Review of Moses McDowall Fatal Incident

On November 6, 2006, Moses McDowall died while in custody at the Sonoma County Main Adult Detention Facility (MADF). As required by state law, a fatal-incident investigation was initiated by the Sheriff's Department. The Grand Jury's review of the Sheriff's investigation revealed evidence that strongly suggests that Mr. McDowall (a profoundly chronic alcoholic) died within the first few hours after being transferred from the booking area to a general-population cell at approximately 3:15 a.m. on November 6, 2006. Sheriff's Department policy requires that each prisoner's cell be checked by a Correctional Officer (CO) every 30 minutes. Thus Mr. McDowall should have been checked five times from his arrival in general population to the delivery of his breakfast at 6:00 a.m. Any one of these checks may have prevented his demise. Did these checks take place? If so, which CO performed them? Documents and sworn testimony regarding these questions contain discrepancies and contradictions, leaving many important questions unresolved. The Sheriff's Department investigation and the District Attorney's review of that investigation ignore these unresolved aspects of the incident.

The Grand Jury has determined that the initial Sheriff's Department investigation of this fatal incident, and the subsequent review of the investigation by the District Attorney were inadequate. The Grand Jury further concludes that the Sonoma County Law Enforcement Chiefs' Fatal Incident Protocol fails to ensure an independent and impartial investigation of jail deaths.

Reason for Investigation

The Grand Jury is required by state law to review all officer-involved fatal incidents that occur in Sonoma County. This requirement includes the obligation to review inmate jail deaths. In the past, the Grand Jury has discharged this responsibility with a cursory review of the incident summary report provided by the District Attorney. In the period between November 2006 and October 2007 four people have died while in custody at the MADF. Mr. McDowall died within hours of being placed in his cell. These circumstances prompted the Grand Jury to examine the McDowall incident closely, and to look into the procedures used to investigate fatalities occurring at the jail.

