VENTURA COUNTY SHERIFF'S OFFICE

- GEOFF DEAN
  Sheriff
- GARY PENTIS
  Assistant Sheriff
- JOHN CROMBACH
  Assistant Sheriff

800 SOUTH VICTORIA AVENUE, VENTURA, CA 93009 PHONE (805) 654-2380 FAX (805) 645-1391

August 27, 2013

The Honorable Judge Brian Back
Presiding Judge, Superior Court of California
County of Ventura
800 South Victoria Avenue
Ventura, CA 93009

Subject: Grand Jury Report, In Custody Death (May 30, 2013)

Dear Judge Back:

This letter is in response to the Grand Jury's Findings and Recommendations pertaining to the August 4, 2012 death of inmate Eydie Stepelton. This document not only addresses the required responses for the Findings and Recommendations enumerated in the Grand Jury report, but many of the Facts and portions of the narrative as well. The Sheriff's Office feels compelled to provide these expanded responses due to what we believe is a less than complete investigation that is based upon assumption, misinterpretation of facts, and a lack of understanding of jail procedures. The evidence as outlined in the Grand Jury report simply does not support many of the critical findings.

The points at issue will be addressed in the order in which they appear in the Grand Jury report. Each point will be listed under the header that corresponds with the Grand Jury report.

SUMMARY

Grand Jury Report: *"The Grand Jury found that during the course of her 24 hours in custody at Medical/Special Housing, the inmate/decedent's health declined rapidly. She became so debilitated that she and others asked for medical care, on more than one occasion, on her behalf. The inmate/decedent's request was noted in her medical records. Other requests for care were reflected in the Simi Valley Police Department's (SVPD) and Ventura County Sheriff's Department (VCSD) records. There were no responses to these requests."*

Response: Ms. Stepelton was in custody at the Pre-Trial Detention Facility (PTDF) for about of 25 hours. She was housed in Special Housing for approximately 23 hours. Special Housing is an area in the jail that houses inmates who require more intense medical or mental health care. Ms. Stepelton was seen by medical staff multiple times throughout the day. Vital signs were taken at booking, upon being moved to Special Housing and every 6 to 8 hours thereafter, including 2 hours before she was found unresponsive. Further, Ms. Stepelton was examined by Dr. Adler on August 4, 2012, at 8:00 a.m., after having been in custody for a little more than 10 hours.

Ms. Stepelton was ALSO interviewed by a California Forensic Medical Group (CFMG) psychiatric nurse on the morning of August 4, 2012. CFMG is contracted to provide medical, dental, and psychiatric services to inmates in our custody. According to notes, it was to this nurse that Ms. Stepelton indicated she did not feel well and wanted to go to the hospital for an IV. This interview took place less than 2 hours after Ms. Stepelton was examined by Dr. Adler. Additionally, approximately 45 minutes after making this statement to the psychiatric nurse, Ms. Stepelton was seen by a medical nurse and her vital signs were taken.

The Sheriff's Office has reviewed the video footage of the Special Housing area during the time Ms. Stepelton was incarcerated. Ms. Stepelton shared a cell with another inmate. During the course of her incarceration, Ms. Stepelton and her cellmate had several contacts with jail and medical staff. In fact, jail staff visually checked on Ms. Stepelton a minimum of every half hour. Several times throughout the day there were conversations between Ms. Stepelton and/or her cellmate with jail and medical staff. Some portions of these conversations can be heard on the video, but many times the conversations cannot be heard or the words cannot be understood for various reasons. Additionally, throughout the day, the cell call button was activated several times. When the call button is activated, the conversation with the inmates typically occurred over an intercom system. As with conversations that occurred at the cell, some of the requests made over the intercom could be heard while others could not.

After reviewing the video of all contacts with jail and medical staff either at the cell door, or over the intercom, the Sheriff's Office confirmed Ms. Stepelton, or her cellmate, did tell jail staff that she was experiencing diarrhea (numerous times), had vomited (once), and had the "shakes" (once). Other than this, no other symptoms or requests for care were heard. Many of the contacts were related to requests for commissary slips, dayroom time, phone calls, and sheets.

Deputies and CFMG staff had contact with Ms. Stepelton's numerous times throughout her incarceration. She was examined by qualified medical professionals several times and was actively being treated for alcohol withdrawal, with which her symptoms were consistent. There was no indication Ms. Stepelton told medical staff she was suffering from sepsis and pancreatitis or that she was even aware of this medical condition.

