

CITY OF SEBASTOPOL
CITY COUNCIL
AGENDA ITEM STAFF REPORT

Meeting Date: July 17, 2018
To: Honorable City Councilmembers
From: City Administration
Subject: Approval of Rejection of Claim Submitted for Money or Damages Against the City of Sebastopol Filed by Law Office of Peter Harris on Behalf of Clyde Cochran
Recommendation : That the City Council Approve the Rejection of the Claim Filed and Forward to Redwood Empire Municipal Insurance Fund (REMIF) for Processing
Funding: Currently Budgeted: _____ Yes _____ No XX N/A

INTRODUCTION: This item is to request that the City Council approve the Rejection of the Claim Filed and Forward to Redwood Empire Municipal Insurance Fund (REMIF) for Processing.

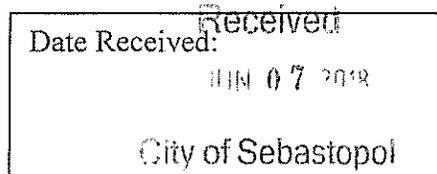
BACKGROUND:
A claim was filed against the City of Sebastopol on June 7, 2018, for claim for money or damages against the City of Sebastopol. The claim was filed by Law Office of Peter Harris on Behalf of Clyde Cochran. A copy of the claim is attached for the City Council's information.

DISCUSSION:
City staff and REMIF have reviewed the claim submitted and believe the claim is without merit.

RECOMMENDATION:
That the City Council City Council approve the Rejection of the Claim Filed and Forward to Redwood Empire Municipal Insurance Fund (REMIF) for Processing.

Attachment:
Claim - Filed by Law Office of Peter Harris on Behalf of Clyde Cochran

File with:
Office of the City Manager/City Clerk
City of Sebastopol
7120 Bodega Avenue
Sebastopol, CA 95472



**CLAIM FOR MONEY OR
DAMAGES AGAINST THE
CITY OF SEBASTOPOL**

A claim must be presented, as prescribed by the Government Code of the State of California, by the claimant or a person acting on his/her behalf and shall show the following:

If additional space is needed to provide your information, please attach sheets identifying the paragraph(s) being answered.

1. Name and Address of the Claimant:

Name of Claimant: **CLYDE COCHRAN**
Address c/o Law Office of Peter R. Harris Post Office Box 3219, Santa Rosa, CA. 95402

Mailing Address (if different than above): **Law Office of Peter R. Harris P O Box 3219, Santa Rosa, CA. 95472**

Telephone Number: [REDACTED]

Address to which the person presenting the claim desires notices to be sent:

Name of Addressee: **Law Office of Peter R. Harris P O Box 3219 Santa Rosa, CA. 95402**
Mailing Address (if different than above): _____

Telephone Number: [REDACTED]

The date, place and other circumstances of the occurrence or transaction which give rise to the claim asserted.

Date of Occurrence 12/17/2017 Time of Occurrence: Afternoon/Evening
Location: Sebastopol Town Plaza aka Mario Savio Free Speech Town Plaza, 6901 McKinley Street, Sebastopol, California, located across the street from Whole Foods Market.

Circumstances giving rise to this claim:

Mr. Cochran was sitting on a park bench in the town square, when his trouser overlapped a loose screw projecting upward from a bracket intended to secure the bench to the underlying brick surface. The screw had loosened, apparently from lack of maintenance, allowing it to rise and extend upwards from the base of the bench, as a thin metal projection. (Please see attached photograph.) As Mr. Cochran stood up to walk, the cuff of his trousers overlapped the top of the screw, which prevented him from taking a step. He stumbled and fell hitting an adjacent trash bin and the ground, causing injury to his head, arm, elbow, shoulder, wrist, hip and other areas of his body.

4. General Description of the indebtedness, obligation, injury, damage or loss incurred so far as it may be known at the time of the presentation of the claim.

Mr. Cochran has incurred medical expenses and lost wages. He received medical treatment from Palm Drive Hospital, Dr. Bollinger M. D., the Veterans Administration Clinic and possibly other locations. He has been unable to work due to injuries.

5. The name of names of the public employee or employees causing the injury, damage, or loss, if known.
Unknown

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6. a. If the amount claimed totals less than \$10,000: The amount claimed if it totals less than ten thousand dollars (\$10,000) as of the date of the presentation of this claim, including the estimated amount of any prospective injury, damage, or loss, insofar as it may be known at the time of the presentation of the claim, together with the basis of computation of the amount claimed.