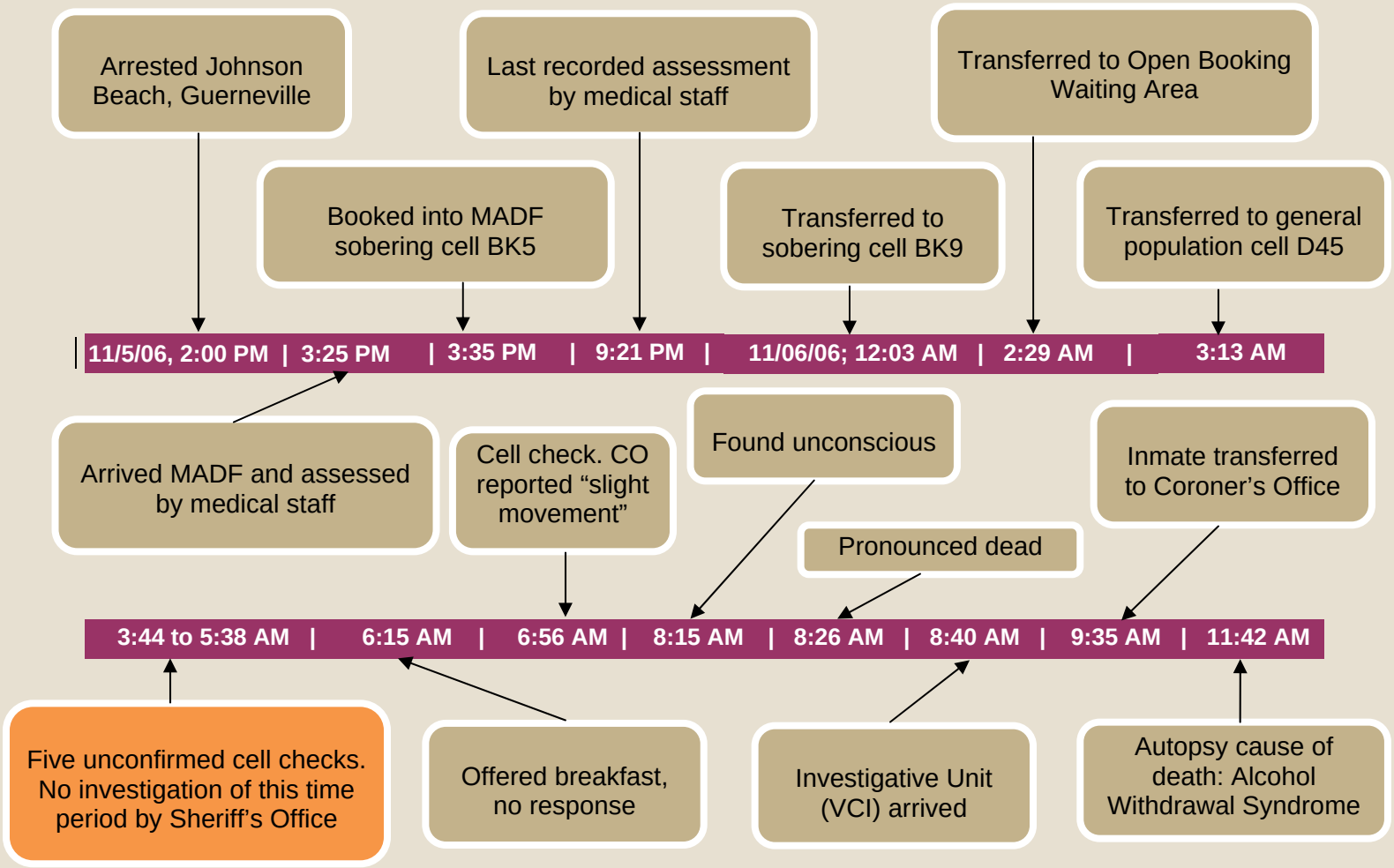
Background

Mr. McDowall was arrested when Sheriff's Department patrol deputies determined that he had two outstanding warrants from San Francisco. He was inebriated when he arrived at the MADF at 3:15 p.m. on November 5, 2006. He spent the next 12 hours in the booking area of the jail, being processed and classified. This exhaustive classification procedure revealed the following information about Mr. McDowall:

- He had consumed 1.75 liters of whisky that day.
- He was a chronic alcoholic;
- He had a history of *delirium tremens*, a potentially fatal aspect of Alcohol Withdrawal Syndrome.

The MADF relies on an independent contractor to manage the medical welfare of detainees. Inmates such as Mr. McDowall who may have medical complications related to alcohol or drug withdrawal are designated with a W classification. This classification is attached to the inmates' computerized records and can be removed only by the medical staff. It is also placed on the inmate's cell door. This is only to ensure that COs are aware of the inmates' medical condition, and that they are able to interpret the inmates' behavior in that context. Several COs interviewed by the Grand Jury confirmed that special attention is paid to inmates with a W classification. (The details of the medical procedures in the jail are the subject of a separate report by this Grand Jury.) Mr. McDowall was moved out of the booking area and placed into a general-population cell at 3:15 a.m. on November 6, 2006. He was found dead in that cell five hours later.

The uniform protocol for the investigation of an officer-involved fatal incident is defined by the Sonoma County Law Enforcement Chiefs' Association. This protocol describes the procedures and the roles of the participants, including the District Attorney. Subsequent to a 1997 Sonoma County Grand Jury recommendation, the protocol was revised to require that the investigation be led by a law-enforcement agency other than the one that is the employer of the involved officers. The purpose of this provision is to ensure the impartiality of the investigation, and to protect the investigated agency from the appearance of impropriety. **Incidents in the MADF are exempt from this requirement. As noted in section 1 subsection H 7 of the current protocol, the Violent Crimes Unit (VCU) of the Sheriff's Department Administration Division will lead the investigation of the Sheriff's Department Detention Division.**



Background (continued)

The Sheriff's Department Internal Affairs Division (IA) is required to conduct a separate investigation of every jail death. The purpose of the IA investigation is to determine**:**

- If the department's policies and procedures were followed;
- If there could be improvement in those policies and procedures;
- If any disciplinary action should be imposed against a particular individual or individuals.

The IA task is separate from the criminal investigation and does not require that there be criminal culpability to recommend disciplinary action. The content of the criminal investigation is available to IA, but by law the IA investigation may not be used in a criminal investigation of the incident. The IA investigation of Mr. McDowall's death appears to be adequate.
However, without any specific complaint in the McDowall case, IA relied completely on the flawed VCU investigation and did no independent interviews or fact-finding.

The District Attorney is required to participate in and review the investigation, and to submit its review to the Grand Jury. The District Attorney's review is intended solely to determine whether a criminal act, an unlawful act, or an act of omission has occurred. However, the protocol also requires the DA's office to participate in the investigation with the VCU. The protocol allows the DA to conduct an investigation independent from the lead agency. In Mr. McDowall's case, two DA investigators assisted the VCU, and no independent DA investigation was conducted.

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Every cell at the main detention facility is required to be visually checked by a CO approximately once every 30 minutes. The checks are automatically recorded by the Rounds Automatic Tracking System (RATS). The Grand Jury attempted to verify that Mr. McDowall's cell was checked five times on the morning he died, as was indicated by printed RATS logs included in the investigative reports. We were informed that this log could not be verified because of a subsequent computer failure. The VCU investigation revealed that no specific CO could be identified as having performed the required cell checks in the early morning hours of November 6, 2006. The Grand Jury determined that several critical issues relating to these visual checks were bypassed by the VCU investigation. These include:

- The CO in charge of the module in which Mr. McDowall was housed stated that he left the module prior to Mr. McDowall's arrival there and did not return that night;
- Another CO, presumed by IA to have performed the cell checks, stated to the VCU investigators that he did not get to the module until 6:00 a.m. that morning.
- RATS computer files were unable to verify the checks by COs of Mr. McDowall's cell.

