIST ALTERNATIVES AND CONSEQUENCES OF NEGATIVE ACTION:

➢ Reject claim as recommended.
➢ Take no action; claim will automatically be denied if no action is taken.

COSTS: (x) Not Applicable
A. Budgeted current FY $________
B. Total anticipated costs $________
C. Required additional funding $________
D. Internal transfers $________

SOURCE: ( ) 4/5ths Vote Required
A. Unanticipated revenues $________
B. Reserve for contingencies $________
C. Source description:
D. Balance in Reserve for Contingencies, if approved: $________

SPECIAL INSTRUCTIONS:
List the attachments and number the pages consecutively:

CLERK’S USE ONLY:
Res. No.: 02-308 Ord. No. __________
Vote - Ayes: __________ Noes: __________
Absent: __________ Abstained: __________
Approved ( ) Denied ( )
() Minute Order Attached ( ) No Action Necessary

The foregoing instrument is a correct copy of the original on file in this office.

Date: __________

ATTEST: MARGIE WILLIAMS, Clerk of the Board
County of Mariposa, State of California
By: __________
Deputy

ADMINISTRATIVE OFFICER’S RECOMMENDATION:
This item on agenda as:

Recommended
Not Recommended
For Policy Determination
Submitted with Comment
Returned for Further Action

Comment: __________

A.O. Initials: __________

Action Form Revised 5/92
COUNTY OF MARIPOSA CLAIM FORM

CLAIM OF Donte W. Brown (Claimant)  

CLAIM FOR PERSONAL INJURY AND/OR PROPERTY DAMAGE (Government Code § 910)

v.  

COUNTY OF MARIPOSA  

TO THE BOARD OF SUPERVISORS OF MARIPOSA COUNTY:

YOU ARE HEREBY NOTIFIED that:  

Claimant: Donte W. Brown  
Whose address is: 950 Fillmore St. #A  
City and State: San Francisco, CA Zip: 94117  

claims damages from the COUNTY OF MARIPOSA in the amount, computed as of the date of presentation of this claim, of $Not Computed at this time  

This claim is based on:  

< > Property Damage  
< > Other (LIST)  
<XX> Personal Injury  
< > Contract  

which occurred on January 10th, 2002, in the vicinity of:  

MH Bullion, Mariposa County, CA  

(PLACE WHERE INCIDENT OCCURRED)  

Describe generally the facts and circumstances that give rise to the claim:  

(PLEASE USE BACK OF THIS PAGE IF MORE SPACE IS NEEDED.)  

On January 10th 2002 I was picking up cut tree limbs while under the supervision of Captain Jerry Jay of The California Department of Forestry and Fire Protection and I was a Ward of The California Youth Authority. Andy Jay an employee of Mariposa County cut and dropped a tree on me without proper warning. Jerry Jay was not paying attention while in conversation with others. The name(s) of the public employee(s) causing claimant's injuries or damages under the above-described circumstances is/are: Andy Jay  

(A claim has also been sent to CDF&FP because I believe both Jerry and Andy Jay have liability)
The injuries sustained by claimant, as far as known, as of the date of presentation of this claim consist of: (DESCRIPTION OF CLAIMANT'S INJURIES OR DAMAGES)

Dislocated Hip

Emotional Trauma

Injured knee

The amount claimed, as of the date of presentation of this claim is computed as follows:

**Damages incurred to date:** Not Computed at this time

Expenses for medical and hospital care

Loss of earnings

Specific damages (ITEMIZE)

Other damages (ITEMIZE)

TOTAL DAMAGES INCURRED TO DATE: $____________

Estimated future damages as far as known from this incident:

Total estimated prospective damages: $____________

TOTAL AMOUNT CLAIMED AS OF DATE
OF PRESENTATION OF THIS CLAIM: $____________

All notices or other communications with regard to this claim should be sent to claimant at: Askia Muhammad 1716 Felton St. San Francisco, CA. 94134

(ADDRESS TO WHICH NOTICES ARE TO BE SENT)

Dated: 7/03/02  Signed: Dante' W. Brown

(CLAIMANT/AGENT FOR CLAIMANT)

Government Code § 911.2. Time of or presentation of claims

A claim relating to a cause of action for death or for injury to person or to personal property or growing crops shall be presented as provided in Article 2 (commencing with § 915) of this chapter not later than six months after the accrual of the cause of action. A claim relating to any other cause of action shall be presented as provided in Article 2 (commencing with § 915) of this chapter not later than one year after the accrual of the cause of action.
EMERGENCY DEPARTMENT FOLLOW-UP DISCHARGE INSTRUCTIONS

- SUTURE CARE: Keep wound clean and dry. Change bandage after 48 hours. Then daily or immediately if area becomes wet. Use no ointments or creams on wound unless prescribed. Return or see own M.D. if redness, swelling, pus, tenderness or red line appears. Suture removal as indicated below.

- SPRAIN CARE: First 24 hours elevate injured area above heart level with towel between ice and sprain. Rest injured part. No weight bearing till pain free. Heat or warm soaks four times daily, 20 minutes each time to area. Begin after swelling has diminished. If pain continues more than 72 hours see own M.D.

