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December 1, 2015

Sheriff Sandra Hutchens
Orange County Sheriff's Department
550 N. Flower Street
Santa Ana, CA 92703

Re: Death of Former Inmate Andrew Gray McClure on Dec. 22, 2014
District Attorney Investigations Case # S.A. 14-022
Orange County Sheriff's Department Case # 14-244456
Orange County Crime Laboratory Case # 14-56767

Dear Sheriff Hutchens,

Please accept this letter detailing the Orange County District Attorney's (OCDA) Office's investigation and legal conclusion in connection with the above-listed incident involving the Dec. 22, 2014, death of 25-year-old former inmate Andrew Gray McClure.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the death of Andrew Gray McClure. In this letter, the OCDA describes the investigative methodology employed, evidence examined, witnesses interviewed, facts discovered, and the legal principles applied to determine whether criminal culpability exists on the part of any Orange County Sheriff's Department (OCSD) personnel or any other person under the supervision of the OCSD.

On Dec. 22, 2014, OCDA Special Assignment Unit (OCDASAU) Investigators responded to 33342 Nottingham Way in Dana Point, where McClure died after receiving medical treatment. During the course of this investigation, the OCDASAU interviewed 15 witnesses, as well as obtained and reviewed reports from the OCSD and Orange County Crime Laboratory (OCCL), incident scene photographs, and other relevant materials.

The OCDA conducted an independent and thorough investigation of the facts and circumstances of this event and impartially reviewed all evidence and applicable legal standards. The scope and findings of this review are expressly limited to determining whether any criminal conduct occurred on the part of OCSD personnel or any other person under the supervision of the OCSD. The OCDA will not be addressing possible issues relating to policy, training, tactics, or civil liability.

INVESTIGATIVE METHODOLOGY

Among other duties, the OCDASAU is responsible for investigating custodial deaths within Orange County when an individual dies while in custody. An OCDASAU Investigator is assigned as a case agent and is supported by other OCDASAU Investigators, as well as Investigators from other OCDA units.

Six Investigators are assigned to the OCDASAU on a full-time basis. There are additional OCDA Investigators assigned to

other units in the Office trained to assist when needed. On average, eight Investigators respond to an incident within an hour of being called. The Investigators assigned to respond to an incident perform a variety of investigative functions that include witness interviews, scene processing, evidence collection, and hospital investigative responsibilities as needed. The OCDASAU audio records all interviews, and the OCCL processes all physical evidence related to the investigation.

When the OCDASAU Investigator has concluded the investigation, the file is turned over to a veteran deputy district attorney for legal review. Deputy district attorneys from the Homicide, TARGET, or Gangs Units review fatal, officer-involved shootings and custodial death cases and determine whether criminal charges are appropriate. Throughout the review process, the assigned prosecutor will be in consultation with the supervising Assistant District Attorney in the Special Prosecutions Unit, who will eventually review and approve any legal conclusions and resulting memos. The case may often be reviewed by multiple veteran prosecutors, their supervisors, the Chief of Staff, and the District Attorney. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTS

McClure had a documented diagnosis of Attention Deficit Disorder (ADD), for which he was prescribed Ritalin. On Nov. 9, 2014, McClure was arrested by the OCSD. McClure was taken into custody for possession of a controlled substance, a violation of Health & Safety Code section 11350(a). During the arrest process, McClure displayed an uncooperative attitude and continually screamed when deputies attempted to advise him of his constitutional rights.

McClure was booked at the OCSD Intake/Release Center (IRC) in Santa Ana. McClure was observed by an inmate at the IRC, repeatedly yelling obscenities and failing to follow the directives given to him by IRC deputies. The inmate initially believed McClure was mentally ill due to his erratic behavior, but subsequently found him to be articulate and friendly when dealing with other inmates. McClure told inmates that he did not like police officers but did not elaborate as why he disliked law enforcement personnel. Jail medical staff did not notate any signs of injury or bleeding upon McClure being booked at the IRC.

On Nov. 10, 2014, McClure was transferred to the OCSD Theo Lacy Facility (TLF) in Orange, with six to seven other inmates. Upon arrival at the TLF, McClure continued his behavior of not following OCSD deputies' directives, being disruptive, and telling the deputies obscenities whenever asked to do something. McClure continued his pattern of disruptive behavior throughout the entire booking process and only complied with the directives after repeated requests from the OCSD deputies, thus delaying the intake process. McClure continued to be disorderly throughout the intake process and created a commotion by being loud and vocal. In an effort to avoid an incident with McClure, an OCSD deputy separated him from the other inmates.

