



# Sacramento County District Attorney's Office

ANNE MARIE SCHUBERT  
District Attorney

Rod Norgaard  
Chief Deputy

Michael M. Blazina  
Assistant District Attorney

Date: October 3, 2022

To: Captain Anthony Paonessa, Commander  
Sacramento County Sheriff's Office  
Correctional Services Unit  
651 I Street  
Sacramento, CA 95814

From: Sacramento County District Attorney's Office

RE: In-Custody Death – Travis Mitchell Welde  
SSD Report No. 2020-248721  
Date of Incident: August 4, 2020

The above case was referred to this office for review of the circumstances surrounding the August 4, 2020, death of inmate Travis Mitchell Welde while in the Sacramento County Main Jail.

Welde was booked into custody at the Main Jail on July 22, 2020, for possession for sale of controlled substances, delaying or obstructing a police officer, carrying a switchblade knife, possession of metal knuckles, and violating his parole. During the initial intake process, Welde participated in a required medical screening exam where the nurse concluded Welde was fit for incarceration. His urine drug screening test was positive for amphetamines, methamphetamines, THC, MDMA, and opiates. Welde had a healing wound to his left upper arm.

Welde was housed for a seven-day observation period with another inmate in accordance with jail COVID-19 protocols. During this time a nurse checked his vital signs, he received treatment for the upper arm wound, and a deputy interviewed him for his prospective jail housing. These seven days were without incident.

On July 30, 2020, Welde moved to a general population housing floor within the jail. He was housed with another inmate. During his brief stay, Welde began engaging in erratic behavior, such as kicking his door and talking nonsensically. A jail psychiatric services staff member met with Welde on August 2, 2020. Welde reported that he feared for his life. The staff member observed that Welde spoke with pressured speech and was having irrational thoughts. Welde was then transferred to the Mental Health Housing Unit where inmates receive intensive outpatient psychiatric services. He was assigned to a single-person cell.

On August 3, 2020, Deputy Sarah Kisch was working as an Intensive Outpatient Psychiatric Program Deputy in the Mental Health Housing Unit. At approximately 6:50 p.m., she received information that Welde had smeared feces on himself and his cell walls. She observed an unknown brown substance on the cell walls but was unable to determine whether it was feces. Deputy Kisch did not observe any feces on Welde's body. However, Welde paced around his cell talking to himself. Welde also appeared wet. Deputy Kisch could not determine whether Welde was sweating or whether he had splashed himself with water. Deputy Kisch asked Welde how he was doing. Welde replied that he was "detoxing" and wanted a shower. Welde flailed his arms and would sit and stand back up repeatedly. Deputy Kisch asked Welde why he was anxious. Welde replied in a confused or unintelligible mixture of seemingly random words and phrases. Deputy Kisch encouraged Welde to continue to drink water and try and relax. After she left, Deputy Kisch continued to hear Welde banging on his door and yelling unintelligibly.

At approximately 10:05 p.m., Deputy Christian Stacey escorted a jail psychiatric services staff member to meet with Welde. When Deputy Stacey and the staff member arrived at Welde's cell, Welde appeared to be having a conversation with himself. When asked, Welde indicated that he was talking to his mother, whom Welde had not seen for several years. The staff member observed that Welde was speaking quickly, not making sense, and sweating. She asked Welde a series of mental health questions. The staff member concluded that Welde was gravely disabled. She placed him on the waiting list for a higher level of mental health care. The staff member also followed standard protocol by requesting that Welde be seen by a nurse. She was concerned about the possibility that Welde was detoxing from drugs. Welde was not seen by a nurse as the nursing staff believed Welde was outside the time period for detoxing from drug use due to the length of time Welde had been in the jail.

Deputy Moises Paredes and Deputy Kisch observed Welde and made brief contact with him at approximately 10:34 p.m. As Deputy Kisch spoke with Welde, Deputy Paredes observed that Welde was fully clothed.

At approximately 3:47 a.m. on August 4, 2020, Deputy Steven Craft was conducting an inmate count in the Mental Health Housing Unit pod where Welde was located. When Deputy Craft arrived at Welde's cell, he observed Welde standing naked at the cell door. Welde was breathing heavily and bouncing back and forth on the balls of his feet. Deputy Craft asked Welde if he was okay. Welde grunted and shook his head. Deputy Craft understood the gesture as Welde acknowledging that he was okay, so Deputy Craft continued with his inmate count and normal duties.

Deputy Kory Garside and Deputy Paredes were conducting an hourly "floor check" at approximately 4:49 a.m. When they arrived at Welde's cell, Deputy Paredes observed Welde on the cell floor face down and naked. Welde was moving his body slightly but did not respond to the deputies' knocking on the door and calling out to him. Given that laying on a cell floor was not uncommon for inmates housed in the Mental Health Housing Unit, the deputies completed their hourly floor check and returned to Welde's cell at approximately 4:55 a.m.

