LAW ENFORCEMENT EMPLOYEE-INVOLVED

FATAL INCIDENT REPORT

Employer Agency: Sonoma County Main Adult Detention Facility
Lead Agency: Sonoma County Sheriff's Department
Decedent: Mikol Wayne Stewart
Date of Incident: September 28, 2014

Report Prepared by:
SONOMA COUNTY DISTRICT ATTORNEY
For Public Dissemination

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I. INTRODUCTION

Sonoma County Main Adult Detention Facility inmate Mikol Wayne Stewart (herein after referred to as Stewart) was discovered hanging by a bed sheet from a ventilation grate in cell H-7 on September 28, 2014, at approximately 1020 hours. Jail personnel cut the sheet the deceased was hanging from and administered CPR until AMR Medics arrived. Jail personnel administered CPR, used a bag valve mask with oxygen to revive the deceased as well as an Automated External Defibrillator (AED). AMR medics arrived at 1031 hours. They learned that deputies had administered approximately 10 cycles of CPR prior to their arrival. AMR medics placed a cardiac monitor on Stewart and found that he was in asystole, had fixed dilated pupils and had been unresponsive for approximately 10 minutes. Based on those findings coupled with the "No Shock Advised" by the AED, he was pronounced dead at approximately 1035 hours.

Patrol Deputies from the Sonoma County Sheriff Department arrived and secured the scene upon Mr. Stewart's declaration of death. The Sonoma County Sheriff's Department Violent Crimes Investigation Unit was notified of the situation at approximately 1106 hours on September 28, 2014. Detective Jayson Fowler (#1813) 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 Mikol Wayne Stewart, 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.

Mikol Wayne Stewart was born in Santa Rosa on June 27, 1977. He was a Caucasian male who stood at 5'5" tall and weighed 135 pounds. Stewart's criminal history dates back to 1993, including two drinking and driving convictions and two convictions for inflicting injury on a spouse.

Stewart's incarceration at the time of his death stemmed from an incident that occurred on September 9, 2014. Stewart became aware that his wife had an affair with a man by the name of Arturo Hinojosa Jr. He confronted Mr. Hinojosa over the phone that day regarding allegations that Mr. Hinojosa had drugged and raped his wife. Mr. Hinojosa denied it and sent Stewart a picture of himself and Stewart's wife at a hotel to prove that the affair was consensual. The next day, Stewart went to Mr. Hinojosa's house and confronted the victim inside his home. He pointed a gun at the victim who was able to push Stewart's arm and gun towards the ceiling. Stewart then allegedly pointed the gun at the victim and shot him causing the victim to fall to the floor. Stewart stood over the victim and shot him a few more times. Stewart started to walk away towards the front door when he shot the victim a few more times. Stewart then exited the home and drove away. Stewart's identity was discovered through interviews with witnesses. On September 11, 2014, at approximately 0143 hours, Stewart was

arrested by a Petaluma Police Department Detective. He was transferred to the Petaluma Valley Hospital for an elevated blood sugar level at 0418 hours and then. was discharged at 0554 hours after his insulin levels had been stabilized and he was cleared for incarceration. He was transported back to Petaluma Police Department and interviewed at 0619 hours during which Stewart admitted that he killed Mr. Hinojosa because he had slept with his wife. At 0946 hours, he was transported to the Main Adult Detention Facility and booked for violations of Penal Code sections 187, Murder; Penal Code section 459, Burglary and Penal Code section 29800(a)(1), Felon in possession of a firearm. While being booked, he reported to medical staff that he had hypothyroidism, diabetes and GERD's. He reported taking the drugs Novolog, Lantus, Trazodone, Xanax and Synthroid. He also reported no drug or alcohol habit which would cause withdrawals at the jail. At 1015 hours, Katie Capeto, a Licensed Social Worker at the Main Adult Detention Facility asked Mr. Stewart a series of questions screening him for suicide ideation. During those questions, he was asked whether he was thinking of killing himself, whether he had previously attempted to kill himself, whether he had any previous in-custody suicide attempts, whether he felt there was nothing to look forward to in the future; he answered all of those questions with a "no" answer. Katie Capeto noted that Mr. Stewart did not show signs of depression, that he did not appear overly anxious, afraid or angry, that he was not acting or talking in a strange manner nor was he displaying signs of a mental illness. He was assessed as being a low risk for suicide. Mr. Stewart was then transported from the booking cell to an observation cell in the mental health module. Individuals housed in an observation cell are checked every fifteen minutes by correctional deputies during rounds. The

doors to these observation cells all have transparent panes for visual observation.