An OCSD deputy attempted to search McClure, which appeared to agitate him further. Attempts by deputies to reason with McClure and get him to calm down failed. A second attempt to search McClure was made, but McClure continued to resist by tensing his body and refusing to cooperate with directives. McClure was eventually searched and after the search, a collective decision was made to place him in a jail cell in an effort to allow him time to calm down before proceeding through the booking process. McClure was escorted to a cell in the booking loop, with a deputy maintaining a control hold on him. As they entered the cell, McClure was able to free one arm from the deputy's control hold, leaned up against a partition in the cell, and attempted to free his other hand. The deputy attempted to regain control of McClure who lunged away from him, which resulted in McClure falling over a privacy partition wall in the cell. McClure attempted to kick the OCSD deputy as he rolled over the wall.

Once McClure was over the wall, he rolled to a position that left him lying on his back, between a toilet and the privacy wall. The deputy came around the wall, in an attempt to regain control of McClure. McClure kicked the deputy in the stomach with both feet, and in response, the deputy dropped his body on top of McClure in an effort to regain control over him. Another deputy struck McClure with two distraction punches to his left abdomen area in order to assist in controlling McClure. The deputies were able to gain control over McClure and then placed him in handcuffs, waist chains, and leg irons.

After McClure was secured, medical staff was summoned and examined him. Medical records indicate that McClure had nodular swelling with abrasions and scant bleeding to the right temporal area. He did not complain of a headache, dizziness or

blurred vision and was able to sit in an upright position. McClure also had fluctuant swelling to the posterior of his right hand but was able to move all phalanges without difficulty and denied any loss of sensation to the hand. At the completion of the examination, McClure was medically cleared for booking.

In mid-November 2014, approximately three to four days after McClure had been arrested, McClure's mother visited him at the TLF. During the visit, McClure told his mother that he had been assaulted by deputies when he was booked into the TLF. McClure's mother observed an approximately 3-inch wound to the right side of McClure's head, which she described as healing but still visible. The wound covered a scar McClure had received as the result of an assault in his teen years. She also observed a dime sized wound on one of his ankles but she was aware of the injury on McClure's ankle prior to him being arrested. McClure's mother said that according to him, the scab on the wound had been reopened as a result of a deputy kicking him. McClure told his mother that deputies had placed him in shackles upon his arrival at the TLF and that he was eventually separated from other inmates and brought into a room with an approximately 3-foot high partition. McClure told his mother that he was thrown over the partition wall by deputies, while shackled, and landed on his head.

On Dec. 15, 2014, McClure was released from custody of the OCSD. On or near Dec. 16, 2014, John Doe 1, an acquaintance of McClure, allowed McClure to stay at his apartment. John Doe 1 rented the apartment with John Doe 2 and Jane Doe 1. McClure told John Doe 1 that his mother would not allow him to stay at her residence due to his use of illegal drugs. John Doe 1 knew of McClure's drug use, having witnessed him use heroin by means of smoking it, as well as injecting it intravenously on several occasions. McClure also was using Klonopin, Valium, and other prescription tranquilizers.

On Monday, Dec. 22, 2014, John Doe 2 and Jane Doe 1 were preparing to leave for work and could hear McClure and John Doe 1, laughing in John Doe 1's bedroom. John Doe 2 and Jane Doe 1 stated that at approximately 5:00 p.m., they returned to the apartment from work. They both observed McClure lying on the floor inside of John Doe 1's bedroom. John Doe 1 told Jane Doe 2 that McClure was just sleeping. Jane Doe 1 stated that approximately between 5:30 p.m. and 6:00 p.m., she observed McClure still lying on the floor in John Doe 1's room. She informed John Doe 2 that something was wrong with McClure. John Doe 2 and Jane Doe 1 went into John Doe 1's room and found John Doe 1 on the telephone with his girlfriend, advising her that McClure was not breathing. John Doe 1 got up and checked McClure for a pulse, but was unable to locate one. McClure was also cold and clammy to the touch.

