OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

March 24, 2021

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

Re: Custodial Death on July 19, 2020
Death of Inmate Namjon Chu (AKA George James)
District Attorney Investigations Case # S.A. 20-018
Orange County Sheriff's Department Case # 20-023304 & 20-023369
Orange County Crime Laboratory Case # 20-47329
Orange County Coroner's Office # 20-03622-RZ

Dear Sheriff Barnes,

Please accept this letter detailing the Orange County District Attorney's Office's (OCDA) investigation and legal conclusion in connection with the above-listed incident involving the July 19, 2020, custodial death of 57-year-old inmate Namjon Chu (AKA George James).

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of James. In this letter, the OCDA describes the criminal investigative methodology employed, evidence examined, witnesses interviewed, facts discovered, and the legal principles applied to review the conduct of any Orange County Sheriff's Department (OCSD) personnel or any other person under the supervision of the OCSD in connection with this custodial death incident.

On July 19, 2020, OCDA Special Assignment Unit (OCDASAU) Investigators responded to the Orange County Global Medical Center where James died while in custody after receiving medical treatment at the hospital. During the course of this investigation, the OCDASAU interviewed 3 witnesses, as well as obtained and reviewed reports from the OCSD and Orange County Crime Laboratory (OCCL), incident scene photographs, hospital records, 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 any 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 an experienced deputy district attorney for legal review. Deputy district attorneys from the Homicide, Gangs, and Special Prosecutions Units review fatal and non-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 Senior Assistant District Attorney supervising the Operations IV Division of the OCDA, who will eventually review and approve any legal conclusions and resulting memos. The case may often be reviewed by several experienced prosecutors and their supervisors. The District Attorney personally reviews and approves all officer involved shootings and custodial death letters. If necessary, the reviewing prosecutor may send the case back for further investigation.

FACTS

On July 16, 2020 at around 12:15 a.m. Orange Police Department (OPD) and Orange Fire Department (OFD) responded to a medical aid call in the city of Orange. James was found supine on the sidewalk in the area of Chapman Avenue and Trails End. James had no visible injuries but told OPD and OFD personnel that he had broken all the bones in his body a year before. In addition, while speaking to OFD personnel, James expressed suicidal ideations. At around 12:49 a.m. James was admitted to Chapman Global Medical Center. James was stable, alert, had full range of motion, and was cleared by medical staff for suicide risk. At around 1:13 a.m., after James was medically cleared, he was arrested for an active felony parole hold per Penal Code 3056. At around 2:16 a.m. James was transported to Orange County Jail (OCJ) and booked into the Intake and Release Center. James was medically screened by an Orange County Health Care Agency (OCHCA) Mental Health Comprehensive Care Nurse and OCHCA Comprehensive Care Nurse. James denied suicidal ideations, denied any pre-existing medical conditions, denied previous drug use, and admitted to a history of depression. James' vitals were taken, and he had a blood pressure of 116/86 and a pulse of 94. James was assigned to Module K Sector 13 Cell 13 pursuant to OCJ Covid-19 protocols.

On July 18, 2020 at around 12:15 p.m. an OCHCA Medical Assistant (MA) and two deputies were preparing inmates for transportation from OCJ to Theo Lacy Facility when one of the deputies noticed that James looked unwell and that his face was swollen. According to the deputy, James' face was so swollen that it was beyond recognition compared to his identification card photo taken two days prior. According to an interview with the OCHCA MA, James' face was severely swollen, and the swelling was consistent on both sides of his face. The MA saw no contusions, abrasions, or lacerations that would be consistent with injuries suffered during an assault. James was able to speak and answer questions. James told the MA that he was feeling fine at the moment, but did not eat breakfast in the morning because he did not feel well. James also denied allergies, denied being

assaulted, and did not believe that his face was swollen. At around 12:40 p.m. James was taken back inside of the OCJ and examined by an OCHCA Registered Nurse (RN) alongside the MA who initially saw him. James' blood pressure, pulse, and mean arterial pressure were significantly down from his original booking.

On July 16, 2020, James had a blood pressure of 116/86, a pulse of 94, and a mean arterial pressure of 96. On this day, James had a blood pressure of 78/50, a pulse of 67, and a mean arterial pressure of 59.33. OCHCA medical staff immediately requested paramedics respond to the OCJ and for James to be transported to the Orange County Global Medical Center (OCGMC) due to the significant change in vitals. At around 12:50 p.m. paramedics from the Orange County Fire Authority (OCFA) arrived to the OCJ and examined James. According to OCFA personnel, James was conscious and alert. James was also displaying facial edema, was hypotensive, and was hypoglycemic. James reported that he had not been hit, stung, or bitten by anything, or eaten anything unusual. James did not complain of any assaults or problems with jail staff or inmates. OCFA personnel took his blood pressure and it was 80/61. James' blood sugar was at 49, the normal being approximately 80 to 120. OCFA gave James 25 grams of dextrose 10% solution intravenously for the low blood sugar and at around 1 p.m. transported James to OCGMC by ambulance.

