STATE'S ATTORNEY'S OFFICE

CALVERT COUNTY

Declination Report Concerning the Death of Angel Manuel Jimenez on December 4, 2023 while incarcerated in the Calvert County Detention Center

October 30, 2024

410-535-1600 ext. 2369 ● 301-855-1243 ● MD Relay: 1-800-735-2258
www.calvertcountystatesattorney.com

Circuit Court Division: 175 Main Street ● Courthouse ● Prince Frederick, MD 20678

I. Introduction

The Calvert County State's Attorney's Office has completed its investigation into the circumstances surrounding the death of Angel Manuel Jimenez (DOB 08-17-1973). This report sets forth the findings and conclusions of that investigation.

The State's Attorney is an elected official holding office under Article V, Section 7, of the Maryland Constitution. He or she is charged with the responsibility of prosecuting all cases on behalf of the State in which the State may have an interest. Md. Code, Criminal Procedure Article, Section 15-102. The State's Attorney is vested with full investigative and subpoena powers. Md. Code, Criminal Procedure Article, Section 15-108.

In the case of Mr. Jimenez's death, the primary investigative agency was the Homicide Unit of the Maryland State Police (MSP). The lead investigator was Sgt. Kyle Simms.

The following documentation was obtained in this investigation and has formed the basis for the findings and conclusions set forth in this report:

- Initial Arrest 23-067395 – St. Mary's County Sheriff's Office – submitted by Dep. Absher
  - Supplemental Report – Interview of Det. Murphy submitted by D/Sgt. Lopez, MSP.
  - Supplemental Report 23-85259 – Arrest Report submitted by Det. Murphy, Calvert County Sheriff's Office (CCSO).
- Calvert County Detention Center (CCDC) booking card and associated documents.
- CCDC Intake records.
- Supplemental Report – Jimenez court proceedings submitted by Sgt. Simms.
- Supplemental Report – Interview of Public Defender Autumn James submitted by Sgt. Simms.
- Supplemental Report – Interview of LCSWs Vendetti and Ueno submitted by Sgt. Simms.
- Calvert Health Department – Mental Health Evaluation submitted by LCSW Vendetti.
- CCSO Criminal Investigation assault of CDFC Cress submitted by Dep. Tiradola.

- Calvert County 911 call, calls for service (CFS) and CAD detail.
    - Supplemental Report – 911 call transcription submitted by Sgt. Simms.
- Supplemental Report – Initial response submitted by D/Sgt. Lopez.
- Supplemental Report – Initial response submitted by Sgt. Simms.
- Supplemental Report – Initial response submitted by Sgt. Schwarb, MSP.
- Supplemental Report – Initial response submitted by Cpl. Wildman, MSP.
- Supplemental Reports – Crime scene analysis and notes submitted by CST Sexton, MSP.
- Supplemental Report – Initial video surveillance review submitted by Cpl. Wildman.
- Supplemental Report – Transcriptions of video surveillance containing audio submitted by Sgt. Simms.
- Supplemental Report – Overall timeline of events submitted by Sgt. Simms.
- Supplemental Report – Brandon Jimenez next-of-kin notification submitted by Sgt. Simms.
- Supplemental Report – Preliminary autopsy findings submitted by Sgt. Muehl, MSP.
    - Supplemental Report – Crime scene analysis and notes from the Office of the Chief Medical Examiner (OCME) submitted by CST Sexton.
    - Selected scene photographs taken by CST Sexton.
- OCME File for Angel Manuel Jimenez
- Supplemental Report – Deputy Newton interview submitted by D/Sgt. Lopez.
    - Supplemental Report – Deputy Newton body camera review submitted by D/Sgt. Lopez.
- Supplemental Report – Review of all body-worn camera submitted by Cpl. Wildman.
- CCDC Medical Records.
- Wellpath Medical records.
- Supplemental Report – Vital Monitor supplement submitted by Cpl. Wildman.
- Supplemental Report – AED extraction submitted by Cpl. Wildman.
- Supplemental Report – Nurse Roseanne Hall interview submitted by Cpl. Wildman.
- Supplemental Report – Attempts to interview Nurse Misty Bell submitted by Sgt. Simms.
- Supplemental Report – Inmate David Snyder interview submitted by Sgt. Simms.
- Supplemental Report – Inmate Karen Hall interview submitted by Sgt. Simms.
- Supplemental Report – Inmate Daniel Bangura interview submitted by Sgt. Simms.
- Supplemental Report – Inmate Joseph Mister interview submitted by Sgt. Simms.
- Supplemental Report – Inmate Nelson Garcia Interview submitted by D/Sgt. Lopez.
- Supplemental Report – CDFC Dakota Cress interview submitted by Sgt. Simms.
- Supplemental Report – CDFC Jarrett Turner interview submitted by Sgt. Simms.