The Grand Jury report further states that in addition to Ms. Stepelton, "others" also made multiple requests for medical care on her behalf. Since the word "others" is plural, it should be assumed that a minimum of 2 other persons requested **care** for Ms. Stepelton. Aside from Ms. Stepelton's cellmate, who arguably never requested care for Ms. Stepelton, rather she only stated Ms. Stepelton had diarrhea and possibly vomited, the Sheriff's Office did not find anybody that requested medical care on behalf of Ms. Stepelton.

Regarding the Simi Valley Police Department reports, jail officials do not read the arrest reports of officers when they book inmates. In the vast majority of cases, such reports have not even been completed at the time of booking.

The Sheriff's Office did not see any requests for medical care in any of its documents that were generated by Sheriff's Office employees.

Grand Jury Report: *"The Grand Jury reviewed documents from the time of arrest to pronouncement of death. They found that certain jail and medical procedures and/or protocols fell short, especially for those inmates assigned to the Medical/Special Housing Unit."*

Response: The Sheriff's Office disagrees with this statement. There are no facts to sustain that "jail and medical procedures and/or protocols fell short, especially for those inmates assigned to the Medical/Special Housing Unit" in any manner that would have contributed to Ms. Stepelton's death.

In addition, the above statement seems to indicate there was a review/investigation of jail and medical procedures for all inmates, and that deficiencies were especially noteworthy for "those inmates" assigned to Special Housing. The Sheriff's Office is unaware of any portion of the Grand Jury investigation that was not related to Ms. Stepelton.

Grand Jury Report: *"The mission of the Ventura County's (sic) incarceration policies should reflect the mission of the VCSD."*

Response: It is unclear where existing policies contradict the mission of the Sheriff's Office.

BACKGROUND

Grand Jury Report: *"The VCMJ, opened in 1980 and located in the Government Center Complex, accepts arrestees from every law enforcement agency in Ventura*

County. It is a secure correctional facility holding pre-trial detainees, both male and female sentenced inmates, and violent/assaultive offenders, psychiatric inmates, and inmates in need of medical services."

Response: The above statement is true, but the Sheriff's Office would like to expand upon the issue of medical services. The Pre-Trail Detention Facility is not a medical facility and does not have a licensed medical in-patient unit. We are equipped to manage inmates with medical needs that do not require in-patient hospitalization. Inmates requiring more advanced care are sent to the hospital for treatment. The Pre-Trial Detention Facility does frequently treat inmates suffering from alcohol withdrawal, but there have been occasions when such inmates have been sent to the hospital due to the severity of their circumstances.

Grand Jury Report: *"The Medical/Special Housing Unit of the jail consists of eighteen cells with two inmates in each cell. Each cell has a combination sink and toilet. There are thirty-six inmate/patients in the unit."*

Response: The 18 cells in Special Housing are equipped to house two inmates; however, there are not always 2 inmates per cell and the total number of inmates housed in Special Housing is not always 36.

Grand Jury Report: *"There is an intercom system between each cell and the nursing station so that inmates can make their needs known. An interior switch to the light over each exterior cell door is another way for inmates to communicate with the deputies and nurses."*

Response: The intercom and light above the cell door are linked. When the intercom button is pushed from within the cell, the light above the door automatically activates. There is no way to activate either the light or the intercom separately from within the cell. Once activated, the intercom rings to both the nurse's station and the deputy's station.

Grand Jury Report: *"The inmate/decedent, a resident of Simi Valley, was arrested by the SVPD on August 3, for an outstanding warrant and then transported from her residence to the VCMJ. She was booked into a shared cell in the Medical/Special Housing Unit of the VCMJ."*

Response: Female arrestees are booked at Women's Booking, located on Level 1 of the Pre-Trail Detention Facility. During the booking process, inmates are assessed and assigned a classification. Inmates can then be housed based upon classification and

any special need. Ms. Stepelton was housed in Special Housing, located on Level 2 of the Pre-Trial Detention Facility, after the booking process was completed.

