LAW ENFORCEMENT EMPLOYEE-INVOLVED

FATAL INCIDENT REPORT

Employer Agency: Sonoma County Main Adult Detention Facility
Lead Agency: Sonoma County Sheriff's Department
Decedent: Diego Armando DePaz
Date of Incident: October 8, 2014

Report Prepared by:
SONOMA COUNTY DISTRICT ATTORNEY

PUBLIC VERSION

TABLE OF CONTENTS

Contents

I. INTRODUCTION

Sonoma County North County Detention Facility inmate Diego Armando DePaz (herein after referred to as DePaz) was discovered unresponsive on October 8, 2014, at the North County Detention Facility. DePaz was discovered at approximately 0450 in his top bunk in unit 502, which is a dormitory style unit that housed approximately 61 inmates at that time. Jail staff immediately began life saving measures. Within minutes, fire personnel arrived to assist with life saving measures and then medics arrived. At approximately 0514, DePaz was pronounced dead.

Inmate interviews indicated that at approximately 0400, many inmates in unit 502 heard DePaz make heavy breathing and moaning noises but the inmates believed DePaz was having a bad dream. The Marin County Coroner's Office took custody of DePaz's body and facilitated the autopsy. Chief Forensic Pathologist Joseph Cohen, M.D., concluded the cause of death was natural, a fatal cardiac dysrhythmia due to hypertensive cardiovascular disease.

Patrol Deputies from the Sonoma County Sheriff Department arrived and secured the scene upon Mr. DePaz's declaration of death. The Sonoma County Sheriff's Department Violent Crimes Investigation Unit was notified of the situation at approximately 0600 hours on October 8, 2014. Detective Joseph Horsman (#1917) was designated as the lead detective. The Sonoma County Sheriff's Department was the lead investigative agency. The Sonoma County District Attorney's Office was also tasked to participate in the investigation.

The role of the Sonoma County District Attorney's Office in the Fatal Incident Protocol is to conduct a complete review of the investigation. This review takes place

upon completion of the lead investigative agency's work. The purpose of the District Attorney's Office review is fourfold: (1) to determine if there is criminal liability regarding any involved party including law enforcement employees (2) to provide legal assistance to the lead investigative agency on any issue (3) to supplement the investigation when necessary and (4) to prosecute, when appropriate, those persons believed to have violated the law. The end result of this fourfold process is a thorough review of the entire investigation. The District Attorney's office then prepares a written report summarizing the investigation and setting forth certain legal conclusions. A copy of the District Attorney's Office report is then submitted to the Foreperson of the Sonoma County Grand Jury. The report includes a summary of facts surrounding the death of Diego Armando DePaz, summaries of the acts of various relevant parties, the relevant law, an analysis of the facts and law and a final conclusion. A redacted copy of the autopsy report is made available to the public.

II. SCOPE OF REVIEW

The purpose of this criminal investigation and review is to establish the presence or absence of any criminal liability on the part of any involved people, including law enforcement employees.

III. STANDARD OF REVIEW

As chief law enforcement officer for Sonoma County, the District Attorney is responsible for reviewing, approving and filing of all criminal cases. The District

Attorney's discretion to charge a person with a crime is limited by well established legal and ethical standards.

The correct standard to be applied by the District Attorney in filing criminal charges is expressed in a publication of the California District Attorneys Association entitled, Uniform Crime Charging standards. 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 office (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 to convict, i.e. proof beyond a reasonable doubt, is the highest burden of proof within the American legal system.

IV. SUMMARY OF FACTS

The following is a summary of facts intended to assist the reader in understanding this report and its conclusions. It is not a substitute for the volumes of reports, interviews, and other evidence from which it is derived. It is an accurate summary of what the District Attorney has determined the material facts in this case to be.

On October 6, 2014, Diego Armando DePaz self surrendered to the Sonoma County North County Detention Facility, ("NCDF") at approximately 1907. DePaz was born November 26, 1982. He was approximately 6'01" and 250 pounds. DePaz was scheduled to serve a 15 day jail sentence for a probation violation based on a prior driving under the influence conviction. Upon intake, DePaz completed the standard pre-booking medical forms with the assistance of jail staff, a correctional deputy and a nurse. In response to the question "Are you taking any medications which you should continue to take in the jail?" the "yes" column is initialed. However, in the notes portion written by jail staff, DePaz informed jail staff he had weaned himself off Percocet in anticipation of his jail sentence and that he had not taken Temazepam for the last three days. The notes indicate that DePaz would complete a form if pain medication was needed. At the time of his surrender, DePaz did not ask for any medication and he was not given any medication during his stay. DePaz did inform jail staff that due to a prior car accident one leg was shorter than the other leg and he requested an insole for his shoe.

At approximately 0400, on October 8, 2014, inmates in unit 502 heard DePaz making moaning and heavy breathing sounds. The inmates in unit 502 believed DePaz

was having a dream and many of the inmates laughed at the breathing noises. At least one of the inmates shook DePaz's bunk and then the noises stopped. None of the inmates notified jail staff.