John Doe 1 and John Doe 2 attempted to bring McClure into the shower to try to revive him but were physically unable to get him to the shower. John Doe 2 called 911 to request medical aid for McClure, and remained on the telephone with the dispatcher until OCSD deputies arrived. At approximately 6:51 p.m., the Orange County Fire Authority (OCFA) received an emergency medical service call from John Doe 1, John Doe 2, and Jane Doe 1's residence on Nottingham Way. At approximately 6:54 p.m., OCFA personnel arrived at the Nottingham Way residence and observed McClure lying in the hallway of the apartment with several OCSD deputies performing cardio pulmonary resuscitation (CPR) on McClure. McClure was unconscious, not breathing, and had a faint pulse.

OCFA personnel relieved the OCSD deputies and initiated Advanced Life Saving measures, continued CPR, and connected a heart monitor to McClure. The heart monitor did not suggest a shock and no shock from an Automatic External Defibrillator was initiated. An Intraosseous Line was established in McClure's right upper leg, through which he was administered a 1- milligram dose of Epinephrine and a 1-milligram dose of Naloxone (Narcan). There was no change in McClure's condition as a result of the administration of the Epinephrine and Naloxone. An Oropharyngeal airway and Bag Valve Mask were used to open McClure's airway and assist with the administration of oxygen.

At approximately 7:07 p.m., the advanced life saving measures failed to establish any signs of life. Based on the lack of signs of life as well as witness statements that McClure had not been seen in a conscious state for an extended period of time, OCFA personnel proclaimed McClure deceased.

AUTOPSY

On Dec. 26, 2014, a post-mortem examination of McClure was conducted by Forensic Pathologist Scott Luzi. The forensic pathologist conducted an extensive examination of the body and found no major or life threatening injuries. The forensic pathologist did observe a 1-centimeter subgaleal hemorrhage of the left parietal scalp and a 0.5-centimeter potential subarachnoid hemorrhage over the left parietal cerebrum. There were no skull fractures or other cerebral hemorrhaging due to the injuries. Following the autopsy, the forensic pathologist was unable to determine the preliminary cause of death. The results of the forensic pathologist's postmortem examination were inconclusive, pending further microscopic and toxicological examinations. After microscopic and toxicological results were received and examined, the forensic pathologist determined McClure's death was accidental resulting from multiple drug intoxication.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of McClure's postmortem blood was collected for testing. The blood was examined for the presence of drugs and alcohol. The following results and interpretations were documented:

DRUG	MATRIX	RESULTS & INTERPRETATIONS
Methamphetamine	Postmortem Blood	2.83 +/- 0.19 mg/L
Methamphetamine	Brain	8.69 +/- 0.057 mg/kg
Amphetamine	Postmortem Blood	0.132 +/- 0.009 mg/L
Amphetamine	Brain	0.392 +/- 0.025 mg/kg
Morphine (Free)	Postmortem Blood	0.0449 +/- 0.0045 mg/L
Morphine (Free)	Brain	0.0387 +/- 0.0039 mg/kg

BACKGROUND INFORMATION

McClure had a California Criminal History Record that revealed arrests including possession of a controlled substance/paraphernalia, driving under the influence/alcohol, and a probation violation.

THE LAW

Homicide is the killing of one human being by another. Murder, voluntary manslaughter, and involuntary manslaughter are types of homicide. To prove that a person is guilty of murder, the following must be proven:

a. The person committed an act that caused the death of another human being;
b. When the person acted he/she had a state of mind called malice aforethought; and
c. He/she killed without lawful excuse or justification.

There are two kinds of malice aforethought, express malice and implied malice. Express malice is when the person unlawfully intended to kill. Implied malice requires that a person intentionally committed an act, the natural and probable consequences of the act were dangerous to human life, at the time he/she acted he/she knew his/her act was dangerous to human life, and he/she deliberately acted with conscious disregard for human life.

A person can also commit murder by his/her failure to perform a legal duty, if the following conditions exist:

a. The killing is unlawful (*i.e.*, without lawful excuse or justification);
b. The death is caused by an intentional failure to act in a situation where a person is under a duty to act;
c. The failure to act is dangerous to human life; and
d. The failure to act is deliberately performed with knowledge of the danger to, and with conscious disregard for, human life.

