READ AND CONSIDERED

DATE 9/11/08 BY

Sonoma County Sheriff's Department

BILL COGBILL
Sheriff-Coroner

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Assistant Sheriff
Law Enforcement Division

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mc Dowell 4
Death by —

September 5, 2008

Honorable Knoel Owen, Presiding Judge
Sonoma County Superior Court
600 Administration Drive
Santa Rosa, CA 95403

RE: Required Responses to the 2007-2008 Grand Jury Final Report

Dear Judge Owen:

Pursuant to Penal Code sections 933 and 933.5, attached is the Sheriff's Department's response to the Grand Jury Final Report on "Death by Incarceration" and "Review of Moses McDowell Fatal Incident."

Additionally, on behalf of the Sonoma County Law Enforcement Chief's Association, attached is their response to the "Review of Moses McDowell Fatal Incident", approved by the membership.

Sincerely,

BILL COGBILL
Sheriff-Coroner

BC/wr

Cc: Board of Supervisors
Denise Gordon, Court Executive Officer
Bob Deis, County Administrator
Janice Atkinson, County Clerk

Attachment: Responses

MOSES MCDOWALL FATAL INCIDENT (Page 10)

Requested response to Finding 1, Page 14

F1 The preponderance of forensic evidence and the testimony of several witnesses suggest that Mr. McDowall expired two to four hours before he was found dead at 8:18 a.m. on November 6, 2006.

RESPONSE: The respondent agrees with the finding.

The criminal investigation does not draw a conclusion as to McDowall's time of death. It is likely that McDowall did die 2-4 hours before he was found dead at 8:18 a.m.

Requested response to Finding 3, Page 14

F3 The VCU/DA conclusion that Mr. McDowall was alive at breakfast (sometime after 6:00 a.m.) is unsupported by the testimony of the only inmate witness to the incident. This erroneous assumption on the part of the lead investigator (a former CO) diverted and minimized the investigation of events earlier that morning. Furthermore, this misinterpretation was an important premise of the IA investigation.

RESPONSE: The respondent disagrees partially with the finding.

This finding states that the VCU (actually the Violent Crimes Investigations unit, hereafter referred to as VCI unit) draws a conclusion that McDowall died after breakfast. This is not correct. The lead investigator never draws a conclusion as to time of death he merely lays out the facts of the case. Some of these facts indicate an earlier death and some indicate a death after breakfast. The true issue and role for the VCI investigator is to determine if a crime occurred. Whether McDowall died at 4:00 a.m or 7:00 a.m. there is no evidence that a crime occurred to contribute to his death; nor is there a conclusion as to a time of death.

The internal affairs unit investigator, however, does draw a conclusion as to the time of death; this conclusion may or may not be correct. Regardless, this conclusion does not interfere with the IA investigation's purpose in determining whether or not policy and procedure were followed.

The perspective that the lead investigator made an "erroneous assumption" may be supportable in part. The lead investigator, in his report, wrote that when the inmate witness tried to serve breakfast to McDowall he heard McDowall having difficulty breathing. The Grand Jury suggested that this is a misinterpretation of the inmate's statement, implying that the inmate did not hear McDowall breathing at the time of breakfast. This conclusion by the Grand Jury is not necessarily supported by the inmate witness's statement.

This inmate witness was housed in the cell next door to McDowall and heard him coughing and spitting throughout the night. This inmate witness was also a module worker, tasked with serving breakfast at 6:00 a.m. The lead investigator questioned the inmate about what he saw and heard during breakfast service and the inmate at one point says that he heard McDowall having a difficult time breathing. The inmate then says that because of all the coughing he did not think anything of this (difficult breathing) and he went back to sleep. This last statement is significant and tends to indicate that the inmate was speaking of earlier during the night when he was sleeping, not at the time of breakfast service.

However, later in the interview the lead investigator brought the inmate back to the time of breakfast and asked him if he noticed anything out of the ordinary, "outside of that heavy coughing and, um, his heavy snoring this morning when you went to feed him breakfast, did you notice anything out of the ordinary..." The inmate responds that he thought the way McDowall was laying on his bed was unusual. The inmate then goes on to explain why the position was unusual. What is significant is that he does not object to the lead investigator's characterization in the question that he heard breathing at the time of breakfast.

Based on these portions of the interview it is not correct to state that the lead investigator made an erroneous assumption. This issue would have been better served had the lead investigator explored this discrepancy further. The conclusion that the lead investigator diverted and minimized the investigation of events earlier that morning based upon this is not substantiated.

This inmate's statement, indicating potential signs of life, is one of two statements from two different people who describe signs of life after breakfast. These are two of 32 interviews conducted by the lead investigator in this process. Although these two statements are significant, they represent only a portion of the investigation. These statements, along with all the other evidence need to be considered in the totality of the investigation. While there was opportunity to improve this aspect of the investigation, the result did not cause any change in the finding that no criminal act occurred in relationship to this death.