On September 13, 2014, reporting party Tom Barber, a licensed MFT, stated that Mr. Stewart had been evaluated by both the psychiatrist and mental health staff and found to have no further need to remain in the mental health module. They determined that his mental status was appropriate and that he had expressed a desire to be moved. Stewart had no delusions, denied substance use or suicidal thoughts and no mania was detected. He also stated that he was not interested in medications. He was considered a maximum security inmate and was housed in a cell by himself in a general population unit. Stewart was transferred to cell H7, the H module. The general population unit is staffed with a correctional deputy. All the cell doors have transparent panes for visual inspection from within the unit. Per policy, the correctional deputy makes security rounds twice an hour.

On September 15, 2014, a complaint was filed in court by the Sonoma County District Attorney's Office alleging that Stewart violated Penal Code sections 187 Murder, 459 Burglary and 29800(a)(1) Felon in Possession of a Firearm. The defendant was arraigned, did not enter a plea and the case was assigned to the Honorable Judge Rene Chouteau, for all purposes. The case was continued to October 02, 2014, for a plea.

Jail medical records show that Stewart had been treated by Petaluma Valley Hospital for a history of hypothyroidism, diabetes and GERD's. Due to his diabetes, his sugar levels were checked on a daily basis during his incarceration. Stewart was prescribed, and staff administered Lantus for his diabetes, Levothyroxine for his hypothyroidism, Ativan for his anxiety and Zantac for his GERD's. On September 27,

2014, he was also given Doxepin, an anti depressant. On September 13, 2014, Stewart placed an inmate request form to Medical stating that he had been taking Trazadone for years to help him sleep and that he was now experiencing problems sleeping. The response was that Medical did not order Trazadone and that it is ordered from Mental Health. He was advised to request the medication from Mental Health. On September 18, 2014, Stewart requested from Mental Health something to help him sleep. He reported that he could not sleep causing headaches and nausea which then affected his gastritis. He also requested Ativan for his panic attacks. Ativan was already being administered to him at that time. At the end of the request, he stated that it was not an emergency. On September 18, 2014, mental health Social Worker Katie Capeto responded to his request and stated that when he was seen by a psychiatrist on that same day, he denied any need for medicine. On September 23, 2014, Dr. Niloofar Fadaki noted that Stewart reported anxiety, depression and insomnia. On September 24, Stewart placed a request to Mental Health seeking help for his anxiety and depression. Stewart was seen on that day by Sharilyn Shaffer, MFT, who noted that he reported symptoms of depression and anxiety, had current suicidal thoughts though no plan or intent as he was responsible to wife and kids. On September 26, 2014, he was screened and prescribed 75 mg of the antidepressant drug Doxepin after he complained of anxiety, depression and an inability to sleep. During that screening, he reported that he had no thoughts of suicide; he had good eye contact with the writer and was fairly calm and cooperative. Doxepin was administered to Stewart the following day. He was already taking Ativan for his anxiety.

On September 28, 2014, at 0500 hours, Deputy Matthew Crook assumed his

post at the H module, Stewart's housing unit. He entered the module and conducted his first round. He stopped by each inmate's cell door, used a flashlight to illuminate the cell in order to check on the inmate to determine if there was anything out of the ordinary. Nothing out of the ordinary occurred during this first round. He conducted a second round during the second half of the five o'clock hour. During this second round, nothing out of the ordinary was observed. Between 0546 and 0549 hours, Stewart came out of his cell and was administered his insulin by Medic II. At approximately 0728 hours, Stewart was given his breakfast tray. The breakfast meal service was completed at 0740 hours and Crook's last round was completed at 0745 hours with nothing out of the ordinary detected.

On that same day, at 0300 hours, Correctional Deputy Josef Hanchey began his shift at the Sonoma County Main Adult Detention Facility. He worked in the G-module until approximately 0745 hours when he took over the duties as the H-module deputy. This had been the second time he had been assigned to that unit in the month of September. His duties included enforcing the rules of the facility, conducting rounds, making sure inmates were being fed and securing inmate safety. He relieved Deputy Matthew Crook's duties and was briefed by Deputy Crook that the inmates had been fed, that the hourly rounds had been completed and that nothing seemed out of the ordinary. Jail records also show that at 0800 hours, another count was done and all 75 inmates were accounted for along with spoons, razors, identifications and fingernail and hair clippers. During that round, Deputy Hanchey looked into Stewart's cell and didn't see anything out of the ordinary. When he looked into his cell, it looked as if Stewart was asleep in bed.