- Supplemental Report – CDFC Alexandra Hart interview submitted by Sgt. Simms.
- Supplemental Report – CD Nicholas Sunderland interview submitted by Sgt. Simms.
- Supplemental Report – Cpl. Jeremiah Maksimovic interview submitted by Sgt. Simms.
- Supplemental Report – Cpl. Erik Snyder interview submitted by Sgt. Simms.
- Supplemental Report – Sgt. Charles Lindsay interview submitted by Sgt. Simms.
- Supplemental Report – CDFC Katie Lavorgna interview submitted by Sgt. Simms.
- Supplemental Report – CDFC Solomon Olumese interview submitted by Sgt. Simms.
- Supplemental Report – MCD Philip Brady interview submitted by Sgt. Simms.
- Supplemental Report – SCD Ross Montgomery interview submitted by Sgt. Simms.
- Supplemental Report – CD Jake Angell interview submitted by Sgt. Schwarb.
- Supplemental Report – CD Robert Stone interview submitted by Sgt. Schwarb.
- Supplemental Report – CD Nicholas Morgal interview submitted by Cpl. Wildman.
- Supplemental Report – Major Thomas "TD" Reece interview submitted by Sgt. Simms.
- Supplemental Report – Capt. Kevin Cross submitted by Cpl. Wildman.
- CCDC Incident Reports, Form 18, submitted by Deputies Hart, Cress, Turner, Maksimovic, Snyder, Lavorgna, Cross, Olumese, Montgomery, Stone and Lindsay.
- CCDC Use of Force Reports, Form 103A, submitted by Deputies Hart, Cress, Turner, Maksimovic, Snyder, Lavorgna, Cross, Olumese, Montgomery, Stone and Lindsay.
- CCDC Shift Supervisor Summary, Form 194, submitted by Cpl. Snyder and Sgt. Mohler.
- CCDC Round Count Sheet, Form 2, 15-minute check (Form 44) for Inmate Jimenez and three random inmates for comparison.
- CalvertHealth Medical Center records for care provided to Dakota Cress.
    - Supplemental Report – Service of subpoena submitted by Sgt. Ewig, MSP.
- Supplemental Report – CCDC policy and procedure manual excerpts submitted by Sgt. Simms.
- CCDC Organizational Chart.
- Training records from CCDC for involved Deputies.
- Training records from Southern Maryland Criminal Justice Academy for involved Deputies.
- Medic: CNA/CMT Misty Bell.
    - License and Certifications
    - Wellpath Job Description

    - Training received
- Medic: LPN Rosanne Hall.
    - License and Certifications
    - Wellpath Job Description
    - Training received
- Wellpath policy on restraints.
- Interview of Dr. Stash and Dr. Fernandez, OCME, conducted by Zoom on 9/23/24 by Calvert County State's Attorney's Office.

II. Timeline

The timeline set forth below is intended to summarize the progression of events that preceded the death of Angel Manuel Jimenez. It is intended as a reference guide and does not include all known facts ascertained in this investigation.

Date	Time	Event
9/29/23	9:00 a.m.	Mr. Jimenez fails to appear for child support hearing in Calvert County Case No. 04-P-08-000122. Body attachment issued by the Court for his arrest. Purge set at $5,000.
11/30/23	8:50 a.m.	Mr. Jimenez arrested in St. Mary's County on open body attachment.
11/30/23	10:30 a.m.	Mr. Jimenez arrives at Calvert County Detention Center (CCDC) and is processed in.
11/30/23	1:01 p.m.	Vitals: BP 156/96
11/30/23	1:52 p.m.	Medical evaluation. History of sickle cell anemia. Undisclosed and untreated high blood pressure.
12/1/23	4:20 a.m.	Vitals: BP 180/80
12/1/23	8:47 a.m.	Mr. Jimenez refuses to meet with his attorney or appear virtually at an Initial Appearance hearing.
12/1/23	10:00 a.m.	Mr. Jimenez undergoes mental health evaluation as ordered by Court.
12/1/23	3:44 p.m.	BP medication prescribed
12/1/23	5:42 p.m.	Initial dose of BP medication (clonidine) administered.
12/1/23	7:53 p.m.	Mr. Jimenez reports that he feels like he is going to pass out. Vitals: BP 188/100. Orders noted for clonidine, lisinopril, hydrochlorathiazide.
12/1/23	7:53 p.m.	Vitals: BP 188/100
12/1/23	9:17 p.m.	Vitals: BP 149/92
12/1/23	9:53 p.m.	Vitals: BP 163/100
12/1/23	9:55 p.m.	Mr. Jimenez placed on low sodium diet.
12/2/23	4:45 a.m.	Vitals: BP 176/111
12/2/23	2:35 p.m.	Mr. Jimenez refuses to take BP medication
12/2/23	3:24 p.m.	Mr. Jimenez complains of chest pain and demands to go to hospital. EKG taken at CCDC and analyzed by certified physician's assistant. No need to transport to hospital. Mr. Jimenez again refuses to take medication.
12/2/23	3:27 p.m.	Vitals: BP 171/111
12/3/23	4:25 a.m.	Mr. Jimenez refuses to take BP medication.
12/3/23	10:48 a.m.	Vitals: BP 144/84
12/4/23	7:00 a.m.	Mr. Jimenez refuses to take BP medication.

12/4/23	9:27 a.m.	Mr. Jimenez appears virtually in Calvert County Circuit Court for an Initial Appearance. Purge reduced to $750. Hearing scheduled for 1/4/24.
12/4/23	1:20 p.m.	Mr. Jimenez complains of headache. When Correctional Deputy (CD) Cress opens cell door to check on Mr. Jimenez, Mr. Jimenez charges at CD Cress, striking him and knocking him to the ground.
12/4/23	1:22 p.m.	Mr. Jimenez subdued by other CDs and spit mask put over his head.
12/4/23	1:23 p.m.	Mr. Jimenez placed and secured in restraint chair.
12/4/23	1:24 p.m.	Mr. Jimenez wheeled into holding cell.
12/4/23	1:45 p.m.	First restraint check on Mr. Jimenez conducted by CNA Bell. Mr. Jimenez complains that he can't breathe. Spit mask adjusted by CD Sunderland.
12/4/23	2:04 p.m.	Second restraint check on Mr. Jimenez by LPN Hall. Hall states "He's good."
12/4/23	2:18 p.m.	Third restraint check by LPN Hall.
12/4/23	2:20 p.m.	LPN Hall leaves cell after completion of restraint check.
12/4/23	2:21 p.m.	SCD Montgomery enters cell and finds Mr. Jimenez non-responsive. Performs sternum rub and summons LPN Hall.
12/4/23	2:22 p.m.	LPN Hall returns to cell and finds Mr. Jimenez non-responsive. Directs removal of spit mask and arm restraints. CPR and AED initiated. EMS called via 911.
12/4/23	2:29 p.m.	EMS arrives. CPR and AED continued. EMS administers 4 doses of epinephrine and 1 dose of Narcan without results. After 47 minutes, all life-saving measures exhausted. Mr. Jimenez pronounced deceased.