On October 8, 2014, Correctional Deputy John Martinez (hereafter CO Martinez) was interviewed. CO Martinez was assigned to oversee Unit 502 of the North County Detention Facility. CO Martinez began his shift at 1500 on October 7, 2014, and had taken a break from 0130 until approximately 0300. CO Martinez conducted his rounds in unit 502 at 0344, 0400, 0413 and 0439.

On October 8, 2014, at approximately 0440, CO Martinez turned on the lights for the inmates in unit 502 to wake up and begin to dress, prepare for breakfast and receive prescribed medications. Within 10 minutes, an inmate approached CO Martinez and informed him that his "bunky is blue." CO Martinez immediately responded to the bunk and observed DePaz. DePaz's forehead, lips and cheeks were very blue. CO Martinez then broadcasted over the radio he needed assistance for a medical issue. CO Martinez approached the medic who was passing out medications and requested her assistance for a man down in the unit. The medic took DePaz's pulse. CO Martinez did a "sternum rub" to attempt to get a reaction, but there was no reaction. At that time, DePaz's was very rigid and one of his arms was sticking straight out with a blanket over the arm.

Additional correctional deputies arrived and with the assistance of some of the inmates, DePaz's mattress with DePaz on the mattress, was lowered to the floor. Once DePaz was on the floor, CO Martinez began CPR chest compressions with the assistance of CO Holt and CO Sgt. Stewart. The medic provided an oxygen mask

which was placed over DePaz's nose and mouth. The jail staff continued CPR efforts until the fire department and ambulance arrived and took over the life saving efforts.

On October 7, 2014, at 2000 Correctional Deputy Steven Carlozzi (hereafter CO Carlozzi) began his shift at the North County Detention Facility. CO Carlozzi relieved CO Martinez from 0130 to 0310 so that CO Martinez could take a break. During that time, CO Carlozzi supervised Unit 502. CO Carlozzi conducted three rounds of Unit 502 at 0130, 0226 and 0247. CO Carlozzi did not observed or hear anything out of the ordinary during that time.

At 0450, CO Carlozzi was in the Control Unit preparing for breakfast which begins at 0500. At that time, he heard CO Martinez request assistance in Unit 502. CO Carlozzi responded to Unit 502.

CO Carlozzi observed DePaz on the bunk. DePaz was not breathing and his face was blue/grey in color. He assisted in lowering DePaz, on his mattress, to the floor. The medic arrived and administered the oxygen mask. Correctional Deputy Holt arrived with the automated external defibrillator (hereafter AED).

When CO Holt arrived with the AED, CO Carlozzi moved the inmates from Unit 502 to the Day Room. CO Carlozzi moved between the Day Room and Unit 502, the AED was placed on DePaz and CO Sgt. Stewart advised CO Carlozzi to request a "code 3 ambulance."

CO Carlozzi went to the front gates and observed CO Hackathorn arriving to work. CO Hackathorn was assigned the gates to expedite the arrival of the ambulance. CO Carlozzi then retrieved paperwork requested by CO Sgt. Stewart including paperwork from the computer to determine the security measures that would need to be

taken for DePaz's transport to the hospital. CO Carlozzi noticed the inmates were still in the Day Room and he moved them to Unit 501. CO Carlozzi monitored life saving measures taken by jail staff and then the arrival of the firefighters and paramedics.

Correctional Deputy Jason Hackathorn (hereafter CO Hackathorn) is typically assigned to the Sonoma County Main Adult Detention Facility. On October 8, 2014, CO Hackathorn was scheduled to work an overtime shift from 0500 to 0700 at NCDF. CO Hackathorn arrived at 0455. He did not observe staff and he called for CO Sgt. Stewart. CO Sgt. Stewart stated he was in Unit 502. When CO Hackathorn reached the door for Unit 502, CO Carlozzi met him and requested he assist the ambulance. CO Hackathorn assisted the fire personnel and then the ambulance personnel enter the facility. He helped them find the correct entrance to Unit 502. CO Hackathorn observed jail staff, fire and ambulance personnel work on DePaz. CO Hackathorn did not observe any staff with the inmates in Unit 501 so he remained near the desk to monitor the inmates in Unit 501.

Correctional Deputy Clint Holt stated that he believed that about 0430 he heard a radio call and he, CO Carlozzi and CO Sgt. Stewart responded to Unit 502. When he arrived at Unit 502, the majority of the inmates were in the Day Room. He was requested to retrieve the AED machine. When he returned, he ordered the remaining inmates to Unit 501. He unpackaged and applied the AED to the decedent's chest. Prior to applying the AED, he observed CO Sgt. Stewart providing rescue breaths and CO Martinez doing chest compressions. He also observed the medic, "Marina", present. He then shared the task of giving chest compressions with CO Martinez.

CO Holt stated that within 7-10 minutes, fire department personnel arrived and

took over chest compressions. The ambulance crew arrived after that and hooked up more machines to DePaz. CO Holt stated that when he first arrived DePaz appeared to have a bluish tint, but with the chest compressions his color appeared to be improving. He thought to himself to just hold on and keep DePaz going until medical arrives.