Grand Jury Report: *"During a routine cell check at 10:21 P.M. on August 4, there was no response from the inmate/decedent. A deputy called for a second deputy and a nurse to render assistance. Once inside the cell, they attempted to rouse the inmate/decedent without success. Then they called for fire and ambulance assistance to respond to a Code-3 (a call for emergency medical services), and cardiopulmonary resuscitation was performed by deputies and medical staff until fire personnel took over. The doctor on call pronounced the inmate expired with the time of death at 10:43 P.M."*

Response: It should be noted the on-call doctor that pronounced death was the on duty doctor at the Ventura County Medical Center. CFMG doctors did not pronounce death.

FACTS

FA-01 – Grand Jury Report: *"The inmate/decedent succumbed on August 4, 2012 at 10:43 P.M., 24 hours after her arrest. The Medical Examiner's Office declared that the cause of death was due to natural causes (probable bacterial sepsis). The VCSD conducted a debriefing documented by a memorandum dated May 16, 2013, as is required by the policies and procedures of the VCSD. The Sheriff's Department failed to produce the document."*

Response: The Sheriff's Office cooperated completely with the Grand Jury during this process. As noted in the Methodology section of the Grand Jury report, the Sheriff's Office provided the Grand Jury with reports, log sheets, policies, camera footage, jail tours, and access to employees. There is a memorandum dated May 16, 2013, that documents a review of the death. The death review took place on August 7, 2012, 3 days after the death, but no memorandum was drafted recording the event until May 16, 2013. The Sheriff's Office has no objection to the Grand Jury revlewing this memorandum, if they have not done so already, as they are aware of its existence.

According to the Simi Valley Police Department report, Ms. Stepelton was arrested on August 3, 2012, at 8:32 p.m. and she was pronounced dead on August 4, 2012 at 10:43 p.m., approximately 26 hours later.

The Medical Examiner's report listed the cause of death as probable bacterial sepsis due to: complications of acute suppurative pancreatitis with peripancreatic abscess; complications of chronic pancreatitis; and complications of chronic ethanolism. The manner of death was natural.

According to the Methodology section of the Grand Jury report, the Grand Jury did not interview anybody from the Medical Examiner's Office regarding this death.

FA-02 – Grand Jury Report: *"During a psychiatric evaluation, the inmate/decedent asked to go to the hospital. There was no response noted in the medical record sheet for this transfer request."*

Response: According to the psychiatric evaluation notes, Ms. Stepelton stated, "I feel sick like I need a IV at a hospital." There are no notations of specific symptoms or pain. The psychiatric nurse further wrote that he would consult with medical staff. It should be reiterated that Ms. Stepelton was seen by Dr. Adler less than 2 hours before making this comment to the psychiatric nurse. Additionally, Ms. Stepelton was seen by a medical nurse and her vital signs were taken about 45 minutes after she made this comment.

FA-03 – Grand Jury Report: *"In her cell, the inmate/decedent experienced diarrhea and other symptoms of withdrawal from alcohol. The inmate/decedent summoned help for breathing difficulties, pain and instability on her feet. No help arrived after several requests."*

Response: The Grand Jury report lists Reference 5 as support for this statement. Reference 5 is described in the Grand Jury report as "VCSD narrative and audio CD, August 4, 2012". Assuming "VCSD narrative" is defined as those reports written by Sheriff's Office employees after the death, I found only one report that indicates Ms. Stepelton was suffering from diarrhea and other symptoms of alcohol withdrawal. This report was written by Major Crimes investigator, Detective Albert Ramirez. Detective Ramirez' report describes an interview he conducted with Ms. Stepelton's cellmate shortly after the death. In her statement, the cellmate said Ms. Stepelton had diarrhea, was hallucinating, having pains and tremors, problems breathing, and that she had fallen down once in the cell during the course of the day.

Most of the above symptoms are associated with alcohol withdrawal, for which Ms. Stepelton was being treated; however, alcohol withdrawal was not the cause of death.

Medical staff actually went into the cell and evaluated Ms. Stepelton on four occasions. The psychiatric nurse had a conversation with Stepelton at the cell door during which she answered several questions. Nursing staff administered medications to Ms. Stepelton at the door (they did not enter the cell) on two occasions. None noted anything unusual about Ms. Stepelton's condition.

Jail staff provided meals to Ms. Stepelton three times and also visually checked on Ms. Stepelton several times throughout the day. The logs indicate jail staff conducted a

visual check of Ms. Stepelton about every half hour, a total of 48 checks were recorded on the log during the 23 hours she was in her cell in Special Housing. However, a review of the Special Housing video clearly establishes visual checks were completed much more frequently.