III. Factual Summary

Angel Manuel Jimenez (Jimenez) was initially taken into custody in this matter after riding his bicycle from his residence in Great Mills, Maryland to the St. Mary's County Sheriff's Office. On November 30, 2023, at approximately 8:50 a.m., Jimenez had traveled to the St. Mary's County Sheriff's Office seeking a background clearance with reference to his employment at PAX River (Naval Air Station Patuxent River). While conducting a wanted persons check, Sheriff's Office personnel discovered that Jimenez had an open warrant with reference to a child support matter in Calvert County. Specifically, Jimenez was the subject of an active child support case, No. P08-122, for which he failed to appear for a court date on September 29, 2023. As a result of that failure to appear, a Calvert County Circuit Court Judge issued a warrant for his arrest on the same date.

Jimenez was arrested and transported to a 7-Eleven whereupon he was turned over to Detective Murphy of the Calvert County Sheriff's Office for transport to the Calvert County Detention Center (CCDC). An associated arrest report from the Calvert County Sheriff's Office indicates Jimenez was arrested on November 30, 2023 at 9:50 a.m. After arriving at CCDC at approximately 10:30 a.m. on November 30, 2023, Jimenez was served with a copy of the warrant and released to the custody of the correctional deputies. Det. Murphy indicated that Jimenez was calm and pleasant during their interaction.

At 1:52 p.m. on November 30, 2023, Rosanne Hall (Hall), a Licensed Practical Nurse working at CCDC, conducted an intake medical and mental health screening with respect to Jimenez. During that screening Jimenez denied having a mental health history or having any current prescriptions for medication. He did, however, report a history of Sickle Cell Anemia.

Jimenez specifically denied both a history of high blood pressure and of having any heart condition. Hall found that Jimenez's blood pressure was elevated (156/96) during this screening and ordered that his blood pressure be monitored for the next 7 days prior to releasing him into general population.

Jimenez was scheduled to appear virtually from CCDC for an Initial Appearance in court with respect to his child support case at 8:30 a.m. on December 1, 2023. At that time, his counsel, Autumn James, Esq., explained to the Court that Jimenez had refused to meet with her and was refusing to appear for the Initial Appearance. The Court ordered that CCDC personnel perform a mental health evaluation upon Jimenez and then reset the Initial Appearance for December 4, 2023. That evaluation was completed by Casey Vendetti (Vendetti), a mental health therapist at CCDC. In an associated report to the Court dated December 1, 2023, Vendetti wrote that while Jimenez showed "no signs of persistent serious mental issue(s)", he "presented as irritable and demanding with little insight related to his behaviors." In an internal CCDC note to the Booking department sent the same day, Vendetti also stated that Jimenez "presents with anger, frustration, and a limited ability to comply with CCDC protocols."

In addition to being evaluated by Vendetti, the CCDC medical staff continued to monitor Jimenez's health. Specifically Misty Bell (Bell), a Medical Technician/Nursing Assistant, checked his blood pressure on three separate occasions on December 1, 2023 with an unknown staff member checking it a fourth time. Additionally, Bell placed a call to Ronald Grubman (Grubman), a Certified Physician's Assistant, with reference to Jimenez's complaint that he felt like he was going to pass out, also on December 1, 2023. Grubman then prescribed Clonidine, Lisinopril, and Hydrochlorothiazide (all medicines for the treatment of hypertension) for Jimenez

and ordered that he was to be placed on a cardiac/low sodium diet. Jimenez took his dose of Clonidine on December 1, 2023, at 5:42 p.m. but refused any additional medication.

On December 2, 2023, Hall again saw Jimenez. At that time, Jimenez stated that he was having chest pains and demanded to be released from CCDC so that he could go to the hospital for an Electrocardiogram (EKG). Hall then asked that Jimenez be transferred to an exam room so that an EKG could be performed at CCDC. Grubman reviewed the results of the EKG and determined that there was no need to transfer Jimenez to a hospital. Hall attempted to explain the importance of taking his prescribed medication to Jimenez, but he refused and stated that he wanted to see a "real doctor." Jimenez was returned to his cell after his vital signs were taken.

On December 3, 2023, CCDC medical staff again conducted a check of Jimenez's vital signs, and he again refused his prescribed medication. At approximately 9:30 a.m. on December 4, 2023, Jimenez was again before the Court for his Initial Appearance. He had refused his prescribed medication prior to that hearing. At the conclusion of that hearing, the Court set Jimenez's child support matter for January 4, 2024, and reduced his purge amount from $5,000 to $750[1].

At approximately 1:20 p.m. on December 4, 2023, Correctional Deputy First Class Dakota Cress (Cress) heard Jimenez ask for medical attention and state that he had "a headache from hell." At that time, Jimenez was being housed in a single cell directly adjacent to a desk at which the correctional deputies assigned to Booking were working. That cell contains a surveillance video that records the interior of the cell without audio. Cress notified Hall of Jimenez's request, and she asked that Jimenez be brought to her so that she could measure his

[1] A purge amount is the amount of money required to purge the Court's finding of contempt.

vital signs. At that point Cress approached the cell in which Jimenez was housed and opened the cell door. Cress then asked Jimenez if he would be willing to have the nurse check his vital signs and to take his prescribed medicine; Jimenez agreed to both. At the time of this conversation, Jimenez was standing in this cell with a blanket wrapped around himself; Jimenez with the blanket is captured on the surveillance video. Because it is against CCDC policy for an inmate to leave a cell with a blanket, Cress instructed Jimenez to take the blanket off and leave it in the cell. Instead of removing the blanket, Jimenez charged at Cress and pushed him away from the entrance of the cell and into the Booking desk. A struggle ensued and Jimenez took Cress to the floor during which Cress hit his head and sustained a concussion. Two separate surveillance cameras located in the Booking area, and directed at the Booking desk, recorded Jimenez assaulting Cress. These cameras are without audio.