The purpose of this VCI unit investigation is to determine if a crime occurred. At no time was there any evidence that this was a criminal matter. The investigation conducted was extensive and ultimately concluded that the cause of death was medical.

Requested response for Finding 4, Page 14

F4 The statement of one CO (no longer with the department) that slight movement was noticed at 6:56am is questionable in light of the inmate witness's testimony, the testimony of other employees, and the forensic expert's estimated time of death. The testimony (to VCU) by this same CO indicates that he first arrived in Module D at 5:45 a.m. on November 6, 2006. No documentary evidence was provided to indicate his

assignment to, or presence in, Module D before 6 a.m. that morning. If the five earlier Module D rounds were done, evidence indicating which CO conducted those rounds and the nature of those checks is missing from the VCU investigation.

RESPONSE: The respondent disagrees partially with this finding.

The "CO's" (actually a Correctional Deputy, hereafter referred to as CD) statement of seeing slight movement at 6:56 a.m., although not consistent with other information in the case, is his account and recollection. It is not uncommon to find portions of witnesses' statements that conflict with other information in a case.

The statement in this finding that no evidence was provided to indicate the CD's presence in Module D earlier than 5:45 a.m. is not correct. The CD's statement at the time of interview by the lead VCI investigator is that he was "solely" in D Module at 6:00 a.m. His use of the word solely is a significant distinction in the facts of this case. This CD also states that he was Movement 1 and he was in and out of the unit. As the movement deputy he assists with rounds checks in modules. On the graveyard shift, there is not one CD assigned to each module, the duties are shared. This CD assisted with rounds checks within D Module.

This issue is further supported by a second CD's statement to the VCI lead investigator during his interview. This second CD said that the first CD took over D Module at 0300 hours, including conducting the rounds.

This finding states in part, "If the five earlier Module D rounds were done..." The five earlier rounds in D Module indeed were done. This is established by the RATS logs attached to the investigation. The RATS system does not record who conducted the rounds and this was not clarified through the investigation. The absence of this information did not undermine our ability to determine whether or not a crime occurred.

It appears that there is a conclusion by the Grand Jury that a CD missed Mr. McDowall in distress during a rounds check or missed his death during a rounds check. According to the Corrections Standards Authority inmates are entitled to a reasonable amount of uninterrupted sleep. The Sheriff's Department policy and procedure takes this into account in its expectations of employees conducting rounds in the middle of the night. The expectation of staff, during a graveyard shift, is that they look in the cell window for any problems, something out of the ordinary. They cannot absolutely identify signs of life from this position. This is a fair balance between the mandate of providing inmates with uninterrupted sleep and the reality that there is always the chance that a sleeping inmate could go into medical distress or die and not show readily observable indications of either.

Requested response for Finding 5, Page 14

F5 The Rounds Automatic Tracking System data files were lost due to hard-drive failure 17 days after the fatal incident and are unavailable to verify the paper documents indicating that rounds were completed in Modules C and D (Mr. McDowall's module) on the morning of November 6, 2006. The only available paper logs contradict statements of several COs interviewed. There is no reliable system available to identify who performed the rounds in Modules C and D that night.

RESPONSE: The respondent disagrees partially with this finding.

The Rounds Automatic Tracking System data files were lost due to hard-drive failure after the fatal incident and are unavailable to verify the paper documents. This is one of the reasons the RATS logs are obtained the day of the investigation. This way the best available evidence is obtained and preserved as soon as possible in the investigation. This way if a machine fails (as it did) the evidence is preserved. Proper investigative procedures have mitigated this hard drive failure.

The Sheriff's Department can find no evidence that the paper RATS logs contradict any of the CDs statements. The RATS system as designed does not account for who did the rounds but records the time that a key fob is placed against sensors throughout the module. This ensures that a CD walked around the module making the key fob entries while checking the inmates. There is no evidence that contradicts the fact that the rounds were done as documented on the RATS logs.

There is a system in place to identify who was assigned to a module and therefore who was responsible for the rounds during a particular time. This is done through an entry in an "Activity Log" that records pertinent events in the module. In this case, the Activity Log information was not accurate due to an entry made by one CD under another CD's name. This log entry is the only contradiction and it is explained by a CD in his interview during the VCI investigation.

Requested response for Recommendation 1, Page 16

R1 The Sheriff's Department should initiate another investigation of Mr. McDowall's death. This investigation should be led by an outside law-enforcement agency. The focus of this investigation may be limited to the resolution of the issues (F1, F3, F4, F5) raised in this Grand Jury report.

RESPONSE: This recommendation will not be implemented as it is not warranted.