At approximately 6:09 p.m., a jail senior deputy entered the cell and spoke with the occupants for a considerable period of time. He also made no notations of anything out of the ordinary.

When the Sheriff's Office reviewed the video and audio of the Special Housing area, at the time Ms. Stepelton was found unresponsive, Ms. Stepelton's cellmate could be heard telling the responding deputies that Ms. Stepelton had been having a hard time breathing. This is the only time during the course of Ms. Stepelton's incarceration that the cellmate could be heard making such a comment.

In the recording of the interview conducted by Detective Ramirez with Ms. Stepelton's cellmate, the cellmate stated she had told staff that Ms. Stepelton was having a hard time breathing and that she was using a cane due to lack of balance. The Sheriff's Office could find no evidence in the video of the Special Housing area that Ms. Stepelton summoned help for breathing difficulties, pain, and instability on her feet, or that Ms. Stepelton's cellmate informed staff of such conditions.

FA-04 – Grand Jury Report: *"A suicide watch was in place for the inmate/decedent."*

Response: Ms. Stepelton was placed in Level 2 Safety Precautions due to suicidal ideation expressed at booking. A 30 minute monitoring log was established and she was restricted from possessing certain items, such as sheets, and was not allowed to go to the dayroom.

FA-05 – Grand Jury Report: *"It was determined during intake that the inmate/decedent needed monitoring for alcohol withdrawal symptoms and to receive medication for same."*

Response: Ms. Stepelton was placed on a medical protocol for alcohol withdrawal, and her condition was monitored by medical staff. There is no requirement for a 30 minute monitoring log for inmates on an alcohol withdrawal protocol. However, there was a 30 minute monitoring log established, due to Ms. Stepelton's status on Level 2 safety precautions, and it was followed.

FA-06 – Grand Jury Report: *"The Medical/Special Housing Unit requires a check every thirty minutes by a deputy who should note an inmate's status on a log sheet outside the cell door. This is a visual check from the hallway through the cell window."*

Response: Not all inmates in Special Housing require a visual check every 30 minutes. Ms. Stepelton required a 30 minute check because she was on Level 2 Safety Precautions due to suicidal ideation, not because she was on an alcohol withdrawal protocol. Her cellmate and many others in Special Housing had no such requirement.

FA-07 – Grand Jury Report: *"After a routine booking process (approximately 2 plus hours) into the VCMJ, the inmate/decedent was placed in a cell around midnight in the Medical/Special Housing Unit."*

Response: At booking, Ms. Stepelton was evaluated by a nurse, placed on an alcohol protocol, and placed on Level 2 Safety Precautions for suicidal ideation. Although none of these are uncommon, this would not be considered routine.

FA-08 – Grand Jury Report: *"At the time of arrest, the inmate/decedent appeared to be intoxicated and the SVPD was informed that she was taking prescription medications. The SVPD indicated the family was concerned about her being incarcerated due to these medical conditions and the possibility of alcohol withdrawal symptoms while in custody."*

Response: Ms. Stepelton was interviewed by a nurse at booking regarding her medical conditions and was placed on an alcohol withdrawal protocol.

FA-09 – Grand Jury Report: *"The subject was arrested by the SVPD at 8:30 P.M. on August 3, 2012, in her home after she made attempts to evade arrest."*

Response: According to the Simi Valley Police Department arrest report, they responded to Ms. Stepelton's residence after receiving information she was present at the house; there was an outstanding warrant for her arrest. Ms. Stepelton hid in a closet within the residence in order to avoid arrest. She was eventually located and arrested without incident. Ms Stepelton was transported directly to the Pre-Trial Detention Facility and booked for the warrant.

FA-10 – Grand Jury Report: *"The VCSD inmate monitoring logs and the CFMG medical records do not match."*

Response: The recorded times at which medical functions were performed, as noted on the deputy log, often do not match with the times at which CFMG medical personnel documented their findings for the corresponding assessments. The monitoring log is not for medical purposes and is not meant to act as an exchange of medical information between jail and CFMG staff. Medical information is confidential and is for medical personnel only. The functions performed and documented by medical staff are confirmed by the video of the Special Housing area.