Correctional Deputy First Class Alexandra Hart (Hart) was working at the Booking desk at the time of the assault. Hart witnessed Jimenez punch Cress in the face with a closed fist after Cress opened his cell door. She initially attempted to assist Cress but instead started videotaping the incident using a handheld camera with the arrival of other correctional deputies. Hart recalled that the correctional deputies were eventually able to place Jimenez into a restraint chair as he actively resisted. Specifically, she witnessed Jimenez attempt to lunge forward out of the chair. Hart also stated that Jimenez was not put in the chair's "soft restraints", but rather remained handcuffed, because of his resistance.

Correctional Deputy First Class Jarrett Turner (Turner) was standing next to Hart at the time of the assault and witnessed Jimenez push Cress backwards into the Booking desk counter and then on to the floor. Turner immediately attempted to assist Cress by attempting to flip Jimenez over, however Jimenez was kicking and actively resisting attempts to subdue and

handcuff him. Despite his attempts to pull away, Turner was able to assist placing Jimenez into the restraint chair.

The CCDC Shift and Booking Supervisor at the time of this incident was Sgt. Charles Lindsay (Lindsay). Lindsay first became aware of the assault of Cress when he heard a distress call over his radio. He immediately ran to the location of the assault and found multiple officers attempting to subdue Jimenez. As Lindsay was observing the altercation, Jimenez reached out and grabbed him by the foot. Lindsay then pulled away and retrieved the restraint chair. As the Shift Supervisor, Lindsay had the ability to authorize the use of the restraint chair pursuant to § 255.002 of the CCDC Correctional Deputy Manual (Manual). Upon returning with the restraint chair, Lindsay observed that, although handcuffed, Jimenez continued to resist attempts by the officers to subdue him. Lindsay ordered that a spit mask (mask) be placed on Jimenez's head as he was being secured in the restraint chair as well as that "the cuffs stay on." The mask was seized by the investigating officers in this case and appears to be made from a mesh fabric. When applied, the mask covered the entirety of Jimenez's head and face. Once secured, Lindsay wheeled the restraint chair into the court holding cell adjacent to the Booking desk at approximately 1:24 p.m.

From the time when he assaulted Cress until the time he was wheeled into the court holding cell, Jimenez yelled various suicidal statements, nonsensical statements, and nonspecific threats toward staff. Some of these statements are captured by the handheld camera used by Hart whose recording included audio. A surveillance camera positioned within the court holding cell (without audio) captures Lindsay wheeling Jimenez into that cell along with several other officers; this camera continuously records Jimenez while he is in the restraint chair. Jimenez is positioned facing toward the wall and away from the camera with the mask on. Once positioned

in this fashion, the officers exit the cell and close the court holding cell door. Approximately two minutes later, an unknown officer opens the court holding cell door and momentarily enters the cell before quickly closing the court holding cell door again. Up to this point in the surveillance video, Jimenez is seen to be constantly fidgeting in the restraint chair. Additionally, Hart recalled that Jimenez continued to scream while inside of the court holding cell.

CCDC personnel performed the first restraint check of Jimenez at approximately 1:45 p.m. or approximately 19 minutes after the unknown officer exited the court holding cell. This check consisted of Deputy Nicholas Sunderland (Sunderland) and Bell entering the cell to check Jimenez's restraints and breathing. This restraint check was visually and audibly recorded by Sunderland using a handheld camera, as well as by the surveillance camera which continuously recorded video only. The handheld recording of that check shows that Jimenez was speaking during that check and made statements including the following: "help me please," "take the mask off," "I'll behave," "I need oxygen," "I'm bleeding to death on my head," "George Floyd," "I need air, I need oxygen." Also captured on the recording is Bell checking the restraints on Jimenez's shoulders, hands, and feet. Sunderland is also seen checking and adjusting the mask. During a subsequent interview, Sunderland stated that he noticed a little blood near the nose part of the mask during the check, and also observed blood under Jimenez's fingernails while he was adjusting his handcuffs. This restraint check took approximately 50 seconds whereupon Sunderland and Bell exit the court holding cell.

The court holding cell surveillance camera shows that Jimenez continues to move until Cpl. Erik Snyder (Snyder) enters the cell approximately three minutes after the first restraint check was concluded. Snyder reported that he entered the cell in an attempt to speak with Jimenez. Jimenez immediately began to yell, and Snyder determined he would not be able to

have a productive conversation, so he exited the cell approximately 10 seconds later. After approximately another minute, Lindsay briefly entered the cell to make sure that Jimenez was breathing. During that interaction, Jimenez asked to get out of the chair and Lindsay denied that request. Satisfied that Jimenez was breathing, Lindsay then exited the cell.

For the next approximately 11 minutes, the surveillance video shows that Jimenez consistently moves his body, including his torso, legs, and head. At the 11 minute mark, Jimenez places his head on the restraint chair's headrest and continues to move it slightly until Sunderland and Hall enter the cell to conduct the second restraint check at 2 p.m. or roughly 14 minutes since Lindsay exited the cell. The court holding cell surveillance video shows that Hall checked the restraints on Jimenez's shoulders, waist, and feet after Sunderland adjusted the restraint chair in the cell by rolling it backward slightly. The handheld video taken by Sunderland, with audio, reveals that Jimenez did not speak during this restraint check which lasted approximately 50 seconds. However, Sunderland subsequently stated that he heard Jimenez breathing and saw his chest moving during that check. Additionally, Hall stated that she saw Jimenez's neck move slightly during this restraint check. Sunderland and Hall both exit the cell together at the conclusion of the restraint check.