- GASTROINTESTINAL UPSET: Drink clear fluids, jello water, juice or flat soda as tolerated. Increase diet slowly (toast/bananas/crackers/boiled chicken/clear broth). No dairy products, greasy fried or fatty foods. If diarrhea is present use Koolaid or one tablespoon sugar in a glass of water, as basic drink.

- TETANUS PROPHYLAXIS - SWELLING, FEVER, REDNESS MAY OCCUR AT INJECTION SITE. TYLENOL/WARM SOAKS FOR 48 HOURS WILL HELP ALLEVIATE THIS PROBLEM.

- BACK CARE: Most pain results from muscle spasm. Heat will help relieve discomfort. Hot bath 2 times daily. Local heating 2 times daily 20 minutes each session. Firm sleeping surface. Pillow under knees may help ease discomfort. No lifting or bending. If discomfort continues follow-up with own M.D. or an orthopedist. Sleep on back or side, not stomach.

- TREAT WITH ICE: Never place ice directly on skin because skin injury may occur. A plastic bag or thin cloth may be used or an ice bag. Ice prevents further swelling. Keep ice pack on swollen area 20 minutes/ hour. Ice may be uncomfortable but continue to use it.

- HEAD INJURY: Signs of concussion and possible brain injury usually occur within six hours after injury but can be delayed for days and rarely weeks. Therefore, check the patient frequently every one to two hours over the first 48 hours after injury for the following and call or return if any of these problems develop:

  1. Excessive drowsiness, unable to arouse easily, (many children are naturally worn out after the excitement is over and judgment is needed here).
  2. Dizziness (most head injuries cause a small amount of bleeding).
  3. Excessive vomiting, (a few episodes may be expected without much cause for alarm, especially in children).
  4. Bleeding from the nose and ears.
  5. Convulsions, (fits).
  6. Drainage of fluid from the nose or ears.
  7. Paralysis or marked weakness of limbs or face muscles.
  8. Severe or increasingly severe headaches, (most head injuries cause headaches mild to moderate in degree).
  9. Unusual irritability, confusion or other definite change in behavior or personality.
  10. Change in ability to see or hear, including double vision.
  11. Difference in size of pupils. (One pupil larger while other is small).
  12. Unsteady walking.

- ANTIBIOTICS - ANTIBIOTICS USUALLY TAKE 24-48 HOURS TO WORK. CONTACT YOUR DOCTOR OR RETURN IF NO RESPONSE AFTER 48 HOURS OR IF CONDITION WORSENS BEFORE 48 HOURS.

- CHILD SAFETY SEATS - PHAMPELT GIVEN TO PARENTS WITH SMALL CHILDREN LESS THAN 40 POUNDS, UNDER 4 YEARS OLD.

- HOME HEALTH REFERRAL NEEDED - PLEASE PROVIDE SPECIFIC INFORMATION BELOW.

- X-RAYS - YOUR X-RAYS HAVE HAD A PRELIMINARY READING AND WILL BE SUBJECT TO FINAL REVIEW BY THE RADIOLOGIST. IT IS IMPORTANT THAT YOU CONTACT YOUR DOCTOR OR JOHN C. FREMONT DISTRICT HOSPITAL EMERGENCY DEPARTMENT THE FOLLOWING DAY FOR THE FINAL INTERPRETATION. THERE MAY BE A FRACTURE THAT WAS UNDETECTABLE AT THE TIME OF X-RAY. IF SYMPTOMS PERSIST SEE YOUR PRIVATE PHYSICIAN OR RETURN TO THE EMERGENCY ROOM FOR REPEAT X-RAY.

Contact phone number:

If any of the above symptoms or signs appear at any time, return to the hospital immediately or consult your family physician.

SPECIFIC INFORMATION

- PATIENT CAN RETURN TO WORK/SCHOOL ON ________________
- LIMITED DAILY ________________ DAYS
- NORMAL WORK

You dislocated your right hip today, and we sedated you and pulled your leg until it fell back in place. You should avoid weight bearing with your right hip bent beyond 35 degrees. Your hip will hurt today and should get better fairly quickly. It will be liable to dislocate again for at least a few months. You will be able to advance activity rather quickly (not this weekend) in Please call Dr. Rose 966 3672 for recheck appointment tomorrow.
RETURN FOR ANY EMERGENCY. Use crutches to prevent painful weight bearing. You may bear weight on your right leg so long as you keep your leg straight. You may bend your hip as comfortable as long as you do not bear weight.

I ACKNOWLEDGE RECEIPT OF COPY

[Signature of Patient or Responsible Party]

DATE 1/10/02
NURSE

DATE 1/10/02
DOCTOR
Within 5 days of your initial examination, for every occupational injury or illness, send this report to insurer or employer (only if self-insured). Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning send one copy of this report directly to the Division of Labor Statistics and Research, P.O. Box 603, San Francisco CA 94101; and notify your local health officer by telephone within 24 hours and by sending a copy of this report within seven days. For a supply of this form, please call (415) 557-1924.