At approximately 1:16 p.m. James arrived to OCGMC and a computed tomography (CT) scan was done. The CT scan showed that James was suffering from ascites, significant abdominal buildup of fluid in the abdomen, often associated with heart and/or liver disease. At around 4 p.m., James was transferred to the Critical Care Unit within OCGMC. His condition was continually monitored by OCGMC personnel. At around 8:30 p.m., James had a bowel movement and was cleaned up by an OCGMC RN. The OCGMC RN explained that James was cleaned, conscious, and alert. At around 10:30 p.m. James was checked on by an RN again. According to the RN, James was able to recite his name and he was aware that he was at the hospital. At around 11:39 p.m. an RN went into James' room to monitor his condition. The RN found that James was unresponsive and had a blood pressure of 60. According to the RN, James' name was yelled out and he opened his eyes, but he did not verbally respond. James' breathing was agonal, and his pulse was weak. James was administered leveophed for his low blood pressure. At around 11:42 p.m. the RN called a code blue. A code blue is common hospital code that indicates a medical emergency such as a cardiac or respiratory arrest. James was intubated and chest compressions were started. James went into ventricular fibrillation five times and was shocked and resuscitated four times. James was also given the maximum amount of epinephrine, bicarbonate calcium, leveophed, and dopamine as part of the life saving measures.

On July 19, 2020 at around 12:34 a.m. the attending physician determined medical intervention was futile and pronounced James deceased.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- 44 Color Digital Photographs
- Fingernail Scrapings
- Swab of Hands
- Heart Blood Standard
- 60 Post-Mortem Color Digital Photographs

AUTOPSY

On July 24, 2020, independent Forensic Pathologist Dr. Scott Luzi of Clinical and Forensic Pathology Services conducted an autopsy on the body of James. Dr. Luzi noted that there were no significant

signs of trauma. Dr. Luzi concluded that the cause of death was pulmonary embolism, with a finding of congestive heart failure associated with hypertensive and atherosclerotic cardiovascular disease.

EVIDENCE ANALYSIS

Toxicological examination

A sample of James' postmortem blood was examined for the presence of drugs and alcohol. No illicit drugs or alcohol were detected. The blood yielded the following results:

DRUG	POSTMORTEM BLOOD
9-Hydroxyrisperidone	Detected
Atropine	Detected
Caffeine	Detected
Etomidate	Detected
Lidocaine	Detected

BACKGROUND INFORMATION

James had a State of California Criminal History record that revealed arrests dating back to 2008 for the following violations:

- Indecent Exposure
- Manufacture/Possession of a Dangerous Weapon
- Injure Railroad/Railroad Bridge
- Trespass
- False Identification to a Peace Officer
- Under the Influence of a Controlled Substance
- Fail to Pay Fare
- Vandalism
- Assault with a Deadly Weapon
- Battery on a Transportation Personnel/Passenger
- Petty Theft with a prior
- Burglary, Second Degree
- Disorderly Conduct: Under the Influence of Drugs
- Obstruct Public Officer
- Robbery
- Throw Substance at a Vehicle with Great Bodily Intent

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 that 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/she 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 this 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.

Although the OCSD owed James a duty of care, the evidence does not support a finding beyond a reasonable doubt that this duty was in any way breached, either intentionally or through criminal negligence. Rather, review of OCJ records and all other relevant evidence reveals that OCSD personnel consistently exercised reasonable care. James was medically cleared by OCHCA staff and he denied any pre-existing medical conditions and denied previous drug use, OCJ staff noticed James looked unwell and immediately James was examined by a RN, James was seen by the OCFD and promptly taken to OCGMC, and his condition was constantly monitored while he was at OCGMC. Based on the totality of all the available evidence, it is our conclusion that OCSD personnel conducted their duties in a reasonable manner and responded effectively and appropriately regarding James' quick deterioration in health while he was under OCJ supervision.

The evidence also support the conclusion that OCJ personnel could not have foreseen that James' health would deteriorate so quickly after his admittance to the jail. When James was admitted to OCJ on July 16, 2020 his blood pressure was normal, his pulse was normal, he denied any pre-existing medical conditions and denied any previous drug use. All OCJ staff knew of James was that he had a history of depression. On July 18, 2020, when a deputy noticed that James' face was swollen, OCJ staff immediately cared for and assessed the well-being of James. James was seen by an OCHCA RN, had his vitals checked, and they found his blood pressure, pulse, and mean arterial pressure significantly low. OCJ staff notified OCFD and once OCFD personnel arrived to OCJ, they conducted further tests on James. After conducting the tests, OCFD took James to OCGMC due to his significant change in vitals. Once James arrived to OCGMC, medical personnel checked on his well-being consistently throughout the day and night. In every instance, medical personnel and OCSD personnel ensured James' health issues were being reasonably treated, and he seemed to be cared for appropriately.

The evidence supports the conclusion that OCSD did not fail to perform a legal duty, nor can their actions be classified as criminally negligent. In order for the OCDA to file criminal charges relating to James' death, we must be able to prove beyond a reasonable doubt criminal culpability, including causation as described above. The OCDA is not able to meet this burden of proof based on all the available evidence. All efforts taken by OCSD were reasonable based on the known circumstances. Additionally, James' death was not the result of any act, or failure to act, by OCSD personnel. Thus, there is no evidence whatsoever to support a finding that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty.

CONCLUSION

Based on all the evidence provided to and reviewed by the OCDA, and pursuant to applicable legal principles, it is our conclusion that there is no evidence to support a finding that any OCSD personnel or any individual under the supervision of the OCSD failed to perform a legal duty causing the death of James. The evidence support the conclusion that James died as a result of pulmonary embolism.

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

Respectfully submitted,

Anna McIntire

ANNA MCINTIRE
Deputy District Attorney
Gangs Unit

Read and Approved by **EBRAHIM BAYTIEH**
Senior Assistant District Attorney
Felony Operations IV

Read and Approved by DISTRICT ATTORNEY **TODD SPITZER**