Both Sunderland and Hall reenter the cell, along with Cpl. Jeremiah Maksimovic (Maksimovic), at approximately 2:15 p.m. From the court holding cell surveillance video, it does not appear that Jimenez moves at all in between the second and third restraint checks. Maksimovic stated that he entered the cell in order to determine if Jimenez had calmed down enough for him to explain the current situation to him. Additionally, Maksimovic wanted to determine if Jimenez was cooperative enough for him to remove the handcuffs and restrain his arms in the restraint chair as designed. The first of two handheld videos taken by Sunderland

during the third restraint check shows that Hall checks the restraints on Jimenez's shoulders, torso, and feet prior to stating "he's good." Jimenez neither moves nor makes a sound during this first handheld video. Sunderland begins to record the brief second handheld video moments after the first one concluded. That video shows Hall examining Jimenez's handcuffs and observing that one of the handcuffs is loose but pushing into his wrist; again, no movement or sound from Jimenez is recorded.

The court holding cell surveillance video of the third restraint check shows that Hall performed these checks while Sunderland and Maksimovic looked on. Hall then departs from the cell after performing these checks while Sunderland and Maksimovic remain in the cell[2]. Sunderland then approaches Jimenez and adjusts his right shoulder restraint before continuing to observe Jimenez along with Maksimovic. At some point after the restraint check, Sunderland stated that he noticed that Jimenez didn't appear to be breathing and notified Hall. Maksimovic reported that he said Jimenez's name a few times after Hall conducted her check and he received no response. The court holding cell surveillance video shows that while Sunderland and Maksimovic appear to discuss the situation in the cell, Senior Correctional Deputy Ross Montgomery (Montgomery) enters the cell and immediately moves Jimenez's head with his hand. Montgomery said that he entered the cell because he heard Sunderland say that he didn't think Jimenez was breathing. Jimenez does not respond to the head movement and Montgomery observed that Jimenez's chest was not moving. Seconds later, Lindsay entered the cell because he had heard someone mention that Jimenez was not breathing. Lindsay in turn called for Hall who responded back to the cell. At that time Montgomery removed the mask and observed no

[2] During a subsequent interview, Hall stated that she could not remember whether she "checked" Jimenez during this third restraint check. What was meant by the word "check" in the specific context of that question and answer is not entirely clear based on the transcript of that interview.

eye movement from Jimenez and was also unable to detect a pulse. Moments later the officers removed the handcuffs and straps from Jimenez and began life-saving measures. Officers and medical staff attempted to use oxygen and an Automatic External Defibrillator (AED) before moving on to chest compressions. These efforts continued for approximately 5 minutes whereupon EMS personnel arrived and took over the chest compressions. These continued for approximately 35 minutes before Jimenez was pronounced deceased.

During subsequent interviews of Bell and Hall, both indicated that they were employed by Wellpath which provides medical staff to the CCDC. Pursuant to the Wellpath Policy Manual reviewed as part of the investigation in this case, the confinement of Jimenez to the restraint chair would be considered a "custody-ordered restraint" because that confinement was initiated by CCDC staff in order to control Jimenez. The Wellpath Manual further states that their employees do not participate in custody ordered restraint aside from notifying staff of "any medical contraindications for restraint and conducting health monitoring while a patient is in custody-ordered fixed restraints[3]." This monitoring includes but is not limited to checking the circulation and respiration of the patient and monitoring the patient's extremities for color, temperature, and pulse[4].

IV. Supplemental Information

On December 5, 2023, Dr. Kamilah Fernandez, an Associate Pathologist with the Office of the Chief Medical Examiner, performed the autopsy of Jimenez. A corresponding Post Mortem Examination Report was completed and dated July 16, 2024, and received by the Calvert County State's Attorney's Office on August 2, 2024. It is the opinion of Dr. Fernandez

[3] *See Wellpath Emerald Policy Manual Policy & Procedures Section 3*.
[4] *See Wellpath Emerald Policy Manual Policy & Procedures Section 6.20.1.*

that Jimenez died of "Restraint complicated by Hypertensive Atherosclerotic Cardiovascular Disease" and that "the manner of death is best certified as Homicide." With reference to the "restraint" aspect of her opinion, Dr. Fernandez notes six specific findings: (1) Subdued and restrained by multiple correctional deputies after charging correctional deputy (2) Placed in handcuffs behind his back and in leg irons (3) Placed in spit hood and strapped in restraining chair via shoulders, waist, and ankles with handcuffs behind his back (4) Contusions on bilateral wrist, tongue, lower lip and right arm (5) Negative anterior and posterior cut downs (6) Negative anterior neck dissection. Elsewhere in her report, Dr. Fernandez gives a fuller description of the contusions cited above. Specifically, she observed a 3/4 inch contusion on the tongue, a 3/4 inch contusion on the right wrist, a 3/8 inch contusion on the left wrist, and a 1 inch contusion on the right arm. No other external injuries were observed.

On September 23, 2024, attorneys with the Calvert County State's Attorney's Office, along with D/Sgt. Frank Lopez and Sgt. Kyle Simms of the Maryland State Police, discussed the autopsy report with both Dr. Fernandez and Dr. John Stash, Deputy Chief Medical Examiner. During that call, the Doctors stated that all of the various modes of restraint, when considered in their totality, in combination with the factor of preexisting Cardiovascular Disease, caused the death of Jimenez. Furthermore, neither Doctor could testify that any particular mode of restraint was more or less significant in causing his death. When specifically asked about the chair restraints, Dr. Stash explained that those restraints, particularly the shoulder restraints, would have inhibited Jimenez's ability to breathe. Moreover, the Doctors could not say whether Jimenez would have died from being restrained absent the complicating factor of his heart disease. However, the Doctors did state that, hypothetically, had Jimenez been found dead in his

cell with the same heart disease five minutes before assaulting Cress, they would have ruled heart disease as the cause of death.