CO Holt stated he had received training in how to use the AED machine. He described the process and stated they followed the AED prompts the entire time. He said the AED never provided a shock.

Correctional Sergeant Rick Stewart (hereafter CO Sgt. Stewart), began his shift at 1842 on October 7, 2014. CO Sgt. Stewart stated that at 0450 CO Martinez broadcasted that he needed a Movement Deputy in Unit 502. He responded to Unit 502 along with CO Holt and CO Carlozzi. He asked CO Martinez his status and the response was inaudible. As they got closer to the unit he learned it was a medical call and he observed the medic in the unit when he got to the front entrance of Unit 502.

CO Sgt. Stewart stated that when he first arrived at Unit 502 he observed DePaz and requested a code 3 ambulance and a Deputy Guard.

CO Sgt. Stewart approached DePaz and took his pulse from his carotid. There was no pulse. DePaz appeared lifeless, was not breathing and his skin was bluish in color. They began CPR while CO Holt retrieved the AED. The AED was applied to DePaz and the analysis of the AED was to continue CPR. This was continued until the arrival of the fire department and ambulance personnel.

According to the background event chronology computer printout, on October 8, 2014, at 0455 an event was created due to a request for a Code 3 EMS and hospital guard.

The rounds conducted by CO Martinez are memorialized in their “RATS” computer system. The “RATS” system works by a correctional deputy taking a metal wand and tapping the wand to a pole at certain locations throughout each unit. That records the time the round was conducted. It also records the specific deputy who completed the round. In order for the system to record the specific deputy, the deputy must input his name to the wand prior to conducting the round. In this instance, it appears CO Martinez forgot to input his name to the wand. This appears to be the case because the “RATS” system shows the rounds conducted at 0130, 0226 and 0247 as conducted by CO Carlozzi. This is correct because CO Carlozzi relieved CO Martinez from approximately 0130 to 0300 while CO Martinez took his break. Then, when CO Martinez returned from his break and took his rounds at 0344, 0400, 0413 and 0439, the time of the round is noted but the round is associated with CO Carlozzi. Based on the statements of both CO Martinez and CO Carlozzi as well as the inmate interviews and Medic interview which all state CO Martinez turned on the lights at 0440 and was the Unit supervisor that initially responded to DePaz at 0450, it is clear that CO Martinez simply forgot to change the name on the wand from CO Carlozzi to himself and therefore the rounds he conducted at 0344, 0400, 0413 and 0439 were attributed to CO Carlozzi rather than himself.

Medic Marina Alberto was interviewed. She is a licensed vocational nurse. She explained that on October 8, 2014, at 0445 she went to Unit 101 to conduct diabetic checks on the inmates that have been diagnosed with diabetes. Then she went to Unit 501 and 502 to administer prescribed medications to the inmates who receive medications. While passing out medications she observed CO Martinez walk into Unit

502. CO Martinez then appeared at the doorway and requested her assistance to check on an inmate in Unit 502.

CO Martinez directed her to DePaz. DePaz was lying on the top bunk. CO Martinez calmly asked her to check DePaz's pulse. DePaz had no pulse and his lips were purple. CO Martinez requested Medic Alberto get the oxygen container. When Medic Alberto returned with the oxygen container, DePaz had been moved to the floor and other correctional deputies were administering CPR. Medic Alberto stated the deputies were taking turns providing chest compressions, moving the inmates to Unit 501 and using a bag valve mask with the chest compressions. She made sure the oxygen tank was working and then placed the mask onto DePaz and began administering oxygen to him.

Medic Alberto stated she observed the correctional deputies bring the AED and apply the AED to DePaz. The AED was saying to start CPR and not shock. They provided CPR until the fire department came.

She said DePaz is not on her list to receive any medications and she was not familiar with him.

Four fire department personnel responded to the North County Detention Facility from the Rincon Valley Fire Department. Those fire personnel were Captain Robert Bisordi, Engineer Eliseo Gonzalez, Engineer Colin Ramos and Volunteer Firefighter Brian Wellington.

The fire department personnel were all separately interviewed. The fire department personnel stated they were dispatched to the North County Detention Facility at approximately 0456. When they arrived at the NCDF, they were directed to

Unit 502. Upon arrival at Unit 502, they observed DePaz laying on the floor on the mattress with a correctional guard administering CPR, oxygen being administered with the use of a bag mask and an AED hooked up to DePaz. The fire personnel took over the administration of CPR until the arrival of the ambulance personnel. The ambulance arrived a short time later.

Upon the arrival of the ambulance personnel, the fire personnel continued with CPR while the ambulance personnel hooked up their own equipment. Shortly after the ambulance personnel hooked up their own equipment, and after two separate analyses by the ambulance personnel, DePaz was pronounced dead.

During the interview of Engineer Gonzalez, Engineer Gonzalez was asked what the AED was saying. Engineer Gonzalez stated the AED was saying "no shock advised, continue CPR." Similarly, during the interview with Engineer Ramos, he stated the AED connected to DePaz was doing a great job and directing chest compressions accordingly.

