



OFFICE OF THE
COUNTY COUNSEL

COUNTY OF SANTA CRUZ

GOVERNMENT CENTER
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GOVERNMENT TORT CLAIM

RECOMMENDED ACTION

ASSISTANTS

Agenda March 23, 1999

To: The Board of Supervisors

Re: Claim of Matthew James Taylor, No. 899-092

Original Document and associated materials are on file at the Clerk to the Board of Supervisors.

In regard to the above-referenced claim, this is to recommend that the Board take the following action:

X 1. Deny the claim of Matthew James Taylor, No. 899-092 and refer to County Counsel.

Deny 2 the application to file a late claim on behalf of _____ and refer to County Counsel.

_____ 3. Grant the application to file a late claim on behalf of _____ and refer to County Counsel.

4. Approve the claim of _____ in the amount of _____ and reject it as to the balance, if any, and refer to County Counsel.

5. Reject the claim of _____ as insufficiently filed and refer to County Counsel.

cc: Mark Tracy, Sheriff-Coroner

RISK MANAGEMENT

By Janet McKinley

COUNTY COUNSEL

By Ellen Lewis

LTR9.WPT

CLAIM AGAINST THE COUNTY OF SANTA CRUZ
(Pursuant to Section 910 et Seq., Govt. Code)

899-098

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TO: BOARD OF SUPERVISORS
COUNTY OF SANTA CRUZ
ATTN: Clerk of the Board
Governmental Center
701 Ocean Street, Santa Cruz, CA 95060

1. Claimant's Name: MATTHEW JAMES TAYLOR

Address: 935 Crook Dr.

Boulder Creek, Ca 95006

Phone No: 831 338-1390

P.O. Box to which notices are to be sent: _____

2. Occurrence: Arrest

Date: 12/23/98 Place: my home

Circumstances of occurrence or transaction giving rise to claim: Brutality during my arrest. Handcuffed extremely tightly & shovelled in a space I could not fit for at least 1 hour. Thoracic ribs torn - Shoulder injury.

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PERSONNEL DEPT - 1
99 FEB 17 AM 11:38

4. General description of indebtedness, obligation, injury, damage or loss incurred so far as is now known:

\$1000 Medical / loss wages \$200
Told to file complaint by my doctor, X-rays taken
& treatment for torn thoracic muscles in neck & shoulder.

5. Name(s) of public employee(s) causing injury, damage or loss, if known: Sheriff's Deputy officer Coyne ID # 66

6. Amount claimed now: \$ 1200

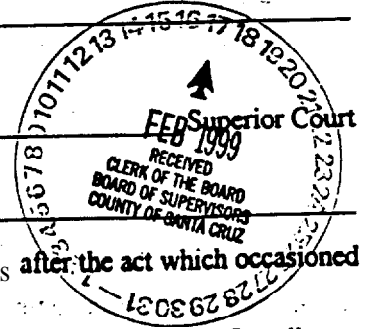
Estimated amount of future loss, if known: 300

TOTAL \$ 1500

7. Basis for above computations: Medical Bills, time off work for Doctor pain & suffering

8. If the amount claimed is over \$10,000, indicate the court of jurisdiction: _____
Municipal Court

CLAIMANT'S SIGNATURE: [Signature]



Note: Claim must be presented to Clerk, Board of Supervisors, within six (6) months after the act which occasioned the injury.

Americans with Disabilities Act questions or requests for accommodations may be directed to the ADA Coordinator at 454-2962 (TDD 454-2123).