When asked if they were able to tell if Jimenez had a heart attack, the Doctors said that, because he died, they would not be able to say with certainty but acknowledged that he could have died from a heart arrhythmia or cardiac arrest. Finally, the Doctors stated that it would be impossible for them to say when Jimenez died from looking at the court holding cell surveillance video of him sitting in the restraint chair.

V. Legal Analysis

The State's Attorney's Office has the sole constitutional prerogative to prosecute, or to decline to prosecute, a criminal case in Calvert County. The decision whether to prosecute a particular case is affected by many variables but must always begin with a review of the evidence. This analysis requires a detailed examination of the evidence needed to prove each and every element of the offense or offenses charged, beyond a reasonable doubt, and of the evidence needed to prove criminal intent.

After thoroughly reviewing the entirety of the investigation in this case, the State considered several potential criminal offenses.

A. Excessive Force

The Maryland Use of Force Statute, Public Safety Article § 3-524, imposes specific constraints on the use of force by police officers. Violations of these constraints subject the offenders to criminal penalties. Police officers are defined in the Statute as individuals who are

"authorized to enforce the general criminal laws of the State[5]." None of the CCDC personnel who were the subject of this investigation meet this definition. None are considered to be sworn police officers pursuant to the Maryland Police and Correctional Training Commissions (MPCTC) standards. Because none of the relevant personnel are subject to the constraints of the Maryland Use of Force Statute, the State did not find any potential criminal liability with respect to that law.

B. Assault

Assault may be defined as the unlawful application of force to the body of one individual by another. Although correctional deputies used physical force to subdue and restrain Jimenez, they were legally justified in doing so because they were coming to the defense of Cress, who had just been assaulted by Jimenez. No more force was utilized than was reasonably necessary to prevent further injury to Cress and the person and property of others. There is no legal basis to bring assault charges against any of the correctional deputies involved in this case[6].

C. Involuntary Manslaughter

Given the facts and circumstances of this case, the State considered the appropriateness of charging one, or more, CCDC personnel with committing Involuntary Manslaughter[7]. Involuntary Manslaughter is a common law felony generally defined as an unintentional killing done without malice, in negligently doing some act lawful in itself or by the negligent omission to perform a legal duty[8]. In order to prove that a particular person committed Involuntary

[5] *See* MD. Public Safety § 3-201.
[6] *See Lamb v. State*, 93 Md.App. 422 (1992).
[7] MPJI-Cr. 4:17.9 Homicide – Involuntary Manslaughter (Grossly Negligent Act and Failure to Perform Legal Duty) (3d. Ed. 2024).
[8] *See State v. Kanavy*, 416 Md. 1 (2010).

Manslaughter, the State must establish, beyond a reasonable doubt, that a defendant acted in a grossly negligent manner, and that their gross negligence caused the death of Jimenez. Gross negligence means that a defendant, while aware of the risk, acted in a manner that created a high degree of risk to, and showed a reckless disregard for, human life. The State's burden will not be satisfied by merely establishing ordinary negligence. Rather, the State must prove such gross negligence, above and beyond mere civil negligence, as to show a wanton or reckless disregard for human life[9]. Additionally, the State must establish a causal connection, beyond a reasonable doubt, between the gross negligence and the death of Jimenez in order to support the conviction. The State is not required to show that the death of Jimenez was foreseen or intended by the defendant. However, the issue of whether a defendant's conduct amounted to gross negligence must be determined by examining the conduct itself and not by the resultant harm[10]. This causal connection includes actual "but-for causation" and "legal causation." In order to prove actual causation, the State must prove that the death would not have happened in the absence of the defendant's conduct. To establish legal causation the State must establish that a reasonable person would foresee the death of Jimenez as reasonably related to the defendant's conduct[11].

There are two variations of Involuntary Manslaughter that are relevant to this investigation; Involuntary Manslaughter – Grossly Negligent Act and Involuntary Manslaughter – Failure to Perform a Legal Duty. After a thorough review of the investigation in this matter, the State has identified three instances where the conduct of CCDC personnel was arguably negligent; two of the Grossly Negligent Act variety and one of Failure to Perform a Legal Duty.

[9] *See State v. Morrison*, 470 Md. 86 (2020).
[10] *See Mills v. State*, 13 Md. App. 196 (1971).
[11] *See Beckwitt v. State*, 477 Md. 398 (2022).

In order to establish the Grossly Negligent Act variation of Involuntary Manslaughter, the State must establish that a defendant caused the death of Jimenez by doing some lawful act in a grossly negligent manner. The first instance involves the use of the restraint chair. Instructions for how to properly use the restraint chair are outlined in § 255 of the CCDC Manual. Specifically, § 255.001 dictates that the restraint chair "will provide containment of an inmate exhibiting violent and/or uncontrollable behavior and/or that has been determined as a threat to themselves or to others." Pursuant to § 255.002, the Shift Supervisor may authorize the use of the restraint chair. Considering the wholly unprovoked and violent assault committed by Jimenez upon Cress, there is no question that Shift Supervisor Lindsay properly authorized the use of the restraint chair in this case. While § 255.003 requires that an inmate be handcuffed behind the back and leg irons be applied prior to being placed in the restraint chair, the same section requires that the handcuffs and leg irons be removed once the inmate is secured in the restraint chair. Section 255.003 does not caution that a failure to remove the handcuffs or leg irons could cause a substantial risk of death or serious physical injury. This is notable especially considering that section does caution that other misuse of the chair does pose those risks: "[t]he chair must always be used in an upright position, leaving the chair on its side or back may cause injury or death to the detainee." Additionally, the instructions for use of the restraint chair (SureGuard Correctional Chair Instructions) from the manufacturer also fail to mention a substantial risk of death or serious physical injury: "[h]andcuffs and leg irons must be removed as soon as possible to prevent injury[12]."

Lindsay never stated during this investigation why he ordered that "the cuffs stay on" after Jimenez was placed in the chair. Hart stated that she attributed this order to the fact that

[12] *See* SureGuard Correctional Chair Instructions.