FA-11 – Grand Jury Report: *"Out of forty-eight entries made in the VCSD inmate monitoring logs for the inmate/decedent, there was not one entry of any symptoms of alcohol withdrawal, no mention of illness, and no record of requests for assistance made by the inmate/decedent and others."*

Response: Deputies are not trained medical professionals and are not expected to note symptoms of alcohol withdrawal or illness; such notations may become speculative in nature. The 30 minute monitoring log was in place because Ms. Stepelton was on Level 2 Safety Precautions due to suicidal ideation expressed in booking, not because she was on an alcohol withdrawal protocol. The monitoring logs are designed to document the actions and statements of the inmate being monitored.

In the interactions heard on the Special Housing video, many involve Ms. Stepelton's cellmate. Recording the statements of Ms. Stepelton's cellmate on the monitoring log would not be appropriate.

The documentation of medical issues was handled by the CFMG medical professionals.

FINDINGS

FI-01 – Grand Jury Report: *"The request by the inmate/decedent to be transferred to the hospital was written in the psychiatric evaluation conducted at 9:30 A.M. on August 4, and repeated in the nurses' progress notes at 5:00 P.M."*

Response: The Sheriff's Office agrees with this finding.

FI-02 – Grand Jury Report: *"The Sheriff's inmate monitoring log, the psychiatric evaluation and the nurses' progress notes do not match. The psychiatric evaluation and the nurses' progress notes each record the inmate/decedent's request to transfer to the hospital. The Sheriff's log did not contain this request. There were discrepancies in the nurses' progress notes and the psychiatric evaluation. The main discrepancy showed time differences, hours apart, documenting the request for hospital transfer."*

Response: A review of the Special Housing video revealed the psychiatric nurse conducted an interview with Ms. Stepelton from outside the cell. The nurse interviewed Ms. Stepelton through the closed door with no deputy present; therefore, the deputy would not record the visit on the log. Furthermore, the content of any conversation between an inmate and psychiatric or medical staff is confidential and best recorded in the medical records and not on a log that is posted outside a cell door. Recording specific medical information on a log that is visible to all, including inmate workers and staff not assigned to the Special Housing area, could be a violation of the inmate's right to privacy related to medical matters.

Again, it is important to remember that the purpose for keeping the deputy's log was to monitor Ms. Stepelton due to suicidal ideation. It was not for the purpose of monitoring her medical condition. Sheriff's deputies do not keep logs for the purpose of recording symptoms of illness, as they are not trained medical professionals.

Jail medical staff makes decisions regarding transfer to the hospital based upon the condition of the inmate, not upon request. Ms. Stepelton was examined by a medical doctor less than 2 hours prior to her statement regarding a desire for an IV at the hospital and her vital signs were taken by a nurse 45 minutes after the request. The statement documented by the psychiatric nurse contained no specific symptoms; it was a statement expressing not feeling well and wanting an IV at the hospital.

FI-03 – Grand Jury Report: *"Neither the Sheriff's monitoring log nor the nurses' progress notes record the psychiatric evaluation that occurred at 9:30 A.M., August 4, 2012."*

Response: The psychiatric evaluation was conducted without a deputy present. This is an acceptable practice. The psychiatric evaluation is reflected in the mental heath portion of Ms. Stepelton's medical record, and according to CFMG, there is no need to record it in the nurse's notes because it is already part of the medical record.

FI-05 – Grand Jury Report: *"The inmate/decedent was determined, during the intake process, to be okay to book and be placed in the Medical/Special Housing Unit."*

Response: The Sheriff's Office agrees with this finding.

FI-06 – Grand Jury Report: *"At the time she died, on August 4, 2012, a contributing factor in the inmate/decedent's death was a lack of timely medical attention while in custody."*

Response: The Sheriff's Office wholly disagrees with this finding and we do not believe it is supported by evidence. The Grand Jury lists FA-02, FA-05, FA-06, FA-07, and FA-011 as the foundation for this conclusion. In essence, the finding is based upon Ms. Stepelton's desire to go to the hospital for an IV, the fact she was going through alcohol withdrawals (which is not disputed), she was subject to a 30 minute monitoring log, she was housed in Special Housing, and the deputy monitoring log did not include symptoms of withdrawal or illness, and did not include requests for assistance.