Engineer Ramos was specifically asked about the condition of DePaz. Engineer Ramos stated as they were doing CPR he did not notice rigor mortis. He said DePaz had mobility in his arms and legs. He said DePaz was warm to the touch. He said DePaz's pupils were fixed and dilated which, to him, was an obvious sign of death.

Paramedic Steve Busher from Bell's Ambulance was interviewed. Paramedic Busher stated he works for Bell's Ambulance and was at their headquarters in Windsor and he arrived within approximately five minutes of the call. Upon arrival at NCDF, they were quickly ushered through the gate and into the facility. Upon his arrival, fire personnel were conducting CPR and the AED was hooked up and advising no shock.

His responsibility was to assess DePaz and that DePaz met the criteria for death in the field. Paramedic Busher stated DePaz had rigidity in his jaw, his pupils were fixed and dilated, there was pooling in the back of his legs and the monitor showed asystole (flat lined).

Paramedic Busher said they were still prepared to do a complete exam. Therefore, they hooked up their own monitor which confirmed the asystole indication from the AED. He polled everyone present and everyone agreed there were no further efforts to be made.

Paramedic Busher noted during his interview that he was impressed with the correction officers in how quickly they got them through the gate, that the fire personnel made a point of how impressed they were with the correctional officers handling of the call and that he believed everyone did a great job and if there was a possibility of survival it was provided to DePaz.

In addition to interviews with the correctional deputies, fire personnel and Bell's Ambulance paramedic, on October 8, 2014, all inmates in Unit 502 were given a Sonoma County Sheriff's Department Area Canvass Form. This form provides designated spaces for name and contact information and lines for writing witness observations.

The majority of the inmates responded on the form that they did not see or hear anything involving DePaz. However, some of the inmates stated on the form they had seen or heard something regarding DePaz. The inmates gave different estimates of the hour when they heard the heaving breathing, snoring and moaning noises. Those inmates indicated that sometime between 0330 and 0430, DePaz was making snoring,

moaning and heavy breathing sounds. The inmates also gave different estimates of the length of time of the noise. The length of time ranged from one or two minutes, a couple minutes or seven to ten minutes in duration.

The inmates thought he was having a bad dream. The inmates laughed. None of the inmates notified jail staff. At least one of the inmates shook DePaz's bunk in an attempt to wake him or have him quiet his sounds. DePaz did quiet down and the inmates went back to sleep or ignored DePaz until the lights came on about 0440.

As a result of the inmates in Unit 502 completing those forms, follow-up investigation was required of some inmates and those inmates were personally interviewed by detectives.

Inmate A wrote an additional statement on October 10, 2014, in which he stated on the night prior to DePaz's death, Inmate A observed DePaz playing cards. Inmate A stated DePaz inquired with other inmates about the purchase of "sleepers" and that four inmates agreed to provide their daily medication. Inmate A identified these four inmates as B, C, D and E. Inmate A stated Elavil and Trazodone were provided to DePaz by these other inmates.

Based on the written statement, Sonoma County Sheriff Department Detective Jeff Toney conducted a follow-up interview with Inmate A. Inmate A stated he is familiar with DePaz because the two of them were cellmates in 2013 when DePaz was serving a sentence for domestic violence and DUI. Inmate A stated he noticed DePaz buying commissary (food items) as soon as he came into custody. Inmate A stated the rumor is that DePaz was taking Oxycodone on the street and did not inform staff upon his arrival because he was scheduled to serve a short sentence and did not want to go to

the Main Jail for detoxification. Therefore, Inmate A believed DePaz sought pills in the jail.

According to Inmate A, DePaz was playing poker on the evening of October 7, 2014. Inmate A stated DePaz was repeatedly purchasing sodas and that a soda can be exchanged for medications with other inmates. Inmate A stated he observed DePaz drink numerous sodas.

Inmate A stated he identified the four inmates as ones selling their medications to DePaz because he knew those four inmates receive medications. According to Inmate A, one of those inmates, Inmate C, was the first one to try to wake up DePaz. Therefore, Inmate A believed Inmate C knew what happened to DePaz.

However, upon further questioning, Inmate A stated he never observed any inmate give DePaz medications. He never heard DePaz ask any inmate for medications. No inmate told Inmate A that other inmates were selling or giving DePaz their medications. He never observed DePaz taking medication.

Based on the written statement and interview with Inmate A, other inmates were interviewed. Prior to an in-person interview, each inmate whose name was mentioned as having provided medication to DePaz, or having knowledge about other inmates providing medication to DePaz, had his locker searched and his person searched for any contraband, including any medication. No contraband was discovered.

One of those inmates was Inmate B. Inmate B stated he did not know DePaz well and that he had only played cards with him on the evening of October 7, 2014. He never observed DePaz taking pills, but he heard rumors that DePaz took pills. He said he has never heard of any inmate giving their medication to DePaz, he never gave his

medication to DePaz and he never heard that DePaz sold commissary for medication.

Inmate B did state that he woke up when DePaz was making the loud breathing and moaning noise. He went to the bathroom, then checked on DePaz and heard him breathing. Inmate B then went back to bed and believed it was about 15 minutes until the lights came on in the unit.