Amount Claimed and basis for computation:

b. If the amount claimed exceeds \$10,000: If the amount claimed exceeds ten thousand dollars (\$10,000), no dollar amount shall be included in the claim. However, it shall indicate whether the claim would be a limited civil case. A limited civil case is one where the recovery sought, exclusive of attorney fees, interest and court costs does not exceeds \$25,000. An unlimited civil case is one in which the recovery sought is more than \$25,000. (See CCP § 86)

Limited Civil Case

X

Unlimited Civil Case

You are required to provide the information requested above, plus your signature on page 3 of this form, in order to comply with Government Code §910. In addition, in order to conduct a timely investigation and possible resolution of your claim, the City requests that you answer the following questions.

7. Claimant(s) date(s) of Birth: 9/17/1950

8. Name, address and telephone number of any witness (es) to the occurrence or transaction which give rise to the claim asserted:

[REDACTED]

9. If the claim involves medical treatment for a claimed injury, please provide the name, address and telephone number of any doctors or hospitals providing treatment.

Mr. Cochran received medical treatment from: Palm Drive Hospital, Sebastopol CA; Dr. Bollinger M.D, Sebastopol CA.; the Veterans Administration Clinic, Santa Rosa, CA. and possibly other locations.

If applicable, please attach any medical bills or reports or similar documents supporting your claim.

10. If the claim relates to an automobile accident:

Claimant (s) Auto Insurance Company: _____ Telephone: _____

Address: _____

Insurance Policy Number: _____

Insurance Broker/Agent: _____ Telephone: _____

Address:

Claimant's Vehicle License Number: _____ Vehicle Make/Year: _____

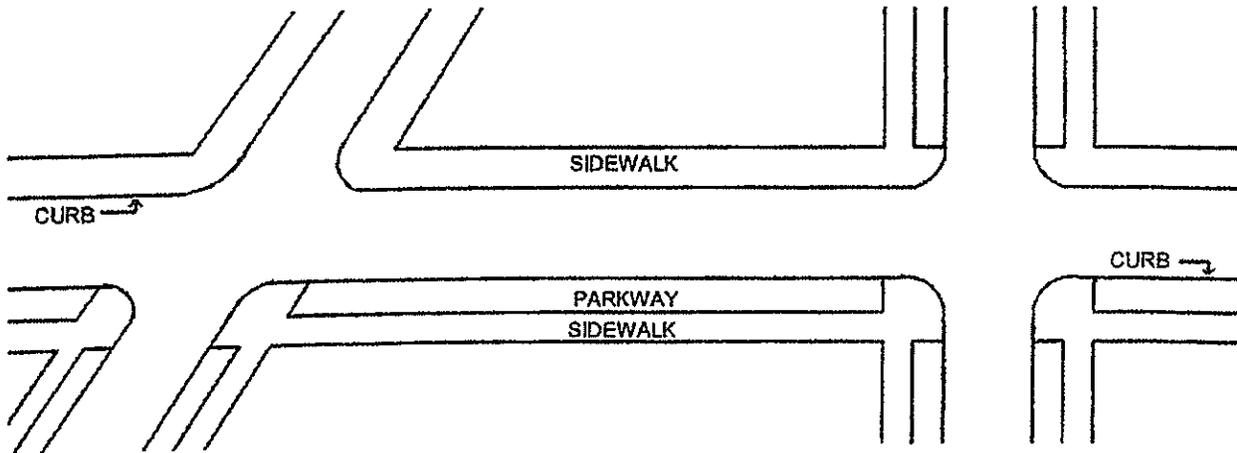
Claimant's Driver License Number: _____ Expiration: _____

If applicable, please attach any repair bills, estimates, or similar documents supporting your claim.

READ CAREFULLY

For all accident claims, place on following diagram name of streets, including North, East, South, and West; indicate place of accident by "X" and by showing house numbers or distances to street corners. IF City/Agency Vehicle was involved, designate by letter "A" location of City/Agency Vehicle when you first saw it, and by "B" location of yourself of your vehicle when you first saw City/Agency Vehicle; location of City/Agency vehicle at time of accident by "A-1" and location of your vehicle at the time of the accident by "B-1" and the point of impact by "x".

NOTE: If diagrams below do not fit the situation, attach hereto a proper diagram signed by claimant.



WARNING: Presentation of a false claim with the intent to defraud is a felony (Penal Code § Pursuant to CCP § 1308, the City/Agency may seek to recover all costs of defense in the event an action is filed which is later determined not to have been brought in good faith, and with reasonable cause.

Signature: *Clyde Cochran*

Date: *6-2-2018*

Printed Name: **Clyde Cochran**

Peter Janni
Attorney at Law