OFFICE OF THE
DISTRICT ATTORNEY
ORANGE COUNTY, CALIFORNIA
TODD SPITZER

April 29, 2021

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

Re: Custodial Death on May 18, 2020
Death of Inmate Michael Lane Gilreath
District Attorney Investigations Case # SA 20-013
Orange County Sheriff's Department Case # 20-015819
Orange County Crime Laboratory Case # FR 20-44981

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 May 18, 2020, custodial death of 61-year-old inmate Michael Lane Gilreath.

OVERVIEW

This letter contains a description of the scope and the legal conclusions resulting from the OCDA's investigation of the custodial death of Gilreath. 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 May 18, 2020, OCDA Special Assignment Unit (OCDASAU) Investigators responded to Theo Lacy Jail Facility (TLF), where Gilreath died while in custody. During the course of this investigation, the OCDASAU interviewed eight 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 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 cases and letters. If necessary, the reviewing prosecutor may send the case back for further investigation.

DISCLOSURE OF OFFICER-INVOLVED SHOOTING VIDEO & AUDIO EVIDENCE

The OCDA recognizes that releasing video and audio evidence of officer-involved shooting and custodial death incidents can assist the public in understanding how and why these incidents occur, increase accountability, and build public trust in law enforcement. Consistent with the OCDA's written policy in connection with the release of video and audio evidence relating to officer-involved shooting and custodial death incidents where it is legally appropriate to do so, the OCDA is releasing to the public video/audio evidence in connection with this case. The relevant video/audio evidence is available on the OCDA webpage http://orangecountyda.org/reports/videoandaudio/default.asp.

FACTS

On April 26, 2020, Newport Beach Police Department (NBPD) arrested Gilreath for burglary, attempted burglary, and for being a felon in possession of ammunition. On April 27, 2020, at approximately 2:38 a.m., NBPD transported Gilreath to the Orange County Jail (OCJ) to be housed pending his court appearance. As with all new inmates entering the jail system, Gilreath was quarantined prior to being placed into the general population due to COVID-19 precautions. On May 1, 2020, Gilreath was transferred to the Theo Lacy Facility (TLF) and remained in quarantine with other new inmates.

On May 11, 2020, it was discovered that Gilreath's cellmate tested positive for COVID-19. Gilreath was tested and moved to a higher quarantine section of the facility located in Sector 58, Cell 10. Sector 58 was designed for inmates who previously had, currently had, or had been exposed to COVID-19 and were awaiting test results. An interview with an inmate, who was housed directly next to Gilreath on May 15, 2020, described Gilreath as quiet, kept to himself, and only interacted with the deputies to be let in and out of his cell. That inmate did not know whether Gilreath was suicidal.

On May 18, 2020, at approximately 11:00 a.m., Gilreath was removed from his cell to participate in a video court hearing. He returned to his cell at approximately 12:00 p.m. At approximately 12:19 p.m., the video surveillance camera recording in Sector 58, captured Gilreath interacting with OCSD Deputy Trong Dinh. Gilreath was the only inmate in his cell and the cell door was closed. As part of a safety check that is done at the top of every hour, Deputy Dinh stopped at Gilreath's cell and provided him with commissary paperwork. Gilreath stood at the cell door, looked out, then walked to the back of the cell. Video surveillance shows that Gilreath could be seen moving within the cell until approximately 12:26 p.m.

At approximately 1:18 p.m., Deputy Dinh walked past Gilreath's cell as he was conducting the hourly safety check. Deputy Dinh saw what appeared to be Gilreath standing toward the back of his cell, near the bunk beds, facing the back corner of the cell. Deputy Dinh found Gilreath's motionless position to be odd and walked back to the cell to get a better view. Once he got a better look, Deputy Dinh saw Gilreath leaning forward with his knees bent and a bed sheet tied around his neck. Deputy Dinh immediately notified the Guard Station tower to remotely unlock the cell door and send additional deputies. Deputy Dinh entered the cell, held Gilreath's body up, and loosened the bed sheet from the bunk and placed Gilreath on the floor. Deputy Dinh immediately began performing cardiopulmonary resuscitation (CPR) on Gilreath. Deputy Dinh noted that Gilreath's body was cold to the touch and unresponsive. Shortly thereafter, Deputy Malenofski arrived and took over chest compressions. Deputy Malenofski saw that Gilreath's eyes were open and vomit was running down the side of his face. Deputy Dinh and Deputy Malenofski rotated performing chest compressions on Gilreath several times until jail medical staff arrived. Deputy Malenofski cut the ligature (bed sheet) from Gilreath's neck.

The attending Registered Nurse (RN) arrived and saw that CPR was being performed. The RN assisted by applying the Automated External Defibrillator (AED) on Gilreath. The AED alerted, "no shock advised." The RN checked the carotid for a pulse and did not find one, but the RN noticed Gilreath's chest was not rising. The RN suspected that Gilreath may have overdosed and administered one dose of Narcan to Gilreath, but there was no change in Gilreath's condition. The RN noted at no point was Gilreath responsive or alert.

At approximately 1:22 p.m., Orange Fire Department (OFD) Truck 6 (OT6) and Rescue (OR6) were dispatched to TLF for medical aid. OT6 and OR6 consisted of 5 Firefighter/Paramedic personnel. At approximately 1:28 p.m., firefighters arrived at the cell and asked the deputies to move Gilreath out of the cell to provide more space for them to work. Deputy Dinh and Deputy Malenofski moved Gilreath out of the cell and continued chest compressions. Paramedics took over CPR and placed Gilreath on a Zoll monitor. The first Zoll monitor reading showed that Gilreath was asystole. An Intraosseous line (IO) was placed into the right tibia and Gilreath was given saline and epinephrine. Gilreath had no reaction and remained asystole. After consulting with UCI medical staff, OFD pronounced Gilreath deceased at 1:49 p.m.