Another interview was conducted with Inmate F. Inmate F stated he knew DePaz from having a thirty minute conversation with him on the evening of October 7, 2014. Inmate F was assigned to Unit 501, not Unit 502. Unit 502 and Unit 501 share a dayroom. Inmate F observed DePaz playing poker the evening of October 7, 2014, and stated DePaz appeared to be winning at first. Inmate F acknowledged that a soda could be traded for two pills.

Inmate F stated he only heard rumors that DePaz was shopping for pills and never actually observed DePaz take pills, never saw DePaz in a conversation to purchase pills and never saw another inmate sell pills to DePaz.

Inmate F did state that DePaz told him during their thirty minute conversation that DePaz was a “pill popper” and that he took the pain pill to get himself right. Inmate F also stated that DePaz had a big smile on his face that evening and appeared to be high. Inmate F stated he observed DePaz looked pale, but that DePaz assured him he was fine. Inmate F also stated he observed DePaz leave a full soda on the table and walk away from the table. He asked DePaz if he knew that he left the full soda and DePaz stated “yeah, yeah.” However, then they walked outside the unit.

Inmate D was interviewed. He stated he does not “cheek” (hide in his cheek and not swallow) his medication. He did not sell or give medication to DePaz. He does not

know DePaz, did not play poker and has only said “hi” to DePaz. He remembers DePaz making moaning noises about 0355-0400 on October 8, 2014. He said the other inmates were laughing and he thought DePaz was having a sex dream. He walked to the bathroom and shook DePaz’s bed. DePaz quieted down and he returned from the bathroom and went back to bed.

Inmate E was interviewed. He stated he did not give pills to DePaz and did not observe other inmates give pills to DePaz. He heard DePaz during the night and thought he was dreaming.

Inmate G was interviewed. Inmate G began the interview by stating he wanted to approach DePaz’s family to get some of the proceeds from a lawsuit, such as 10% of any lawsuit settlement. Then, Inmate G stated he would agree to not testify against the county if he received some sort of a “kick”, i.e. favor, from the county. He was asked to tell the truth. He mentioned that DePaz may have bought medication from other inmates. Inmate G then continued by stating he heard DePaz’s sister was already looking for a lawyer and he should contact her and get something in return for his statements.

Inmate G continued his interview making statements about the correctional deputies, continuing to discuss taking 10% of the proceeds of a lawsuit and then stated DePaz seemed fine when he went to bed and that he heard CO Martinez yell “shut up” from his station during the time DePaz was making his moaning noises and the other inmates were laughing.

Inmate C was interviewed. Inmate C stated that he was housed in Unit 501, but that Unit 501 and 502 share a dayroom. Inmate C stated he played poker the evening

of October 7, 2014, with DePaz. Inmate C stated he did not give his medication to DePaz, he did not observe DePaz ask any inmates for their medication and he did not observe any inmate give their medication to DePaz. Inmate C repeatedly stated he did not give or sell his medication to DePaz. He also stated that DePaz told him that DePaz took 30 Oxycontin pills per day while out of custody.

Inmate H was also interviewed. Inmate H stated he heard rumors that DePaz was requesting medications from other inmates the night before he died. Inmate H also stated he heard that DePaz was drinking a lot of sodas the night before he died. Inmate H stated he did not play poker with DePaz the night before he died. He also stated he did not sell or give any medication to DePaz and did not observe DePaz request or take medication. He also heard a rumor that DePaz was addicted to Oxycontin and took 20 pills per day while out of custody. That rumor came from other inmates.

Interviews were done of the four inmates who assisted the correctional deputies with lowering DePaz and his mattress from his bunk to the floor. These interviews were conducted on October 8, 2014. The four inmates were Inmate I, Inmate J, Inmate K and L.

The interview statements from all four inmates were similar to the inmate written statements submitted by all inmates in Unit 502. Inmate K stated he did not wake up to the moaning noises from DePaz, and he only heard about the noises from other inmates. All four of the inmates confirmed they helped lower DePaz and his mattress to the floor with the assistance of CO Martinez at approximately 0450. The inmates did not remain to assist with life saving measures because additional jail staff responded and they were moved out of the area. The inmates indicated DePaz was making a loud

noise and other inmates were laughing. They were surprised CO Martinez did not hear them laughing or hear the noise. The inmates indicated jail staff was never notified and that not all of the inmates woke up to the noise.

On October 8, 2014, after the death of DePaz, the Marin County Coroner was contacted. The Sonoma County Sheriff Department requested an autopsy be performed by the Marin County Coroner. On October 8, 2014, Investigator Advincula, from the Marin County Coroner, arrived at the NCDF to investigate the death of DePaz and collect DePaz's body for an autopsy. Upon arrival, Investigator Advincula was escorted to Unit 502 and located DePaz's body.

The initial observations of Investigator Advincula were of DePaz on his mattress on the floor. DePaz was wearing jail issued clothing with the t-shirt cut. Multiple cardiac monitoring pads and AED pads were present on DePaz's torso. An oxygen tank and bag valve mask were located near DePaz's body. An oropharyngeal airway trumpet protruded from DePaz's mouth. DePaz's body was slightly warm to the touch with purple lividity present in the posterior aspects of his body. Rigor was present in the extremities and broke with firm resistance. Lividity and rigor were consistent with the body position and with the time of death.