At 0815 hours, Deputy Hanchey conducted out of cell activities for the inmates, hereinafter referred to as OCA's. The H-module had four classification groups. Each group got an allotted amount of time out of their cells, usually between 45 minutes to an hour. Once that group's time was up, they were ordered back into their cell and those cells were locked before the next group could be let out. Those groups were made up of two medium groups, one maximum and one maximum BP (behavioral problem) group. Stewart belonged to the maximum group. The first medium group got out of their cells starting at around 0815 hours. The second medium group got out of their cells around 0920. The maximums, Stewart's group, got 45 minutes starting at around 1020 hours and the maximum BP's got 45 minutes once a day. When Deputy Hanchey lets a group out, he informs them of the expectations and that they have access to push the release button in their cell, allowing them access to the day room to watch television as well as having access to the yard. If inmates want to stay in their cell, they have that ability to do so and deputies don't check to see if inmates exercise that option. Starting at 0815 hours, Deputy Hanchey allowed one of the two medium groups out for OCA's, each group received an hour of out of cell time. He conducted his rounds for the two hours associated with the first two OCA groups. At around 1020 hours, Deputy Hanchey let out the maximum group, Stewart's group. Within a minute from being granted access for OCA, inmate Paul Clarke, who was in the same maximum group as Stewart, walked out of his cell, walked past Stewart's cell and noticed that he was hanging. He immediately went over and informed Deputy Hanchey that Stewart was hanging himself. Deputy Hanchey ran to cell H-7 and saw Stewart hanging from a facility issued sheet which was tied to the holes in the vent and around his neck, his

back was against the wall and his head was facing to the left with no color to his face. Deputy Hanchey then yelled out to the other inmates to lock it down, made the radio call to medic-one explaining that he had an inmate trying to hang himself. Deputy Hanchey then ran to the emergency tool kit and grabbed a "cutter," a tool to cut thick fabric. He ran back to Stewart's cell and cut the sheet releasing Stewart, dragged him out of his cell, laid him out in front of his cell and started chest compressions. He administered approximately 30 chest compressions before other responding staff arrived. When other responding deputies arrived, Hanchey allowed them to take over rendering aid.

Deputy Matthias Williams and Deputy Todd Greiner were working in the booking area of the Main Adult Detention Facility. Deputy John Cillia was located in the E module when all three of them heard the call come in from Deputy Hanchey requesting for medic-one to respond to H module for a hanging inmate. All 3 responded to the H module. They arrived to find Deputy Hanchey administering chest compressions to Stewart. Deputy Cillia took over chest compressions while Williams and Greiner went to the medical room to retrieve the oxygen bottle and medical bag. Deputy Greiner called for an ambulance over the radio and returned to where Stewart was. Deputy Cillia had already completed 2 rounds of chest compressions when the Bag Valve Mask (BVM) arrived. He also checked for a pulse and couldn't detect one on Stewart. Deputy Williams conducted a head/chin tilt lift to clear Stewart's airway and placed the BVM on Stewart. Ventilations were administered while Deputy Cillia continued with chest compressions. Deputy Cillia continued to give chest compressions at the rate of 30 compressions to 2 breaths with the BVM. Deputy Halligan checked for a pulse but was unable to locate one. Deputy Cillia continued with chest compressions until someone

brought the Automated External Defibrillator machine.

Deputy Craig Stempek was located in the R module when he heard Deputy Hanchey's back up call. He and Deputy Anthony Halligan responded and entered the elevator with Sergeant Mark Pedersen, and Nurses Kristen Hansen and Kim Cordano. When Deputy Stempek arrived at the area where Stewart was, he noticed Deputy Cillia administering chest compressions, Deputy Williams was controlling the head of inmate Stewart while Deputy Alexander Lund was on his knees to the side of Stewart. Deputy Stempek ran and grabbed the AED which was located just outside J module and returned to Stewart's location. He handed the AED to Deputy Lund. Deputy Anthony Halligan grabbed a pair of trauma shears from the medic's bag and cut the t-shirt and sweatshirt off of Stewart. He then placed the AED pads on Stewart's chest while Nurse Kim Cordano activated the AED at 1027 hours. The AED gave the audible command of "no shock advised" and Deputy Cillia continued with chest compressions. Deputy Williams secured the nose cup of the BVM while Deputy Halligan manipulated the bag portion administering breaths to Stewart. Deputy Lund checked for a pulse, found none and Deputy Cillia continued with chest compressions until AMR paramedics arrived.