Investigative Procedures

The Grand Jury interviewed the Assistant Sheriff in charge of the county detention facilities and toured the MADF. We examined closely the complex and exhaustive procedures used to classify inmates during booking. We observed the methods and procedures of COs working in the general-population modules of the MADF.

We obtained all Sheriff's Department documents relating to Mr. McDowall's time in the MADF. These included medical-classification documents generated during the 12 hours Mr. McDowall spent in the booking area. We verified that Mr. McDowall had been assigned a W classification due to his potential for alcohol withdrawal while in custody. Two Medical Experts were interviewed to determine the severity of the risks associated with alcohol withdrawal.

We interviewed the VCU lead investigator and obtained a copy of the department's own investigation, including recordings of interviews conducted by the investigators. The VCU investigation concluded that Mr. McDowall died after breakfast was served in Module D. Breakfast service ended at 6:30 a.m. It claimed that an inmate in Module D heard Mr. McDowall breathing loudly at about 6:15 a.m., but the Grand Jury found evidence in the recorded interviews which contradicted this claim. The remaining basis for the VCU conclusion as to time of death was that a CO observed "slight movement" (while sleeping) at 6:56 am. We interviewed the CO involved and investigated the circumstances of his observation. The Grand Jury determined that this CO's account of slight movement from outside a closed cell door was dubious at best.

The Grand Jury examined all of the accounts of Mr. McDowall's body when it was discovered in his cell at 8:18 a.m. on November 6, 2006. These included documented opinions by several "first responders" that he had died hours earlier. We explored the transcripts describing his degree of *rigor mortis* and lividity. Our research into the forensic significance of the observations made by the "first responders" indicates that Mr. McDowall died at least several hours before his body was discovered. We obtained expert verification of our research. An independent forensic pathologist and several other Doctors were consulted. They reviewed the autopsy, photographic evidence and documented observations. The expert's interpretation of the evidence confirmed our analysis and revealed additional indications of an earlier time of death.

After careful examination of the VCU documentation and recorded testimony, we focused our investigation on the discrepancies noted in the timeline between Mr. McDowall's arrival in Module D at 3:15 a.m. on November 6, 2006, and the time his body was discovered. The Grand Jury's own interviews of several COs discovered more inconsistencies and contradictions in the accounts of Mr. McDowall's time in Module D of the MADF.

Documents produced by the VCU investigation indicate that a CO performed the required cell checks in Module D on the morning of Mr. McDowall's death. The Grand Jury requested RATS logs for several modules in an attempt to cross-check the validity of the information included in the VCU report. The Sheriff's Department was unable to produce the requested information because the logs could not be regenerated from the RATS database due to a computer failure which occurred 17 days after the incident. An MADF computer specialist was interviewed to determine the nature of the "glitch", the overall integrity of the system, and other details of RATS.

The separate Internal Affairs report was reviewed and determined to be entirely based on the information provided by the VCU investigation. We searched in vain to find any indication of interviews conducted by IA. We looked for the basis on which IA determined the identity of the CO who performed the 5 cell checks between 3:15 and 5:38 am. We sought any IA investigation of that time period. The Internal affairs report included none of this information.

The Deputy District Attorney in charge of the fatal-incident review was questioned to determine the extent of the DA's participation in the investigation and the criteria used by the DA's office to conclude that no criminal acts, unlawful acts, or acts of omission occurred.

Findings

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.

F2 An independent forensic pathologist, consulted by the Grand Jury, concluded that the preponderance of evidence indicates that Mr. McDowall died before 6:00 a.m., and probably much earlier.

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.

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.

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.

F6 The Association of Joint Chiefs' Fatal Incident Protocol specified that this investigation be led by a division of the same law enforcement agency in which the fatal incident occurred (employer agency). The lead investigator was a former CO. The Grand Jury had to consider the obvious possibility that discrepancies in the investigation may have been intentionally overlooked. The appearance of, and possibly the actuality of, an impartial independent investigation is destroyed by this exception to the Fatal Incident Protocol.