Investigator Advincula examined DePaz's body, making observations and looking for objective signs of trauma or suspicious findings. He observed that DePaz was moderately obese and top-heavy. He palpated DePaz's scalp and did not observe crepitus (the crackling or popping noise of bone rubbing against cartilage). Investigator Advincula opened DePaz's eyes and noted red skin discoloration on the lining of both upper eyelids. There was no sign of petechial hemorrhages in both eyes. An upper

right tooth was missing, but that did not appear recent or due to acute trauma. There were no signs of bodily fluids in and around the mouth or nostrils, no marks on the neck, no trauma to the torso and no defensive wounds to the hands.

It is noted in the report that DePaz did not receive any medications from the jail medical staff. Reportedly, DePaz made a verbal request for medication while walking around the yard on October 8, 2014, and was informed he needed to complete a written request form. The verbal request for medication appears to be an error in the report as DePaz was deceased on October 8, 2014, and the jail staff notes about completing a slip for pain medication is dated October 6, 2014.

On October 7, 2014, DePaz submitted a written request form. However, on that written request form DePaz stated his health problems as "knee and sleep problems have pain." He did not request a specific medication and he did not state he required any prescribed medication.

Investigator Advincula completed his examination and investigation at the scene and DePaz was transported to the Napa County Sheriff's Office for an autopsy by the Marin County Sheriff's Department. The coroner report lists the time of death as 0514.

An autopsy was performed Joseph Cohen, M.D., Chief Forensic Pathologist of Marin County. The autopsy was performed on October 10, 2014.

Doctor Cohen examined DePaz's body including the inner organs. Doctor Cohen also took blood samples for toxicology testing. The toxicology testing resulted in positive findings for certain compounds including Oxycodone. Oxycodone was found at a level of 9.2 ng/ml and in twelve oxycodone related deaths the concentrations averaged 1600 ng/ml with a range of 240 – 8400 ng/ml. In addition, a level of 900 ng/ml

of Flouxetine was found in the toxicology. Flouxetine deaths are attributable to levels of 2000 – 11,000 ng/ml.

Upon review of DePaz during the autopsy and review of the toxicology report, Doctor Cohen determined the cause of death to be fatal cardiac dysrhythmia within seconds and hypertensive cardiovascular disease taking place over years. Dr. Cohen also noted other significant conditions including chronic alcoholism, diabetes mellitus, obesity and chronic prescription drug abuse. In his autopsy report, Dr. Cohen specifically stated "toxicology evaluation, noncontributory". Therefore, toxicology was explicitly ruled out as a cause of death.

Based on the findings at the autopsy, the observations of Investigator Advincula at the scene as well as the investigation by the Sonoma County detectives, the Marin County Coroner determined the cause of death to be natural.

V. STATEMENT OF THE LAW

The relevant law that will guide the legal analysis of this particular incident is that of involuntary manslaughter. The definition of this crime is contained in California Penal Code Section 192:

> "Manslaughter is the unlawful killing of a human being without malice. It is of three kinds…Involuntary: in the commission of an unlawful act, not amounting to a felony; or in the commission of a lawful act which might produce death in an unlawful matter or without due caution or circumspection…"

California Criminal Jury Instruction (CALCRIM) #581 is the instruction given to a

jury by a trial court in any homicide prosecution involving the theory of involuntary manslaughter:

"To prove a defendant guilty of this crime, The People must prove that:

1. The defendant committed a crime or a lawful act in an unlawful manner;

2. The defendant committed the crime or act with criminal negligence;

AND

3. The defendant's acts caused the death of another person.

"Criminal negligence involves more than ordinary carelessness, inattention, or mistake in judgment. A person acts with criminal negligence when:

1. He or she acts in a reckless way that creates a high risk of death or great bodily injury;

AND

2. A reasonable person would have known that acting in that way would create such a risk.

In other words, a person acts with criminal negligence when the way he or she acts is so different from the way an ordinarily careful person would act in the same situation that his or her act amounts to disregard for human life or indifference to the consequences of that act.

An act causes death if the death is the direct, natural, and probable consequence of the act and the death would not have happened without the act. A natural and probable consequence is one that a reasonable person would know is likely to happen if nothing unusual intervenes. In deciding whether a consequence is natural and

probable, consider all of the circumstances established by the evidence.

There may be more than one cause of death. An act causes death only if it is a substantial factor in causing the death. A substantial factor is more than a trivial or remote factor. However, it does not need to be the only factor that causes the death.

Great bodily injury means significant or substantial physical injury. It is an injury that is greater than minor or moderate harm.