AMR paramedics Greg Gizzi, Eric Melligan and Michael Stallard were working together on this day. They were dispatched at 1028 hours, and responded from Administration and Paulin Drive with the lights and sirens on. They arrived to the detention facility at 1029 hours. AMR staff arrived by patient's side at 1031 hours. After AMR staff arrived, Deputy Cillia continued with two more rounds of chest compressions. AMR staff was informed that Deputy Cillia had given between 10-15 minutes of chest compressions, that Stewart was found hanging inside his cell and that he had no pulse.

Stewart was very pale at this time and his eyes appeared to be fixed and dilated. AMR medic Greg Gizzi took a pen light and found that Stewart's pupils were non-reactive to light. AMR medic Eric Melligan then attached Stewart to the cardiac monitor which indicated an asystole (flat-line). Mr. Gizzi made the determination that Stewart was not salvageable and terminated the resuscitation efforts given the 10 minute down time, the no shock advice from the AED machine, the no pulse and his apneic condition. Stewart was pronounced dead at 1035 hours.

Forensic Pathologist Dr. Arnold R. Josselson conducted an autopsy of Mikol Wayne Stewart on September 29, 2014, at 0915 hours. Witnesses included Detective Jayson Fowler, Detective Jeff Toney, Deputy Troy Newton, Deputy District Attorney Juliette Olson, District Attorney Investigator Matthew Stapleton and District Attorney Investigator Denise Urton. Dr. Josselson made the following findings:

1. No drugs or alcohol were detected in Stewart's system
2. Abrasion to furrow of neck
3. Pulmonary congestion and edema
4. Hemorrhage around base of each greater horn of thyroid cartilage
5. The cause of death was asphyxia due to hanging

Detectives conducted follow up investigation and interviewed inmate James Paul Northen who was also housed in the H module, in cell H-49. He had befriended Stewart who told him he was in jail for murder and would most likely get the death penalty. Northen spoke about an incident where Stewart had talked about suicide and told him that he should take a bunch of his medication and that is how "he should go out." Inmate Northen believed that what really "pushed him over the edge" was his

relationship with his wife. Stewart had told Northen that his wife was not going to be with him. Four to five days prior to Stewart's death, Northen saw Stewart crying hysterically because his wife told him she couldn't do it and that she was not going to hold on to the relationship. He described Stewart as very emotional and depressed over the situation. He had witnessed Stewart slamming the phone down when she wouldn't answer the phone when he called her. He last saw Stewart the morning of his death. Northen was part of the medium groups, the first group to be released for OCA time. He walked by Stewart's cell and saw him sitting at his desk with a pen or pencil in his hand. He asked Stewart if he was alright in which Stewart replied that he was. About two hours later, he heard Deputy Hanchey yell for everyone to get down and later learned that Stewart had committed suicide.

Inmate Paul Andrew Clarke was interviewed as well. He was also housed in the H module in cell H-36. He was also in the same maximum group as Stewart for OCA time. Clarke stated Stewart told him he didn't know if he could make it or deal with everything that was going on in his life. Inmate Clarke told Stewart that he would move into his cell with him. He stated that the three days leading up to his death, Clarke could feel and see it. Stewart told him, "I don't think I can do this Paul." Clarke tried to encourage him that he could do it and to think of his children. On September 28, 2014, he made his way down to Stewart's cell within one minute of being released for OCA time. He immediately noticed Stewart hanging in his cell and that he was blue in color. He then went over and informed Deputy Hanchey of the situation.

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

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

VI. LEGAL ANALYSIS

Mikol Wayne Stewart was an inmate housed in the H-module of the Sonoma County Main Adult 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 Stewart. This determination must be made as to each group that had a nexus to the decedent, to wit: Sonoma County Main Adult Detention Facility Staff and AMR medics.