Jimenez was actively resisting being placed in the chair and lunged forward when officers attempted to secure him in the chair. It appears that Maksimovic had similar thoughts about the situation. He stated that he entered the cell during the third restraint check to see if Jimenez was cooperative enough to be placed in the restraint chair as designed.

Regardless, Lindsay's order that "the cuffs stay on" while the officers placed Jimenez into the restraint chair was contrary to CCDC policy. However, the evidence does not establish that Lindsay exhibited a wanton or reckless disregard for human life by failing to remove the handcuffs and leg irons after Jimenez was secured in the chair. Lindsay reentered the cell after Jimenez was restrained in the chair so as to personally observe his condition after the first restraint check. Moreover, Lindsay knew that medical personnel would be checking on Jimenez at 15 minute intervals. Lastly, because the Doctors are unable to say that any individual mode of restraint caused the death of Jimenez, in conjunction with his cardiovascular disease, the evidence does not establish that Lindsay's order actually caused that death.

The second instance of arguably negligent conduct relates to the use of the mask. The CCDC Manual addresses the use of the mask (or "spit net") in § 255.004[13]. That section states that the mask "may be applied before the inmate is placed in the restraint chair." Additionally, that section notes that the "spit net will not restrict breathing" and will be removed "if any difficulty in breathing is observed." The decision of when to remove the mask is left to the discretion of the supervisor on-duty, in this case Lindsay. The surveillance video shows that Lindsay briefly entered the cell with Jimenez in between the 1:45 p.m. and 2 p.m. restraint

[13] According to § 255.004, the "spit net is placed over the head and secured under both arms and is not restricting the neck by any means." After reviewing photos of the mask and reviewing the video of officers applying, adjusting, and removing the mask, it does not appear that this particular mask was, or could be, secured under the arms of Jimenez. It is unclear from this investigation whether § 255.004 contemplates a different type of mask than was used on Jimenez.

checks. Lindsay stated that he entered the cell to make sure Jimenez was breathing and determined he was because he was speaking; at that point Jimenez had been wearing the mask for approximately 25 minutes. Just prior to the interaction between Lindsay and Jimenez, Sunderland and Bell conducted the 1:45 p.m. restraint check. During that check, Jimenez asked that the mask be removed because he needed oxygen. Sunderland found that Jimenez was breathing and speaking during this check. Furthermore, he observed that the mask had ridden up on his face and adjusted it to the proper position. Sunderland made a similar observation of Jimenez's breathing during the 2 p.m. restraint check; that Jimenez's chest was moving and that he was breathing. The next opportunity for the staff to personally observe Jimenez wearing the mask was during the third restraint check at approximately 2:15 p.m. It was during this check that the officers, including Lindsay, observed that he was not breathing, and the mask was removed.

The evidence does not establish that Lindsay exhibited wanton or reckless disregard for human life for ordering Jimenez to wear the mask for as long as he did. Lindsay personally checked on Jimenez and found that he was not having difficulty breathing after wearing the mask for approximately 25 minutes. He knew that other personnel would also be checking on Jimenez at regular intervals. None of these personnel reported to Lindsay that Jimenez was having difficulty breathing until well into the third restraint check when he had stopped breathing entirely. Jimenez did ask that the mask be removed and said he needed oxygen during the first restraint check, but he also said that he was "bleeding to death on my head" at the same time. Neither of these statements were contemporaneously corroborated by observations of CCDC personnel. Moreover, while the Doctors noted the "spit hood" as an aspect of the way in which Jimenez was restrained, they stated during the September 23, 2024, call that the spit hood was

not an especially significant mode of restraint when compared to the others listed. As such, there is no evidence that the application of the mask caused the death of Jimenez, especially since asphyxiation is not listed as a cause of death.

The final potential charge that the State considered related to Involuntary Manslaughter was for Failure to Perform a Legal Duty related to the medical care, or lack thereof, provided by Hall and Bell. Essentially, the State considered whether there was evidence that Hall and Bell acted with wanton and reckless disregard for human life by failing to appropriately monitor Jimenez while he was confined to the restraint chair. Again, after a review of the investigation, the State has found no evidence to support this charge.

It is without question that CCDC personnel had a duty to provide medical care for Jimenez while he was incarcerated in that facility[14]. According to Manual § 314.001, all matters of medical judgement are the province of qualified medical personnel. While the decision on when to use the restraint chair is the purview of the Shift Supervisor, this decision must be made in conjunction with input from the medical staff[15]. Both officers and medical staff are required to observe inmates restrained in the chair at 15 minute intervals. Medical staff is specifically required to review the chair restraints, examine the inmate to ensure proper circulation, and ensure the inmate's airway is clear and that their torso is upright when confined to the chair. These requirements are augmented by those contained within the Wellpath Manual mentioned previously.

As described above, Bell and Sunderland conducted the first restraint check approximately 19 minutes after Jimenez was placed in the restraint chair. Both the surveillance

[14] *See State v. Kanavy,* 416 Md. 1 (2010).
[15] *See Manual §§ 255.002 and 255.003 related to Use and Application of the restraint chair.*

and handheld videos show that Bell checked the restraints on Jimenez's shoulders, hands, and feet. Additionally, Jimenez was seated upright in the restraint chair and talking throughout the check. Jimenez says he will behave and asks for the mask to be removed as soon as Bell and Sunderland enter the room. He subsequently says that he needs oxygen and is "bleeding to death" on his head. While in the room, Sunderland remarks that he doesn't "see any blood…I'm going to fix that spit mask though." Sunderland then tells Jimenez that he is going to fix his mask so that it is not over his mouth. Bell also tells Jimenez that they are going to fix his mask. Jimenez states, "I need air…I need oxygen" after the mask adjustment. Bell acknowledges that statement with an "ok" before exiting the cell at the same time as Sunderland.