CALCRIM #582 is the instruction given to a jury by the trial court in any criminal homicide prosecution based upon an involuntary manslaughter theory where there is a legal duty between the parties:

"To prove a defendant guilty of this crime, the People must prove that:

1. The defendant had a legal duty to the decedent;
2. The defendant's failed to perform that legal duty;
3. The defendant's failure was criminally negligent;

AND

4. The defendant's failure caused the death of the decedent

"Criminal negligence involves more than ordinary carelessness, inattention, or mistake in judgment. A person acts with criminal negligence when:

1. He or she acts in a reckless way that creates a high risk of death or great bodily injury;

AND

2. A reasonable person would have known that acting in that way would create such a risk.

In other words, a person acts with criminal negligence when the way he or she acts is so different from the way an ordinarily careful person would act in the same situation that his or her act amounts to disregard for human life or indifference to the consequences of that act.

An act causes death if the death is the direct, natural, and probable consequence of the act and the death would not have happened without the act. A natural and probable consequence is one that a reasonable person would know is likely to happen if nothing unusual intervenes. In deciding whether a consequence is natural and probable, consider all of the circumstances established by the evidence.

There may be more than one cause of death. An act causes death only if it is a substantial factor in causing the death. A substantial factor is more than a trivial or remote factor. However, it does not need to be the only factor that causes the death.

Great bodily injury means significant or substantial physical injury. It is an injury that is greater than minor or moderate harm.

VI. LEGAL ANALYSIS

Diego Armando DePaz was an inmate housed in Unit 502 of the Sonoma County North County Detention Facility when he died. The purpose of this Critical Incident Report is to make a determination if the parties who owed a duty to the decedent while he was in their care or custody were criminally negligent in the execution of their duties that resulted in the death of DePaz. This determination must be made as to each group that had a nexus to the decedent, to wit: Sonoma County North County Detention Facility Staff, Rincon Valley Fire Personnel and Bell's Ambulance medics.

Sonoma County North County Detention Facility Staff

DePaz turned himself in to the NCDF on October 6, 2014, at 1807 to serve a 15-day sentence for a violation of probation.

Upon his admission to NCDF, DePaz did indicate to jail staff that he was taking medication which he should continue to take while in the jail. However, the notes reflect that DePaz told staff that he had weaned himself off Percocet and that he had not taken Temazepam for the last three days. The notes further show that DePaz would complete a slip and request any pain medication he may need while in-custody. DePaz did request medicine for sleeping and knee pain, but did not request any specific medication or note any serious medical conditions. He only requested medication for sleep and knee pain. There is no indication that DePaz informed the jail staff he needed medication for anything other than pain control or sleep. In addition, it is clear from the autopsy report and the Marin County Coroner that DePaz died from a heart attack due to natural causes. There is nothing in the autopsy report to indicate DePaz died from a lack of any required medication. Therefore, there was no criminal negligence by any staff member with regard to DePaz's indications on his intake form and there is insufficient evidence to support criminal charges for any jail staff because of an alleged failure to provide medication.

The first officer to respond to Depaz was CO Martinez. CO Martinez was responsible for supervising Unit 502 at the time of DePaz's death. CO Martinez conducted his rounds in Unit 502. According to the "RATS" system, the rounds on October 8, 2014, were made in Unit 502 at 0344, 0400, 0413 and 0439. There is no evidence to suggest that CO Martinez was aware that DePaz was in distress. In fact,

the review of the inmate statements and interviews show that CO Martinez was never made aware that Depaz was in distress. The inmate statements and interviews consistently state that no inmate informed CO Martinez that DePaz was making heavy breathing and moaning noises. No inmate stated that CO Martinez was making his rounds during the time DePaz was making noise. The inmates did not give an exact time when DePaz was making noise and the inmates did not give any exact duration for the time of the noise. Therefore, it is clear that CO Martinez was not making a round in Unit 502 at the time DePaz was in distress. CO Martinez made three rounds within a close duration, 0344, 0400 and 0413. The close duration of the rounds shows his active supervision of Unit 502 as well as indicates that DePaz must have been in distress for a short duration and it must have been between two of the rounds. This would be consistent with some inmate statements which state DePaz was making noises for as short as one or two minutes.

CO Martinez turned on the lights for Unit 502 at approximately 0440. During the next ten minutes the inmates woke up, used the bathroom and lined up for their prescribed medications. At approximately 0450 CO Martinez was informed that DePaz "was blue." At that time, the evidence shows that CO Martinez acted in a proper manner. He immediately responded to DePaz. He obtained the assistance of the nurse already in Unit 502. He radioed for assistance. He utilized the help of other inmates to lower DePaz, and his mattress, to the floor to begin life saving measures. He began CPR and continued with life saving measures until he was relieved by the Rincon Valley Fire Personnel. His life saving measures were properly performed. Finally, from the statement and observation made by CO Martinez, it appears DePaz was already

deceased when CO Martinez first contacted him in his bunk. This is based on the observations from CO Martinez that when he first observed DePaz, DePaz's lips, forehead and cheeks were very blue. DePaz did not react to the sternum rub. Also, DePaz was rigid with one of his arms sticking straight out of the blanket. Statements from the inmates confirm that DePaz was blue and one inmate stated DePaz was not breathing at the time CO Martinez responded to DePaz. Therefore, CO Martinez acted appropriately and did not act with any criminal negligence.

