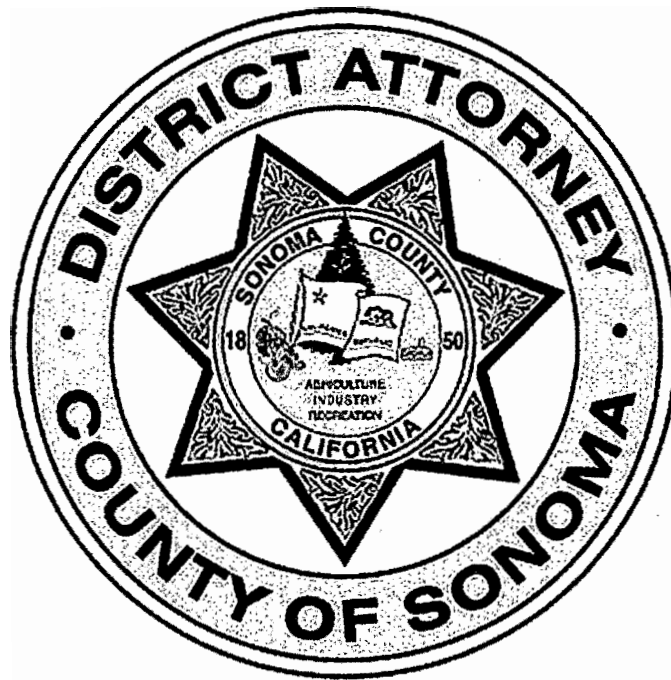


**LAW ENFORCEMENT EMPLOYEE-INVOLVED**  
**CRITICAL INCIDENT REPORT**



Employer Agency: Sonoma County Sheriff's Office Corrections  
Division

Investigating Agency: Sonoma County Sheriff's Office

Injured Subject: Michael Joe Medina

Date of Incident: January 31, 2018

SONOMA COUNTY DISTRICT ATTORNEY

**REPORT TO THE PUBLIC**

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## **I. INTRODUCTION**

On January 31, 2018, Windsor Police Department Deputy G. Bone contacted Michael Joe Medina (32) regarding a citizen complaint that Medina had urinated outside of his car. After being contacted by Deputy Bone, Medina was arrested for being too intoxicated to care for himself (Penal Code section 647(f)) and was transported to the Main Adult Detention Facility ("MADF"). Approximately two and a half hours after being cleared through booking, Medina suffered a medical emergency and died. The cause of death was Sequelae of Acute Volatile Substance Abuse likely from inhalant abuse, with contributing factors of chronic obstructive pulmonary disease, and cardiac hypertrophy.

The Sonoma County Sheriff's Office conducted the investigation of this incident. It was a Sheriff's Office (Corrections) related death solely because Medina died while in custody at MADF. The purpose of this protocol is to set forth procedures and guidelines to be used by Sonoma County law enforcement agencies in the criminal investigation of specifically defined incidents involving law enforcement employees. Accordingly, detectives with the Sonoma County Sheriff's Office assumed responsibility for the investigation of this incident and requested the Marin County Sheriff's Office Coroner to perform the autopsy.

## **II. SCOPE OF REVIEW**

The role of the Sonoma County District Attorney's Office in a law enforcement employee-involved critical incidents is to review the investigation to determine if there exists any criminal liability on the part of the law enforcement employee; to provide assistance to the investigating agency regarding legal issues; to supplement the investigation when necessary; and, when appropriate, prosecute those persons believed to have violated the criminal law.

Once the investigation is complete, the District Attorney is required to complete a thorough review of the investigation and prepare a report summarizing the investigation and documenting her conclusions. A copy of this report is to be submitted to the foreperson of the Sonoma County Grand Jury. The following report has been prepared by the Sonoma County District Attorney. It includes a summary of facts surrounding this incident, as well as specific conclusions. The sole purpose of this investigation and review is to establish the presence or absence of any criminal liability on the part of the involved law enforcement employee(s).

## **III. STANDARD OF REVIEW**

The District Attorney, as the chief law enforcement official of Sonoma County, and as the

person responsible for deciding what cases to prosecute within this jurisdiction, has the responsibility to review and approve the filing of all criminal cases. The discretion to exercise this function and to charge a person with a crime is not without limit.

The standard to be applied by the District Attorney in filing criminal charges is accurately expressed in a publication of the California District Attorneys Association entitled, *Uniform Crime Charging Standards*.<sup>1</sup> It provides:

The prosecutor should consider the probability of conviction by an objective fact-finder hearing the admissible evidence. The admissible evidence should be of such convincing force that it would warrant conviction of the crime charged by a reasonable and objective fact-finder after hearing all the evidence available to the prosecutor at the time of charging and after hearing the most plausible, reasonably foreseeable defense that could be raised under the evidence presented to the prosecutor.

Additional restraint on the charging authority is found in *The California Rules of Professional Conduct, Rule 5-110*, which provides that an attorney in government service (this definition includes prosecutors) shall not institute or cause to be instituted criminal charges when the member knows or should know that the charges are not supported by probable cause.

The standard for charging a crime is high because the burden of proof required at trial is quite high, i.e. proof beyond a reasonable doubt. Proof beyond a reasonable doubt is the highest burden of proof under the law.

#### IV. SUMMARY OF FACTS

The following is a summary of facts intended to assist the reader in understanding this report and conclusion. It is not a substitute for the reports, interviews, and other evidence from which it is derived. It is, however, an accurate composite of what the District Attorney believes are the material facts in this case as presented.