A person can also commit involuntary manslaughter by failing to perform a legal duty, if the following conditions exist:

a. The person had a legal duty to the decedent;
b. The person failed to perform that legal duty;
c. The person's failure was criminally negligent; and
d. The person's failure caused the death of the decedent.

In *Giraldo v. California Dept. of Corrections and Rehabilitation* (2008) 168 Cal.App.4th 231, 250-251, the court held that there is a "special relationship" between jailer and prisoner:

> "The most important consideration 'in establishing duty is foreseeability.' [citation] It is manifestly foreseeable than an inmate may be at risk of harm.... Prisoners are vulnerable. And dependent. Moreover, the relationship between them is protective by nature, such that the jailer has control over the prisoner, who is deprived of the normal opportunity to protect himself from harm inflicted by others. This, we conclude, is the epitome of a special relationship, imposing a duty of care on a jailer owed to a prisoner, and we today add California to the list of jurisdictions recognizing a special relationship between jailer and prisoner."

California Government Code 845.6 codifies that the special relationship that exists in a custodial setting gives rise to a legal duty, as follows:

> "A public employee, and the public entity where the employee is acting within the scope of his employment, is liable if the employee knows or has reason to know that the prisoner is in need of immediate medical care and he fails to take reasonable action to summon such medical care."

Criminal negligence involves more than ordinary carelessness, inattention, or mistake in judgment. A person acts with criminal negligence when he acts in a reckless way that creates a high risk of death or great bodily injury and a reasonable person would have known that acting in that way would create such a risk. In other words, a person acts with criminal negligence when the way he acts is so different from how an ordinarily careful person would act in the same situation that his/her act amounts to disregard for human life or indifference to the consequences of that act.

An act causes death if the death is the direct, natural, and probable consequence of the act and the death would not have happened without the act. A natural and probable consequence is one that a reasonable person would know is likely to happen if nothing unusual intervenes. There may be more than one cause of death. An act causes death only if it is a substantial factor in causing the death. A substantial factor is more than a trivial or remote factor; however, it does not need to be the only factor that causes the death.

LEGAL ANALYSIS

In the present case, there is no evidence whatsoever of express or implied malice on the part of any OCSD personnel or any inmates or other individuals under the supervision of the OCSD. Accordingly, the only possible type of homicide to analyze in this situation is murder or manslaughter under the theory of failure to perform a legal duty which caused the death of McClure.

The evidence does not show that the OCSD failed to perform a legal duty which caused McClure's death. Although the OCSD owed McClure a duty of care while he was in custody, McClure's death did not occur while he was in custody. McClure was released from custody on Dec. 15, 2014 and died on Dec. 22, 2014. Furthermore, McClure's death was not caused by any injuries he sustained from the incident that occurred while he was in custody on Nov. 10, 2014. During this incident, after McClure was secured, medical staff examined him immediately. McClure did not complain of a headache, dizziness or blurred vision and was able to sit in an upright position. At the completion of the examination, McClure was medically cleared for booking. After McClure's death, the forensic pathologist conducted an extensive examination of McClure's body and found no major or life threatening injuries. Microscopic and toxicological results allowed the forensic pathologist to conclude that McClure's death was accidental, caused by multiple drug intoxication. There is no evidence to suggest McClure ingested the drugs that caused his death while he was an inmate at the TLF and in the custody of OCSD. In fact, the evidence clearly indicates that McClure's person was searched for drugs and other paraphernalia several times by deputies during the booking

process. Moreover, McClure was out of custody for approximately seven days prior to his death, making it clear that McClure ingested the drugs that caused his death while he was out of custody.

CONCLUSION

Based on all the evidence provided to and reviewed by the OCDA, and pursuant to applicable legal principles, it is our conclusion that in connection with McClure's death, there is no evidence to support a finding of criminal culpability on the part of any OCSD personnel or any individual under the supervision of the OCSD. The evidence shows that McClure's death was accidental resulting from multiple drug intoxication after he was released from custody.

Accordingly, the OCDA is closing its inquiry into this incident.

Respectfully submitted,

JASON BAEZ
Senior Deputy District Attorney
Gangs Unit

Read and Approved by **EBRAHIM BAYTIEH**
Assistant District Attorney
Supervising Head of Court – Special Prosecutions Unit