The other involved jail deputies, CO Carlozzi, CO Holt and CO Sgt. Ryan, responded to the radio call for assistance in Unit 502. They responded to Unit 502 and the different responsibilities and tasks were quickly delegated. The additional deputies responded to Unit 502, one of them brought the AED, they requested medical assistance through dispatch and that request was initiated at 0455, they assisted with CPR, they moved the remaining inmates out of the way and to a different unit, they supervised those other inmates to ensure everyone's safety, they went to the front gate to make sure the fire and ambulance personnel could enter the facility and find Unit 502, they properly hooked up the AED, and they provided life saving measures until they were relieved by Rincon Valley Fire. The jail deputies quickly responded to the emergency announced by CO Martinez, divided up the necessary tasks, assisted with life saving measures and maintained order to ensure the best efforts could be focused on saving DePaz's life.

CO Hackathorn arrived at 0455 for his scheduled 0500 shift and immediately assisted the other jail deputies.

Medic Alberto reasonably assisted the correction deputies. She assisted CO

Martinez with checking the medical condition of Depaz when she noted his lips were purple and she did not feel a pulse. She then obtained the oxygen tank. When she returned, other deputies were already providing CPR. She applied the oxygen tank mask and assisted the deputies with life saving measures until the arrival of the Rincon Valley Fire Personnel. Nothing she did was criminal negligent or reckless.

In addition, it appears that DePaz was already dead when the additional deputies arrived to Unit 502. This is based on the observations of CO Martinez, observations of Medic Alberto, as well as the observations of CO Carlozzi that DePaz was not breathing and his face was a little blue/grey in color, the observations of CO Holt that DePaz appeared to have a bluish tint to him and the observations of CO Sgt. Ryan that DePaz was not breathing, CO Sgt. Ryan did not detect a pulse, DePaz appeared lifeless and DePaz's skin was bluish in color.

The evidence that DePaz was already deceased by the time CO Martinez was first informed there was a problem is also supported by the autopsy report that listed the cause of death as a fatal cardiac dysrhythmia within seconds.

Therefore, based on the reasonable manner in which the jail staff responded to the emergency as well as the strong evidence that DePaz was deceased before any jail staff had knowledge of his medical emergency, there is insufficient evidence any of the jail staff or correctional deputies acted with criminal negligence. In fact, responding medical personnel commended the efforts of the jail staff.

A close review of all individual interviews with jail staff, inmates, and the jail logs indicate that all relevant parties acted in a reasonable fashion to execute their duties. Their acts did not create a high risk of death or great bodily injury. The acts of all

relevant parties do not appear to be so different from the way an ordinary person would act in the same situation. Nor does it appear that they acted in a reckless manner. There were no acts or omissions that displayed a disregard for human life or indifference to the consequences of the acts. The record discloses no evidence that the staff at the North County Detention Facility acted in a criminally negligent fashion toward DePaz. There is no basis to file any criminal charges.

Rincon Valley Fire Personnel

The Rincon Valley Fire Personnel were dispatched and quickly responded to NCDF. The Fire Personnel arrived at Unit 502 and took over CPR from the correctional deputies. Fire Personnel stated the AED was properly applied and was giving verbal commands. Those commands were followed. Furthermore, the evidence is strong that DePaz was already deceased even with the prompt arrival of Fire Personnel.

The Rincon Valley Fire Personnel acted in a reasonable manner. No act by any Fire Personnel created a high risk of death or great bodily injury. No act by any Fire Personnel was reckless. No act or failure to act displayed a disregard for human life or an indifference to the consequences of the acts. There is no evidence any Fire Personnel acted with criminal negligence.

Bell's Ambulance Medics

The Bell's Ambulance Medics responded quickly to the jail. They were impressed with how quickly the Correction Officers got them through the gate and how quickly they had everything together. They followed the advisement of the AED.

DePaz had rigidity in his jaw, his pupils were fixed and dilated, there was pooling the back of his legs and back, the monitor was showing asystole (flat lined), they hooked up their own monitor which confirmed the AED showing asystole and everyone present was polled and agreed DePaz was dead. Paramedic Busher stated he believed everyone did a great job. The acts of all relevant parties do not appear to be so different from the way an ordinary person would act in the same situation. There are no acts or omissions that display a disregard for human life or indifference to the consequences of the acts. The record discloses no evidence that the Bell's Medics acted in a criminally negligent fashion toward DePaz. There is no basis to file any criminal charges.

VII. CONCLUSION

It is my opinion that based on the totality of the facts presented; there is no evidence to warrant the filing of any criminal charges against the staff of the North County Detention Facility, Rincon Valley Fire Personnel or the Bell's Ambulance Medics. Based on the evidence provided, it is clear that DePaz died from fatal cardiac dysrhythmia due to hypertensive cardiovascular disease.

Based on all of the facts and circumstances, as explained above, the actions of the staff of the North County Detention Facility, Rincon Valley Fire Personnel and the Bell's Ambulance Medics were legally justified, and therefore no criminal charges are warranted.

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JILL R. RAVITCH

District Attorney, County of Sonoma