Sonoma County Main Adult Detention Facility Staff

Stewart was booked into the Main Adult Detention Facility on September 11, 2014, for violations of 187 PC Murder, 459 PC Burglary and 29800 (a)(1) PC Felon in possession of a firearm in relation to Petaluma Police Department agency case number 144318. He was assessed when he entered the detention facility for any physical or mental health ailments. Stewart reported that he suffered from hypothyroidism, diabetes and GERD's. He reported taking the drugs Novolog, Lantus, Trazodone, Xanax and Synthroid. He also reported no drug or alcohol habit which would cause withdrawals at the jail. He was screened for suicide ideation and was assessed as being a low risk for suicide. He was placed in an observation cell and later assessed by the psychiatric and mental health staff who determined that he was no longer in need of being observed. Mr. Stewart was then transferred to the H module. Stewart had placed inmate request forms complaining of anxiety, depression and insomnia. On September 24, 2014, it was noted by mental health staff that he reported symptoms of depression

and anxiety and had current suicidal thoughts though no plan or intent. He was screened again by mental health on September 26, 2014, and prescribed 75 mg of Doxepin which was administered to him the next day. During that screening, Stewart reported no thoughts of suicide. There were no reports to jail staff that he had any thoughts, a plan or intent to kill himself. Jail staff didn't see nor report anything different or unusual in Stewart that would have alerted them that he was suicidal. The only people who saw that Stewart may harm himself were inmates James Northen and Paul Clarke, and that was only because Stewart actually talked to them about his legal and relationship problems. There are no reports that these two inmates reported Stewart's thoughts of harming himself to jail staff. There are no reports by jail staff nor any requests placed by Stewart that he needed assistance because of plans to commit suicide.

On the morning of Stewart's death, he was observed sleeping in his cell, he was administered his insulin between 0546 and 0549 hours, was given breakfast around 0728 hours, he was accounted for and nothing unusual was noted at the rounds conducted at 0745 hours and he was observed sitting at his desk somewhere around 0800 hours. When James Northen saw him around 0800 hours, he asked Stewart if he was alright in which he replied that he was. Nothing out of the ordinary was observed from Stewart by jail staff nor was jail staff informed that Stewart had a plan to kill himself.

Upon learning from inmate Clarke that he observed Stewart hanging, Deputy Hanchey's response was immediate. After observing Stewart hanging, he ran to grab a tool to cut him down from the sheet he was hanging from. He dragged him out of the

cell and immediately started chest compressions hoping to resuscitate him. He immediately called for medics and reported the situation. Deputy Hanchey had already performed approximately 30 chest compressions, one cycle of CPR, when he was relieved by responding deputies. The responding deputies continued to perform CPR, retrieved the oxygen bottle and BVM and applied it to Stewart. The second group of responding deputies retrieved the AED, attached the pads to Stewarts chest and after they were informed that no shock was advised, the deputies continued with CPR until AMR medics arrived. AMR staff learned that jail staff had administered approximately 10 cycles of CPR prior to their arrival. AMR medics placed a cardiac monitor on Stewart. AMR medics found that Stewart was in asystole, had fixed dilated pupils and had been unresponsive for approximately 10 minutes. Based on the aforementioned findings coupled with the "No Shock Advised" by the AED, AMR medics pronounced Stewart dead at 1035 hours. Every effort was made to revive Stewart. The jail staff appeared to go above and beyond in their attempts to resuscitate Stewart who had more than likely already succumbed at the time of his discovery.

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 Main Adult Detention Facility acted in a criminally negligent fashion toward

the inmate Stewart. There is no basis to file any criminal charges.

AMR Medics

The AMR medics responded quickly to the call from the jail. They received a call from dispatch at 1028 hours, arrived to the jail at 1029 hours and were by Stewart's side at 1030 hours. AMR medics were impressed with the quality of CPR that was being administered by the jail staff upon their arrival. At 1035 hours, AMR medics pronounced Stewart dead. The acts of the AMR medics, by placing a cardiac monitor on Stewart and declaring him dead after being given the information that jail staff had administered approximately 10 cycles of CPR prior to their arrival, after placing a cardiac monitor on Stewart, finding that he was in asystole, had fixed dilated pupils and had been unresponsive for approximately 10 minutes coupled with the "No Shock Advised" by the AED, 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. 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 AMR medics acted in a criminally negligent fashion toward Stewart. 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 Main Adult Detention Facility or the AMR medics. Based on the evidence provided, it is clear that Stewart died from asphyxia due to hanging during a suicide.

Based on all of the facts and circumstances, as explained above, the actions of the staff of the Main Adult Detention Facility and the AMR medics were legally justified, and therefore no criminal charges are warranted.

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JILL R. RAVITCH

District Attorney, County of Sonoma