1. **INSURER NAME AND ADDRESS**

2. **EMPLOYER NAME**

3. **Address:**

4. **Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes)**

5. **PATIENT NAME (First name, middle initial, last name)**

6. **Sex**
   - [ ] Male
   - [ ] Female

7. **Date of Birth**

8. **Address:**

9. **Telephone number**

10. **Occupation (Specific job title)**

11. **Social Security Number**

12. **Injured at:**

13. **Date and hour of injury**
   - Mo. Day Yr. a.m. p.m.

14. **Date last worked**
   - Mo. Day Yr.

15. **Date and hour of first examination or treatment**
   - Mo. Day Yr. a.m. p.m.

16. **Have you (or your office) previously treated patient?**
   - [ ] Yes
   - [ ] No

**Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.**

17. **DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED (Give specific object, machinery or chemical. Use reverse side if more space is required.)**

18. **SUBJECTIVE COMPLAINTS**

19. **OBJECTIVE FINDINGS (Use reverse side if more space is required.)

   A. Physical examination
     - Deformity
     - Injury

   B. X-ray and laboratory results (State if none or pending.)

20. **DIAGNOSIS (If occupational illness, specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved?**
   - [ ] Yes
   - [ ] No

21. **Are your findings and diagnosis consistent with patient's account of injury or onset of illness?**
   - [ ] Yes
   - [ ] No

22. **Is there any other current condition that will impede or delay patient's recovery?**
   - [ ] Yes
   - [ ] No

23. **TREATMENT RENDERED (Use reverse side if more space is required.)**

   - [ ] Regular work
   - [ ] Modified work

24. **If hospitalized as inpatient, give hospital name and location.**

25. **WORK STATUS**

   - Is patient able to perform usual work?**
     - [ ] Yes
     - [ ] No

   If "no", patient can return to:

   - [ ] Regular work
   - [ ] Modified work

   Specify restrictions

---

**Doctor's Signature**

**Doctor Name and Degree (Please Type)**

**Address**

**Date**

**CA License Number**

**IRS Number**

**Telephone Number**

---

**Incomplete information or delay in submitting this report (Rev. 3)**

1989
JEFFREY G. GREEN
County Counsel
P. O. Box 189
5100 Bullion Street
Mariposa, CA 95338

BEFORE THE BOARD OF SUPERVISORS

OF

MARIPOSA COUNTY, STATE OF CALIFORNIA

In the Matter of: CLAIM NO. 02-9

CLAIM FOR DAMAGES PURSUANT TO GOVERNMENT CODE § 911.6

ASKIA MUHAMMAD, representing Donte W. Brown, San Francisco California, having filed with this Board on July 8, 2002, a claim for damages in an undisclosed amount.

NOW, THEREFORE, IT IS ORDERED by the Board of Supervisors that the claim is hereby rejected.

The foregoing order was passed by the following vote of the Board:

AYES: Parker, Reilly, Stewart, Balmain
NOES: None
ABSENT: Pickard
ABSTAINED: None

Dated this 6th day of August, 2002.

ROBERT C. STEWART, Chair
Board of Supervisors

ATTEST:

MARGIE WILLIAMS, Clerk of the Board
TO: Askia Muhammad  
1716 Felton Street  
San Francisco, CA 94134  

RE: CLAIM FOR DAMAGES (Donte W. Brown Claim No. C02-9)  
AMOUNT OF CLAIM: undisclosed  
NOTICE OF REJECTION  

NOTICE IS HEREBY GIVEN that the claim, which you presented to the Board of Supervisors of Mariposa County on July 8, 2002 was rejected by action of the Board on August 6, 2002.  

WARNING  

"Subject to certain exceptions, you have only six (6) months from the date this notice was personally delivered or deposited in the mail to file a court action on this claim." (See Government Code § 945.6)  

"NOTE: This six-month filing period applies only to State Court actions. If your action is based on federal law and/or you intend to file it in Federal Court, a shorter or longer period within which to file the action may apply."  

"You may seek the advice of an attorney of your choice in connection with this matter. If you desire to consult an attorney, you should do so immediately."  

JEFFREY G. GREEN  
Mariposa County Counsel  

PROOF OF SERVICE BY MAIL (1013a, 2015.5 C.C.P.)  

STATE OF CALIFORNIA, COUNTY OF MARIPOSA:  

I am a citizen of the United States and a resident of the County aforesaid. I am over the age of eighteen years and not a party to the within entitled action; my business address is 5100 Bullion Street (P.O. Box 189), Mariposa, CA 95338. On August 9, 2002, I served the within Notice of Rejection of Claim on the claimant in said action by placing a true copy in a postage paid envelope addressed to the person(s) hereinafter listed, by depositing said envelope in the U.S. Mail, or by placing a copy into an inter-office delivery receptacle located in Counsel’s office:  

Askia Muhammad  
1716 Felton Street  
San Francisco, CA 94134  

I declare, under penalty of perjury, that the foregoing is true and correct. Executed on August 9, 2002 at Mariposa, California.  

Rhonda Schertf