The Sheriff's Office firmly believes the Grand Jury's analysis is flawed and their conclusion is unsubstantiated and illogical for the following reasons:

1. The Grand Jury references in support of this finding do not reasonably provide a foundation for this claim. There is a misunderstanding/misinterpretation of the purpose for the 30 minute monitoring logs, withdrawal from alcohol was not a contributing factor in the death, and Ms. Stepelton was checked many times by licensed medical professionals who did not believe, based upon her condition and statements, that there was a reason to transport her to the hospital.
2. The Medical Examiner's report lists the cause of death as "probable bacterial sepsis", which is unrelated to acute alcohol withdrawal.
3. Other than chronic ethanolism, there is no indication Ms. Stepelton or jail medical staff were aware of the medical conditions (acute suppurative pancreantitis with peripancreatatic abscess and chronic pancreatitis) that caused her death.
4. The Medical Examiner's report did not list "a lack of timely medical attention" while in custody as a contributing factor.
5. There is no indication in the report that the Medical Examiner or any other medical doctor was consulted regarding FI-06.
6. Ms. Stepelton was examined by a medical doctor on the morning of August 4, 2012.
7. Ms. Stepelton's vital signs were taken multiple times while she was in Special Housing.
8. The Grand Jury did not appear to have considered the findings of the medical assessments, as those findings are not referenced in the report.
9. There is no indication the Grand Jury spoke with relevant CFMG staff regarding the specific medical care provided or for the purpose of clarifying any questions they might have had.
10. An independent review was conducted by a medical doctor. The reviewing doctor concluded the medical attention Ms. Stepelton received and the actions taken were appropriate given Ms. Stepelton's signs and symptoms.

FI-07 – Grand Jury Report: *"Lack of documentation and its discrepancies led to the inability of staff to adequately assess her condition. The inmate/decedent's medical chart was incomplete."*

Response: In support of this conclusion, the Grand Jury lists FA-02, FA-06, FA-07, and FA-011. For the reasons listed in the above response, the Sheriff's Office disagrees with the first sentence of this finding and we do not believe it is supported by evidence.

Regarding the completeness of the medical charts, the Sheriff's Office does not see enough evidence in this report to substantiate this finding.

FI-08 – Grand Jury Report: *"There was a debriefing by the VCSD after the death, but no formal document was written or recorded into the inmate/decedent's record."*

Response: The memorandum documenting the debriefing of an inmate death is not placed into the inmate's medical record.

RECOMMENDATIONS

R-01 – Grand Jury Report: *"The Board of Supervisor (BOS authorize the VCSD to embark on a competitive bidding process that should include an in-depth search to select the best medical care provider for all inmates in Ventura County."*

Response: The Sheriff's Office does, in conjunction with the Probation Department and County Procurement, participate in the RFP process to find high quality medical services. The last RFP was completed in 2006 and, after a competitive process; CFMG was awarded the contract as they were the best medical care provider for Ventura County inmates.

R-03 – Grand Jury Report: *"The VCSD should have significant oversight requirements of any contracted services to the jails; i.e. supervising their strategic plan, policy and procedures, to ensure they meet the mission of the VCSD."*

Response: The Sheriff's Office does have oversight of contracted services in the jails to ensure our mission is achieved.

R-04 – Grand Jury Report: *"The VCSD and CFMG should issue a formal de-briefing (Review Team Report) document after an inmate's death."*

Response: A thorough and complete review is conducted with any inmate death in compliance with state law and Ventura County Sheriff's Office policies and procedures. This includes a review of the investigative reports completed by the Sheriff's Office

Major Crimes Unit, consultation with CFMG regarding the medical treatment provided, the Medical Examiners report, and the viewing of video evidence.

In addition, CFMG hired Dr. Lanyard Dial, a respected, independent, and objective physician to review the incident and the medical care provided. After reviewing the medical records, Dr. Dial concluded CFMG's treatment of Ms. Stepelton was in compliance with standards of care and did not contribute to her death.

Thank you for the opportunity to respond to this Grand Jury report. If additional explanation is needed, please feel free to contact Captain Eric Dowd at 648-9275 or eric.dowd@ventura.org

Geoff Dean
Sheriff

Cc: Foreman, Ventura County Grand Jury
Assistant Sheriff Pentis
CEO Michael Powers
Frank Chow, CEO Analyst