EVIDENCE COLLECTED

The following items of evidence were collected and examined:

- Two sheets tied together from upper bunk frame
- Strips of fabric tied together wet with brown liquid
- Clothing from decedent
- White shirt wet with brown liquid
- Bloodstain standard
- 67 Autopsy Photos
- 19 Post Embalming Photos

- 124 OCCL Scene Photos
- 14 OCCO Scene Photos

AUTOPSY

On May 28, 2020, independent Forensic Pathologist Dr. Scott Luzi conducted an autopsy on the body of Gilreath. On October 15, 2020, Dr. Luzi issued his final findings in the death of Gilreath. Dr. Luzi determined the cause of death as hanging and the manner of death as suicide.

EVIDENCE ANALYSIS

Toxicological Examination

A sample of Gilreath's postmortem and antemortem blood yielded the following results:

DRUG	Postmortem Blood	Antemortem Blood
Caffeine	Detected	N/A
Naloxone	Detected	N/A

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/she 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 the present case, there is no evidence 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 Gilreath a duty of care, the evidence does not support a finding that this duty was in any way breached, either intentionally or through criminal negligence. It was not foreseeable that Gilreath would take his own life while he was in custody, or that he was even contemplating suicide. When OCSD obtained custody of Gilreath, OCSD did not have any reason to know that Gilreath was suicidal. Gilreath did not act out of the ordinary at any point in time to signal that anything was wrong or that he required special attention. According to one inmate, Gilreath was quiet and did not talk to other inmates. Nothing gave rise to an indication to OCSD that Gilreath would take his own life.

Because Gilreath was exposed to COVID-19, OCSD provided the proper care to Gilreath by testing him and housing him in a special quarantine unit until his test results were obtained. While Gilreath was housed in this unit, routine safety checks were conducted on the inmates at the top of every hour. On May 18, 2020, at approximately 12:19 p.m., when Deputy Dinh handed Gilreath his commissary paperwork, there was nothing about their interaction to lead Deputy Dinh to suspect that Gilreath would take his own life. Gilreath did not reach out to Deputy Dinh with any concerns and Gilreath did not display any signs out of the ordinary.

While video surveillance shows that there was no movement coming from Gilreath's cell starting at approximately 12:26 p.m., Gilreath was in a position in his cell where it was unreasonable to see on the video surveillance what he was doing. Lack of movement alone would not give rise to any suspicion that Gilreath would commit suicide. Deputy Dinh noted that it is typical for inmates to be sleeping when they cannot be seen by deputies from the Guard Station tower.

On the next round of safety checks, at approximately 1:18 p.m., Deputy Dinh walked past Gilreath's cell, looked inside for a moment, walked a few steps further, then walked right back to Gilreath's cell because he had a feeling something was not right. When he checked again, Deputy Dinh saw Gilreath facing the corner in a slumped manner and immediately notified the Guard Station tower to open Gilreath's cell door. As soon as Deputy Dinh entered, he grabbed ahold of Gilreath's body, loosened the bed sheet that was tied to Gilreath's neck, brought him down to the ground, began chest compressions, and called for the medical staff. Additional OCSD deputies and jail medical staff arrived within minutes. Medical staff applied the AED and administered Narcan to Gilreath, both of which were to no avail. Afterwards, paramedics arrived and ran an Intraosseous line to his right tibia to try and save him, but there was no response.

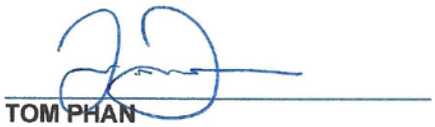
Accordingly, OCSD did not breach its legal duty of care that it owed to Gilreath because it was not foreseeable that Gilreath would take his own life. While Gilreath was quiet and kept to himself, OCSD did not have any reason to know that Gilreath would commit suicide. Because Gilreath was exposed to COVID-19, OCSD tested and moved him to a special unit out of precaution for his health and safety. OCSD followed the proper jail protocol by providing routine safety checks at the top of every hour. Gilreath did not request medical assistance or display any signs or symptoms of someone contemplating suicide. Once it was noticed he was in an unusual position in his cell, OCSD personnel took immediate action by providing CPR and summoned additional medical staff. OCSD deputies, jail medical staff, and OFD paramedics took every measure in attempts to rescue and revive Gilreath. Therefore, OCSD did not fail to act, act recklessly, or act with gross negligence to cause Gilreath's death. For these reasons, the OCDA will not be able to prove beyond a reasonable doubt that OCSD breached its legal duty of care it owed to Gilreath.

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 Gilreath. The evidence shows that Gilreath died as a result of hanging and that the manner of death was a suicide.

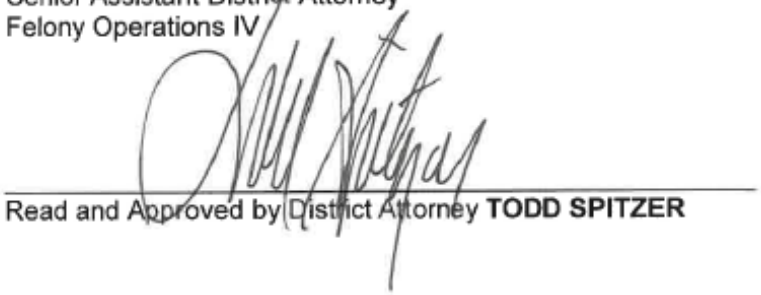
Accordingly, the OCDA is closing its inquiry into this incident.

Respectfully submitted,



TOM PHAN
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**