Snyder and Lindsay each separately checked on Jimenez in between the first and second restraint checks and found him to be speaking and breathing. The second check occurred approximately 14 minutes after Lindsay conducted his check and was conducted by Sunderland and Hall. The videos show that Hall checked the restraints on Jimenez's shoulders, waist, and feet. Jimenez was seated upright in the chair as before. Sunderland stated that he both heard breathing sounds and saw his chest move despite Jimenez not speaking during the check. Hall additionally saw Mr. Jimenez's neck move during this interaction. The last restraint check was conducted approximately 15 minutes later. This time, Hall was joined by Sunderland and Maksimovic. She again checks the restraints on Jimenez's shoulders, waist, and feet and finds him seated upright in the same position. Finally, Hall checks Jimenez's handcuffs before departing and leaving Sunderland and Maksimovic in the cell. Approximately two minutes later, Hall returns to the cell after being notified by other officers that Jimenez did not appear to be breathing.

With the exception of a four minute delay in conducting the first restraint check and failing to check Jimenez's airway during the third restraint, Bell and Hall fulfilled the basic requirements of § 255.002. The Wellpath Manual additionally required them to monitor Jimenez's extremities for color, temperature, and pulse. Nowhere during the course of the investigation does it show that either Bell or Hall ever checked any of Jimenez's extremities for either temperature or pulse. However, there is no evidence that these omissions amounted to wanton or reckless disregard for human life when considered within the overall context of care they provided and the dichotomy between what is required by the CCDC and Wellpath manuals. More crucially, the State is not able to meet its burden with respect to causation. The State cannot point to any omission in the first restraint check as causing the death considering that the evidence shows Jimenez was alive during the second restraint check. As for any omission in the second or third restraint check, the State has no evidence of when Jimenez died and certainly none showing that any of those omissions caused that death.

D. Reckless Endangerment

The State also considered the potential charge of Reckless Endangerment. Reckless Endangerment is a misdemeanor and lesser included offense of Involuntary Manslaughter. Criminal Law Article, § 3-204, states that "a person may not recklessly create a substantial risk of death or serious physical injury to another." The test is whether a defendant's conduct, viewed objectively, was so reckless as to constitute a gross departure from the standard of conduct that a law-abiding person would observe. As outlined in paragraph C above, the State has determined that none of the CCDC personnel in this case acted with wanton or reckless disregard for human

life. Accordingly, the charge of Reckless Endangerment is not supported by the evidence in this case[16].

E. Misconduct in Office

The last criminal charge that the State considered in this case was Misconduct in Office. Misconduct in Office is a common-law misdemeanor in Maryland and is defined as "corrupt behavior by a public officer in the exercise of the duties of his [or her] office or while acting under the color of" his or her office. It is possible to commit this offense in three ways: (1) nonfeasance, (2) misfeasance, and (3) malfeasance. "Nonfeasance is the omission of an act which a person ought to do; misfeasance is the improper doing of an act which a person might lawfully do, and malfeasance is the doing of an act which a person ought not to do at all."

Regardless of which of the three ways listed above form the basis of the charge, the State must prove beyond a reasonable doubt that the public officer acted willfully, fraudulently, or corruptly. This is required because this charge punishes only corrupt behavior by a public officer in the exercise of their duties and not honest mistakes or errors in judgement. However, in the case of malfeasance, because the conduct at issue falls outside of the official's authority and discretion, it is corrupt on its face if done so willfully. Otherwise, because the conduct normally falls within the official's authority and discretion, the State must prove that the official "*intended* to act corruptly - with a 'sense of depravity, perversion, or taint[17].'" A "public officer" is anyone holding employment or appointment under the government[18].

[16] *See Minor v. State*, 326 Md. 436 (1992).
[17] *See Sewell v. State*, 239 Md. App. 571 (2018).
[18] *See Chester v. State*, 32 Md. App. 593 (1976).

In this case, the State considered whether Lindsay's order that "the cuffs stay on" with reference to the handcuffs and leg irons was an instance of Misconduct in Office. Of the three possible modes, this act would be one of misfeasance since the ability to order that an inmate be restrained in this manner is within his authority and discretion as a shift supervisor. In fact, the CCDC Manual requires that detainees who are going to be placed in the restraint chair are handcuffed and placed in leg irons prior to that placement. The issue is that those restraints should have been removed after Jimenez was secured in the chair pursuant to the CCDC Manual. Again, the instructions from SureGuard also state that those restraints should be removed as soon as possible to prevent injury.

There is no evidence that Lindsay intended to act corruptly with respect to his order to keep the handcuffs and leg irons on Jimenez after he was secured in the chair. Likewise, there is no evidence that Lindsay intended to act corruptly with respect to not removing the spit mask at an earlier time. The State would be required to prove that element beyond a reasonable doubt because as a shift supervisor Lindsay was within his authority and discretion to order that Jimenez be placed in the restraint chair and that he wear a mask.

With respect to Bell and Hall, the State considered whether either of them had committed an act of Misconduct in Office, in the form of nonfeasance, by not giving adequate medical care to Jimenez. Both were obviously required to attend to the medical needs of Jimenez as part of their duties, so the State would be forced to prove beyond a reasonable doubt that they intended to act corruptly by withholding appropriate medical care in order to convict either of Misconduct in Office. After a review of the investigation in this case, there is no such evidence.

VI. Conclusion

This report has presented factual findings and legal analysis and conclusions relevant to the death of Angel Manuel Jimenez on December 4, 2023, while incarcerated at the Calvert County Detention Center. The Calvert County State's Attorney's Office has declined to seek charges in this case because, based on the evidence obtained in its investigation, no Detention Center personnel committed a crime.

Respectfully submitted,

_/s/_____
Robert H. Harvey, Jr.
State's Attorney

_/s/_____
Timothy J. Maher
Deputy State's Attorney