On January 31, 2018 at 9 AM, Deputy G. Bone was dispatched to a call of a man urinating outside his vehicle in the Burger King parking lot at 6351 Hembree Lane, in the town of Windsor. The caller stated Medina had reentered his car with his pants around his knees. When Deputy Bone arrived, Medina was seated in his car and unresponsive, his pants were down, and he had a canister of "Ultra Duster" aerosol compressed air (typically abused as an inhalant) in between his legs.

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<sup>1</sup> California District Attorneys Association, *Uniform Crime Charging Standards* (1996) p. 12.

Deputy Bone woke Medina and had him exit the vehicle, Deputy Bone noted Medina had urinated on himself and had the odor of alcohol on his breath. Medina was under the influence to the point he did not realize his pants were still down, exposing his genitalia. During the contact, Deputy Bone used voice commands to control the situation, and only touched Medina to place him under arrest for violating Penal Code section 647(f) (being intoxicated in public) and to handcuff him. Two more deputies, K. Johnson and R. Dunlap arrived on scene to assist Deputy Bone. Deputy R. Dunlap put Medina in his vehicle and transported him to MADF for booking. Subsequently, Deputy Bone discovered over 12 cans of Dust-Off and multiple small bottles of alcohol in Medina's vehicle. Medina was transported to MADF at 9:38 and arrived at 9:50 AM. All three Deputies were wearing body worn cameras and recorded the incident.

After booking and while waiting to be medically cleared, Medina was offered a shower to wash the urine off. He walked without assistance and showered for approximately 10 minutes, and then dressed himself in jail clothing. Medina then sat in the "Book Wait" area waiting for medical screening.

Approximately 2 hours later, at 12 PM, Medina was screened by a Registered Nurse who took his pulse, measured his oxygen level, and completed the Pre-Acceptance Medical Screening Questions. The interview lasted 11 minutes. The only question with an affirmative answer from Medina was that he required pain medication, Percocet, 10 mg, which he said he takes 8 times per day and has for 5 years. During the interview, the RN stated Medina was not under the influence and was able to respond appropriately to all the pre-booking questions and move about the Book Wait area of the jail without assistance. All his test results were normal. According to the RN interview "[t]here was nothing that I could tell, at that time, that would lead me to believe that this would happen later on." Medina was "[a]lert, oriented" and his pupillary response were non-sluggish during questioning.

At approximately 12:15, another inmate who was in the Book Wait area, began yelling about Medina being down. During her interview, the inmate confirmed she saw Medina suffer the medical emergency and slide down the wall onto the floor. The RN verbally asked his coworkers to call for medical help. The following Correctional Deputies arrived at various stages of the emergency (though Medina was only attended to by medical staff who will be named later): Sgt. J. Alcalá, Deputy M. Chavez, Deputy H. Flint, Detention Specialist M. Castaneda, Deputy M. Mann, Deputy B. Welch, and Deputy C. Cornejo.

Detectives also interviewed another inmate who works as a janitor while she is in custody and was assigned, at the time, to clean the Book Wait area. She was present when Medina suffered the medical emergency. She did not see him fall, but saw him both before and after the medical emergency. According to her, prior to collapsing Medina was acting like he was sick and threw up multiple times in a bathroom in the Book Wait area. She also stated the other inmate had stated Medina was drinking lots of water and was dehydrated. She stated she had cleaned up a large amount of "puke" all over the bathroom in the Book Wait area just prior to Medina's medical emergency. She described the vomit as green in color and looked like stomach fluid.

She cleaned the vomit with rags that were still present on her cleaning cart. The rags were seized and booked. In addition, she stated she had used paper towels to clean up additional vomit, but those paper towels had been discarded and were not located during a search of the trash.

After hearing the inmate yell about the medical emergency, a Physician's Assistant (PA), RN, and Licensed Vocational Nurses (LVN) ran from their respective locations and began life saving measures. They performed hands-on CPR, provided oxygen, assisted Medina in breathing using an "Ambu bag" (a ventilation delivery method in lieu of mouth-to-mouth resuscitation), multiple cycles using an Automated External Defibrillator, and administration of the opioid overdose reversal drug Narcan and epinephrine to try to reverse Medina's loss of consciousness. The medical staff also started an IV in Medina's leg. The RN checked Medina's pupillary response during the medical emergency and found them to be non-responsive. In addition, Medina uttered two agonal breaths, also described as "death gasps." When the RN heard the agonal breathing, he requested an ambulance.

CPR was continued until paramedics arrived at which time they assumed CPR. Medina was taken to Kaiser Permanente where additional life-saving measures were attempted to no avail. Medina was pronounced dead at 13:02 hours.

The responding Sheriff's Deputies guarded the room as a "crime scene" until the Marin County Sheriff's Office Coroner arrived, took possession of the body and transported it to Marin County for an autopsy.

The results of the autopsy list cause of death as Sequelae of Acute Volatile Substance Abuse—essentially a condition which is the consequence of previous disease or injury—in this case caused by inhalant abuse, chronic obstructive pulmonary disease, and cardiac hypertrophy (abnormal enlargement of the heart). Measurable levels of Difluorethane (the primary chemical propellant in Ultra Duster) was found in Medina's blood.

## V. CONCLUSION

All the responding Correctional Deputies, Sergeant, nurses, and Physician's Assistants who attempted to revive Medina did so with all due care and expediency based on the emergent nature of his condition. His pulse and oxygen levels were checked upon intake, he was ambulatory, did not appear to be under the influence, and was able to both shower and eat under his own power. There was no sign that Medina would subsequently suffer a medical emergency.

As the death of Medina was not due to any use of force by law enforcement and was due to Sequelae of Acute Volatile Substance Abuse with secondary factors of chronic obstructive pulmonary disease and cardiac hypertrophy, there was no criminal conduct found.

Jill R. Ravitch

District Attorney, County of Sonoma