When they returned to Welde's cell, Welde was still on the floor and not responding to their

voice commands. Deputies Garside and Paredes then informed Deputy Craft of Welde's condition. They decided to enter the cell to check on Welde. Deputy Garside called Sergeant James Spurgeon and medical staff to respond to Welde's cell. Given the possible feces on the cell walls, Deputies Craft, Garside, and Paredes clothed themselves in Ty-vek suits prior to entering the cell. At approximately 5:02 a.m., Deputies Craft, Garside and Paredes entered Welde's cell. Deputies Garside and Paredes handcuffed Welde while Deputy Craft checked Welde's vital signs. Deputy Craft observed that Welde did not appear to be breathing and did not have a pulse. The deputies moved Welde from the cell, removed the handcuffs, and began chest compressions.

Additional deputies and nurses arrived to assist. An automated external defibrillator was applied. Sacramento Fire Department medics arrived at approximately 5:14 a.m. and continued medical treatment. Welde was pronounced deceased at approximately 5:17 a.m. by Sacramento Fire Department medics.

An autopsy was performed by Dr. Jason Tovar, a forensic pathologist working for the Sacramento County Coroner's Office. Dr. Tovar concluded the cause of Welde's death was hemopericardium due to a ruptured acute myocardial infarction resulting from mixed drug intoxication. During the autopsy, Dr. Tovar obtained a sample of Welde's femoral blood. The sample was tested by the Sacramento County District Attorney Laboratory of Forensic Services. The testing confirmed the presence of amphetamine, methamphetamine, fentanyl, morphine, Delta-9-THC, and 11-nor-9-carboxy-THC in the sample. Dr. Tovar concluded that based on the circumstances and cause of death, the manner of death was to be listed as Accident.

### **LEGAL ANALYSIS:**

The Office of the District Attorney reviews deaths that occur while in law enforcement custody to assess and apply the law relating to police use of force and to determine if the officers' acts fall within the state laws of criminal responsibility. This office conducted its review by applying the facts of this case to the controlling legal authority.

There is no evidence that any of the deputies intentionally or willfully tried to harm Welde. Thus, the only possible source of criminal liability is under California Penal Code section 192(b). The relevant portion of Penal Code section 192(b) defines involuntary manslaughter as a "killing . . . in the commission of a lawful act which might produce death . . . without due caution and circumspection." The statutory phrase "without due caution and circumspection" has been described by the California Supreme Court as the equivalent of "criminal negligence." (See *People v. Penny* (1955) 44 Cal.2d 861, 869-880; *People v. Stuart* (1956) 47 Cal.2d 167, 173-174.)

Under California law, more than ordinary negligence is required to support a charge of involuntary manslaughter. Evidence must prove that a person acted in an aggravated, culpable, gross or reckless manner, a manner so imprudent as to be incompatible with a proper regard for human life, or in other words, a disregard of human life or an indifference to consequences of the act. (*Somers v. Superior Court* (1973) 32 Cal.App.3d 961, 968-969.) The evidence must prove that the consequence of the negligent act could reasonably have been foreseen, and it must

appear that the death or danger to human life was not the result of inattention, mistaken judgment or misadventure, but the natural and probable result of an aggravated, reckless, or grossly negligent act. (*People v. Villalobos* (1962) 208 Cal.App.2d 321, 326-328; *People v. Rodriguez* (1960) 186 Cal.App.2d 433, 437-441.)

Although the term “negligence” is used in both criminal and civil actions, it is defined differently in each. Criminal negligence differs from civil, or “ordinary negligence,” in that it requires a finding of more aggravated reckless conduct. Further, criminal negligence requires a higher standard of proof than ordinary negligence (i.e., proof beyond a reasonable doubt).

The determination of whether conduct rises to the level of criminal negligence must be determined from the conduct itself and not from the resultant harm. (*Somers v. Superior Court*, supra, 32 Cal.App.3d at p. 969; *People v. Rodriguez*, supra, 186 Cal.App.2d at p. 440.)

Sheriff’s deputies were observant and reactive to Welde’s mental condition while he was in the jail. Deputies noted the onset of erratic behavior after Welde was moved to the general population and they requested a jail psychiatric services visit for Welde. This request resulted in a psychiatric services staff member recommending Welde’s transfer to Intensive Out-Patient Psychiatric Services. After the transfer, Welde’s mental deterioration continued. Again, Welde received a visit from a psychiatric services staff member who recommended a higher level of care and a medical appointment due to Welde’s statement he was “detoxing.” Deputies and psychiatric services staff were addressing the situation as they observed it and as it was described to them by Welde. It was not unreasonable for them to take Welde’s symptoms as a mental health crisis and detoxing from drugs given his actions were consistent, in their experience, with this phenomenon. It also was not unreasonable for Correctional Health Services to decline the request to examine Welde for detoxing when they observed that he had already been in custody for approximately twelve days. Furthermore, he was housed so as to receive psychiatric care. Law enforcement officers did not act in an aggravated, culpable, gross, or reckless manner, nor did they act with a disregard for human life or an indifference to the consequences of their actions.

## **CONCLUSION:**

No evidence of criminal misconduct is presented or suggested in any of the supporting reports. Accordingly, the District Attorney’s Office will take no further action in this matter.

cc: Francine Tournour, Sacramento County Office of the Inspector General  
Sacramento County Sheriff’s Office Lieutenant Janae Galovich  
Sacramento County Sheriff’s Office Sergeant Quis Formoli  
Kimberly Gin, Sacramento County Coroner’s Office