F7 The District Attorney's review of the VCU investigation concludes that no criminal acts, unlawful acts, or acts of omission occurred between 3:15 a.m. and 6:00 a.m., which in all probability was when Mr. McDowall died. There is no clear evidence indicating which, if any, CO performed the five required cell checks during this period. Any one of these security checks, if done, may have saved his life. The DA and the VCU investigation failed to look into what occurred during this critical time. The unlikelihood of a successful criminal prosecution was given as a justification for the lack of pursuit of these issues. Justifications aside, the Grand Jury found that the Deputy District Attorney did not identify any of the issues we raised.

F8 Our review discovered errors in the investigation, which resulted in false assumptions. Principal among these were miscalculation of Mr. McDowall's time of death, and a failure to properly investigate events prior to the presumed time of death.

Conclusions

- The investigation of the in-custody death of Mr. McDowall represents a perfect example of "**how not to do it"** by all parties involved. Mr. McDowall's demise was officially recorded in the autopsy as "Alcoholic Withdrawal Syndrome as a result of chronic alcoholism, a natural cause of death." There is a viewpoint expressed by CO's and staff in the Sheriff's Department Detention Division that sick people die everywhere, including in jail. The Grand Jury disagrees with both the attitude and the assessment. Mr. McDowall's severe alcoholism had put his health at risk for many years. Until he was incarcerated, he was able to cope with the affliction in his own way. In jail, he does not have that option. It is the responsibility of the Sheriff's Department to assess Mr. McDowall's health and take the necessary measures to keep him alive. **With appropriate attention and minimal effort, this death was preventable**. Neither the initial VCU investigation nor the subsequent Grand Jury investigation indicate that the Sheriff's Department lived up to its responsibility to sufficiently monitor an inmate whose health was at risk. The Fatal Incident Report sheds no light on the matter.

- Mr. McDowall died sometime after he entered his cell at 3:15 am but before he was offered breakfast that morning. Our own research of the evidence and the independent assessment by a forensic pathologist concur. Usually the Coroner's autopsy report includes no speculation as to time of death. The autopsy was normal in that respect. Several of the doctors we consulted, including the forensic pathologist, commented that the cause of death was unusually non-specific.

- The VCU did not competently and impartially investigate the Detention Division's role in Mr. McDowall's death. The interviews of involved parties appeared to be prompted rather than interrogatory. The VCU investigator asked leading questions of the witnesses he interviewed. Misinterpreted testimony led to the failure to explore important issues.

  The Sheriff's Department did not decide on its own to lead the investigation of its own Detention Division. That decision is mandated by the Association of Law Enforcement Chiefs' Protocol. For that reason, the inference that the Sheriff's Department wanted an in-house investigation for some clandestine purpose is **not supported by the Grand Jury.**

- The District Attorney's participation and review of the Fatal Incident Report was not adequate to conclude that there was no criminal act, unlawful act, or act of omission. The Deputy District Attorney's review of the VCU investigation should have raised the same questions posed by the Grand Jury. Several prosecutors indicate that it is very difficult to prevail in a case involving a correctional officer. We do not presume that there was a criminal act. However, there could be criminal liability. The unlikelihood of a successful prosecution does not justify failure to investigate.

- The IA investigation relied on documentary evidence from the flawed VCU investigation. No independent interviews were conducted. The presumption that a specific CO did rounds in Module D before 6:00 a.m. on November 6, 2006, is unsupported by any documentary or testimonial evidence in either investigation.

- The Law Enforcement Chiefs' Association Fatal Incident Protocol generally provides for an impartial investigation free from the appearance of impropriety because the inquiry is led by a separate law-enforcement agency. The association's exemption for jail fatalities leaves those investigations open to the suspicion of bias and conspiracy.

- Sonoma County correctional officers are confronted with over 12,000 bookings annually into a jail system with a constantly changing average population of 1,100 inmates. COs often view an inmate withdrawing from alcohol addiction as "just another drunk." This indifference can result in cursory security checks and missed opportunities for intervention in health crises. An inmate's death may be the byproduct of such apathy.

Recommendations

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.

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

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

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.

R5 The District Attorney should conduct a new investigation into Mr. McDowall's death, either independently or in concert with the outside agency referred to in R1.

R6 The Law Enforcement Chiefs' Association should amend the Law Enforcement Employee-Involved Fatal Incident Protocol to require that investigations of deaths in custody be led by an outside law-enforcement agency. The exceptions to the routine prohibition--that the employer agency not lead or directly participate in the investigation--would be consistent with the procedures mandated for other law-enforcement employee-involved fatal incidents.

Required Responses to Findings	
Sheriff's Department	**F1, F3, F4, F5**
District Attorney	**F7**
Law Enforcement Chiefs' Association	**F6**

Requested Responses to Recommendations	
District Attorney	**R1**

Required Responses to Recommendations	
Sheriff's Department	**R1, R2, R3, R4**
District Attorney	**R5**
Law Enforcement Chiefs' Association	**R6**