There is no need for another investigation into this death. The initial facts of this case indicated a medical death. As the investigation progressed and further information developed this premise was only substantiated. The only purpose for a second criminal investigation would be if there was a question as to whether or not a crime occurred. There is no evidence or suggestion that the outcome or the facts of this case would change if the case was re-investigated.

F1 discusses the time of death. The facts of this case do not allow for a better time estimate of McDowall's death, whether or not it was re-investigated. The facts do establish that he died sometime after 3:15 a.m. and before 8:18 a.m.

F3 incorrectly states that the VCI investigator drew a conclusion as to time of death. F3 states that the VCI investigator bases that conclusion on a misinterpretation of the inmate witness' statement. As previously mentioned, this inmate's statement of whether or not he heard breathing at the time he attempted to serve McDowall breakfast is unclear. If indeed this inmate did not hear breathing at the time of breakfast service, this potential contradictory information will not change the facts of the case any further. There is still another witness, a CD, who states that he saw movement after the time of breakfast service and several witnesses to the rigor McDowall was in when he was found. This one inmate witness's statement, interpreted either way, will not point to any criminal actions leading up to McDowall's death. Therefore another investigation is not necessary. The evidence must still be evaluated in its totality to draw the most reasonable conclusion as in any investigation.

F4 finds doubt in the CD's statement regarding seeing slight movement from McDowall at 6:56 a.m. While there is some basis for this doubt, questioning this CD again will not make him change his statement. Witnesses' statements are not always consistent with all the facts and must be interpreted in the totality of the circumstances at hand.

F4 questions if the rounds checks were done in D module prior to 5:45 a.m. As established in the response to F4 the best evidence of these rounds was obtained and preserved the day of the initial investigation, proving that rounds were done. As mentioned by the Grand Jury, since that date the RATS system failed, a new investigation would not be able to verify the best evidence already obtained, as the data no longer exists.

F4 Questions if this CD was in D Module prior to 5:45 a.m. and what was the nature of the rounds checks in this module prior to 5:45 a.m. As stated in F4 this CD was in D Module prior to 5:45 a.m. This CD was not assigned solely to this module but was in and out as a Movement Deputy. The nature of the rounds checks in this module, prior to 5:45 a.m., although not clarified in the investigation, was not significant in determining if a crime occurred.

F5 discusses the hard drive failure of the RATS system. A second investigation cannot bring this data back. F5 also alleges that the RATS logs are contradicted by the CDs interviewed. As stated in the Response to F5, there is no evidence that the RATS logs are contradicted by anyone's statements. The RATS logs are a record of time stamps showing rounds in a module. No one contradicts this.

Requested response for Recommendation 2, Page 16

R2 The Sheriff's Department should develop a procedure to identify the COs performing rounds in MADF modules.

RESPONSE: This recommendation has not been implemented but will be implemented in the future when funds become available.

The RATS system in and of itself does not account for who did the rounds. There is an Activity Log that documents pertinent events in each module. This Activity Log should contain the name of the CD responsible for a given module at a given time; therefore the rounds stamped during that time would have been done by that CD. What this does not account for is the occasion where the CD responsible for the module is not available to conduct a round and another CD steps in for that particular round. The activity log would not necessarily capture the substitute CD who conducted the particular round.

In a pending capital improvement plan for MADF there is also a proposal for cameras in the day rooms. If this modification is made one would be able to see who was doing the rounds on a timed camera and cross check that with the RATS system. The estimate for this project is $350,000 to $548,000 depending on the selected options. This current proposal is on hold due to cost. It is anticipated that this upgrade will occur, at the latest, when the jail expansion project takes place.

Requested response for Recommendation 3, Page 16

R3 The Sheriff's Department should review the integrity of RATS and provide redundant storage of RATS data.

RESPONSE: This recommendation has been implemented.

Procedures regarding backup storage have been changed since the hard drive crash. Now the electronic media is backed up in another, redundant, location.

Requested response for Recommendation 4, Page 16

R4 The Sheriff's Department Internal Affairs Unit should investigate independently what occurred in Module D during the time that Mr. McDowall was housed there, specifically findings F1, F3, F4 and F5. This investigation should determine: which COs were involved, if procedures were followed, and if procedures need to be revised. If warranted, recommendations for disciplinary action should be made.

RESPONSE: This recommendation has not yet been implemented but will be implemented in the future. The time frame for implementation of this recommendation is six months.

Based upon the previous response to findings above, it is clear that the rounds checks were done and it is unlikely that any additional information as to who did the rounds

before 5:45 a.m. will change the end result. However, the Sheriff's Department agrees that who did the rounds and the issue of the incomplete log may be relevant to determine if policies and procedure were followed and or could be improved. For this reason the Sheriff's Department will add an addendum to the IA investigation addressing who conducted the rounds checks, the issue of the incomplete Activity Log, and whether or not procedures were followed or need to be revised. If warranted any recommended disciplinary action will also be included. This addendum will be completed within six months.